St Helens and Knowsley Teaching Hospitals NHS Trust

# Patient Access Policy

**Version No 10**

**Document Summary:**
This policy applies to all staff involved in the management of patient access. The policy will outline good practice, key principles and identifies the roles and responsibilities of the Trust and its staff in relation to waiting time management.

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|---|---|---|
| **Document status** | Approved | |
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| **Accountable Director** | Director of Operations & Performance | |
| **Policy Author** | Assistant Director of Operations Clinical Support Services | |
| **Target audience** | All staff | |

**The intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as "uncontrolled," as they may not contain the latest updates and amendments**

# Document Control

**[Author to complete all sections apart from Section 4 & 5]**

## Section 1 – Document Information

| | |
|---|---|
| **Title** | Patient Access Policy |
| **Directorate** | Operations |

**Brief Description of amendments**

Review of policy and update on new processes and procedures in line with local and national requirements

***Please state if a document has been superseded.***

| | |
|---|---|
| **Does the document follow the Trust agreed format?** | Yes |
| **Are all mandatory headings complete?** | Yes |
| **Does the document outline clearly the monitoring compliance and performance management?** | Yes |
| **Equality Analysis completed?** | Yes |

## Section 2 – Consultation Information

| | | | |
|---|---|---|---|
| **Consultation Completed** | ☐ Trust wide ☐ Local ☑ Specific staff group | | |
| **Consultation start date** | 01/07/2020 | **Consultation end date** | 14/07/2020 |

## Section 3 – Version Control

| Version | Date Approved | Brief Summary of Changes |
|---|---|---|
| 9 | 04/09/2020 | Review of policy post Covid, with amendments made throughout to reflect the changes required |
| 8 | 01/07/2019 | Review of policy, incorporating new processes and policy related to Medway |
| 7 | 19/07/2018 | Validation of active monitoring or patients, review of no capacity patients, amendments of eRS \Paper Switch Off process |
| 6 | 01/10/2017 | Clinicians to review state of clinics. Reasonable notice for cancer patients |
| 5 | 13/04/2016 | Amendments in line with new RTT guidance |
| 4 | 28/10/2015 | Update in line with new RTT guidance |
| 3 | 02/01/2012 | Update in line with new performance monitoring. New terminology. Addition of planned waiting list management<br>Managing patients who have breached 18 weeks. Update on DNA procedure. Update on departmental SOPs. Inclusion of range of standards for DQ audits |

| Section 4 – Approval – *To be completed by Document Control* | | | |
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| **Document Approved** | ☑ Approved ☐ Approved with minor amendments | | |
| **Assurance provided by Author & Chair** | ☐ Minutes of Meeting ☑ Email with Chairs approval | | |
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|---|

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|---|---|
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| **Date Withdrawn:** | Click here to enter a date. |

# Contents

## 1. Scope

The Trust is committed to delivering high quality and timely elective care to patients. This policy sets out the rules and principles under which the Trust manages all patients requiring access to outpatient appointments, elective inpatient treatment, elective day case treatment and diagnostic tests consistently.

## 2. Introduction

St Helens and Knowsley Teaching Hospitals NHS Trust is committed to ensuring that patients receive treatment in accordance with national rules and targets.

Since Covid 19 March 2020 performance against national access targets has been monitored but not managed against. Restoration plans are in place. The priority remains the safety of patients and staff and as a result this policy has been adapted to reflect the necessary changes at a local and national level although the principles of patient access remain.

The Patient Access Policy sets out the Trust's local access policy and takes account of guidance from NHS England. This policy is intended to support a maximum wait of 18 weeks from referral to first definitive treatment and is designed to ensure fair and equitable access to hospital services.

A quarterly review of national mandated guidance will be completed, and any new changes applied as an appendix to the policy for distribution. This policy will be reviewed and updated annually or earlier if there are national rule changes or changes to Trust processes.

This policy should be read in full by all applicable staff once they have had and successfully completed the relevant elective care training. It should not be read in isolation as a training tool.

Implementation of this policy and associated standard operating procedures ensures that the Trust complies with all directives. The overall aim of the policy is to ensure patients are treated in a safe, timely and effective manner, specifically to:

- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.
- Reduce waiting times for treatment and to ensure patients are treated in accordance with agreed targets.
- Reduce the number of cancelled operations for non-clinical reasons.
- Allow patients to maximise their right to patient choice in the care and treatment that they need.
- Increase the number of patients with a booked outpatient or in-patient / day case appointment, thereby minimising Did Not Attends, (DNA's), cancellations, and improving the patient experience.
- Patient Access is delivered in a safe environment that is compliant with infection control and national and local guidance and legislation regarding social distancing
- Ensure shielded patients are managed in line with national and local guidance

The purpose of this policy is to include locally and nationally agreed standards for access to care, including details of those patients excluded from the national Referral to Treatment standards. Additionally, it will include key definitions to guide staff in understanding the rules and their application. However, the Standard Operating Procedures (SOPs) will provide staff with the operational guide to manage these standards.

All clinical and non-clinical staff must ensure they comply with both principles within this policy and the specific instructions with the following key Standard Operating Procedures, these documents are listed in Appendix 1 and can be located on the St Helens and Knowsley Teaching Hospitals NHS Trust shared folders and accessed via the following link: **Trust1\groups\GM\shared\SOP's** or via the intranet policy pages

This policy should also be read and followed in conjunction with the subsequent National and Trust Policies:

- Private Patients and Overseas Policy (Trust Intranet)
- Procedures of Lower Clinical Priority Policy (PLCP) (Trust1\groups\GM\shared\SOPs)
- Criteria Based Clinical Treatments Policy (CBCT) (Trust1\groups\GM\shared\SOPs
- Covid guidance available via intranet pages

## 3. Statement of Intent

The policy has been developed to ensure the Trust provides a consistent, equitable and fair approach to the management of patient referrals and admissions that meets the requirements of the National waiting time standards and the commitments made to patients in the NHS Constitution.

The NHS Constitution sets out the following right for patients:

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

This means patients have the right to start Consultant or Allied Health Professional (AHP) led treatment within a maximum of 18 weeks from referral and be seen by a specialist within a maximum of 2 weeks of GP referral for suspected cancer or where this is not possible, for the NHS to take all reasonable steps to offer the patient a quicker appointment at a range of alternative providers if the patient makes such a request. This constitution came into force for patients referred on or after 1st April 2010.

The NHS Constitution also sets out responsibilities of patients including responsibility to attend appointments. According to the constitution, patients

*'Should keep appointments or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless patients observe this important practice.' (Ref: Section 3b of the NHS Constitution – http://www.gov.uk)*

This policy sets out how the Trust will manage the access of patients in line with these principles.

## 3.1 Waiting Times

Waiting times for Consultant/ AHP led elective treatment and urgent cancer referrals are already covered by existing operational standards. The Department of Health (DH) have set out a sole measure of patient's constitutional rights to start treatment within 18 weeks:

- 92% of patients on an incomplete pathway have waited less than or up to 18 weeks.

To sustain the delivery of this standard, the Trusts will need to ensure that 92 per cent of patients on an incomplete pathway should have been waiting no more than 18 weeks, meaning that the backlog must only account for up to 8% of total incomplete pathways. However, the Trust will ensure that all patients breaching their 18-week RTT times across any of the above indicators are managed appropriately in line with the NHS Constitution. In addition, less than 1 per cent of patients should wait longer than six weeks for a diagnostic test (Ref: Everyone Counts: Planning for Patients 2014/15 to 2018/19 – http://www.england.nhs.uk) *(Please see section 6.3, Diagnostic Waiting List Management).*

RTT performance during and post Covid has dropped below the national 92% standard nationally creating backlogs of patients. The aim of the trust is to return to previous performance but will adhere to the principles of dating patients in priority and chronological order.

## 3.2 Cancer Timescales

The maximum wait for a first outpatient appointment or interaction for patients referred by GPs via a Cancer Fast Track Referral Pro-forma is 2 weeks (14 days). Patients referred from an urgent 2-week GP referral should not wait longer than 62 days to first definitive treatment or 31 days from the decision to treat, whichever date is earliest.

The maximum wait for all cancer patients from the date of decision to treat (date patient agrees treatment plan with Clinician), to the first definitive treatment should be no more than 31 days.

### 3.2.1 Cancer Performance Measures

**NHS Constitution Measures**

| Measure | Operational Standard |
|---|---|
| Two Week Wait – Urgent GP Referral for Suspected Cancer | 93% |
| Two Week Wait – Referral with Breast Symptoms | 93% |
| 31 Day – Decision to Treat (DTT) to First Treatment | 96% |
| 31 Day – Subsequent Treatment (Surgery) | 94% |
| 31 Day – Subsequent Treatment (Drug Treatment) | 98% |
| 31 Day – Subsequent Treatment (Radiotherapy) | 94% |
| 31 Day – Urgent GP Referral to Treatment *(Leukemia, Testicular, Children's Cancer)* | 85% |
| 62 Day – Urgent GP Referral to Treatment | 85% |
| 62 Day – Screening to Treatment *(Bowel, Cervical & Breast)* | 90% |
| 62 Day – Consultant Upgrade *(Monitored but no National Standard)* | No Operational Standard Set |

## 4. Definitions

| Definition | Meaning |
|---|---|
| **Active Monitoring** | A waiting time 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. A new waiting time clock would start when a decision to treat is made following a period of active monitoring (also known as watchful waiting). 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 stops a waiting time clock. If a patient is subsequently referred to a consultant-led service, then this referral starts a new waiting time clock. |
| **Active Waiting List** | All patients awaiting elective admission for treatment, first outpatient appointment or diagnostic test, whether dated or undated |
| **Admitted Pathway** | A pathway that ends in a clock stop for admission (day case or inpatient) |
| **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 appointment but will take overall clinical responsibility for patient care. |
| **Day Case** | Patients who require admission to hospital for treatment but who are not intended to stay in hospital overnight and are discharged home on the same day. |
| **Decision to Admit** | Where a clinical decision is taken to admit the patient for either day case or inpatient treatment. |
| **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, for example, as an outpatient. |
| **Did Not Attend (DNA)** | Patients who agreed their admission date (inpatients/ day cases / diagnostics) or appointment date (outpatients) and who, without notifying the hospital, did not attend for admission/ appointment |
| **Directly Booked Patients** | Patients who have booked their outpatient appointment via E-Referral Service. |
| **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 judgement, in consultation with others as appropriate, including the patient. |
| **Fit and ready (in the context of bilateral procedures)** | A new RTT 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. |
| **Inpatients** | Patients who require admission to hospital for treatment and are intended to remain in hospital for at least one night and stay overnight. |
| **NHS e-Referral Service (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. |
| **Non-Admitted Pathway** | A pathway that results in a clock stop for treatment that does not require an admission. |

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| **Non-Responders** | Patients who have been invited to contact the Trust to agree a date for |

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| | admission, an outpatient consultation, or a diagnostic event, as part of a partial booking process, and have failed to contact the hospital within the agreed time. |
| **Outpatients** | Patients referred by a general medical or dental practitioner, another consultant or relevant health professional for clinical advice or treatment. |
| **Partially Booked Patients** | *(Inpatients, Day cases and Outpatients)* Patients who have been given the opportunity to agree a date for their elective admission or appointment after 1 working day of the decision to refer or treat. |
| **Patient Tracking List (PTL)** | A prospective reporting system to review patients / associated information about when they will breach and how they are managed within the waiting time standards |
| **Planned Care (Surveillance) Admissions** | An appointment /procedure or 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. |
| **Priority Patients** | Patients who are deemed clinically a priority over routine patients by the Clinician or the nature of their procedure or diagnostic. This includes patients added to a waiting list for cancer treatment and diagnostics. |
| **Prisoners** | All elective standards and rules are applicable to prisoners. Delays to treatment incurred because of difficulties in prison staff being able to escort patients to appointments or treatment do not affect the recorded waiting time for the patient. The Trust will work with staff in prison to minimise delays through clear communication and be offering a choice of appointment or admission in line with reasonable notice criteria. |
| **Reasonable Offer** | An offer that is reasonable where the offer for an outpatient appointment or an offer of admission is for a time and date three or more weeks from the time that the offer was made. Diagnostic reasonable offer is 7 days. The Trust should seek to fulfil "reasonableness" criteria when offering patients appointments for diagnostic tests/procedures. You can offer appointments that do not fulfil the reasonableness criteria where it is in the clinical best interest of the patient. |
| **Reinstatement** | If a patient previously referred to the trust is removed for reasons other than treatment, and the GP contacts the trust to reinstate their journey the trust does not require a new referral from the GP or other referrer if the referral letter is less than 3 months old or within 3 months of listing for surgery. The 18-week clock starts from the date the patient contacts the hospital to reinstate (locally agreed). |
| **Referral to Treatment Period** | An RTT period is the time between a person's referral to a consultant-led service, which initiates a clock start, and the point at which the clock stops for any of the reasons set out in the RTT national clock rules, for example the start of first definitive treatment or a decision that treatment is not appropriate. |
| **Resume Active Monitoring** | A new 18-week clock would start when a decision to treat is made following a period of watchful waiting/active monitoring. |
| **Tertiary Referrals** | Patients referred by another clinician, either within the Trust or another Hospital, for clinical advice or treatment. |
| **Waiting List Administrator (WLA)** | A clerk or receptionist who manages the day-to-day administration of the waiting lists. |

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| **War Pensioner / Military Veterans** | All veterans are entitled to priority access to NHS hospital care for any condition if it's related to their service and subject to the clinical need of others.<br><br>When referring a patient who is known to be an armed forces veteran, GPs have been asked to consider if the condition may be related to the patient's Military Service. If the GP decides that a condition is related to |

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| | Service any referral for treatment should make this clear. It is for the hospital clinician in charge to determine whether a condition is related to Service and to allocate priority. Where hospital clinicians agree that a veteran's condition is likely to be Service-related, they have been asked to prioritise veterans over other patients with the same level of clinical need. However, veterans will not be given priority over patients with more urgent clinical needs. |

# 5. Duties, Accountabilities and Responsibilities

This section outlines the key responsibilities of key groups of staff within the Trust in relation to this policy. The list is not exhaustive, and each group will have other roles and responsibilities that are not listed here. Specific tasks are included in the Standard Operating Procedures (SOPs).

## 5.1 Chief Executive

The Chief Executive has overall responsibility for delivering access targets as defined in the NHS Plan, NHS Constitution, and current Operating Framework.

## 5.2 Director of Operations and Performance

Board level responsibility lies with the Director of Operations and Performance, who is responsible for ensuring that there are robust systems in place for the audit and management of access targets. These will be monitored and reported to the board. The Director of Operations will ensure this patient access policy is implemented and adhered to. The Director of Operations (or Deputy) will monitor Patient Access via the weekly PTL meeting and review all external reports for verification. Response DM SOPS ISG – proposal signed off

## 5.3 Director of Informatics

Responsible for ensuring that there are robust, reliable and valid data collection systems and appropriate training for key staff in place to support the audit, management and delivery of access standards. Responsibility for achieving quality and performance indicators lies with the Directorates. Responsible for the facilitation of Clinic Template management within the EPR, in receipt of relevant data and sign-off from Specialty Directorate Managers, Information and Reporting Departments

## 5.4 Assistant Director of Operations (ADO)- CSS

Is responsible for administering the Patient Access Policy and for the administration and governance of the Standard Operating Procedures in Patient Booking Services (Appointments and Receptions), and Outpatient Clinics.

## 5.5 Assistant Director of Information (Finance Department)

Is responsible for administering data required for managing and reporting waiting list activity and ensuring there is a robust Standard Operating Policy for the external reporting of performance and that Data Quality Audits are produced and policed.

## 5.6 Information Management & Technology (IM&T)

Responsibility of the IT Training Manager is to ensure IT system training is aligned and the training solution meets the operational needs and requirements. This is in accordance with Training Service

Accreditation Standards (TSA) to ensure the following of good practice and the quality of the training delivery and all related activities including governance, documentation and system updates are of a high standard.

### 5.7 The IM&T Department

All staff to whom this document applies will ensure that any data created, edited, used, or recorded on Trust IT systems within their area of responsibility is accurate and recorded in accordance with this policy and other Trust policies relating to collection, storage and use of data in order to maintain the highest standards of data quality and maintain patient confidentiality. Will ensure that system level data fields/options are available, accurate and comply with national and local data standards.
Identify incorrect or unsafe system processes and advise on correct use and/or best practice.

In addition, consistent waiting list reporting must be achieved internally and externally. System changes will be actioned in liaison with suppliers. Software and process changes are to be implemented in liaison with users.

### 5.8 Assistant Directors of Operations for Surgery, Medicine, Community Services and Clinical Support

Are responsible for ensuring their respective directorates deliver the activity and capacity required to meet the waiting list targets, and for the necessary governance arrangements required to ensure adherence to the Patient Access Policy and associated Standard Operating Procedures.

### 5.9 Consultants

Are responsible for managing patient expectation of anticipated waiting times. Individual consultants are responsible for managing their waiting lists as effectively as possible through the application of the principles set out in this policy. Individual consultants have a shared responsibility with Trust Managers for managing their patients' waiting times in accordance with the maximum guaranteed waiting time.

Best practice identifies that where consultants personally review each decision to add a patient to the waiting list this reduces inappropriate listing, particularly when the decision has been made by a junior member of the team.

Consultants, along with their Directorate Managers, will regularly review clinic templates to ensure an appropriate demand & capacity fit. Any template changes must consider the potential for appointment rearrangements and every effort must be taken to prevent this.
Requests for template and clinic maintenance changes will only be accepted and actioned if supplied in writing with Directorate Manager sign-off.

Consultants and their clinical teams are required to comply with the Trust Annual Leave and Study Leave policy to ensure there is a minimum of six weeks' notice if they are unable to fulfil their planned clinical programmed activity.

Consultants are expected to always follow the Trust Standard Operating Procedures and operational checklists.

### 5.10 Directorate & Departmental Operational Managers

Managers will be responsible for ensuring all patients receive treatment within national and locally agreed targets, and that all staff and clinicians adhere to the Trust Patient Access Policy and associated Standard Operating Procedures.

Managers are to ensure appropriate training programmes are available to support staff, with special regard given to newly recruited staff. All staff involved in the implementation of this policy, clinical and clerical, will undertake initial training and regular updating.

Key elements of the roles and responsibilities for each manager and their staff will be included in relevant job descriptions. Roles and responsibilities will be reviewed regularly and updated in response to changes in national and local standards.

Consultants, along with their Directorate Managers, will regularly review clinic templates to ensure an appropriate demand & capacity fit. Any template changes must consider the potential for appointment rearrangements and every effort must be taken to prevent this.
Requests for template and clinic maintenance changes will only be accepted and actioned if supplied in writing with Directorate Manager sign-off.

### 5.11 Health Records

Are responsible for ensuring appropriate medical records are available as per the trust's Health Records Policy.

### 5.12 Head of Patient Booking

Will be responsible for maintaining the Directory of Services (DoS) and for ensuring outpatient referral processes are reviewed in line with the requirements of NHS e-Referral.

### 5.13 Appointments/Waiting List Clerks

Are responsible for the day-to-day management of their own waiting lists, and ensuring they are following all departmental procedures in their respective areas as outlined in the local Standard Operating procedures for each department.

### 5.14 Wards and Departments

Must ensure patients are admitted and discharged on the Hospital IT System as per the ADT (Admission, Discharge and Transfer system) Standard Operating Procedure. Must comply with data standards and ensure accuracy.

### 5.15 Theatre/Ward Managers

Must follow the Management of Pre and Peri Operative Patient Journey (Cancelled Operations Policy) and Cancelled Operations Standard Operating Procedure.

### 5.16 Commissioners' Duties

To take all reasonable steps to ensure that any patients for whom the 18 week or 2-week maximum waiting time is not met are offered a quicker appointment to start treatment at a range of clinically appropriate alternative providers, if the patient requests this.

To provide patients on 18 week and 2-week pathways with a dedicated contact point to approach if the maximum waiting time has been, or will be, breached and if they wish to seek an alternative.

To ensure providers give a contact point for patients to approach if the maximum waiting time has been, or will be, breached and if they wish to seek an alternative.

These duties apply both to CCGs and to NHS England. CCGs also have a duty to let NHS England know if a patient notifies the CCG that they have not or will not start treatment within 18 weeks in a service that NHS England commissions.

The NHS Standard Contract does not permit commissioners to set minimum waiting times.

It is the General Practitioner (GP) responsibility to inform the patient why they were referred and into the Trust and how this is to be monitored. Ensuring quality of referrals are submitted appropriately.

### 5.17 Referring Agent Responsibility:

Referring agents, (as agreed with Commissioners), may include the following Professions and Services:

- General practitioners (GPs)
- General dental practitioners (GDPs)
- General practitioners (and other practitioners) with a special interest (GPSI's)
- Optometrists and Orthoptists
- Accident and Emergency Department (A&E)
- Minor injuries units (MIU)
- Walk-in centres (WiC)
- Sexual Health Clinics (locally)
- National screening programmes
- Specialist nurses or allied health professionals with explicit authorisation
- Prison health services (locally)
- Consultants (or Consultant-led services)

Referrals should only be sent to the Trust if the patient is willing and able to be treated within the maximum access times target and should not be sent if the referrer knows the patient is unavailable (e.g., on a tour of duty, extended holiday, or work / study commitments). Patients who are unavailable to attend for a period of 6 weeks or more from their referral date will be discharged back to the referring agent for a new referral to be made when the patient is available to attend their appointment (excluding children and vulnerable patients as defined by the responsible clinician).

### 5.18 eRS (electronic Referral Service)

eRS is the Trust and Commissioners only method of GP referral as per the National eRS Paper Switch Off programme and the National CQUIN 2017-19. As of 1st October 2018, no GP referral will be accepted by the Trust unless via eRS. The Trust is working in collaboration with Commissioners to ensure referrals are sent via eRS and any other method of referral rejected back to the referring GP Practice.

Agreed specialties have been excluded from this programme and a list of these exclusions is available here.

T:\NHS eReferral Service Programme\useful information

All referrers have a responsibility to ensure that any referrals reflect the Trust and National policy on managing referrals i.e., that they are clear, concise, and addressed via the Appointments Department, or are made using E-Referral Service. Referral letters will be periodically reviewed through clinical audit, in line with the Trust Recording Keeping Policy. Referrals should also contain the patients NHS number, and information on any special needs of patients including the patient's entitlement to priority treatment in the case of veterans of the armed forces.

### 5.19 Responsibilities of all staff

- To act kindly in the patients' best interest
- To understand and actively support the principles of Waiting List Management
- To adhere to the Patient Access Policy and to escalate issues of non-compliance
- Ensure all local procedures are captured and followed in local Standard Operating Procedures
- To ensure social distancing and infection control measures are in place for patients and staff

## 6. Process

Patients often find it difficult to engage with health providers. Therefore, this policy will be implemented to facilitate, not hinder, access to healthcare.

Waiting lists should be managed according to clinical priority. Patients with the same clinical priority should be treated chronologically. Clinically urgent patients (as defined by a consultant), and cancer / suspected cancer patients will always take priority.

Commissioners and the Trust must work together to ensure adherence to national directives on patient access management and to ensure that all patients are treated in compliance with local contractual agreements. In addition, timely regard should be paid to the implementation of Data and SCCIs (Standardisation Committee for Care Information), National targets for access times, and any other mandatory requirements relating to patient access.

Communication with patients should be informative, clear, and concise. In addition, the process of waiting list management should be transparent to the public.

Ensure that no equality target group (Black & Minority Ethnic, Age, Gender, Disability, Religion, and Sexual Orientation & Transgender) are discriminated against or disadvantaged by this policy and its associated procedures.

To positively promote access for hard-to-reach communities.

This policy covers all elective and planned patients except for Sexual Health Medicine, and Maternity services.

Exceptions to this access right are mental health services that are not consultant-led; maternity services; public health services provided or commissioned by local authorities.

### 6.1 Outpatients

#### 6.1.1 Receiving referrals

The date a referral is received into the Trust will be recorded as the start date of the patient's 18-week pathway ('clock start'). Referrals will arise through 2 main routes:

- NHS e-referral (Choose & Book)

- Net account or paper for excluded services

The process for administering outpatient bookings for traditional paper and eRS referrals is contained within the Standard Operating Procedures for Receptions and Booking Outpatient Appointments. This process is based on the following principles:

- Open *(or 'Dear Doctor')* referrals should be allocated to the consultant with the shortest waiting time within the appropriate specialty/ subspecialty.
- There are ***four*** priorities of referral - 2 week wait rule (suspected cancer, seen within 2 weeks), rapid access (to enable a patient with symptoms that might indicate cancer as quickly as possible i.e., within 7 days), Urgent (seen within 4-6 weeks, locally agreed with Contract Review Board) and Routine (appointed to next available appointment).
- Clinicians are required to triage referrals within 3 working days and will have the ability at this point to upgrade the clinical priority i.e., bring forward a patients' appointment, redirect to a more appropriate clinic, or reject. E-referrals which are re-directed will be managed by the Patient Booking Services Team which will re-direct the referral to the appropriate clinic / specialty.
- Clinicians are expected to triage new and follow up referrals to determine whether they are required to be seen face to face, telephone or telehealth.
- All patients (and referring agents in the case of new appointments), will receive confirmation of their appointment date, location, and time in writing. As technology and Medway PAS develops further preferred methods of contact may be available. These may also include text, email, and patient portals.

### 6.1.2 Management of New Patient Referrals

Outpatient services should be provided virtually whenever possible to progress treatment where face-to-face contact is not required.

Details on the tasks associated with making a new patient appointment are contained within the Standard Operating Procedures for Booking Outpatient Appointments. The following principles apply:

- Unless the referral is specified as '2-week rule' (suspected cancer), or 'urgent', the patient will be offered the next available appointment slot for their required specialty.
- Where possible, patients will be offered the hospital site (i.e., Whiston, Newton or St Helens) closest to their home address.
- Where clinically appropriate the patient can be offered a telehealth or telephone consultation rather than face to face
- Patients undergoing a procedure considered to be an Aerosol Generating procedure (AGP) will be PCR swabbed for Covid prior to the procedure including a period of self-isolation. Clinical assessment is made for those patients unable to be swabbed prior to the procedure due to urgency and appropriate PPE measures put in place to manage the episode
- Patients will be offered two alternative dates with at least 21 days' notice.
- Patients who are continually unavailable to attend for their outpatient appointment will be discussed with the clinician and a decision made as to the appropriate action to be taken
- Where patients decline dates due to being fearful about coming into a hospital setting because of the COVID-19 pandemic, the usual rules on patient choice will apply and the clock should continue to tick.
- If a patient is self-isolating and is temporarily unavailable for treatment so the appointment

has been cancelled for clinical reasons, the RTT clock should continue to tick.

### 6.1.2 Management of Follow Up Outpatient Appointments

The detail for the administration of a follow up appointment is contained within the SOP for Booking Outpatient Appointments. The policy principles are:

- Follow-up appointment should be kept to a minimum and are regularly reviewed against national benchmarks (via the performance report and weekly PTL reports). Where clinically appropriate the patient can be offered a telehealth or telephone consultation rather than face to face

- Patients undergoing a procedure considered to be an Aerosol Generating procedure (AGP) will be PCR swabbed for Covid prior to the procedure including a period of self-isolation. Clinical assessment is made for those patients unable to be swabbed prior to the procedure due to urgency and appropriate PPE measures put in place to manage the episode is the responsibility of the clinician to review their clinics prior to patients attending clinic to understand what follow up capacity is available before completing the clinical outcome form. In the event of a patient or the Trust postponing and/ or re-arranging a follow-up outpatient, 'fire break' clinics should be utilised to minimise delay to patient care and mitigate any risk associated with a delay in being seen. If there is no fire break capacity available, additional clinical oversight is required to agree a safe time window for rebooking within, and alternative dates should be agreed with the patient.

- 'Fire break' clinics are clinics which are left empty in case a fully booked clinic needs to be cancelled and rearranged due to unforeseen reasons. The patients of the cancelled clinic are then moved to the fire break clinic, thus minimising the amount of rebooking/administrative work required.

- It should be remembered that many patients require structured follow-up to detect the need for further treatment at appropriate follow-up intervals for individual clinical conditions and this must be considered by an appropriate clinician when initiating any clinical cancellation.

- Examples may include patients with diabetic eye disease, or other eye conditions, who need eye examination to detect progression requiring urgent treatment to prevent blindness, or patients with long term conditions who require planned monitoring including those on disease-modifying drugs (such as for rheumatoid arthritis), where both potential side-effects of the drugs and response to treatment must be assessed**.** Patient Booking Rules and an associated escalation procedure is in place to ensure that patient rearranges are overseen and agreed by a consultant.

- Patients who rearrange on a second occasion will be brought to the attention of their consultant/clinician to agree the appropriate action (i.e., offer another appointment or discharge back to primary care). This should not adversely impact on those patients deemed vulnerable or at risk e.g., children, cancer patients and vulnerable adults and therefore must be agreed with the consultant responsible for the patient.

- Patients who are hospital rearranged on 2 consecutive occasions should be actively reviewed and monitored to prevent adverse effects on patients' care.

- If a patient is self-isolating and is temporarily unavailable for treatment so the appointment has been cancelled for clinical reasons, the RTT clock should continue to tick.

### 6.1.4 Management of patients on the waiting list choosing to decline offered treatment dates at current provider or an alternative provider.

**Patients wishing to delay treatment (currently P6)**
In circumstances where a patient wishes to delay their treatment the following approach may be considered:

- Following declining a 1st TCI, the patient should be recorded on the WLMDS as a 'C1'.
- A 2nd TCI should be offered which is within 6 weeks of the 1st TCI.
- TCIs offered should be reasonable (i.e., with 3 weeks-notice)
- If a 2nd TCI is declined it may be appropriate, following a clinical conversation and agreement with the patient, to consider placing a patient on hospital initiated active monitoring.
- Where it is appropriate to place a patient on active monitoring, this should be for a maximum period of 12 weeks.
- If a patient is placed on active monitoring the RTT clock should be stopped.

- Patients placed on active monitoring should be managed through local reporting and local clinical governance arrangements.
- Throughout the agreed active monitoring period the patient should be advised of the process to follow should they wish to go ahead with treatment and be reinstated on the waiting list.
- If a patient wishes to go ahead with treatment, the provider should offer a new TCI date acting as if the patient is on the waiting list at the point which they previously left ie. They should not be returned to the beginning of the waiting list.

TCI date offered must include date, provider, and team. It is not appropriate to start a period of active monitoring and stop the clock based on a patient declining earlier treatment at a provider for which the detail has not been confirmed.

**Patients declining earlier treatment at an alternative provider (currently choice category)**
Patients included within this cohort should be clinically validated to be appropriate (clinically and socially) to be offered earlier treatment at a reasonable[1] alternative provider.

In circumstances where a patient declines earlier treatment at an alternative provider the following approach may be considered:

- Following declining a 1st TCI at an alternative provider, the patient should be recorded on the WLMDS as a 'C1'.
- A 2nd TCI should be offered which is within 6 weeks of the 1st TCI.
- TCIs offered should be reasonable (i.e., with 3 weeks-notice)
- If a 2nd TCI is declined it may be appropriate, following a clinical conversation and agreement with the patient, to consider placing a patient on active monitoring.
- If a patient is placed on active monitoring the RTT clock should be stopped.
- Patients placed on active monitoring should be managed through local reporting and local clinical governance arrangements.
- Throughout the agreed active monitoring period the patient should be advised of the process to follow should they wish to go ahead with treatment and be reinstated on the waiting list.
- Should a patient decline the subsequent offered TCIs at the existing provider, the guidance relating to cohort (a) above should be followed.

TCI date offered must include date, provider, and team. It is not appropriate to start a period of active monitoring and stop the clock based on a patient declining earlier treatment at a provider for which the detail has not been confirmed.

### 6.1.5 Outpatient DNAs (Did Not Attend, excluding Paediatrics)

The Trust is proactive in the management of DNAs, and this is included in the SOP for outpatients' administration under the following policy principles:

- Patient contact details should be checked by the clinical teams via PAS or SCR before enacting the DNA procedure to ensure that the patient is not classed as vulnerable or at risk (i.e., children, cancer patients or vulnerable adults).

- New 'Routine' DNA's may be removed from the waiting list and returned to the care of the patients GP or other referrer, with their 18-week clock stopped on the date of their DNA'd appointment. This will be communicated to the patient and to the referrer.

- **In the case of children and vulnerable adults,** the treating Consultant must consider whether there is a safeguarding risk in the non-attendance and then act accordingly in following any concerns up. It is their responsibility to liaise with the referrer to assess this risk and consider further actions if appropriate. For guidance, please refer to the ***Trusts Policy: Safeguarding Children and Young People.***

- Where patients who DNA cannot be discharged in line with the principles of this policy (i.e., children, cancer patients and vulnerable adults), the patient's clock will start again on the date that the Trust agrees the new appointment date with the patient.

- New 'Urgent' DNA – the treating clinician should review decide if a further appointment is offered based on clinical need. If the clinical decision is made not to offer a further appointment, the referrer and patient will be informed, and the patient's clock stopped. Where the decision is made to offer the patient another appointment, then a new clock start will be set when the Trust agrees a new date with the patient.

- Follow up DNAs should be removed from the waiting list and returned to the care of their referrer with the exception of children, cancer patients or other vulnerable patients (*for guidance, please refer to the Trusts Policy: Safeguarding Children and Young People)* which will be at the treating Consultants discretion or as specified in local specialty SOPs (e.g. Glaucoma patients). A patient can only be discharged back to the care of their GP provided the following guidance is met:

    i) the provider can demonstrate that the appointment was clearly communicated to the patient.

ii) discharging the patient is not contrary to their best clinical interests.

iii) discharging the patient is carried out according to local, publicly available/published, policies on DNAs.

iv) These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g., children) and are agreed with clinicians, commissioners, patients, and other relevant stakeholders.

- An 18-week clock can only be stopped providing that the provider can demonstrate that the appointment was clearly communicated to the patient. Patients will not be considered DNA if reasonable offer has **not** been given for the appointment (see definitions above).

### 6.1.6 Hospital Cancellations – Outpatients

As is detailed within the Standard Operating Procedure for Booking Outpatients Appointments, the Trust will take all reasonable steps to minimize the incidents of cancellations/ clinic reductions, including the enforcement of the 6-week cancellation notice period for annual leave and study leave.

Each specialty is required to review and introduce 'fire break' clinics to their schedules to support with minimising the impact of cancellations on the patient's treatment pathway.

The frequency of the 'fire break' clinics needs to bespoke to support each specialty's requirements, but be no further than 6 weeks apart.
Once a clinic template has been booked any cancellation, or reduction requests with less than 6 weeks' notice will be declined (unless the clinician is off sick or electives are stepped down due to hospital pressures). This is required to be managed within specialty. If there is a requirement for a clinic to cancelled within 6 weeks outside of the above stipulation it requires Authorisation and sign off by the relevant DM and ADO.

For any clinic cancellation, or reduction requests greater than 6 weeks the patients should be moved in the 'fire break' clinic. If there is no available fire break clinic on the system, this needs to be escalated to the relevant DM to see it is possible to support with an additional ad hoc clinic to minimise the delay to the patients being seen. If this is not possible clinical oversight of the patient list is required to identify the safe timeframe required between the cancellation and the next bookable appointment for each patient on the list.

If a patient is self-isolating and is temporarily unavailable for treatment so the appointment has been cancelled for clinical reasons, the RTT clock should continue to tick.

If the hospital cancels a patient's appointment due to staff being unavailable, this will have no effect on the RTT waiting time and the RTT clock should continue to tick.

If the hospital cancel's a patient's appointment due to temporarily suspending a service, this will have no effect on the RTT waiting time and the RTT clock should continue to tick.

### 6.1.7 Paediatric Outpatient DNAs (Did Not Attend) (Was not brought)

The Outpatient Reception staff must check PAS for any Safeguarding alerts on the system and to confirm that the hospital has the correct address and contact details for the patient. Before the end of clinic, the consultant should document that the child has not been brought to clinic on the outcome sheet which should be clearly displayed on the front of the medical notes. The consultant must thoroughly review the child's notes/referral letter and make a clinical decision as to whether:

a) another appointment is to be sent out for the child, or

b) the child is to be discharged back to the care of their GP/referrer and no further appointment is to be given

It is the consultant's responsibility to clearly document the clinical decision (per above) on the outcome sheet. Failure to document a clear instruction on the outcome sheet will result in the child being sent another outpatient appointment.

Children who are not brought to their OPD appointment and are subsequently discharged back to the care of their GP/referrer should only be offered a further appointment if requested by the referrer, or a new referral is sent. Parents/carers cannot instigate a further appointment once discharged.

### 6.1.8 Urgent referrals including clinical or Safeguarding Concerns

If this appointment is deemed to be urgent from either a clinical or safeguarding perspective, telephone contact to the family and the referrer should be attempted as soon as possible by a member of the Paediatric team. Once contact has been made, it must be made clear to the main care giver/parent regarding the importance of attending clinic and another appointment must be arranged that is mutually agreeable. It must be made clear to the main care giver/parent that if the child not brought to the next appointment, then safeguarding concerns would be raised and necessary actions will be taken which could include a referral to Children's Social Care.

If the consultant feels the child is at immediate risk of significant harm, then the consultant must discuss with the Safeguarding Children Team and a referral considered to Children's Social Care, referring to the Trust's Safeguarding Children Policy.

If the child is subject to a Child Protection Plan or is a Looked After Child, the allocated social worker must be contacted as soon as possible by a member of the Paediatric team to assist in arranging attendance for the child.

### 6.1.9 Routine referrals and no Safeguarding Concerns

If the consultant decides to discharge the patient, a DNA letter is generated to the GP/referrer, with a copy to the Health Visitor (if applicable), the patient's parents/carers and a copy is to be filed within the child's medical notes. Child is discharged on PAS.

If the child is subject to a Child Protection Plan or is a Looked After Child, the same process as above should be followed. However, the allocated social worker should be informed that the child was not brought and the decision to discharge.

## 6.2 Inpatient and Day Case Elective Admissions

Details on the procedures associated with creating an inpatient and day case admission are contained within the SOP for Admissions Department. The following policy definitions apply:

- The decision to add a patient to an inpatient waiting list must be made by someone with a 'Right of Admission,' i.e., a consultant or a member of their team.
- Patients will be added to the waiting list within a maximum of 2 working days from the decision to admit. The date recorded on the system will be the decision to admit date.
- STHK COVID-19 Guidance must be adhered to: Elective Admissions (including Day Surgery Admissions and Day Attendances for Interventions) – STHK COVID-19 Guidance
- Consultants leaving the Trust will have their waiting list transferred to another Consultant and patients will retain their original DTA (decision to admit) date.
- Patients added to the waiting list must be clinically fit on the day that the decision to admit is made (i.e., if there was a bed available the following day in which to admit a patient, would they be considered fit, ready, and able to come in).
- Patients who are not fit, ready and able to come in and need an anaesthetic opinion, will be referred to Anaesthetic Clinic. Once the patient is deemed fit the patient can then be added

to the waiting list to ensure appropriate waiting list management.

- If a patient is deemed not clinically fit by the Consultant for surgery, the clinician should review the patient medical records and advise what the most appropriate action is for the patient, i.e., follow up appointment to review fitness, or discharged back to their GP for on-going care.

- Patients should only be added to the waiting list when they have accepted consultant advice for elective treatment, i.e., if the patient is unsure and wishes to have 'thinking time' by the consultant, the effect on the RTT clock will depend on the individual scenario.

- Where a patient is given 'thinking time' by the consultant, the effect on the RTT clock will depend on the individual scenario. If the agreed 'thinking time' is short, then the RTT clock should continue to tick. An example is where invasive surgery is offered as the proposed first definitive treatment, but the patient would like a few days to consider this before confirming they wish to go ahead with the surgery.

- If a longer period of 'thinking time' is agreed, then active monitoring is more appropriate. An example is where the clinician offers a surgical intervention, but the patient is not keen on invasive surgery at this stage, as they view their symptoms as manageable. A review appointment is agreed for three months' time and the patient is placed on active monitoring. The RTT clock would stop at the point that the decision is made to commence active monitoring.

- If patients are added to the waiting list, this is under the provisions that they are fit and have taken the advice to lose weight; stop smoking etc as per clinician guidance. Therefore, a patient should be seen back in clinic to review that these guidelines have been followed before adding the patient to the active waiting list.

- Patients requiring bilateral procedures which are not required to be undertaken simultaneously will be listed for one procedure at a time. The patient should only be listed for their second operation when the first operation has been successful, and the recuperation period completed. A new clock will then start when the patient becomes fit and ready for the second 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.

- Patients who have been added to an elective waiting list for two unrelated procedures will have 'Active Monitoring' applied to the least clinically urgent pathway (unless clinically inappropriate) until the first procedure has been successful and the recuperation period completed. The patient will need to be re-assessed in clinic and declared fit by the clinician before the second pathway clock will restart for the second procedure (locally agreed).

- Patients who are offered an admission date with a reasonable offer (21 days) but decline as they are unavailable for more than a 6-week period will be discussed with the clinician as to the best course of action

- Where patients decline dates due to being fearful about coming into a hospital setting because of the COVID-19 pandemic, the usual rules on patient choice will apply and the clock should continue to tick.

- If a patient is discharged back to GP. They can be reinstated to the waiting list with a new

clock start if their original referral is <3 months old or within 3 months of being added to the

waiting list without re-referral by the GP but does require the GP to send a referral letter to the Admissions Department or Gastroenterology Department with validation of 'appropriateness.' A new clock is started on commencement of availability. If > 3 months or detrimental to patients' health, then discharged back to GP to manage the patient's condition (locally agreed with Contract Review Board).

- Patients who have a 2-week cancer target, 31-day cancer target and 62-day cancer target, along with diagnostic procedures, have a reasonable notice of 7 days.

- The Admissions Department send out two consecutive invitation letters to a patient if they cannot contact them by telephone to agree an admission date. The first is for them to respond within 2 weeks and the second letter to respond within one week (this gives the patient reasonable notice). If the patient does not respond, clinical advice is sought before removing the patient from the waiting list and discharging back to the GP.

- The Endoscopy Department send out an invitation letter to a patient if they cannot contact them by telephone to agree an admission date. If the patient does not respond the patient's demographics are checked on SCR against Medway and patient is removed from the waiting list for no response and discharged back to the GP.

- Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made. The definition of active monitoring is designed to ensure that national measurement of patients' waiting times reflects the realities of clinical decision-making. Stopping a patient's clock for a period of active monitoring requires careful consideration on a case-by-case basis and its use needs to be consistent with the patient's perception of their wait.

For example, stopping a clock to actively monitor a patient knowing full well that some form of diagnostic or clinical intervention would be required in a couple of days, is unlikely to make sense to a patient, as they are likely to perceive their wait as being one continuous period from the time of their initial referral. Its use may be more appropriate where a longer period of active monitoring is required before any further action is needed. Patients may initiate the start of a period of active monitoring themselves (for example by choosing to decline treatment to see how they cope with their symptoms).

- The importance of treating patients in chronological order, at whatever stage in their pathway is paramount, making allowances only for clinical urgency, case mix and patient choice.

### 6.2.1 Patients Requiring Planned Care (Surveillance) / Admission

Patients who are to be admitted as part of a 'planned sequence of treatment following previous admissions do not form part of the active waiting list and their RTT clock (18-week pathway) will have stopped at the point of their first definitive treatment. A delay related to COVID-19 is not a reason to add a patient to a planned list.

This includes patients waiting for a planned diagnostic test or treatment or a series of procedures (outside the scope of RTT measurement) carried out as part of a treatment plan which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Examples may include check procedures such as cystoscopies, colonoscopies etc

and patients proceeding to the next stage of treatment (i.e., undergoing chemotherapy, removal of metalwork or breast reconstruction following mastectomy).

Patients who are on an RTT pathway should not be placed on a planned list if they are unfit for a procedure or operation. Instead, their clock should keep running unless a clinical decision is made to discharge or start active monitoring.

Patients should also be given verbal confirmation by the clinician at the point of listing if they are placed on such planned lists, including the review date. When patients on planned lists are clinically ready for their care to commence, and reach the date for their planned appointment, they should either receive that appointment within due date. For example, where a patient is due to have a consultant-led planned procedure in six months' time, the patient should be added to the 'planned' list for six months' time and a firm date for the procedure booked in nearer the time. If a patient is not treated within their planned due date, they should be transferred to an active waiting list with a new RTT clock must start and must be treated as a 28 day relist cancelled operation (Locally agreed with Contract Review Board).

It will be recorded on PAS before each procedure 'SS' to state that the patient has been removed from the planned waiting list and put back to the active waiting list. Therefore, identifiable to all staff that these patients cannot revert back to planned patient and need to be treated within 28 days.

Each Directorate Manager is responsible for reviewing the planned PTL list on a weekly basis to ensure compliance. This review will include checking that patients are being brought in, in accordance with their planned review dates, and have been listed appropriately to the planned PTL list data definition.

Where different surgeons working together will perform more than one procedure at one time, the patient should be added to the waiting list of the consultant surgeon for the priority procedure, with any additional procedures noted.

### 6.2.2 Selecting Patients for Admission

- The process of selecting patients for admission and subsequent treatment is a complex activity, ensuring that the needs and priorities of the patient are balanced against the available resources of theatre time, staffed beds, and surgical expertise.

- As per DoH and MOD guidance, all veterans are entitled to priority access to NHS hospital care for any condition, if it's related to their service and subject to the clinical need of others. Please remember that priority treatment does not entitle you to jump the queue ahead of someone with a higher clinical need and only relates to a condition associated to your time within the armed forces.

- All patients are treated in accordance with their clinical priority. Clinically non-urgent patients are managed in chronological order *(i.e., next in turn/ referral date order)*.

- Patients may be dated outside of their 18 weeks if they are defined as 'clinical exception' and is in the best interest of the patient's clinical needs.

- Where specialities offer services across hospital sites with a mixed provision of outpatient, day case and inpatient facilities. The patient should be made aware of their options. Where a treatment is available on more than one site, patients should be asked whether they are willing to go to either site.

- In some cases, the choices will be limited by the clinical appropriateness of the services available at the sites. This may include factors such as:

    - Requirement for general anaesthetic
    - Inpatient beds
    - Critical care facilities
    - Specialist staffing
    - Specialist on-site equipment

- The general principle remains that patients can be offered the choice of receiving treatment by a different hospital/hospital site/consultant, but their waiting time clocks should continue to tick if they choose not to accept this opportunity. This includes situations where a patient is offered an appointment with a private provider as part of an outsourcing arrangement.

### 6.2.3 Cancellation of Admission

Cancellations can be classified into 3 main categories, namely patient cancellation, hospital cancellation or patient did not attend (DNA). It is essential that accurate records are kept within the admissions (TCI) Department of all patient and hospital actions during the TCI appointment process.

### 6.2.4 Patient who is Declared Unfit

If a patient is declared unfit for a 4-week period or more, they should not be listed for surgery in the first instance but reviewed in an outpatient setting (locally agreed with Contract Review Board).

If a patient is listed for surgery and declared unfit at Pre-op Assessment for this period of time, then they will be removed from the waiting list after discussion with the clinician to determine the appropriate course of action.

### 6.2.5 Patient Initiated Delay

There is no longer any provision to report pauses or suspensions in RTT waiting time clocks in monthly RTT returns to NHS England under any circumstances. However, the Trust need to maintain a local record of all patient-initiated delays, to aid good waiting list management and to ensure patients are treated in order of clinical priority. The Trust will have to be able to identify those patients who chose to start treatment after 18 weeks, which is those who were offered a reasonable appointment within 18 weeks of referral but chose to wait longer, for personal or social reasons.

A reasonable offer of an appointment is one for a time and date three or more weeks from the time that the offer was made. It is good practice to offer patients at least two reasonable offers.

If a patient is discharged back to their GP because they are not fit for surgery, can be reinstated to the waiting list with a new clock start if their original referral is <3 months old or within 3 months of being added to the waiting list without re-referral by the GP. A new clock is started on commencement of availability. If > 3 months or detrimental to patients' health, then discharged back to GP to manage the patient's condition (locally agreed with Contract Review Board).

Clinicians should provide booking staff with guidelines as to how long (in general) patients should be allowed to defer their treatment without further a clinical review. Patients requesting a delay longer than this should have a clinical review to decide if this delay is appropriate. If the clinician is satisfied that the proposed delay is appropriate then the Trust should allow the delay, regardless of the length of wait reported.

If the clinician is not satisfied that the proposed delay is appropriate, then the clinical risks should be clearly communicated to the patient and a clinically appropriate TCI date agreed. If the patient refuses to accept the advice of the clinician, then the responsible clinician must act in the best interest of the patient.

If the clinician feels that it is in the best clinical interest of the patient to discharge the patient back to the care of their GP and inform them that treatment is not progressing, then this must be made clear to the patient. This must be a clinical decision, taking the healthcare needs of each individual patient into account.

### 6.2.6 Patient Initiated Cancellation

If a patient cancels, rearranges or postpones their appointment, this has no effect on the RTT clock, which should continue to tick – this is also the case if a patient is fearful about coming into a hospital setting as a result of the COVID-19 pandemic. Patients should not be discharged back to their GP simply because they have cancelled or rearranged appointments; referral back to the GP should always be a clinical decision, based on the individual patient's best clinical interest.

### 6.2.7 Hospital Cancellation

A hospital cancellation is where the patient has agreed a date for admission, but the hospital subsequently cancels this. This has no effect on the RTT clock (18-week pathway), which continues from the original RTT start date.

If a patient is self-isolating and is temporarily unavailable for treatment so the appointment has been cancelled for clinical reasons, the RTT clock should continue to tick.

If the hospital cancels a patient's admission due to staff being unavailable, this will have no effect on the RTT waiting time and the RTT clock should continue to tick.

If the hospital cancels a patient's admission due to a service being suspended, the RTT waiting time clock should continue to tick.

In any event, a patient's admission should not be cancelled on more than one occasion due to hospital non-clinical reasons. If a patient is cancelled on two occasions this must be reported through Submissions (Information Department) as part of the daily sitrep.

### 6.2.8 Hospital Last Minute Cancellations *(on the day)*

Last minute cancellation is defined as: “On the day of planned admission, after admission, or on the day of operation/surgery.”

Patients who have their surgery cancelled by the hospital at the last minute for non-clinical reasons must be rescheduled within 28 calendar days of the cancellation. The Trust cancelled operations procedure (Management of Pre and Peri Operative Patient Journey Policy) must be always adhered to in order that these patients are rescheduled for surgery at the appropriate time.

The RTT clock for these patients will continue to tick until the patient starts their treatment.

If treatment is cancelled by the Provider after admission for clinical reasons (for example, patient deemed temporarily unfit for surgery due to chest infection), then the RTT clock should continue to tick unless a clinical decision is made that the patient is unsuitable for surgery/treatment and they are discharged back to primary care or a decision not to treat is made. These scenarios should be minimal as they should be picked up earlier on in the pathway.

### 6.2.9 Urgent Cancellations

Count all urgent operations that are cancelled by the Trust for non-clinical reasons, including those cancelled for a second or subsequent time. This should exclude patient cancellations, and only include cancellations where the operation was scheduled to take place in the previous 24 hours regardless of the date it was cancelled.

Urgent cancelled operations definitions that need to be submitted as part of the daily sitrep are as following NCEPOD guidelines:

- Immediate - Immediate (A) lifesaving or (B) limb or organ saving intervention. Operation target time within minutes of decision to operate.

- Urgent – acute onset or deterioration of conditions that threaten life, limb, or organ survival. Operation target time within hours of decision to operate.

- Expedited – stable patient requiring early intervention for a condition that is not an immediate threat to life, limb, or organ survival. Operation target time within days of decision to operate.

### 6.2.10 Inpatient / Day Case DNA

Patient DNA’s will be recorded when reasonable notification of an admission date is provided (21 days) and the patient fails to attend (DNA). At this point a patient’s clock will be stopped and they will be referred back to their GP (unless clinically urgent, a child, or a vulnerable adult).

A patient DNAs any other appointment and is subsequently discharged back to the care of their GP, provided that:

- the provider can demonstrate that the appointment was clearly communicated to the patient.

- discharging the patient is not contrary to their best clinical interests.

- discharging the patient is carried out according to local, publicly available/published, policies on DNAs.
- These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g., children) and are agreed with clinicians, commissioners, patients, and other relevant stakeholders.

Once the demographic details have been checked using PAS and the SCR, and every effort has been made to contact the patient by telephone (2 phone calls in the day and 2 in the evening), should be treated as a DNA. Routine DNA's will be removed from the waiting list and returned to the care of their referrer. Urgent patients will be discussed, and a plan agreed with the treating clinician. This should not adversely impact on those patients deemed vulnerable or at risk e.g., children, cancer patients and vulnerable adults and therefore must be agreed with the consultant responsible for the patient (locally agreed).

### 6.2.11 Patients Vulnerable to COVID-19

Where patients are asked to stay at home due to being vulnerable to COVID-19 (including those aged over 70 and those in other vulnerable groups), in most circumstances, it will be appropriate to consider them 'temporarily unfit' for treatment and the RTT clock will continue to tick. This will ensure that their RTT waiting time is visible and remains on the active RTT waiting list.

For limited cases, it may be appropriate to agree a review appointment and to start the patient on a period of active monitoring. In these cases, it is important to agree and communicate this with the patient. A new RTT clock will start when a decision to treat is made following a period of active monitoring.

Some patients in this vulnerable group will still be advised to come in for their appointments/treatments as their condition is urgent.

## 6.3 Pre-operative Assessment

Pre-operative Clinic validity - Once a patient has been to the pre-op clinic, the validity is 16-week period.

Anaesthetic Clinic validity - This is mostly case by case but is valid for 12-month period. Therefore, if a patient has attended anaesthetic clinic within last 12 months, but needs a further pre-op appointment, they would not need to attend a further anaesthetic appointment unless deemed necessary by the nurse clinician assessing them.

Patients require a clinical assessment of their fitness to proceed with certain procedures. Patients who are assessed as unfit to proceed will have their clock adjusted in line with the following principles:

- Patients referred for a specialist opinion before they can proceed will have their clock stopped on the date of their pre-op assessment and restarted when the patient is assessed as fit to proceed (e.g., patients requiring a cardiology assessment).
- Patients who require further treatment and assessment from primary care before they are fit to proceed will be referred back to their GP and their clock will be stopped. A new referral should be made for the patient once they are fit to proceed with surgery.

### 6.3.1 Pre-op Assessment DNAs (Did Not Attend) including children not brought to Pre-Op Assessment

- Patients who rearrange their appointments in advance (irrespective of how short the period of notice they give) should not be classed as a DNA.
- Routine patients who have been provided written reasonable notice or verbally confirmed their pre-op appointment in which they have a second DNA, the patient should initially be discussed with the clinician and a decision made as to the most appropriate action, i.e. to be removed from the waiting list and returned to the care of the patients GP or other referrer, with their 18 week clock stopped on the date of their DNA'd appointment. This will be communicated to the patient and to the referrer.
- **In the case of children and vulnerable adults,** the treating Consultant must consider whether there is a safeguarding risk in the non-attendance and then act accordingly in following any concerns up. It is their responsibility to liaise with the referrer to assess this risk and consider further actions if appropriate. For guidance, please refer to the ***Trusts Policy: Safeguarding Children and Young People.***
- Where patients who DNA cannot be discharged in line with the principles of this policy (i.e., children and vulnerable adults), the patient's clock will be reset on the date that the patient agrees the new appointment date.
- New 'Urgent' DNA the treating clinician should decide if a further appointment is offered. If the clinical decision is made not to offer a further appointment, the referrer and patient will be informed, and the patient's clock stopped. Where the decision is made to offer the patient another appointment, then a new clock start will be set on the date that the patient agrees the new appointment date
- An 18-week clock can only be stopped providing that…
    - The provider can demonstrate that the appointment was clearly communicated to the patient.
    - Discharging the patient is not contrary to their best clinical interests, which may only be determined by a clinician
    - discharging the patient is carried out according to local, publicly available, policies on DNAs
    - These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (for example, children) and are agreed with clinicians, commissioners, patients,' and other relevant stakeholders. If the above criteria are fulfilled, then the RTT clock stops on the date that the patient is discharged back to the care of their GP.
- Local DNA policies must be clearly defined and published, and specifically protect the clinical interests of vulnerable patients (for example, children) and be agreed with clinicians, commissioners, patients, and other relevant stakeholders. There should be no blanket rules that do not take account of the circumstances of individual patients; therefore, it is for clinicians to determine whether discharging a patient is or is not contrary to the patient's healthcare needs.

## 6.4 Patients moving between NHS and private care

This section should provide a summary of how the trust will manage (including clock statuses) patients who decide to transfer part or all their treatment to a private provider. Patients can choose to move between NHS and private status at any point during their treatment without prejudice. Where it has been agreed, for example, that a surgical procedure is necessary the

patient can be added directly to the elective waiting list if clinically appropriate. The RTT clock starts at the point the GP or original referrer's letter arrives in the hospital.

- The UBRN system technically only applies to GP Referrals
- Where it is a tertiary referral, where the trust is considered the Specialist Centre, it is reasonable to accept these direct from a private hospital without first going back to the GP
- Where it is not a tertiary referral, e.g., where the private hospital could be seen to be acting like a GP or where a consultant is referring to themselves (from Private to NHS), then this is likely to be challenged and should go back to the GP first.

The RTT pathways of patients who notify the trust of their decision to seek private care will be closed with a clock stop applied on the date of this being disclosed by the patient.

## 6.5 Procedures of Lower Clinical Priority (PLCP) or Criteria Based Clinical Treatments (CBCT) or that need prior approval from Commissioning (CCG's)

This section should provide details on how the trust will manage procedures of limited effectiveness and reference the trust's policy/process for approval. Patients referred for specific treatments where there is limited evidence of clinical effectiveness, or which might be considered cosmetic can only be accepted with the prior approval of the relevant CCG.

A revised policy: Criteria Based Clinical Treatments 2018-19 is awaiting final agreement between the provider and commissioners and will be available in below folder once agreement reached.

Procedures of Lower Clinical Priority for the Trust can be found in the following location: Trust1\groups\GM\shared\SOP's

## *6.6* 18 weeks - referral to treatment consultant-led waiting times rules *(National Clock Rules)*

### 6.6.1 Clock Starts

1. A waiting time clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to:
    a) a consultant-led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner.
    b) an interface or referral management or assessment service, which may result in an onward referral to a consultant-led service before responsibility is transferred back to the referring health professional or general practitioner.

2. A waiting time clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional permitted to do so.

3. Upon completion of a consultant-led referral to treatment period, a new waiting time clock only starts:
    a) when a patient becomes fit and ready for the second of a consultant-led bilateral

procedure.

b) upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.
c) upon a patient being re-referred into a consultant-led; interface; or referral management or assessment service as a new referral.
d) when a decision to treat is made following a period of active monitoring.
e) when a patient rebooks their appointment following a first appointment 'did not attend' (DNA) that stopped and nullified their earlier clock.

### 6.6.2 Clock Stops for Treatment

4. A clock stops when:
   a) first definitive treatment starts. This could be:
      I. treatment provided by an interface service.
      II. treatment provided by a consultant-led service.
      III. therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions.
   b) A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

### 6.6.3 Clock Stops for 'Non-Treatment'

5. A waiting time clock stops when it is communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay that:
   a) it is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care.
   b) a clinical decision is made to start a period of active monitoring.
   c) a patient declines treatment having been offered it.
   d) a clinical decision is made not to treat.
   e) a patient DNAs their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient
   f) a patient DNAs any other appointment and is subsequently discharged back to the care of their GP, provided that:
      I. the provider can demonstrate that the appointment was clearly communicated to the patient.
      II. discharging the patient is not contrary to their best clinical interests.
      III. discharging the patient is carried out according to local, publicly available/published, policies on DNAs.
      IV. these local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g., children) and are agreed with clinicians, commissioners, patients, and other relevant stakeholders.

**From 1 October 2015, there is no provision to pause or suspend an RTT waiting time clock under any circumstances.**

Patients should not be referred from one specialty within the Trust to another for a new clinical

condition, except for clinically urgent / suspected cancer where it is in the best interest

of the patient. A patient's clock should be stopped, and the patient should be discharged back to their GP who should make a new referral if required.

Where Consultant to consultant referrals are made for the same condition, the 18 week pathway (RTT clock) continues.

## 6.7 Pregnancy

Patients who become pregnant and the waiting time is such that an offer could be made before the gestation time is complete, should be removed from the waiting list and referred back to their GP, unless the procedure is clinically advisable during pregnancy. The GP should make arrangements to re-refer the patient when they are no longer pregnant and are medically fit. (Locally agreed with Contract Review Board)

## 6.8 Reinstating To Waiting List

Patients wishing to be reinstated to a hospital treatment or endoscopic diagnostic day case waiting list following removal can do so by being reviewed by their own GP within 3 months of their removal if it is still clinically appropriate. The GP will send a referral letter to the Admissions Department or Gastroenterology Department with validation of 'appropriateness.'

The PAS system will then show a new 'date on list' and 18-week clock start from the date of patient contact. Therefore, the new clock start (18-week RTT pathway) would be from when the patient agrees the appointment with the hospital (locally agreed with Contract Review Board).

## 6.9 Inter-provider Transfers (Tertiary Referrals)

Where patients are transferred between providers, including primary care intermediate services, the standard minimum data set (MDS) form must accompany the referral. The same template must be used when referring patients within the Trust for the same condition. The template is used when there is no other pre-existing template in place i.e., Cancer. This is to ensure national compliance regarding provision of information for tertiary referrals.

When a patient is transferred for treatment in the middle of a pathway, the 18-week clock will continue, and it will be the joint responsibility of all providers involved to ensure that the patient is managed within 18 weeks. There will also be occasions when a patient is transferred for further treatment of a significantly different condition after the original clock has stopped – this information will also need to be shared with the onward provider, hence an MDS form will still be required. In this instance a new 18-week clock will start with the new provider.

Where a patient's care is being transferred from another provider, information in accordance with SCCI must be provided by the transferring provider, this is the MDS (minimum data set), using NHS net account. This will include the start date of the patients' 18 Week journey and the pathway identifier which must be entered into the Pathway ID field on PAS to ensure the correct clock start date (start of RTT pathway, not the date of receipt of referral). If there is not enough information on the MDS, the patient's treatment will not be compromised, and PBS (Patient Booking Services) will chase the remaining MDS information.

Consultants may also accept a referral to treat a patient referred to them by a consultant from

another hospital for a condition where the 18 week pathway to treat has already commenced. The clock will continue ticking from the date it commenced at the referring hospital.

### Management of Welsh Patients

Welsh patients should be managed in the same way as all other patients on our waiting list, and the Patient Target Times for their local commissioners should be applied.

## 6.10 Management of patients outside of our commissioning areas

The current national tariff does not necessarily apply where a Scottish, Northern Irish or Welsh Commissioner (with exception of North Wales as we have a contract with Welsh Health Specialised Services Committee) commissions a service from an English hospital. For these patients to be treated a referral from their own GP ***MUST*** be received for funding to be agreed and identified before a decision to add a patient to any pathway within the Trust.

## 6.11 Data Quality Audits

Adherence to the Patient Access Policy is monitored through the completion of the following Data Quality Audits. These are reviewed during the weekly PTL meeting and, as a minimum, include

- Audit of 'Clinic Disposal,' i.e., recording the outcome of appointment and closing an outpatient clinic. The target is for 100% of clinics to be closed within five working days of the clinics being held. This audit is completed on a weekly basis.
- Audit of Missed Additions – all patients who are recorded as 'added to Outpatient WL' as the outcome of outpatient attendance. This audit is completed on a weekly basis by Patient Booking Services.
- Audit of Missed Additions – all patients who are recorded as 'added to inpatient WL' as the outcome of an outpatient clinic attendance. This audit is completed on a weekly basis by the Admissions Department Team.
- Audit of 1% of monthly DNA against outcome sheet and SOPs / policy to be completed by Data Quality Team.

## 6.12 Waiting List Validation

When a patient attends clinic they are given information to contact the Admissions Department within 72 hours for validation. The Admissions Department are then responsible for ensuring that all waiting list entries have been validated appropriately on a weekly basis as part of PTL reporting. This includes checking of patient demographics, GP details and availability for surgery. Waiting lists will be checked by a Team Leader / Assistant Directorate Manager against the date on list (DOL) and when the patient was last validated, this will then capture all patients that have not contacted the department following their clinic appointment and being listed for surgery.

## 6.13 Active Monitoring Validation

When a patient is placed on active monitoring due to clinical reasons, the information is recorded by the Admissions Team on a database. This database is reviewed weekly as part of the PTL process. The patient pathway will be reviewed in line with the reasons for the initial active monitoring. Any patients that become fit / available will be given a new clock start. Active Monitoring patients will have a limit of 6 months, once a patient reaches this timeframe with no potential outcome for treatment, this will be reviewed by the clinician and were agreed patient removed from the waiting list.

## 6.14 No Capacity Patients

All patients that become 'no capacity' will be validated as part of the weekly PTL process. The Capacity Manager will then discuss additional activity with the relevant clinicians to try and accommodate these patients prior to breach date were possible. The Directorate Manager for each service will also receive a copy of this report weekly, to be managed and discussed with clinicians / Specialties. No capacity patients validated as part of the 104-week, 78-103 week, 52 week plus and 18 week plus process. All P code patients are also validated weekly to ensure that they still meet the criteria of the P Code that they have been assigned.

## 6.15 Reviewing patients who have waited longer than 18 weeks

Weekly reviews will be undertaken, and reports provided to the Trust's PTL meeting which include:

- A report of all admitted incomplete patients who have breached 18 weeks with the reasons why.
- A report of all non-admitted incomplete patients who have breached 18 weeks with the reasons why.
- A report of all incomplete patients who have breached 18 weeks with the reasons why.

Department Managers for Outpatients and Admissions will be responsible for providing these reports with an analysis of trends by specialty.

These trends should be discussed weekly at PTL, and action plans provided by Directorate Managers (DMs) to address any specialty issues.

It is the responsibility of the ADOs and DMs for each specialty to take action to address themes where 18-week breaches are caused for non-clinical reasons (e.g., capacity). Updates on actions must be provided weekly at the Trust PTL meeting.

It is the responsibility of the Consultant to ensure all patients on the waiting list who have waited over 18 weeks are clinically reviewed to ensure they are safe to continue to wait for surgery. If any patient needs expediting from a clinical point of view this is highlighted to the Admissions Manager with the reason why.

## 6.16 Right To Redress Process

*(Appendix 2, page 46)*

Department of Health published updated guidance in relation to the NHS Constitution in July 2015. The NHS Constitution sets out the following right for patients. *'You have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.'*

This means that patients have the right to start consultant-led treatment within 18 weeks from referral or seen by a specialist within 2 weeks of GP referral for suspected cancer. Where this is not possible, the NHS is to take all reasonable steps to offer the patient a quicker appointment at a range of alternative providers if the patient makes such a request. This will be the responsibility of the Admissions Department to make arrangements.

## 7. Training

Training on waiting list management (18 weeks) for new staff is mandatory and will be undertaken by the Trusts IT Training Department, Data Quality team and Department Leads. Key individuals will be tasked with ensuring that all new staff members involved in managing access targets and waiting times have the required knowledge and skills necessary to manage RTT performance effectively. These key individuals will also ensure that any future guidance in respect of 18 weeks is cascaded to the appropriate staff members through local inductions and periodic updates in a timely manner, and that any additional training is introduced as required. This policy, along with supporting suite of SOP's will form the basis of training programmes and ongoing support for staff.

## 8. Monitoring Compliance

### 8.1 Key Performance Indicators (KPIs) of the Policy

| No | Key Performance Indicators (KPIs) Expected Outcomes |
|---|---|
| 1 | To ensure that 92% of patients on an incomplete pathway have waited less than or up to 18 weeks. To ensure all diagnostic and cancer patients are booked within timeframe |
| 2 | To ensure that 99% of patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral |
| 3 | To ensure that 93% of patients on a two week wait urgent GP referral for suspected cancer have waited less than 2 weeks. |
| 4 | To ensure that 93% of patients on a two week wait referral with breast symptoms have waited less than 2 weeks. |
| 5 | To ensure that 96% of patients on a 31-day pathway from decision to treat to first treatment have waited less than 31 days |
| 6 | To ensure that 94% of patients on a 31-day pathway for surgical subsequent treatment have waited less than 31 days. |
| 7 | To ensure that 98% of patients on a 31-day pathway for drug treatment have waited less than 31 days. |
| 8 | To ensure that 94% of patients on a 31-day pathway for radiotherapy have waited less than 31 days. |
| 9 | To ensure that 85% of patients on a 31-day pathway from urgent GP referral to treatment for Leukaemia, Testicular and Children's Cancers have waited less than 31 days |
| 10 | To ensure that 85% of patients on a 62-day pathway from urgent GP referral to treatment have waited less than 62 days. |
| 11 | To ensure that 90% of patients on a 62-day pathway for screening to treatment have waited less than 62 days. |

## 8.2 Performance Management of the Policy

| Minimum Requirement to be Monitored | Lead(s) | Tool | Frequency | Reporting Arrangements | Lead(s) for acting on Recommendations |
|---|---|---|---|---|---|
| To ensure that 92% of patients on an incomplete pathway have waited less than or up to 18 weeks. To ensure all diagnostic and cancer patients are booked within timeframe | Deputy Director of Operations and Performance - Chair of PTL<br><br>Director of Operations and Performance | Regular Audits and internal and external reporting systems | Weekly and Monthly | PTL Meetings, Finance and Performance Committee | Deputy Director of operations and Performance - Chair of PTL |
| To ensure that 99% of patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral | | | | | |
| To ensure that 93% of patients on a two week wait urgent GP referral for suspected cancer have waited less than 2 weeks. | | | | Cancer specific PTL meeting, PTL meeting, Finance & Performance Committee, Trust Cancer Advisory Group | |
| To ensure that 93% of patients on a two week wait referral with breast symptoms have waited less than 2 weeks. | | | | | |
| To ensure that 96% of patients on a 31-day pathway from decision to treat to first treatment have waited less than 31 days. | | | | | |
| To ensure that 94% of patients on a 31-day pathway for surgical subsequent treatment have waited less than 31 days. | | | | | |
| To ensure that 98% of patients on a 31-day pathway for drug treatment have waited less than 31 days. | | | | | |
| To ensure that 94% of patients on a 31-day pathway for radiotherapy have waited less than 31 days. | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| To ensure that 85% of patients on a 31-day pathway from urgent GP referral to treatment for Leukaemia, Testicular and Children's Cancers have waited less than 31 days. | | | | | |
| To ensure that 85% of patients on a 62-day pathway from urgent GP referral to treatment have waited less than 62 days. | | | | | |
| To ensure that 90% of patients on a 62-day pathway for screening to treatment have waited less than 62 days. | | | | | |

| Audit Area | Frequency | Reporting | Responsibility |
|---|---|---|---|
| Audit: Reasonable Notice | Monthly | PTL Meetings | Data Quality |
| Audit: Clinic Disposal | Weekly | PTL Meetings | Patient Booking Services |
| Audit: WL Additions | Weekly | PTL Meetings | Admissions Team |
| Audit: End Date for Clock Pauses | Weekly | PTL Meetings | Data Quality |
| Audit: Hospital Rearrangements OP/IP/DC | Monthly | PTL Meetings | Data Quality |
| Audit: SOP's PBS Rules | Weekly | PTL Meetings | PBS Manager |
| Audit: Spot checks of Coding | Continuous | PTL Meetings | Data Quality |
| Audit: 1% DNA | Monthly | PTL Meetings | Data Quality |

## 9. References


| No. | |
|---|---|
| 1 | DOH The 18 week rules suite – definitions, national clock rules and 'how to' guide: https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks |
| 2 | DOH Diagnostics – Frequently asked questions https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01-FAQs-v-3.0.doc) |
| 3 | DOH 18 weeks RTT: Frequently asked questions https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Accompanying-FAQs-v7.2.pdf |
| 4 | Health Service Guidelines (97) 31 – priority treatment for war pensioners, NHE Executive, June 1997 |
| 5 | DOH Gateway 9222: Access to Health Services for Military Veterans, Dec 2007 |
| 6 | **MOD** The Armed Forces Covenant: Today and Tomorrow, May 2011 https://www.gov.uk/government/publications/the-armed-forces-covenant |
| 7 | DOH Gateway 12620: Reviewing patients who have waited longer than 18 weeks and reporting any unnecessary waits (breaches of the 18 weeks standard), January 2012 |
| | https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Reviewing-pathways-over-18-weeks-January-2012-Final.pdf |
| 8 | DOH NHS Choices http://www.nhs.uk/pages/home.aspx |
| 9 | DOH Handbook to the NHS Constitution, July 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/474450/NHS_Constitution_Handbook_v2.pdf |
| 10 | DOH Gateway 01000: Everyone Counts: Planning for Patients 2014-15 to 2018-19: https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf |
| 11 | NHS eReferral Service: Guidance for managing referrals. April 2018 https://www.england.nhs.uk/wp.../2018/04/nhs-e-rs-guidance-on-digital-referrals.pdf |


### 9.1 Links

http://www.dh.gov.uk/en/index.htm
www.dh.gov.uk
http://www.nhs.uk

## 10. Related Trust Documents

| No | Related Document |
|---|---|
| 1 | SOP: Outpatient Appointments |
| 2 | SOP: Receptions |
| 3 | SOP: Admissions (IP/DC) |
| 4 | SOP: Pre-op Booking Officer |
| 5 | SOP: PBS Booking Rules and Escalation Procedure |
| 6 | SOP: Booking Appointments (Radiology) |
| 7 | SOP: Cancer Management |
| 8 | SOP: 18 Weeks Reporting |
| 9 | SOP: Admin Surgical & Medical |

## 11. Equality Analysis Form

The screening assessment must be carried out on all policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects at the earliest stage in the planning process to ascertain whether a full equality analysis is required. This assessment must be attached to all procedural documents prior to their submission to the appropriate approving body. A separate copy of the assessment must be forwarded to the Patient Inclusion and Experience Lead for monitoring purposes.
Cheryl.farmer@sthk.nhs.uk. If this screening assessment indicates that discrimination could potentially be introduced, then seek advice from the Patient Inclusion and Experience Lead. A full equality analysis must be considered on any cost improvement schemes, organisational changes or service changes which could have an impact on patients or staff.

| **Equality Analysis** | | | |
|---|---|---|---|
| **Title of Document/proposal /service/cost improvement plan etc:** | Patient Access Policy | | |
| **Date of Assessment** | 13/07/2020 | **Name of Person completing assessment /job title:** | Patricia Keeley |
| **Lead Executive Director** | Director of Operations & Performance | | Assistant Director of Operations |

| | **Does the proposal, service or document affect one group more or less favourably than other group(s) based on their:** | **Yes / No** | **Justification/evidence and data source** |
|---|---|---|---|
| **1** | Age | No | Click here to enter text. |
| **2** | Disability (including learning disability, physical, sensory or mental impairment) | No | Click here to enter text. |
| **3** | Gender reassignment | No | Click here to enter text. |
| **4** | Marriage or civil partnership | No | Click here to enter text. |
| **5** | Pregnancy or maternity | No | Click here to enter text. |
| **6** | Race | No | Click here to enter text. |
| **7** | Religion or belief | No | Click here to enter text. |
| **8** | Sex | No | Click here to enter text. |
| **9** | Sexual Orientation | No | Click here to enter text. |
| | **Human Rights – are there any issues which might affect a person's human rights?** | **Yes / No** | **Justification/evidence and data source** |
| **1** | Right to life | No | Click here to enter text. |
| **2** | Right to freedom from degrading or humiliating treatment | No | Click here to enter text. |
| **3** | Right to privacy or family life | No | Click here to enter text. |
| **4** | Any other of the human rights? | No | Click here to enter text. |

| **Lead of Service Review & Approval** | |
|---|---|
| **Service Manager completing review & approval Job Title:** | Patricia Keeley<br>Assistant Director of Operations |

## Appendix 1 – process for PALS contact