Trust-wide Document

Great Western Hospitals NHS Foundation Trust

Elective Patient Access, Booking and Choice of Date Policy

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Target Audience- who does the document apply to and who should be using it. - The target audience has the responsibility to ensure their compliance with this document by: • Ensuring any training required is attended and kept up to date. • Ensuring any competencies required are maintained. • Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.	All employees directly employed by the Trust whether permanent, part-time or temporary (including fixed-term contract). It applies equally to all others working for the Trust, including private-sector, voluntary-sector, bank, agency, locum, and secondees. For simplicity they are referred to as "employees" or "staff" throughout this Policy.		
Special Cases	The RTT standards in this policy do not apply to non-consultant-led services. Certain activity is excluded from the 18-week **Referral to Treatment (RTT)** [25] standard, as detailed in Section **2.3.1** of this Policy.		
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Review period. This document will be fully reviewed annually to reflect the potentially fast-moving changes to guidance etc. specifically related to this Policy. Interim (monitoring) reviews will also be undertaken at 6 months, 18 months etc. to monitor adherence to guidance post Covid-19. Changes in practice, statutory requirements, revised professional or clinical standards, or local / national directives will be made as and when the changes are identified.			

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1 Introduction & Purpose

1.1 Introduction

The **Elective Patient Access, Booking and Choice of Date Policy** (hereafter, "the Policy") of Great Western Hospitals (GWH) NHS Foundation Trust (hereafter, "the Trust") is intended to ensure that all patients who are referred to, and are treated within, the Trust receive fair and equitable access. *Equitable access* describes access that ensures all patients, regardless of age, race, gender or other characteristic, receive access to care that gives them an improved health outcome. Because of structural inequality some people will have poorer health outcomes and lower life expectancy, and providing equitable access should seek to address this. All patients should receive services in line with the 18-week Referral to Treatment (**RTT**) guidance, the Cancer Waiting Time (**CWT**) standards, and the Diagnostic (**DM01**) guidance. Certain categories of patient will be accorded greater priority in line with the **Action required to tackle health inequalities in latest phase of COVID-19 response and recovery** [32] that describes the need to "restore services inclusively".

All GWH patients should receive services in line with the **NHS Constitution for England** [20], which brings together what staff, patients and the public can expect from the NHS. As well as capturing the purpose, principles and values of the NHS, the Constitution brings together a number of rights, pledges and responsibilities for staff and patients alike. These rights and responsibilities are the result of extensive discussions and consultations with staff, patients and the public and it reflects what matters to them.

The Policy will be reviewed regularly reflecting any changes in light of patient feedback, shared plans of the Swindon place-based partnership, the BSW Integrated Care System, or NHS Constitutional rights and pledges.

1.2 Purpose

The Policy will provide the Trust with a coherent approach to the management of waiting lists, scheduling and booking across the organisation, and will ensure that patients are treated in line with local and national policies regarding vulnerable adults, patients with learning disabilities, the safeguarding of children, and military veterans. The Trust is committed to the delivery of Same Sex Accommodation, preserving and protecting patient and client privacy and dignity whilst in Hospital, through the provision of segregated facilities for men and women.

It is essential that all staff involved in the management of patients awaiting elective treatment have a clear understanding of their roles and responsibilities in this process. This includes clinical, managerial and administrative staff. Every process in the management of patients who are waiting for treatment must be clear and transparent to the patients and to partner organisations and will be open to inspection, monitoring and audit. The Trust will give priority to clinically urgent patients and treat everyone else in turn and will share correspondence sent between clinicians and patients regarding their care.

The Policy details how patients will be managed administratively at all points of contact with the Trust, and should be implemented by staff in conjunction with any supporting SOPs.

The Policy states the overall expectations of the Trust and local Commissioners for the management of referrals and admissions into and within the Trust, and defines the principles on which the Policy is based.

The Policy reflects the key targets for access to Outpatient, Diagnostic and Inpatient services, for Planned Waiting List management, and for national **Referral to Treatment (RTT)** [25] standards, all in line with the **NHS Constitution for England** [20].

The Cancer Waiting Time (CWT) standards are referenced and explained within this Policy. However, the monitoring and management of cancer standards in relation to timed pathways is managed by the relevant tumour site service supported by the Trust's **Great Western Hospitals Adult Cancer Services Operational Policy**. It is anticipated that the diagnostic and treatment services will manage the CWT and clinical pathway standards via appropriate Standard Operating Procedures (SOPs) and that these should be read in conjunction with this Policy.

The Policy is intended to be of interest to, and used by, all those individuals within the Trust who are responsible for referring patients, managing referrals, and adding to / maintaining waiting lists for access to hospital treatment. The principles of the Policy apply to both medical and administrative waiting list management.

The Policy is a reference for patients, their families and carers, providing information regarding how their referrals and elective treatment plans will be managed by the Trust.

1.3 Glossary / Definitions

The following terms and acronyms are relevant and may be referenced within this document:

Acronym / Term	Definition
2WW - Two Week Wait	The maximum waiting time for a patient's first outpatient appointment or "straight to test" appointment if they are referred as a 62-day cancer pathway patient.
A&G – Advice and Guidance	A&G provides **Primary Care** with continued access to specialist clinical advice, enabling a patient's care to be managed in the most appropriate setting, strengthening shared decision making and avoiding unnecessary outpatient activity. It is **Non-F2F** activity which may be synchronous (e.g. telephone) or asynchronous (e.g. electronically vie **e-RS** or similar).
Active Monitoring	An 18-week clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures. A new 18-week clock would start when a decision to treat is made following a period of active monitoring.
Active Waiting List (Elective patients)	The list of elective patients who are fit, ready and able to be seen or treated at that point in time. Applicable to any stage of the **RTT** pathway where patients are waiting for hospital resource reasons.
Admitted Pathway	An admitted pathway refers to patients who require admission to hospital as either a **day case** or an **inpatient**, to receive their **first definitive treatment**.
ASI – Appointment Slot Issue	When patients or professional users of the **e-RS** are unable to book an appointment. The most common reason for this is a lack of appointment slots being made available to the **e-RS**.
Bilateral Procedures	Where a procedure is required on both the right and left sides of the body.
Breach	When a patient has not had a clock-closing event within the required 18-week target for elective treatment or the 6-week target for a diagnostic procedure.
BSW – Bath and North East Somerset, Swindon and Wiltshire CCG	The Trust's **CCG**.
C&B - Choose & Book	See **e-RS - e-Referral Service**.
CareFlow (Medway)	The Trust's **PAS**.
CATS - Clinical Assessment and Triage Service	The aim of a CATS clinic is to assess patients and determine the most appropriate course of action to manage and improve their symptoms. It is an **Interface Service**. CATS allow patients to be assessed and, where required, investigated and treated quickly.
CCG - Clinical Commissioning Group	Clinical Commissioning Groups commission most of the hospital and community NHS services in the local areas for which they are responsible. Commissioning involves deciding what services are needed for diverse local populations, and ensuring that they are provided.
Chronological Booking	Refers to the process of booking patients for appointments, diagnostic procedures and admission in date order of their clock start date.

Clinical Decision	A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements.
CNA - Can Not Attend	Patients who, on receipt of reasonable offer(s) of admission, notify the hospital that they are unable to attend.
Consultant	A senior doctor who has completed full medical training in a specialised area of medicine and is listed on the General Medical Council's specialist register.
Consultant-led	A service where a consultant retains overall clinical responsibility for the service, care team or treatment. Patients may be seen in nurse-led clinics that come under the umbrella of consultant-led services. The consultant will not necessarily be physically present for each patient's appointment, but he / she takes overall clinical responsibility for patient care.
CQC - Care Quality Commission	The Care Quality Commission regulates all health and social care services in England. The commission ensures the quality and safety of care in hospitals, dentists, ambulances, and care homes, and the care given in people's own homes.
CWT – Cancer Waiting Times	The **Operating Framework for the NHS in England 2012-13** [30] identified a series of performance standards relating to elective access, including cancers; the specific cancer targets are defined in the **National Cancer Waiting Times Monitoring Dataset Guidance** [19].
Day Cases	Patients admitted electively who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.
DHSC - Department of Health and Social Care	The Department of Health and Social Care helps people to live more independent, healthier lives for longer. It leads, shapes and funds health and social care in England, making sure people have the support, care and treatment they need, with the compassion, respect and dignity they deserve.
Diagnostic Test	A type of test used to help diagnose a disease or condition. Also called a diagnostic procedure.
Direct Access	Where GPs refer patients to hospital for diagnostic tests only. These patients will not be on an open **RTT** pathway.
DM01	Diagnostics Waiting Times and Activity – a national monthly diagnostics waiting times and activity return which collects data on waiting times and activity for 15 key diagnostic tests and procedures.
DNA - Did Not Attend	Patients who have the capacity to make a decision (i.e. Gillick competent or have capacity as defined in the Mental Capacity Act 2015) to attend appointments without a parent or carer and have been informed of their date of admission or pre-assessment (**inpatients/day cases**) or appointment date (**outpatients**, **diagnostic** appointment), and who then without notifying the hospital did not attend.
DOS - Directory of Services	The Directory of Services is the list of services that the Trust provides through the **e-RS** system. In effect, it is the shop window of the services offered by the Trust to its patients.
DPA – Data Protection Act	The **Data Protection Act 2018** [10] controls how an individual's personal information is used by organisations, businesses or the government. It is the UK's implementation of the General Data Protection Regulation (**GDPR**).
DRR - Date Referral Received	This is the date on which a hospital receives a referral letter from a GP. The waiting time for outpatients should be calculated from this date. For NHS **e-RS** referrals, this will be the date that the patient converts their **UBRN** (Unique Booking Reference Number). In relation to **Diagnostics** this is the date an internal request is made or the date of an external paper request is received.
DTA - Decision To Admit	Where a clinical decision is made to admit the patient for either **day case** or **inpatient** treatment.
DTT date - Decision To Treat date	The date on which a consultant decides a patient needs to be admitted for a procedure. This date should be recorded in the relevant waiting list & case-notes.
EIA - Equality Impact Assessment	An equality impact assessment is an evidence-based approach designed to help organisations ensure that their policies, practices, events and decision-making processes are fair and do not present barriers to participation or disadvantage any protected groups from participation.
Elective Care	Any pre-scheduled care that does not come under the scope of emergency care. Elective surgery or an elective procedure is surgery that is scheduled in advance because it does not involve a medical emergency.
EPEX	Community Electronic Patient Record.

e-RS - e-Referral Service	A national electronic referral service (formerly Choose & Book) that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic.
F2F – Face To Face	A consultation in which the patient is physically present with their clinician; compare to **Non-F2F**.
Fast Track Team	The Fast Track Team (Outpatient Booking Centre team, formerly the Cancer Administration Services Team (CAS)) is responsible for co-ordinating the administration of patients through a clinically timed cancer pathway.
FDT - First Definitive Treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further invention. What constitutes First Definitive Treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.
Fit, Willing and Able	To allow patients to receive the most appropriate form of treatment, they must be available, within reasonable notice, and be willing to receive the treatment as agreed with the treating clinician.
Fixed Appointments	Where an appointment or admission date is sent in the post or via email to the patient without the opportunity to agree a date.
Full Booking	Where an appointment or admission date is agreed by the patient, either over the phone or when the appointment date has been selected by the patient via **e-RS**. A confirmation letter or email is sent to the patient after the date is confirmed.
GDP – General Dental Practitioner	A qualified dental practitioner, registered with the General Dental Council (GDC), who provides general dental services.
GDPR – General Data Protection Regulation	A legal framework that sets guidelines for the collection and processing of personal information from individuals who live in the European Union (EU).
GP - General Practitioner	A doctor based in the community, registered with the General Medical Council (GMC), who treats patients with minor or chronic illnesses and refers those with serious conditions to hospital.
GWH - Great Western Hospitals	Great Western Hospitals NHS Foundation Trust.
Incomplete Pathway	Patients who are waiting for treatment on an open **RTT** pathway, either at the **non-admitted** or **admitted** stage.
INNF - Intervention Not Normally Funded	An intervention not normally funded i.e. a non-commissioned procedure.
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night. See **Admitted Pathway**.
Interface Service	Any service (excluding consultant-led services) that incorporates intermediate levels of triage, assessment and treatment between Primary Care and Secondary Care.
IPC - Infection Prevention and Control	Infection Prevention and Control is a practical, evidence-based approach to preventing patients and health workers from being harmed by avoidable infections.
IPT – Inter-Provider Transfer	An IPT occurs when a patient follows a pathway of care that involves a referral between providers.
KPI - Key Performance Indicator	A quantifiable measure used to evaluate the success of an organization, employee, etc. in meeting objectives for performance.
MATS - Musculoskeletal Assessment and Treatment Service	This specialist service manages the care of patients with musculoskeletal and spinal conditions - it is run by extended scope physiotherapists, who are highly specialised physiotherapists with many years' experience in musculoskeletal conditions.
MDS - Minimum Data Set	A specific set of information required to be provided at the point of referral or transfer.
MDT - Multi-disciplinary Team	A multi-disciplinary team involves a range of health professionals, from one or more organisations, working together to deliver comprehensive patient care.
NHS - National Health Service	Government-funded medical and health care services that everyone living in the UK can use without being asked to pay the full cost of the service.
Non-admitted Pathway	A non-admitted pathway refers to patients that do not require admission to hospital to receive care, i.e. the care is given or prescribed in outpatients. The care may take many forms e.g. First Definitive Treatment, Active Monitoring, discharge without treatment etc.
Non-consultant-led	A service where a consultant does not retain overall clinical responsibility for patient care.
Non-elective	Surgery required immediately or urgently for a clinical emergency.
Non-F2F – Non Face To	A consultation which is undertaken virtually and usually remotely, either via

Face	telephone or video. It is also known as Telemedicine / Telemed; compare to **F2F**.
Nullified	Where the **RTT** clock is discounted from any reporting of **RTT** performance.
OPD - Outpatient Department	The **Outpatient** Department is the part of the hospital designed for the treatment of outpatients, people with health problems who visit the hospital for diagnosis or treatment, but do not at this time require a bed or to be admitted for overnight care.
Outpatients	Patients referred by a General Practitioner or another health care professional for clinical advice or treatment. Patients who attend hospital for a clinic or treatment, but do not stay overnight, are called "Outpatients". See **Non-admitted Pathway**.
Partial booking	Where an appointment or admission date is agreed with the patient near to the time that it is due.
PAS – Patient Administration System	A user-friendly system for recording patient details and for the management of admissions, attendances and appointments.
Patient-initiated Cancellation	A cancellation is when a patient gives any advance notice of non-attendance. A cancellation is a cancellation even if the notice is very short. By cancelling an appointment a patient has shown a willingness to engage with the NHS.
Patient-initiated Delay	Where the patient cancels, declines offers or does not attend appointments or admission. This in itself does not the stop the RTT clock. A clinical review must always take place.
PIFU – Patient Initiated Follow Up	An arrangement in which the patient themself arranges a follow-up appointment as and when they need it, rather than it being at a routine interval. PIFU can avoid unnecessary appointments and be more convenient to the patient.
Planned Patient	A Planned Patient is a patient who will have an agreed treatment at an agreed future date after a staged treatment plan e.g. a reversal of a colostomy etc.
Primary Care	Primary Care services provide the first point of contact in the healthcare system, acting as the "front door" of the NHS. Primary Care includes general practice (GP), community pharmacy, dental, and optometry (eye health) services.
Prior Approval	Required for procedures that commissioners have either prohibited or restricted, and funding request / authorisation processes apply. In some health economies they are called "Procedures of Limited Clinical Value" or "Planned Procedures within Threshold".
PTL - Patient Tracking List	The PTL is a list of patients (both inpatients and outpatients) whose waiting time is approaching the breach date, who should be offered an admission / appointment before the breach date is reached. The Trust's **PTL** contains Admitted / Diagnostic / Non-Admitted patients waiting 0-100 wks - anyone over 19 wks will have already breached their 18-week pathway. The Trust's **RTT PTL (unvalidated)** contains a list of all Admitted / Diagnostic / Non-Admitted patients who are on an incomplete RTT pathway.
PWL - Planned Waiting List	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18-week **RTT** pathway. If a patient misses their planned admission date they are added to a Waitlist and a RTT and / or DM01 clock is started.
RACPC - Rapid Access Chest Pain Clinic	A clinic in which the patient is seen within two weeks of their date of referral, by a specialist nurse or GP (may also be within a clinically led clinic in secondary care).
RAS – Referral Assessment Service	A RAS gives providers the ability to triage referrals before booking an appointment for patients using the NHS **e-RS**. It supports clinical pathways and helps to reduce demand to elective care services.
RCPATH - Royal College of Pathologists	The Royal College of Pathologists is a professional membership organisation concerned with all matters relating to the science and practice of pathology.
Reasonable Offer	A "reasonable offer" is an offer for a time and date three or more weeks from the time that it is made. It is good practice to give patients at least two reasonable offers. Part of being reasonable means that the patient has been consulted and listened to, considering what the patient would find reasonable. For Urgent 2WW appointments- (**2WW** suspicious of cancer or consultant **2WW** upgraded referrals) to be deemed reasonable patients must be verbally offered 2 appointments within 14 days of receipt of the referral within a minimum of 24 hours' notice. Therefore offering day 13/14 on the pathway may not be considered a reasonable offer and should not be classed as patient choice if an

	appointment is booked passed 14 days.
RMC - Referral Management Centre	Referral Management Centres generally impose external control measures onto the referrals made by GPs into secondary care, such as triaging referral letters from GPs, linking referrals to booking centres, deciding the treatment route for a patient etc.
ROTT - Removal other than Treatment	An indication that a patient has been removed from a waiting list for any reason other than treatment.
RTT - Referral to Treatment	Referral to Treatment - 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. RTT data is collected nationally for 19 defined treatment functions.
SOP - Standard Operating Procedure	A set of written instructions that describes the step-by-step process that must be taken to perform properly an activity. SOPs should be followed the exact same way every time to guarantee that the activity remains consistent and in compliance with organisational standards.
Straight to Test	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an **RTT** pathway. This is a specific type of direct access diagnostic service whereby a patient will be assessed and may, if appropriate, be treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional.
Surveillance Patient	A Surveillance Patient is a patient who may need a follow-up test / procedure which is not planned for a specific date, but which may be undertaken on an ad hoc basis or at an undecided time in the future. At a specified future review date an assessment is made as to whether treatment is required or if a procedure is necessary e.g. a regular cystoscopy for the potential recurrence of a bladder tumour.
TAT - Turn Around Time	The time from a pathology sample being taken to the reporting of results, as defined within **RCPATH** guidance.
TCI - To Come In	Refers to an expected date of elective day case or inpatient admission.
TCI date - To Come In date	The offer of admission, or TCI date, is a formal offer in writing of a date of admission. A telephone offer of admission should not normally be recorded as a formal offer. Usually telephoned offers are confirmed by a formal written offer.
UBRN - Unique Booking Reference Number	The reference number that a patient receives on their appointment request letter when generated by the referrer through the NHS **e-RS**. The UBRN is used in conjunction with the patient password to make or change an appointment.
Virtual Clinic	A clinic where a patient case is reviewed without the patient being physically present (i.e. not a face-to-face consultation).
Waiting List	Patients awaiting elective admission for treatment and are currently available to be called for admission.
WNB - Was Not Brought	Applies to children, young people and adults who require the support or presence of a parent or carer to attend appointments) who did not attend a planned appointment and had not cancelled or rearranged the appointment.

2 Main Document Requirements

2.1 National Standards

2.1.1 Referral to Treatment (RTT) and Diagnostic Standards

The **Operating Framework for the NHS in England 2012-13** [30] identifies a series of performance standards relating to elective access, including cancers; the RTT and diagnostic targets are referenced in **Appendix B** and may be summarised as follows:

Referral to Treatment - RTT	92% of all patients must be treated within 18-weeks.
Diagnostics – DM01	99% of diagnostic tests must be completed within 6-weeks.

The reason why the RTT target is not 100% is because of an 8% allowance that is made for patients who, through no fault of their own, are unable to be seen and treated within 18-weeks (including social reasons). The 8% allowance considers the following scenarios:

- **Clinical Exception** - patients for whom it is not clinically appropriate to be treated within 18-weeks.
- **Choice** - patients who choose to wait longer for one or more elements of their care.
- **Co-operation** - patients who do not attend their appointments.

2.1.2 Cancer Waiting Times (CWT) Standards

The **Operating Framework for the NHS in England 2012-13** identified a series of performance standards relating to elective access, including cancers; reference should be made to the **Great Western Hospital Acute Adult Cancer Services Operational Policy** [13]. The specific cancer targets are defined in the **National Cancer Waiting Times Monitoring Dataset Guidance** [19], are referenced in **Appendix C**, and may be summarised as follows:

Urgent Referral (2WW)	• 93% of patients urgently referred by their GP (GMP, GDP or Optometrist) for suspected cancer will wait no longer than 2-weeks to their first outpatient attendance. • 93% of patients referred with breast symptoms (where cancer is not suspected) will wait no longer than 2-weeks to their first hospital assessment.
Cancer 28 Day Standard (Faster Diagnosis Standard - FDS)	75% of patients who are: • urgently referred (2WW) by their GP (GMP, GDP or Optometrist) for suspected cancer, or • urgently referred from a cancer screening programme (breast, bowel, cervical), or • referred (2WW) with breast symptoms (where cancer is not suspected) will be informed within 28 days of either a diagnosis or that cancer has been ruled out.
Cancer 31 Day Standard	• 96% of patients will wait no longer than 31 days from the Decision to Treat to First Definitive Treatment. • 94% of patients will wait no longer than 31 days from the Decision to Treat / earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients (including those diagnosed with a recurrence) where the subsequent treatment is **surgery**. • 98% of patients will wait no longer than 31 days from the Decision to Treat / earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients (including those diagnosed with a recurrence) where the subsequent treatment is **drug treatment**. • 94% of patients will wait no longer than 31 days from the Decision to Treat / earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients (including those diagnosed with a recurrence) where the subsequent treatment is **radiotherapy**.
Cancer 62 Day Standard	• 85% of patients will wait no longer than 62 days from an urgent referral for suspected cancer to first treatment. • 90% of patients will wait no longer than 62 days from an urgent referral from a NHS Cancer Screening Programme (breast, cervical or bowel) for suspected cancer to first treatment.
No separate operational standards set	• 85% (local measure) of patients will wait no longer 62 days from a consultant upgrade of referral urgency to first treatment. • 85% (as per the 62 Day Standard) of patients will wait no longer than 31 days from urgent GP (GMP, GDP or

	Optometrist) referral to first treatment for rare cancers i.e. acute leukaemia, testicular cancer and children's cancers.

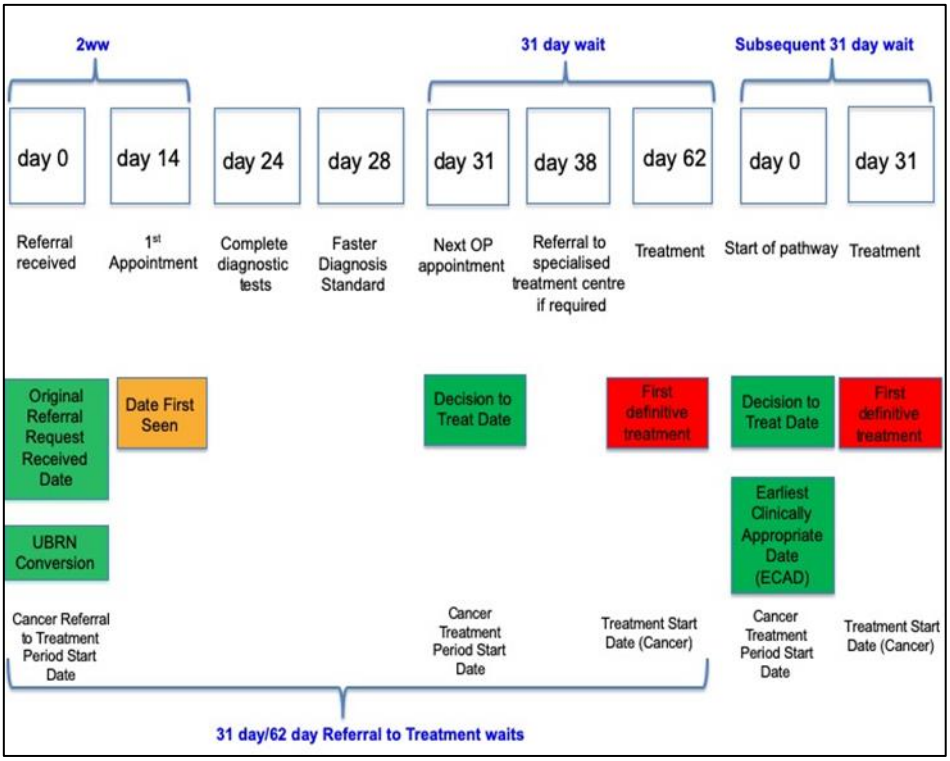


Figure 1 CWT 2WW, 28 day, 31 day and 62 day Standards

2.1.3 Patients Excluded from Monitoring under the CWT Standards

Excluded	Exception
Patients with a non-invasive cancer in situ	• Breast – included.
Patients with a basal cell carcinoma (BCC)	
Patients who die before treatment commencing	
Patients receiving diagnostic services and treatment privately	• Where a patient chooses to be seen initially by a specialist privately but is then referred for treatment under the NHS, the patient should be included under the 31-day standard. • Where a patient is first seen under the 2WW standard, and then chooses to have diagnostic tests privately before returning to the NHS for cancer treatment, only the 2WW standard and 31-day standard apply. The patient is excluded from the 62-day standard as the diagnostic phase of the period has been carried out by the private sector.

2.2 Eligibility and Patient Rights

2.2.1 Patient Eligibility

The Trust has an obligation to identify patients who are not eligible for free NHS treatment and specifically to assess liability for charges in accordance with Department of Health guidance / rules.

The Trust will check every patient's eligibility for treatment. Therefore, at the first point of entry, patients will be asked questions that will help the Trust to assess their "ordinarily resident" status "ordinarily resident" will qualify the patient to receive free hospital treatment. Some visitors to England do not have to pay for NHS hospital treatment because they are within one of the exemption categories. See the **NHS entitlements: migrant health guide** [31] for further information.

All members of staff have a responsibility to identify patients who are overseas visitors and to refer if necessary to the *Overseas Administration Team* for clarification of status regarding entitlement to NHS treatment before a first appointment is booked or a date to come in (TCI) is agreed.

Queries may be addressed to the *Overseas Administration Team* at gwh.overseasadmin@nhs.net.

2.2.2 Patient Rights

The **NHS Constitution for England** [20] clearly sets out a series of pledges and rights stating what patients, the public and staff can expect from the NHS. A patient has the right…

- to a choice of hospital and consultant, and
- to begin their treatment for routine conditions following a referral into a consultant-led service within a maximum waiting time of 18-weeks to treatment, and
- to be seen by a cancer specialist within a maximum of 2-weeks from a GP urgent 2WW referral where cancer is suspected.

If this is not possible, the NHS has to take all reasonable steps to offer a range of alternatives.

The right to be seen within the maximum waiting times does not apply…

- if the patient chooses to wait longer, or
- if delaying the start of the treatment is in the best clinical interests of the patient, or
- if it is clinically appropriate for the patient's condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage.

All patients are to be treated fairly and equitably regardless of race, gender, religion or sexual orientation.

2.2.3 Patient Choice – the e-Referrals Service (e-RS)

The NHS e-RS service gives patients (and their GPs) a choice of place, date and time for the first consultant-led outpatient appointment. Patients have the facility to schedule their appointment date and time via either the Internet or a dedicated e-RS Appointment line.

2.2.4 Patients Moving Between NHS and Private Care

Patients can choose to move between NHS and private status at any point during their treatment without prejudice. This is provided NHS care is delivered in clear episodes that are demonstrably separate from any privately funded care. This is to ensure the patient does not combine elements of NHS and private treatment / care within the same episode.

Following a private outpatient appointment, a consultant can refer into the NHS without the need for it to go via a GP. 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 information from the private consultation should be forwarded in the referral into the NHS; this is so that the patient follows the correct pathway and the Trust can collect the correct payment.
If, during an NHS consultation, the patient enquires about private treatment, it is acceptable for the Consultant to explain the options available to them; the Consultant should not, however, promote solely their own private practice. In cases where clinically appropriate treatment is not funded by the NHS, patients should be informed of the options open to them, including the option of seeking the treatment privately.

All doctors have a duty to share information with others providing care and treatment for their patients. This includes NHS doctors providing information to private practitioners.

Private to NHS referrals should be made using "consultant to consultant" functionality until functionality exists within e-RS to carry out "any to any" referrals.

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.

2.3 General Principles – RTT and Diagnostic Standards

2.3.1 Waiting Times

18-week waiting times are calculated from the pathway start (referred to as a clock start) to the pathway end (referred to as a clock stop). There cannot be a pause applied to the pathway or any adjustment made. The patient breaches their waiting time on day 127 (18-weeks).

Breaches of an 18-week wait are to be avoided wherever possible. In addition, the Trust will work towards reducing the waiting time for a first outpatient appointment via the following:

- A maximum of six weeks from date requested to the date of appointment for specialties with admitted pathways i.e. those that may end in an admission to hospital (either inpatient or day case) for treatment.
- A maximum of six weeks from date requested to date of appointment for diagnostic tests (including Audiology).
- A maximum of twelve weeks from date requested to the date of appointment for specialties with non-admitted pathways i.e. those that do not end in an admission to hospital for treatment.

The following activities are excluded from the 18-week RTT standard and hence will not start an RTT clock:

- Non-elective admissions.
- Obstetric / Maternity pathway.
- Patients on non-consultant-led pathways (a list of the 19 consultant-led pathways which are included in the 18-week RTT standard is included in **Appendix D**).
- Patients receiving on-going care for a condition for which First Definitive Treatment has already occurred.
- Diagnostic services if the referral is on an agreed straight-to-test pathway.
- Referrals from non-English commissioners.
- Genitourinary medicine (GUM) services.
- Emergency pathway non-elective follow-up clinic activity.

- Patients participating in research projects, requiring treatment according to the research protocol.
- Primary dental services provided by dental students in hospital settings.
- Planned patients, unless their intended recall date is breached at which point a new RTT clock will start.
- Surveillance patients.

Occasionally the Trust may use patient services from alternative providers, particularly diagnostic investigations. For all patients, but particularly those who are on 18-week pathways, the management teams must continue to monitor the patient pathway and ensure wherever practical that any delays are minimised.

2.3.2 Waiting List Size

Overall waiting list size for both admitted and non-admitted pathways is monitored regularly through the *Trust Access Meetings*, the *RTT Oversight Group* and the *Elective Care Steering Group*.

Internal Trust targets for overall waiting list size will be set annually by service and by cohort (admitted / non-admitted / diagnostic) and reported on a weekly basis to maintain rigour and to give assurance. Divisions and services are responsible for escalating through the appropriate forums to the *Divisional Director - Surgery, Women and Children's* and the *Deputy Chief Operating Officer* if there is any risk of an unexpected increase in waiting list size for any service.

Stable waiting list sizes for individual services will be reviewed quarterly in line with referral growth analysis and demand and capacity modelling.

2.3.3 Internal Standards for Urgent 2WW Referrals

- Systems should be in place to allow GPs, GDPs and Optometrists to make Urgent 2WW suspected cancer referrals, and for symptomatic breast referrals to be made via any route. Urgent 2WW referrals can be made and recorded via other sources where this is agreed locally between the CCG and the Trust.
- A patient should not be discharged because they are unavailable within the specified timeframe (see proviso in next bullet), and processes should be in place to ensure patients have the choice to book outside of the 2WW timeframe.
- At the point of referral the GP / referrer will ensure that the patient is aware for the reason for referral, that they are available to attend an appointment within the two-week timeframe, and that they understand the importance of attending.
- The duty of care is with the referring GP Practice. The Practice will therefore need to have systems in place to ensure that referral letters are sent promptly and to ensure that patients convert their UBRNs in a timely way wherever patients book their appointments directly through the e-RS.
- For 2WW referrals the required information should be sent to the Trust within one working day of the date of the GP referral. The date of a referral's creation within the e-RS is shown as "defer to provider" and the calculation will be made between this date and the "UBRN Received" date.

2.3.4 Internal Standards for Routine & Urgent (non-2WW) Referrals (RTT 18-week)

The key steps of a typical RTT pathway are:

- Initial referral into the Trust from a GP or another provider, or from within the Trust to a consultant-led service or interface service.

- First outpatient (OP) or straight to test appointment.
- Diagnostic test phase – elective and planned.
- Subsequent outpatient appointment phase, if required.
- Admission for surgery – elective and planned.

and are shown chronologically in Figure 2 below:

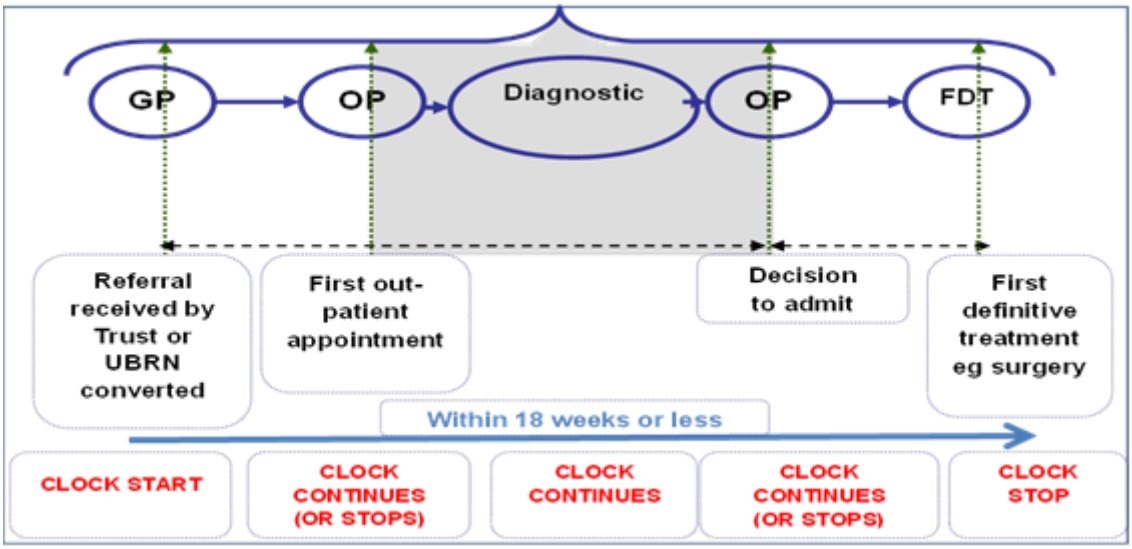


Figure 2 Typical RTT Pathway Chronology

2.3.5 Referral to Treatment (RTT) Rules [27] / Pathways

2.3.5.1 Clock Starts

The RTT clock starts when…	• via **Primary Care**, the patient or GP books (or attempts to book) a consultant-led appointment or an interface service appointment, or • an internal **Consultant to Consultant** referral is received into a different service / specialty, or • a Decision to Treat is made at the **End of Active Monitoring**, or • a **New and Significantly Different Treatment Plan** is agreed between the consultant and patient, or • a patient on a **Planned List** reaches their planned appointment date, or • a patient is fit, willing and able following their first **Bilateral Procedure** and is now ready for their second procedure.

Primary Care

The date of the UBRN conversion date for e-RS referrals is the date that the clock starts, or the date that the Trust receives a paper referral letter (only in cases where the referrer does not have access to e-RS). 18-week RTT pathways start with referrals from Primary Care as follows:

- Medical or surgical consultant-led services - irrespective of setting.
- Cancer services, for which a 62-day cancer target clock also starts.
- Diagnostic services, provided the patient will be assessed and, if appropriate, treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional.

- Practitioners with special interests if they are part of a referral management arrangement.
- Where a patient has been seen privately and then is referred by the GP to the Trust after being offered the choice.

Note that GP requests for Advice and Guidance will not start a RTT clock.

Consultant to Consultant

Consultant to Consultant referrals are acceptable if the referral is for the same condition that the patient was originally referred to the Trust for. If a condition can be managed in Primary Care then the patient should be discharged back to their GP. Consultant to Consultant referrals must not be made by junior medical staff without the approval of a Consultant.

Where a patient has been referred by a GP to one service within the Trust, the clinician is allowed to make an onward outpatient referral to any other service, without the need for referral back to the GP, where…

- the onward referral is directly related to the condition for which the original referral was made, or
- the patient has an immediate need for investigation or treatment (suspected cancer, for instance).

By contrast, the **NHS Standard Contract** [22] requires that a secondary care clinician should not refer onwards where the condition is not directly related to the originally referred condition or if a patient's condition is non-urgent. In this situation the clinician should refer to the patient's GP; if the GP agrees, the onward referral can then be made by either the clinician or the GP, although the GP may instead choose to manage the patient's condition themselves or else refer into a different service.

The **Academy of Medical Royal Colleges – Clinical Guidance: Onward referral – A working group report** [1] advises, however:

"The working group believes that decisions on whether an onward referral is appropriate or the patient should be referred back to the GP are matters for individual clinical judgement whilst, of course, working within the contract requirements…Discussions should therefore be essentially clinical not contractual."

End of Active Monitoring

If, after a period of active monitoring, the patient or the care professional then decides that treatment is now appropriate, a new 18-week RTT clock starts. This new clock starts at 0 weeks; it does not restart at the point at which the previous clock was stopped. There is then a new 18-week RTT period in which the patient must receive their First Definitive Treatment.

New and Significantly Different Treatment Plan

If a decision is made to start a new and significantly different treatment plan, a new RTT clock will start at the date the decision is made. To support the correct start of an RTT pathway in this regard, treatment plans must be clearly documented in clinic consultations. If the treatment was part of the original plan i.e. not just preferred by the patient, then this does not constitute a new clock start.

Planned List

When patients on planned lists are clinically ready for their care to commence and reach the date for their planned appointment, they either should receive that appointment or be transferred to an active waiting list and a RTT clock started (and a DM01 clock started if a diagnostic test is also required).

Bilateral Procedures

If a decision to treat involves bilateral procedures e.g. both cataracts, both knees, as part of a single pathway of care, the patient should be listed on the waiting list for the first procedure with a comment noting that a second "bilateral" procedure is to take place when the patient has recovered from the first. After surgery for the first procedure the 18-week RTT clock stops. When the Consultant deems the patient fit from the first procedure, they should then be placed on the waiting list with a new RTT period and clock start for the second procedure.

2.3.5.2 On-going Clocks – Specific Observations

Flight Restrictions

There should be few cases in which flight restrictions will apply to surgical patients. If, during consultation, a clinical decision is made that a patient must not have surgery before or after a long-haul flight, any periods of excluded time must be taken into account within the patient's 18-week RTT pathway. The RTT clock will continue to tick. Therefore, when planning surgery for such patients the excluded time must be taken into account to prevent an RTT breach, and this must be clearly documented in the patient's record.

DNAs

When a patient DNAs a first outpatient appointment, and the clinical decision is to offer a further appointment, the RTT clock should be restarted from the date contact is made with the patient and not the date of the new appointment.

2.3.5.3 Clock Stops

The RTT clock stops when…	• **First Definitive Treatment is given** (outpatient setting), or • the patient is admitted and **First Definitive Treatment is given** (inpatient setting), or • a **Period of Active Monitoring** is started, or • the **Patient Does Not Attend (DNAs)** their first or subsequent activity (excluding cancer 2WW, urgent or safeguarding-related patients), or • the **Patient Cancels Care Activity**, or • the patient is discharged (**Treatment Not Required**), or • the patient's **Care is Transferred** to another provider, or • the **Patient Dies Before Treatment**.

First Definitive Treatment is Given

The RTT clock stops when the first definitive treatment starts.

First definitive treatment is defined as being an intervention intended to manage a patient's disease, condition or injury and avoid further intervention. The date that the first definitive treatment starts will stop the clock. This may be in either an interface service or a consultant-led service.

Start of a Period of Active Monitoring

This is where it is clinically appropriate to monitor the patient in secondary care without clinical intervention or further diagnostic procedures. Active monitoring can be initiated by either the patient or the Clinician. The start of a period of active monitoring stops the RTT clock. If a new form of treatment is required at the end of the active monitoring period, a new clock starts from zero weeks and the Trust has a further 18-weeks to treat the patient.

Patient Does Not Attend (DNAs) Their First Activity

Excluding cancer 2WW, urgent or safeguarding-related patients (see Section 2.3.5.9).

When a patient fails to attend the first activity (appointment or diagnostic test) in their pathway, their RTT pathway is nullified subject to a more definitive action being taken.

Where the clinician feels it appropriate to offer the patient a new appointment, then a new RTT clock would start on the date that the patient agrees the new appointment date (not the date of the rescheduled appointment itself).

Where this is not the case, the patient may be referred back to Primary Care, providing it can be demonstrated that…

- the appointment was clearly communicated and reasonable notice of the appointment was given, and
- discharging the patient is not contrary to their best clinical interest.

Particular attention should be made to protect the interests of vulnerable patients e.g. children.

Patient Does Not Attend (DNAs) Their Subsequent Activity

Excluding cancer 2WW, urgent or safeguarding-related patients (see Section 2.3.5.9)

When a patient DNAs a subsequent appointment, diagnostic test, pre-assessment appointment or To Come In date (TCI) for elective admission, and where it is appropriate to continue to retain clinical responsibility for the patient at the Trust, a further appointment should be offered and the patient's RTT clock should continue ticking.

The patient may be discharged back to Primary Care, and their 18-week RTT clock will be stopped, providing that the Trust can prove that…

- the appointment was clearly communicated and reasonable notice of the appointment was given, and
- discharging the patient is not contrary to their best clinical interest.

Should the patient wish to receive treatment, then they can be re-referred by their GP – a new RTT pathway and period would start on receipt of the re-referral to the Trust.

This guidance also applies to children unless there is concern raised as part of the **Safeguarding Children and Young People at the Great Western Hospital Policy** [29], and which would suggest that further appointments might be given; however, the RTT clock

continues from the date of the original referral. Reference should also be made to the Trust's **Managing Child Missed Health Appointments Policy and Guideline** [15].

Patient Cancels Care Activity

See Section **2.3.5.7** for details.

Treatment Not Required

When the Clinician and/or the patient decide that treatment is not required, or a decision is made that no treatment is to occur, the patient's RTT clock is stopped.

A decision not to treat may occur outside of a face-to-face clinical consultation e.g. if a patient is discharged on the basis of a test result which is communicated to the patient and their GP by letter or telephone. This can occur at any stage of the patient's pathway and will also stop the RTT clock.

Care is Transferred

If a patient is referred from one provider to another as part of their RTT period, their original 18-week RTT clock will keep ticking *with the new provider* until the first definitive treatment, but the clock with the originating provider will be nullified. The originating provider should ensure that the patient's initial RTT start date forms part of the onward referral information; this information is known as the Minimum Data Set (MDS). An Inter-Provider Transfer (IPT) form is required and this is the responsibility of the originating provider.

Patient Dies Before Treatment

When a patient dies before they receive treatment, their 18-week RTT clock will be stopped and their RTT pathway ended.

2.3.5.4 Patient Initiated Delays

A patient may wish to delay their appointment or treatment for greater than two months for social reasons e.g. outside of school term for teachers or university term for students. Such delays do not have any impact on recorded RTT waiting times. However, the patient should inform the Trust of these delays when they occur. Upon being notified, the relevant booking team will inform the consultant responsible for the patient's care and a clinical decision will be made as to the risk to the patient.

Consultants must review every patient's case individually to determine whether there is the potential for any delay to cause clinical harm to the patient and the decision recorded and held within the patient's clinical record.

Should the delay not cause any clinical risk to the patient it may be appropriate to discharge the patient back to their GP on the basis that the patient should only have been referred if they were available for appointment or treatment. This decision can only be made by the consultant in charge of the patient's care and should be clearly communicated to both the patient and their GP.

Should the delay cause a potential clinical risk to the patient the risks must be communicated to the patient and the patient should be encouraged to make every effort to attend. It is advisable for this conversation to be led by the responsible clinician. The relevant clinical risk assessment must be documented in the patient's clinical record.

The delay of two months should not be seen as a blanket delay period to instigate the above process. An individual judgement by the consultant should be made on an individual case-by-case basis, with the initial assessment being whether the request for a delay in treatment is reasonable or not.

2.3.5.5 Patient Requiring Thinking Time

A patient may wish to spend time thinking about the recommended treatment options before they proceed. If the patient requires thinking time of up to two weeks it would not be appropriate to stop the RTT clock. The patient should be asked to contact the Trust within an agreed time period with their decision. The agreement and timescale should be recorded in the clinic letter as part of the patient's consultation.

It may be appropriate for the patient to be entered into active monitoring (and the RTT clock stopped) when they do not anticipate making a decision within this timeframe. This decision can only be made by a clinician on an individual case-by-case basis and with the patient's best clinical interests in mind. In this scenario, a follow-up appointment must be arranged around the time the patient would be in a position to make a decision. A new RTT clock should start from the date of the decision to admit if the patient decides to proceed with surgery.

Should a patient require thinking time of greater than two weeks it may be appropriate to discharge the patient back to their GP. This decision can only be made by a consultant on an individual case-by-case basis. The patient's best clinical interests must be considered before a decision to discharge the patient back to the GP can be made. When the patient feels they are ready for treatment they may then be re-referred by their GP.

2.3.5.6 Reasonableness

Reasonableness is a term that is applicable to all stages of the 18-week pathway and refers to the criteria that should be met when offering patients outpatient appointments or inpatient admission dates. For the purposes of this Policy, a reasonable offer is the choice of two appointment dates with at least three weeks' notice. If the patient accepts an offer at shorter notice (which is particularly relevant in urgent / cancer 2WW cases) then this also represents a reasonable offer in respect to the management of cancellations or DNAs. Patients who refuse two reasonable offers will be subject to a clinical review and may potentially be discharged back to their GP.

The aim of the Trust will always be to offer a date appropriate for a patient's clinical priority and to treat in as timely a manner as possible.

Prior to referral, patients should be made familiar with their obligations to the RTT pathway and that recurrent cancellations of their appointments could delay their treatment. Specifically patients have a responsibility to be "fit, willing and able":

- **Fit** – aware of their planned treatment and are in their best health to get the maximum benefit from it. This can include maintaining a healthy weight and stopping smoking for example.
- **Willing** – clear about what their treatment entails and are willing to sign up to it at the outset.
- **Able** – committed to attending future appointments and understand that this may require flexibility on their part.

A patient should only be added to an active waiting list if…

- there is a sound clinical indication for surgery, and
- the patient is clinically fit, willing and able, and
- any Prior Approval, re. both criteria and funding, has been agreed in the case of an Intervention Not Normally Funded (INNF).

2.3.5.7 Patient Initiated Cancellations

Cancellations by patients who give prior notice, however small, are classed as "Patient Initiated Cancellations". If a patient cancels their first appointment or TCI date anywhere in an RTT pathway, another appointment or TCI date should be re-arranged at that contact, and ideally within two weeks of the original appointment or TCI date.

If a patient cancels, rearranges or postpones their appointment, this has no effect on the RTT clock, which should continue to tick.

Upon a second cancellation, assuming reasonable notice for each has been provided, the patient should be clinically reviewed and a decision taken to either…

- discharge them and return them to the care of their referrer (excluding cancer 2WW and urgent patients and any patients managed under safeguarding arrangements, which would not under any circumstance warrant discharge upon a second cancellation), or
- arrange another appointment or TCI date ideally within two weeks of the most recently cancelled appointment or TCI date.

For 2WW referrals, patients should never be referred back to their GP after single or multiple appointment cancellations unless this has been agreed with the patient; by cancelling an appointment a patient has shown a willingness to engage with the NHS.

Where a decision is made to return a patient to their GP, their 18-week RTT clock will be stopped. Should the patient wish to receive treatment, they then can be re-referred by their GP; a new RTT pathway would start on receipt of the re-referral to the Trust.

If a patient cancels their appointment via e-RS and does not rebook following the receipt of reminder letters, it will be assumed that the referral is not required, the UBRN will be cancelled, and the patient will be referred back to their GP.

When a patient has a different condition that is being managed by their GP but which is preventing the treatment of the condition they were referred for i.e. the patient is not fit, willing and able, the 18-week RTT clock should be stopped and the pathway ended. The clinician should write to the GP explaining that if the patient is fit, willing and able within 12 weeks they should contact the Trust to place the patient back on the waiting list.

If a patient cancels their appointment and does not require further appointments, the 18-week RTT clock will be stopped, the RTT pathway ended, and the patient referred back to their GP.

Patients with a minor ailment, such as a cold or a cough, which would be resolved in a short period of time (considered to be approximately two weeks), should be added to the waiting list. The RTT clock will continue to tick.

Given that patients booking through e-RS have the ability to amend or cancel their appointment numerous times, the respective booking service should monitor the number of cancellations carefully.

2.3.5.8 Trust Cancellations & 28 Day Return

If the Trust cancels an appointment or TCI date anywhere on an RTT pathway, the clock continues to tick. For an Outpatient or Diagnostic appointment, the patient should have a new appointment arranged as soon as practically possible.

If the Trust cancels an Inpatient operation / procedure on the day of admission for non-clinical reasons, the patient must be offered a new date that is within 28 days of their original date. Ideally, if the patient has attended, they should leave the hospital with their new TCI date. If not, the patient must be contacted within 5 working days of their cancellation and offered a new TCI date.

Patients who are cancelled at any point in time prior to surgery will always be notified by telephone and offered a new date (reasonableness criteria remain applicable). A notification of cancellation letter will be sent to the patient's GP.

2.3.5.9 Did Not Attends (DNAs)

Excluding cancer 2WW, urgent or safeguarding-related patients…

If a patient DNAs their first activity following referral (the first outpatient appointment or first diagnostic appointment) the patient's clock will be nullified.

Where the clinician feels it appropriate to offer the patient a new appointment, then a new clock would start on the date that the patient agrees the new appointment date (not the date of the rescheduled appointment itself).

Where patients who attend their first appointment but then DNA any subsequent appointment in their pathway, and where it is appropriate to continue to retain clinical responsibility for the patient at the Trust, a further appointment should be offered and the patient's waiting time clock should continue ticking.

In all other cases the patient may be discharged back to their GP, the patient's 18-week RTT clock stopped, and the RTT pathway ended.

In all instances of a patient being re-referred back to the Trust this will be a new referral that starts a new 18-week RTT pathway and clock.

In all cases of clock nullification because of a patient's DNA the Trust must be able to prove that…

- the appointment was clearly communicated and reasonable notice of the appointment was given, and
- discharging the patient is not contrary to their best clinical interest.

For cancer 2WW, urgent or safeguarding-related patients…

Patients should not be referred back to their GP after a single Did Not Attend (DNA); they should only be referred back to their GP after multiple DNAs and only following a clinical decision to do so.

2.3.5.10 Active Monitoring

Active monitoring is where a decision is made that the patient does not require any form of treatment currently but should be monitored in secondary care. When a decision to begin a period of active monitoring is made and communicated with the patient, the RTT clock stops. Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made.

It is not appropriate to stop a clock for a period of active monitoring if some form of diagnostic or clinical intervention is required in a couple of days' time, but it is appropriate if a longer period of active monitoring is required before further action is needed. Stopping a patient's clock for a period of active monitoring requires careful consideration case by case and needs to be consistent with the patient's perception of their wait.

2.3.5.11 Uncontactable Patients

If a patient is uncontactable at any time the first action is to check if the contact details we have for the patient are correct and current on the PAS; this is done via the NHS Spine or by contacting the patient's GP. Once the details have been confirmed / updated, two further attempts will be made to contact the patient by the route(s) most likely to result in a successful contact. All contact attempts via telephone or letter are to be documented on the PAS.

It is recommended that a letter should specify timeframes and subsequent actions e.g. *"You have 14 days to respond to this letter; if we do not hear from you in this time a clinical review will be undertaken which could result in you being discharged back to your GP"*

If the patient remains uncontactable then a clinical review should decide if further attempts at contact are to be made or if the patient should be discharged back to their GP.

2.3.6 Pre-Operative Assessment

Pre-operative assessment (POA) will be used in elective surgical cases to determine the patient's fitness for surgery at the proposed time. A patient may be assessed by questionnaire / telephone and may be asked to attend a multi professional pre-op appointment. If the patient is found to be medically unfit, Trust personnel should implement the guidance in Section **2.3.7** below.

2.3.7 Medically Unfit Patients

This excludes those patients for whom the risk of not having surgery outweighs the risk of proceeding when unfit. The decision to proceed with these types of patients lies entirely with the consultant anaesthetist / consultant surgeon who, following a review, will make a decision whether to proceed or not.

Patients awaiting admission who become medically unfit for surgery three weeks after a Decision to Admit is made, and who will be medically unfit for longer than four weeks, must be discussed with the clinical teams and may be discharged back to the care of their GP. If this situation occurs as a result of nurse led Pre-Op Assessment (POA), then the POA nurse must communicate the outcome back to the consultant for review. Removal of the patient from the waiting list cannot be decided at this point.

2.3.8 Determining Priority

All patients who are added to the Inpatient Waiting List must be given an appropriate Clinical Prioritisation Code, as defined in Section **2.4.3.4**.

A number of specialities within the Trust operate “shared patient care”, or “list pooling.” This enables patients to be listed to the most appropriate clinician with the shortest possible wait times (unless a particular clinician is expressly stated on clinical grounds or via patient choice). Within the **NHS Constitution for England** [20], all patients should be offered choice.

See section **2.3.18.3 Vulnerable Patients / Safeguarding** for more specific prioritisation information for vulnerable patients.

2.3.9 Chronological Booking

Patients will be selected for booking appointments or admission dates according to clinical priority (see Section **2.4.3.4 Clinical Prioritisation Codes**). Generally patients of the same clinical priority should be appointed / treated in RTT chronological order, i.e. the patients who have been waiting the longest will be seen first. Patients will be selected using the Trust’s Patient Tracking Lists (PTLs).

See section **2.3.18.3 Vulnerable Patients / Safeguarding** for more specific booking / prioritisation information for vulnerable patients.

2.3.10 Planned Patient Lists

Commissioners and providers need to plan and manage their services so that new and planned patients are treated at the right time and in order of clinical priority. Patients requiring initial or follow-up appointments for clinical assessment, review, monitoring, procedures, or treatment must be given a specific date and time, as required by best clinical evidence. Patients should only be added to a planned list where clinically they need to wait for a period of time. This includes planned diagnostic tests or treatments or a series of procedures carried out as part of a treatment plan – which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.

Patients on planned lists should be booked in for an appointment at the clinically appropriate time and they should not have to wait a further period after this time has elapsed. For example, a patient due to have a re-test in six months’ time should be booked in around six months later and they should not get to six months, and then have to wait again for non-clinical reasons. This is not an acceptable use of a planned list.

When patients on planned lists are clinically ready for their care to commence and reach the date for their planned appointment, they either should receive that appointment or be transferred to an active waiting list and a RTT clock started from the date of the planned appointment (and a DM01 clock started if a diagnostic test is also required).

Where patients are waiting for a planned diagnostic test or procedure, the diagnostic waiting time guidance would apply in relation to cancellations and DNAs.

2.3.11 Surveillance Patient Lists

Surveillance, or follow-up tests / procedures that are not planned for a specific date but rather are undertaken on an ad hoc basis or at an undecided time in the future, are not categorised as planned waits. These patients should only be placed on an active waiting list once the decision to test / referral for a test has been made. A DM01 clock is started on the first day of the month after the surveillance test becomes due; this will also be the date of an RTT clock start for any subsequent treatment (if elective).

2.3.12 Inter-Provider Transfers (IPTs)

The Department of Health mandated the use of a minimum data set (MDS) for Inter-Provider Transfers from 1st January 2008. The pathway data contained within this data is essential in order for receiving organisations to accurately monitor and report patient waiting times.

Referrals from other providers to the Trust must include a completed Inter-Provider Transfer MDS or ensure that one is sent within 48 hours of referring a patient. Likewise, the Trust must ensure the appropriate standard MDS is sent to any provider the Trust refers to.

The principles for administering this system are:

- Where patients are transferred between providers, including Primary Care Intermediate Services, the MDS must accompany the referral.
- The principle need for using the MDS form is to ensure that all service providers involved in a patient's pathway have adequate information about clock starts etc. to enable the patient's management to be conducted within appropriate timeframes.
- When a patient is transferred for treatment or diagnostic investigation in the middle of a pathway, the 18-week clock will continue and it is the joint responsibility of involved providers to ensure that the patient is managed within 18 weeks.
- There will also be occasions when a patient is transferred for management 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 clock will start with the new provider.

Incoming IPTs

The Trust expects an accompanying MDS pro-forma with the IPT, detailing the patient's current RTT status (the Trust will inherit any RTT wait already incurred at the referring Trust if they have not yet been treated) and if the patient has been referred for a new treatment plan for the same condition (where a new RTT clock will start upon receipt at this Trust). The patient's pathway identifier should also be provided. If the IPT is for a diagnostic test only, the referring Trust retains responsibility for the RTT pathway.

If any of the above information is missing the referral should be recorded but the missing information actively chased by the team receiving the IPT.

Outgoing IPTs

The Trust will ensure that outgoing IPTs are processed as quickly as possible to avoid any unnecessary delays in the patient's pathway.

An accompanying MDS pro-forma will be sent with the IPT, detailing the patient's current RTT status (the receiving Trust will inherit any RTT wait already incurred if the patient has not yet been treated). If the patient has been referred for a new treatment plan for the same condition, a new RTT clock will start on receipt at the receiving Trust. The patient's pathway identifier will also be provided.

If the outgoing IPT is for a diagnostic test only, this Trust retains responsibility for the RTT pathway.

2.3.13 Patients With More Than One Admitted RTT Pathway

Where it is clinically acceptable, patients may be on more than one admitted RTT pathway at any given time. All referrals for routine procedures should be carefully considered if the patient is already on an admitted RTT pathway.

When there is a clinical reason for a patient not to be on more than one admitted pathway, it will be the responsibility of the Consultant to make a clinical decision in discussion with the patient as to which RTT pathway will be given priority. The referral deemed the lowest priority may be removed from the waiting list and returned to the GP with instructions to re-refer once the patient is fit, willing and able. This re-referral will commence a new 18-week RTT pathway.

2.3.14 Patients Requiring More Than One Procedure

If more than one procedure will be performed at one time by the same surgeon, the patient should be added to the waiting list with the extra procedures noted. If different surgeons will work together to perform more than one procedure, the patient will be added to the waiting list of the consultant surgeon for the priority procedure with additional procedures noted. If a patient requires more than one procedure performed on separate occasions (by different or the same surgeon(s)):

- The patient will be added to the active waiting list for the primary procedure.
- When the first procedure is complete and the patient is fit, ready and able to undergo the second procedure, the patient will be added (as a new waiting list entry) to the waiting list and a new RTT clock will start.

2.3.15 Communication

All communications with patients and anyone else involved in the patient's care pathway e.g. the patient's GP or a person acting on the patient's behalf, whether verbal or written, must be informative, clear and concise. Copies of all correspondence with the patient must be kept in the patient's clinical notes or stored electronically for auditing purposes.

The patient's GP or referrer must be kept informed in writing of the patient's progress. When clinical responsibility is being transferred back to the GP / referrer, e.g. when treatment is complete, this must be made clear in any communication.

2.3.16 Confidentiality

Members of staff are reminded that at all times they must comply with the law of confidentiality, the requirements of the GDPR, the DPA 2018 and the Human Rights Act 1998 and that they must abide by the principles in the **Confidentiality: NHS Code of Practice** [7] published by the Department of Health in 2003.

This is particularly relevant to staff who are making contact with patients to book appointments / TCIs who are encouraged not to leave messages unless they are urgent. Members of staff are reminded not to leave personal or sensitive information on answerphone machines and that any verbal contact is made with the intended patient.

2.3.17 Locally Agreed Commissioner Requirements

The Trust's commissioning is predominantly with the BSW CCG and their access requirements have been, and are expected to remain, in line with the national requirements at any given time.

2.3.18 Special Patient Groups

2.3.18.1 Military Veterans

In line with the **Armed Forces Covenant** [3] enshrined within the **NHS Constitution for England** [20] all veterans and war pensioners should receive priority access to NHS care for any conditions related to their service, subject to the clinical need of all patients. Military veterans should not need to have applied and become eligible for a war pension before receiving priority treatment.

GPs will notify the trust of the patient's condition and its relation to military service when the patient is referred. This is so that the Trust can ensure that it meets the current guidance for priority access to NHS care over other patients of the same level of clinical need. Patients with more urgent clinical needs will continue to receive priority.

2.3.18.2 Persons Detained Within the HM Prison Service

All elective waiting time standards and rules apply to prisoners. Any delays to treatment that are incurred as a result of difficulties in prison staff being able to escort patients to clinic do not affect the 18-week waiting time for the patient.

Trust staff will work with the staff in the prison service in an attempt to minimise delays through clear and regular communication channels and by offering reasonable choices for appointments or admission dates.

2.3.18.3 Vulnerable Patients / Safeguarding

It is essential that all staff ensure that patients, who are vulnerable for whatever reason, are identified as early as possible in the referral pathway. Staff should ensure that patients are provided with whatever additional help and support is required. Patients are provided with communications in the appropriate format to access services.

We should prioritise Learning Disability (LD) and No Fixed Abode (NFA) patients, and enable clinicians to upgrade Clinical Prioritisation Codes, where there is an equity rationale i.e. the patient is subject to poorer health outcomes (because of their socio-economic status, race, or other protected characteristic) and earlier intervention would go some way to addressing that inequality in outcomes.

The referrer should make clear what needs have been identified, and this should be recorded on any relevant Trust systems, reviewing and updating on subsequent visits. When safeguarding issues are identified, Trust procedures should be followed in the normal way.

2.3.18.4 Private and Overseas Patients

Patients referred to and seen within a private clinic and in a fee-paying capacity do not start an RTT waiting time clock. Please see the Trust's **Charging of Overseas Visitors at the GWH Policy** [5] for further information.

2.3.18.5 Prior Approvals

Treatments for which there is limited evidence of clinical effectiveness may be identified by the commissioner as requiring *prior approval*, or that the treatment is only appropriate on a criteria based assessment basis.

Any patients who do not meet the clinical criteria should be advised by the clinician at the time of their consultation and referred back to the GP.

All patients who meet the relevant criteria must have a booking form completed and be added to the waiting list. Where necessary, approval should be sought following the relevant commissioner protocol for INNFs. The RTT clock continues during this period - no adjustments or clock stops can be made to a pathway whilst commissioner approval is being obtained.

If funding is declined, the patient will be notified and removed from the waiting list and discharged back to their GP and the RTT clock stopped. If funding is agreed, the relevant booking officer will proceed to provide an admission date.

Deterioration in performance as a result of prior approval patient numbers will be escalated via the *Trust Access Meetings* to the *Divisional Director - Surgery, Women and Children's* and the *Deputy Chief Operating Officer* on a monthly basis. The process, pathway, and identified list of treatments requiring prior approval will be reviewed annually alongside the commissioner.

2.4 Managing the Pathways

2.4.1 The Outpatient (Non-admitted) Pathway

This section of the Policy details the principles under which the Trust will govern access and choice within the outpatient setting. It is intended to provide an outline of the core rules and an overview of procedures to be followed. It should be read in conjunction with any relevant outpatient Standard Operating Procedures (SOPs).

2.4.1.1 Referrals

- Wherever possible referrals should be made to a service rather than to a named clinician, and should be aligned with the Patient Choice national agenda.
- Urgent 2WW suspected cancers should be referred using the appropriate referral pro-forma and process.
- Referrals must be registered and stored onto the Trust's electronic system within one working day of receipt of referral by the Trust.
- Patient contact must be made within seven working days of receipt of referral for routine and urgent referrals which are not into a RAS; referrals into a RAS must allow for an additional seven days to facilitate triage.
- Patient contact must be made within two working days of receipt of referral for a 2WW referral.
- Clinical review must take place within seven working days of receipt of routine referrals and two working days of urgent 2WW suspected cancer referrals.
- GP requests (via the Cinapsis system) for Advice and Guidance do not start an RTT clock.

2.4.1.1.1 Management of Urgent 2WW GP Referrals

The administrative rules for patients on a clinically timed cancer pathway vary from those for patients on an 18-week pathway. The *Fast Track Team* is responsible for the processing of urgent 2WW GP referrals from the point of receipt to the booking of first appointments, adding details to the Cancer Registry and to CareFlow, and for the management of any 2WW breaches; the rebooking of appointments arising from cancellations and DNAs also sits within their remit. Responsibility for the remainder of the pathway sits with Cancer Services and the MDT. Please refer to the Trust's **Great Western Hospital Acute Adult Cancer Services Operational Policy** [13] and departmental SOPs for further information.

Patients who are referred with suspected cancer must be seen within 14 days from the receipt of the referral. At the point of referral the GP / referrer will ensure that the patient is aware for the reason for referral and that they are available to attend an appointment. All such patients must receive a booked appointment. The *Fast Track Team* will ensure that patients are offered a choice of appointments. All referral letters should be sent to Medical Records for registration on CareFlow.

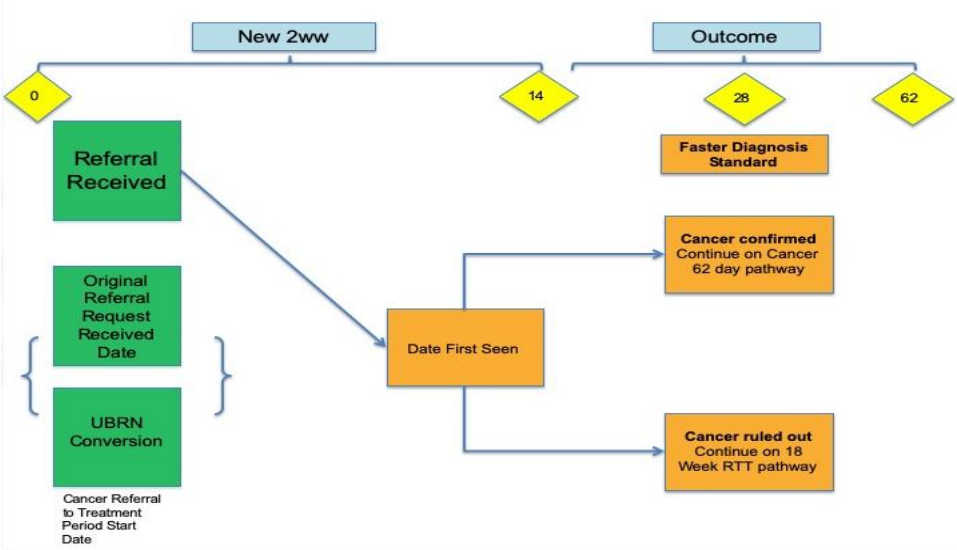


Figure 3 2WW Referral and Outcome

2.4.1.1.2 NHS e-Referrals Service (e-RS)

For patients booking an appointment through the e-RS it is good practice to ensure that the patient has booked an appointment before leaving their GP Practice. It is also good practice to ensure that someone at the Practice monitors e-RS bookings on a daily basis to check that all UBRNs have been converted into a booking.

For urgent 2WW appointments, e-RS will only offer patients an appointment within the next 14 day period. If a patient cannot make themselves available for an appointment within two weeks, despite having been given appropriate information, it is essential that the referrer fully informs the patient of the clinical urgency of their appointment to ensure the patient can make an informed choice. Patients who choose an appointment outside of two weeks do not exempt themselves from the standards. The operational standards for the 2WW commitments take account of the volume of patients likely to be seen outside of two weeks because of patient choice.

Triage Arising from an Abnormal Direct Access Diagnostic

When a pathway has been implemented and agreed locally, in which a patient is directly triaged following an abnormal direct access diagnostic scan with a suspicion of cancer, then the decision to triage directly would act as the start of the pathway.

Screening Programmes

The 2WW standard does not apply to patients from the NHS national cancer screening programmes. However, it is important that the clock start, the first seen activity and the clock stop is recorded for monitoring of the 28-day FDS and 62-day screening standard if cancer is confirmed.

Non-site Specific Symptom Referrals

Referrals into a non-site specific rapid diagnostic centre (RDC) or service should be recorded in the same way as urgent 2WW suspected cancer referrals. These referrals would be included in the 2WW, faster diagnosis and the 62-day referral to treatment standards.

Consultant Referral for Suspected Cancers

A consultant or an authorised member of the consultant team can upgrade a patient if cancer is suspected. The ultimate responsibility for upgrades rests with the consultant responsible for the care of the patient who will have delegated their authority by local agreement. The upgrades could come from any part of the health service, not just from consultants and teams that most commonly see cancer patients. Please see the Trust's **Great Western Hospital Acute Adult Cancer Services Operational Policy** [13]. If a consultant upgrades a patient for a first primary cancer the 62-day period starts at the consultant upgrade date.

Note that a patient's 2WW referral can also be downgraded or withdrawn if the consultant believes it to be inappropriate, but *only by the referrer*. The **National Cancer Waiting Times Monitoring Dataset Guidance** [19] advises: *"If a consultant thinks the two week wait referral is inappropriate this should be discussed with the referrer. Only the referrer can downgrade or withdraw a referral."*

e-Referrals Service (e-RS) Process

The Trust is measured against contractual e-RS standards defined by the Clinical Commissioning Group.

The core principles of the e-RS process are:

- The responsibility for managing the e-referral process sits with the *Deputy Divisional Director - Outpatients* working in conjunction with the responsible Divisions.
- The responsibility for managing the Directory of Services sits with the relevant *Deputy Divisional Director* and *Heads of Service*.
- The *Deputy Divisional Director - Outpatients* will be responsible for validating whether all clinics are open to e-RS and report any non-compliant areas to the relevant *Deputy Divisional Director* via the *Trust Access Meetings*.
- Individual Divisions will make sure sufficient capacity exists in the e-RS to avoid the occurrence of Appointment Slot Issues (ASIs).
- The date of referral is to be recorded on the hospital's patient administration system (this is the date on which a patient referred via e-RS converts their unique booking reference number (UBRN), irrespective of whether or not an appointment is made). This is the RTT clock start.
- Not all referrals booked via e-RS will be appropriate and it may be necessary to change or reject some appointments. This is the responsibility of the triaging clinician and will include the returning of the referral to the referrer with the reason and within 7 days of receipt.
- If the e-RS appointment has been booked in the correct specialty, but in an incorrect clinic, it is the responsibility of the receiving Clinician at triage to re-direct the appointment to the appropriate clinic rather than rejecting it back to the GP.
- The patient must be informed if the appointment is to be re-booked and given the opportunity to agree a convenient date within the agreed Trust timeframe. The 18-week RTT clock keeps ticking throughout this process.

- If the Trust is attempting to rebook an e-RS appointment, and is unable to contact the patient after two attempts, an appointment is to be booked and confirmed in writing. The 18-week RTT clock keeps ticking throughout this process.
- If the patient or GP has been unsuccessful in directly booking via e-RS, an Appointment Slot Issue (ASI) will be generated. A weekly ASI report will be generated by the Booking Centre from the national e-RS system and escalated to the appropriate *Head of Service* and copied into the relevant *Deputy Divisional Director*.
- Each day (Mon-Fri) the *Booking Centre Manager* is to review the ASI list on ERS. Any patients identified that do not sit within an approved service are to be booked into the next available slot for the speciality. Where there is not slot available the polling range on the speciality is to be extended so that the patient receives an appointment date. The Booking Centre Manager is to ensure that his team are aware of this process and action this daily to prevent any ASI build-up.

2.4.1.1.3 Paper Referrals

Any paper referral letters (which are only accepted in cases where the referrer does not have access to e-RS) must be registered on CareFlow by the registration team in Medical Records within 24 hours of receipt; after this time, they must be clinically triaged within 48 hours of the date the referral was received by reviewing the referral within CareFlow.

This may be monitored via audit; where this standard is not being achieved action will be required from the relevant speciality. For recording purposes, and the start of the 18-week RTT clock, the date of referral is the date received at the hospital, (except for referrals mentioned below) and all referrals should be clearly date stamped by each department upon receipt. In the case of rejection at the point of triage, the patient's GP should be advised of the reason for the rejection and written to, and the referral removed from the system.

2.4.1.1.4 Referrals via a CATS (interface service) or via a RMC

For referrals which come via a Clinical Assessment and Triage Service (CATS, which is an interface service) such as the Musculoskeletal Assessment and Treatment Service (MATS) or via a Referral Management Centre (RMC), the 18-week RTT clock start is the date those services received the referral from the GP, and the date of their date stamp should be entered as the RTT clock start date if the patient is subsequently registered with the hospital regarding an appointment with a consultant clinician.

2.4.1.1.5 Referrals via a RAS

Within e-RS there are services that utilise a RAS (Referrals Assessment Service) to triage referrals. No new referral should be triaged ahead of a direct booking unless the service has installed a RAS as part of their patient pathway and indicated this to Primary Care by updating their Directory of Service within e-RS. There are differing timescales attached with this triage process ranging from 1 to 7 days. Where 7 days has been exceeded the referral will be highlighted as this is outside of the agreed SOP for referral management.

2.4.1.1.6 Consultant to Consultant Referrals

Consultant to consultant referrals should not be made in routine cases. For guidance when an onward referral is for a different condition, see the **Consultant to Consultant** subheading in Section **2.3.5.1**.

If a patient is referred internally for the same condition, perhaps for a specialist opinion or review, then it is a continuation of the original clock until first treatment is commenced. If the patient has been internally referred for a new problem, one that is separate to the original referral, whether or not they are being seen by the original specialty, a new 18-week clock

will start when the receiving department date stamps the referral and a new treatment pathway commences.

2.4.1.2 Appointment Slot Issue (ASI) List

If the patient chooses to attend the Trust and attempts to book an appointment but there are no appointment slots available, then the referral is deferred to the provider to book and the patient is placed into a queue. This queue is referred to as the Appointment Slot Issue (ASI) list.

Referrals deferred to the provider are immediately visible in the ASI work list. The referral date will display in red after a number of working days dependent upon the priority of the referral:

- 2WW 3 days
- Urgent 3 days
- Routine 7 days

It is important to note that when a referral enters the ASI process, the patient will be informed that the provider will contact them within these timescales.

2.4.1.3 Clinic Templates

Clinic templates are crucial to ensuring that new and follow-up clinic capacity is managed and utilised in the most efficient manner possible, and should be maintained robustly.

The core principles are:

- The speciality *Clinical Lead* and *Head of Service* will review their outpatient clinic templates quarterly in order to reflect the changing demands of the service – as part of the demand and capacity process.
- Any changes to an existing template must be submitted in line with the Outpatients Standard Operating Procedure for clinic template changes.

Any template changes (including reductions and cancellations) require a minimum notice period of six weeks. Services have two weeks to consider backfill options for alternative clinicians to run clinics at risk of cancellations.

Requests for clinic changes or cancellations made less than six weeks from the clinic date must be escalated to the relevant *Deputy Divisional Director* or *Divisional Director* for approval with an explanation of why circumstances are exceptional and these will be monitored monthly via the *Outpatients Transformation Board*.

2.4.1.4 Booking Rules and Directory of Service (DoS)

A number of basic booking rules apply to managing outpatient capacity (including diagnostic tests), to ensure patients are able to be treated in a clinically appropriate way, and so that the Trust can provide a sustainable service:

- All patients will be offered appointment dates in chronological order, unless there is an appropriate clinical decision that patients need to be treated more urgently to prevent deterioration in their clinical condition.
- No patient waiting for an outpatient appointment can have his or her RTT clock suspended or paused for any reason.

- Patients should wherever possible be offered a choice of appointment dates, in line with national policy and good customer service principles.
- Each clinical lead and Head of Service should be aware of the target first to follow-up appointment outpatient ratios associated with their service and manage activity accordingly.
- Each clinic will be set up with a template defining the number of available new and follow-up slots, 2WW and new e-RS slots.
- Agreed limits of over bookings may be locally agreed with specialty clinicians and not exceeded without clinical authorisation.
- Cancer 2WW slots should not be used for any other type of appointment, until three days prior to the clinic date. At this point, employees booking appointments may book into available appointments of this type with the specific agreement of the *Outpatient Supervisor*.

The Directory of Services is the list of services that the Trust provides through the e-RS system. In effect, it is the shop window of the services offered by the Trust to its patients. As such, it is an important virtual document that needs authorisation by both *Heads of Service* and *Consultants*. Any changes to the Directory of Services must be agreed between the *Heads of Service* and *Consultants* in conjunction with the *Head of RTT Performance and Data Quality*.

2.4.1.5 Transfer Between Providers

Patients may be transferred to or from the Trust in relation to their 18-week RTT pathway. The responsibility for achieving the 18-week deadline is transferred with the clinical responsibility and as such, the originating provider should ensure that the patient's initial RTT clock start date forms part of the onward referral information. However, if the patient is only transferred for a diagnostic test, the referring Trust retains responsibility for the RTT pathway.

A mandatory Minimum Data Set (Inter-Provider Transfer pro-forma) must be completed and transferred to the receiving provider.

Cancer Inter-Provider Transfers (IPTs)

Inter-Provider transfers (IPTs) should be recorded when the responsibility for care is formally transferred. The date that a referral request is received by the provider will mark the point at which the IPT is made. As per the **National Cancer Breach Allocation Guidance** [18] published by NHS England and NHS Improvement in April 2016, it is the Trust's policy to refer patients for treatment to tertiary centres by day 38 of the pathway. In the case of a shared pathway that breaches the 62-day standard, the breach will be allocated between the referring and treating Trusts.

Referral with a Transfer of Care

- The patient has been informed they are being referred to another provider, meaning that the receiving provider can act freely in arranging the next steps of the pathway.
- The purpose of the referral is clear.
- All relevant clinical information is included.
- A complete IPT form is included with the referral or provided separately.
- All required diagnostics/imaging and associate results are available.

2.4.1.6 Outpatient Appointments

Documentation from Clinic Visits

In keeping with both local and national record keeping guidance and policy, all staff involved with providing patient care must ensure that patient records remain both up to date and be an accurate reflection of the care provided to the patient. Letters documenting discussions at clinic visits (clinic letters) are of particular importance, providing both an appropriate audit trail and clarity in where a patient is on their RTT pathway. The typing turnaround in days will be monitored routinely via the *Trust Access Meetings* and any associated action plans will be shared with the *Chief Operating Officer*. 90% of letters should be written and sent to the patient and GP within 7 days of the clinic attendance (from April 2017 the Trust has measured performance against the 7 day target only).

General Principles

All patients are to be seen in order of referral (and where appropriate, clinical priority). Referral dates and waiting times are to be correctly recorded and measured.
Patients are to be able to choose/negotiate their appointment time and date (recognising that clinics are held on specific dates during set time periods).

Declining Appointment Dates

Patients will be offered a choice of at least two appointment dates with reasonable notice. Should they decline the dates offered and if it is not clinically detrimental to the patient in the opinion of the consultant, the patient may be discharged back to their GP.

Hospital Reschedules

The Trust aims to avoid rescheduling hospital appointments wherever possible. The Trust has an agreed **Medical Leave Policy** [16] for clinical staff which states that a minimum of eight weeks' notice must be given by all medical staff in order to minimise disruption to clinics and improve the patient experience.

Approval for any appointment reschedules as a result of short notice (less than 8 weeks) must be obtained from the *Deputy Divisional Director* or *Divisional Director*, and a contingency plan outlined for accommodating the rescheduled patients if there are patients who may suffer any harm, potentially breach waiting time targets, or who have been rescheduled previously.

Where patients have to be rescheduled at short notice it is best practice for a clinical review to be undertaken to ensure that the reschedule will not cause the patient harm. Waiting times are not reset in the event of Trust rescheduling outpatient appointments.

Patient Non-attendance

Any patient who fails to attend their first appointment must have their pathway reviewed by a consultant, who will decide if a further appointment is clinically appropriate. In the event that the consultant decides a further appointment is not required, the consultant must communicate this to both the patient and GP in writing. It is expected that such a review will take place whilst the consultant is in clinic and the letter dictated at this time.

In the event that the consultant decides that a further new appointment is not required, the patient's RTT waiting time clock will be nullified (as if never referred). The Trust will need to be able to demonstrate that the appointment offer was agreed in principle and clearly communicated to the patient. It may be considered clinically inappropriate to return the referral and in these cases the patient will be given a new appointment, but the patient will have a new clock start from the date that the patient contacts the hospital to rebook their appointment.

If a patient fails to attend a follow-up appointment, the RTT clock will continue if the consultant indicates that a further appointment should be offered. If a patient waits for longer than 18-weeks due to this delay, they will become part of the 8% allowance as outlined in Section **2.1.1**.

The consultant responsible for the care of a child on the Child Protection Register must be informed if the parent/guardian of the child DNAs *any* appointment or admission. The consultant should liaise with the child's GP to agree how to manage the child's care. Copies of any communication with the child's GP / other referrer must be filed in the child's clinical record.

Cancellations and Reschedules (patient-led)

Patients are entitled to cancel and/or reschedule their outpatient appointments without any effect on their RTT waiting time clock. Such actions can be made at any point that is prior to the time of the appointment and this includes on the day of the appointment itself.

If, however, the appointment is cancelled and/or rescheduled a second time, the patient pathway will be reviewed by the clinical team to determine if it is in the patient's best clinical interest to be referred back to the GP or other referrer. Should this be the outcome, the consultant must communicate this in writing to both patient and GP.

Clinic Outcomes

Every Outpatient clinic attendance (excluding diagnostics or virtual clinics) must have a clinic outcome recorded by the clinical team as part of the clinical decision making process and whilst the patient is in clinic. Note that the following refers primarily to the use of the clinic outcome form but increasingly electronic outcoming is being used within the Trust.

Outcoming is an essential part of the RTT pathway, ensuring that the Trust is able to monitor accurately patient waiting times and follow-up on any decision making required to progress the patient journey. The responsibility for entry of the outcome details from the form onto CareFlow sits with the outpatient administrators and other designated employees. All parts of the clinical outcome form are to be completed at consultation and are to be entered into CareFlow within 24 hours of attendance (and ideally before the patient leaves the clinic).

The clinic outcome form must be filled in correctly, indicating the clinic visit outcome and also up-dating the 18-week pathway status at every outpatient visit. These forms must then be returned to the reception desk where the appropriate next actions will be taken as specified for that patient.

It is the responsibility of the reception employees via their management structure to ensure that all clinic outcomes received are recorded. A report on un-outcomed clinics is provided daily to all *Outpatient Supervisors* (via the Data Warehouse) for them to chase. 100% of clinic outcome forms received must be recorded on the system within 48 hours.

Where a patient has received treatment in an outpatient setting, it is the responsibility of the consultant / a member of the clinical team who performed the treatment to record the necessary procedure on the outcome form to ensure that appropriate coding is undertaken.

Where the patient is part of a virtual clinic, an ad-hoc review or a telephone appointment, the responsibility for completion of the outcome form sits with the clinician. It is the responsibility of the relevant *Outpatient Manager* covering that speciality to ensure appropriate procedures are in place to input the information into CareFlow within 24 hours.

2.4.2 The Diagnostic (Non-admitted) Pathway

This section of the Policy details the principles under which the Trust will govern access and choice within the diagnostics setting. The diagnostics phase of the RTT pathway starts at the point of a decision to refer (request) for a diagnostic test and ends when the diagnostic test is complete. There are two situations in which a diagnostic test is part of an RTT pathway:

- Request as part of an established RTT pathway.
- Straight to Test request directly from a GP.

The diagnostic clock is separate with its own waiting time, starting at the same time as the referral i.e. Straight to Test, or somewhere along an established RTT pathway i.e. when diagnostics are required. A list of the 15 diagnostic tests which are included in the DM01 standard is included in **Appendix E**.

If a patient fails to attend their diagnostic test, the diagnostic waiting time is reset to the date of the last appointment for that test (providing that the Trust can prove reasonable notice of the appointment was given to the patient). Failure to attend does not reset the RTT waiting time clock.

For all diagnostic tests and appointments the maximum time from date of request to test must be six weeks for all routine referrals and two weeks for all urgent referrals. Patients awaiting a diagnostic test will be monitored and managed via the appropriate PTL. Concerns will be managed and escalated via the *Trust Access Meetings* and *Trust RTT Oversight Group*.

All members of staff working in, managing and reporting diagnostic waiting times need to be familiar with the specific guidance underpinning diagnostic waiting times and performance reporting whilst also understanding the impact of diagnostic pathways on other elective targets e.g. cancer and 18-weeks.

Where a pathway has been implemented and agreed locally, in which a patient is directly triaged from an abnormal direct access diagnostic scan with a suspicion of cancer, then the decision to triage directly would act as the start of the cancer pathway.

Delays in the diagnostic pathway due to patient choice (which can be deducted from diagnostic waiting time performance reporting) cannot be adjusted for in either cancer or 18-week reporting, and so management of this stage of the pathway is critical to the timeliness and streamlining of the patient's pathway as a whole.

Adjustments to a diagnostic 6-week pathway because of patient choice can only be applied if the patient has declined two offers of dates with three weeks' notice. This does not mean that patients should not be offered appointments earlier than three weeks.

Results reporting must be available in time to allow progress through all likely stages of the RTT pathway. Results for routine tests will be made available within five working days of the examination and for urgent tests within 24 hours. Separate standards apply for turn around times (TATs) in line with Royal College of Pathologists (RCPATH) guidance, and there are clinical reasons e.g. sending samples off site, waiting for bacteriology specimens to grow etc. why these timescales will not always be achievable. It is essential to receipt all specimens in the Pathology Laboratory within one working day.

2.4.2.1 Direct Access Referrals (patients with a diagnostic clock only)

When a patient is referred into the Trust for only a diagnostic test, with no consultant-led treatment, the RTT clock does not start as the clinical responsibility for the patient remains with the GP. However, a 6-week diagnostic clock does start at the receipt of this referral. These referrals are known as direct access referrals.

Patients may also have a diagnostic clock running only where they have had an RTT clock stop for treatment or non-treatment and their consultant refers them for a diagnostic test with the possibility that this may lead to a new RTT treatment plan.

2.4.2.2 Booking Imaging Appointments

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

The following basic principles are therefore to be applied to the booking and management of all diagnostic tests and test appointments:

- Clinicians making a request for any diagnostic test must ensure that the clinical status of the patient is clearly denoted on that request i.e. if the patient is on a routine, urgent or planned pathway. For all urgent 2WW suspected cancer referrals the request must be clearly marked as “suspected cancer” in the clinical history section of the request form / electronic template.
- The request should be received in the relevant department within one working day of being completed (in the case of pathology, accompanying the specimen) and the patient’s details and date of the request are to be added to the diagnostic PTL to facilitate both active monitoring / management of the patient’s pathway, and reporting of the diagnostic waiting time target.
- Where possible the request for examination should include the current status of the patient’s 18-week pathway, if the test is needed to achieve the pathway, and if this is known by the requesting clinician.
- Patients recorded as a day case activity for their diagnostic tests (e.g. Endoscopy Suite activity) are to be added to the waiting list and to the admitted 18-week PTL.
- All routine patients are to be contacted, and appointment date(s) agreed, within a maximum of two weeks from the date of the request being made.
- All urgent patients are to be contacted, and appointment date(s) agreed, within a maximum of five working days from the date of the request being made.
- Patients are to be offered clinic dates according to their clinical status and at a date and time which is convenient to them.
- Contact must be made with the patient by telephone wherever possible. Three attempts must be made to contact an “urgent” patient by telephone over a 24 hour period. If the patient has been referred urgently, the member of the team making the call must inform the patient that they have been referred for an urgent appointment and should encourage the patient to make an early appointment.

- The patient is to be sent a confirmation letter within 24 hours of agreeing the appointment. The letter must be clear and informative and must include a point of contact and telephone number to call if they have any questions relating to the appointment. The letter should explain clearly the consequences should the patient cancel their appointment(s) or fail to attend the diagnostic test(s) at the agreed time(s).
- Where telephone contact cannot be made the patient is to be sent a letter requesting either that they make contact with the relevant department to arrange the date and time for their appointment, or offering the patient a date and time a minimum of five working days after the letter is sent. Urgent test appointment letters must be sent by first class post (with authorisation).

2.4.2.3 Patient Non-attendance

Patients who have confirmed their attendance at a given date / time and subsequently DNA this appointment will be referred back to the referrer as to the next course of action.

Patients who DNA an appointment for which they have not confirmed their attendance will be offered a second appropriate appointment date / time; ideally confirmation from the patient should be sought for this new date / time. If this second appointment is DNAd then the patient will be referred back to the referrer as to the next course of action.

2.4.2.4 Planned Patients

Patients who require a diagnostic test to be carried out at a specific point in time for clinical reasons are exempt from the diagnostic clock rules and will be held on a planned waiting list with a clinically determined due date. However, if the patient's wait goes beyond the due date for the test, they will be transferred to an active waiting list and a new diagnostic clock and RTT clock will be started.

2.4.2.5 Surveillance Patients

Surveillance, or follow-up tests / procedures that are not planned for a specific date but rather are undertaken on an ad hoc basis or at an undecided time in the future, are not categorised as planned waits. These patients should only be placed on an active waiting list once the decision to test / referral for a test has been made. A DM01 clock is started on the first day of the month after the surveillance test becomes due; this will also be the date of an RTT clock start for any subsequent treatment (if elective).

2.4.2.6 Therapeutic Procedures

When a patient is waiting solely for a therapeutic procedure there is no 6-week diagnostic standard. However, for many such patients there is also a diagnostic element to their admission / appointment and so these patients would still need to have their procedure within 6-weeks.

2.4.3 The Inpatient (Admitted) Pathway

This section of the Policy details the principles under which the Trust will govern access and choice of date within the inpatient elective / day case setting. It is intended to provide an outline of the core rules and an overview of procedures to be followed.

2.4.3.1 Principles of Access to Elective Inpatient Care

The decision to add a patient to a schedule for surgery (Inpatient or Day Case waiting list) must be made by a consultant or a member of their clinical team in the name of the consultant (as only consultants have admitting rights). When a Decision to Admit (DTA) is made, the patient must be both available and clinically fit for the procedure. Short periods

of illness / unavailability i.e. less than two weeks, should be tolerated and the patient still considered as waiting.

For nationally agreed clinically timed cancer pathways, each tumour site specific clinical team has an agreed best practice clinically timed pathway for patients; this takes into account the most likely tests and investigations and identifies clinically agreed pathway timescales to ensure that the national access standards are met.

2.4.3.2 Waiting List (Booking) Form

Note that the following refers primarily to the use of the booking form but increasingly electronic booking is being used within the Trust. Once the decision to add a patient to the Waiting List has been made the form must be completed, dated and signed by the clinician in the outpatient clinic. It is the consultant's responsibility to ensure that the details are completed clearly and correctly, including any details of patient unavailability and whether the procedure is planned or elective.

This form must be completed at the time of the decision to admit, which in most cases will be during the outpatient appointment. This form should then be passed to the booking office within 24 hours, who will then contact the patient to agree a date and book the TCI date into CareFlow. The card must reach and be logged into CareFlow by the appropriate scheduling team within 24 hours.

2.4.3.3 Adding Patients to the Inpatient Waiting List

When logging a patient on the waiting list within CareFlow the admissions team must ensure that…

- the patient is not already listed for the same condition, and
- the entry is recorded correctly as either Elective or Planned, and
- the patient is not already scheduled for surgery for another procedure, and
- patients are scheduled in clinical priority and length of wait order.

Patients must be made aware of the likely waiting time if a date cannot be agreed at the time they are added to the waiting list. They should be asked if they are available at short notice and this information should be entered into CareFlow with a contact telephone number.

The list will consist of "Active Patients", "RTT and non-RTT" and "Planned Patients". Where patients are of equal clinical priority, preference should be given to those patients who have waited the longest for their procedure and are on an active RTT pathway.

2.4.3.4 Clinical Prioritisation Codes

When a patient is added to the Inpatient Waiting List the clinical priority of the patient must be included. The clinical prioritisation codes are as follows:

Clinical Prioritisation Code	Description
P1a	Emergency operation needed within 24 hours.
P1b	Urgent operation needed with 72 hours*.
P2	Surgery that can be delayed for up to 1 month.
P3	Surgery that can be delayed for up to 3 months.
P4	Surgery that can be delayed for more than 3 months.
P5	Patient wishes to postpone surgery because of COVID-19 concerns **.
P6	Patient wishes to postpone surgery because of non-COVID-19 concerns **.

* Urgent is defined as:
- Life, limb or sight threatening.
- Likely to cause harm to a pregnant woman or unborn baby.
- Where the delay to treatment would cause a significant deterioration in prognosis.

** Official guidance states that this decision needs to be reassessed with the patient after six months; the Trust has adopted a local target of reassessment within three months.

3 Monitoring Compliance and Effectiveness of Implementation

Measurable Policy objectives	Monitoring or audit method	Monitoring responsibility (individual, group or committee)	Frequency of monitoring	Reporting arrangements (committee or group the monitoring results are presented to)	What action will be taken if gaps are identified
Performance of the Trust against the national RTT standards in line with national policy and reporting requirements	Review performance in weekly PTLs, Trust Access Meetings and Operational Performance Report	Divisional Directors	Weekly (PTL and Access) and monthly (Divisional Performance Review, ECSG, ExCo, Trust Board)	ECSG ExCo Trust Board	Action plan to be agreed between the Executive and relevant Division
Policy Review	First Review in 1 year, and then every two years or following significant change in standards	Planned Care Division	Yearly	ECSG ExCo Trust Board	As Above

3.1 Application of, and Compliance with, this Policy

This Policy applies to all clinical and administrative employees and services relating to elective patient access managed by the Trust, including outpatient, inpatient, day case, therapies and diagnostic services.

All employees involved in the management of patients' access to the service are expected to follow this Policy. Each clinical service across all Divisions must follow this Policy to deliver high quality, consistent care to patients across the organisation as a whole.

Key Performance Indicators (KPIs) have been identified to monitor compliance with the Policy, and where performance is below the expected thresholds corrective action will be taken e.g. further training and support.

3.2 Escalation

In accordance with the Trust's training needs analysis, employees involved in the implementation of this Policy, both clinical and administrative, must undertake appropriate training provided by the Trust. It is the responsibility of all employees to understand the principles and definitions that underpin delivery of all elective access performance measures i.e. cancer, RTT (18-weeks) and diagnostics. All employees involved in managing or administering patients' pathways for elective care must not carry out any action about which they feel uncertain, or that could contradict this Policy. They should escalate their concerns / uncertainties to their manager in the first instance.

3.3 Performance Monitoring and Reporting Structures

Performance of the RTT targets will be incorporated as appropriate into the *Trust Access Meetings*, the monthly *Elective Care Steering Group Meeting* (Trust level, where RTT reports

from a governance perspective) and monthly *Divisional Performance Reviews*. Reporting up to the Executive Committee and Board will be via a revised format of the existing Performance Report.

In the event that the Trust does not meet the monthly RTT or diagnostic targets, the *Informatics Team* will inform the *Divisional Director - Surgery, Women and Children's* and a detailed breach report with lessons learnt will be submitted.

3.4 Recording the Status of Patients

Alongside patient and referrer communications all employees (clinical and non-clinical) must be aware of their responsibility to accurately and contemporaneously record interactions with patients which impact on their pathway status, whether that be an 18-week pathway, a cancer pathway or a diagnostic pathway.

This includes the 'cashing up' (i.e. the recording of the outcomes of the clinic attendance) of activity within 24 hours of that activity occurring (e.g. outpatient attendance, admission, discharge etc.) This requires the completion of clinical outcome sheets for every patient-clinician interaction in every outpatient clinic and for any clinical decision made out of an outpatient environment (i.e. virtual clinics, telephone clinics, office-based reviews etc.). *Outpatient Supervisors* and *Deputy Divisional Directors* have a responsibility to ensure that their activity is up to date and to make arrangements for clearing of backlogs should these occur. Such backlogs must be escalated and monitored via the *Trust Access Meetings*.

3.5 Validating the Status of Patients

The management of RTT patient pathways requires specialty teams to be active in understanding where a patient is on their pathway and for how long they are currently waiting. The process for reviewing RTT patient pathways is referred to as "validation" and involves checking the pathway against the clinical record to confirm whether the data is reflective of the clinical decisions made.

The *RTT Validation Team* is available to provide advice and guidance; however their role is to ensure that the RTT PTL is validated – with a particular focus on the Non-admitted cohort of patients. The Admitted patients remain the responsibility of the Service.

3.6 Long Waiting Patients (Greater than 35 Weeks)

Note that the following guidance relating to patients waiting longer than 35 weeks is the *ambition* towards which the Trust is working. The ability to deliver the guidance across all specialities is currently limited as a result of the Covid-19 pandemic, but progress against this guidance will be reviewed through a review of the Policy every six months.

It is further noted that the Trust will be working in partnership across BSW to offer support in specialties which at a BSW level are subject to potentially waiting / waiting over 104 weeks (2 years), prevention of which is national policy.

The remaining paragraphs in this section 3.6 have been retained in their current form since they reflect the current national guidance and alignment to the NHS Constitution for England. At such time when the Constitution / guidance is amended this information will be updated.

All long waiting patients should be managed by the operational and clinical teams responsible for the patient's pathway in a proactive and timely manner. This is to ensure that a solution and appropriate plan are put into place. The following processes should be followed when reviewing / validating patients who are waiting over 35 weeks for definitive treatment:

- All patients over 35 weeks on the PTL should be reviewed at the *Trust Access Meetings* to identify the number of patients that are yet to be treated and do not have a plan. All patients who have waited 35 weeks or more should have their pathway validated by the relevant *Operational Manager* to ensure that the current status recorded on the PTL is correct and that any relevant information or action is updated on the PTL.
- All patients that exceed a waiting time of 52 weeks on the PTL should have clinical harm review undertaken by the *Divisional Director* and / or *Clinical Lead* for the relevant service in which the long waiter is attributed to. A pro-forma should be completed to indicate whether clinical harm has been identified or not, including whether the patient may yet come to harm. All patients who exceed 52 weeks wait for their treatment will have their pathway escalated to the *Medical Director* who will determine if any clinical harm has been caused that can be attributed to the excessive wait.
- Any concerns in relation to capacity that may impact on the length of RTT wait for long waiting patients should be escalated to the *Divisional Director* concerned.
- Any issues that are preventing or delaying a definitive plan being made for a patient that is exceeding a waiting time of 45 weeks should be escalated to the *Divisional Director* for support and resolution. If after escalation to the *Divisional Director* the matter is not resolved, then this should be escalated through the *Trust Access Meetings* and / or *Medical Director* if it relates to clinical delay with decision making.
- Clinical harm reviews will be completed for any patient who waits over 104 weeks.

3.7 Long Waiting Cancer Patients (Backstop 104+ days Policy)

The **Going Further on Cancer Waiting Times** [12] operational standards have been designed to take in to account the practicalities of managing very complex diagnostic pathways, patients who are temporarily clinically unfit for cancer treatment, and those who choose to defer their diagnosis or treatment for personal reasons. For these reasons, some patients may have a recorded waiting time in excess of 62 days, which is both accurately reported and is clinically directed in the best interests of the patient concerned.

It is recognised that a small proportion of patients will have a recorded waiting time of more than 104 days for this reason i.e. 6 weeks beyond a breach of the 62 day standard. The exact approaches to managing patients with a long waiting time, both proactively and retrospectively, require clarification so that avoidable nonclinical factors can be identified and separated from clinically appropriate management, and patient choice. The "Backstop" 104+ days Policy aims to ensure that the cancer operational standards, performance management and reporting arrangements act as a tool to improving access times for all cancer patients. Please refer to the **Great Western Hospital Acute Adult Cancer Services Operational Policy** [13] for more information.

3.8 Action Cards

Action Cards provide *quick-reference* information. The objective is to have an Action Card in place for any top-level administrative process known to be confusing and / or which may cause significant patient safety / data quality issues if applied incorrectly or inappropriately.

At the time of issue of this V4.0 of the Policy the Action Cards are in development; further information is available in **Appendix F**.

4 Duties and Responsibilities of Individuals and Groups

4.1 *Chief Executive*

Responsibility for the implementation of this Policy. The *Chief Executive* has overall responsibility for the management of the Trust and its performance, including statutory returns regarding patient waiting times and ensuring Trust compliance with the objectives set out in the **NHS Constitution for England** [20].

4.2 *Ward Managers* and *Managers for Non-clinical Services*

Responsibility for ensuring that standard operating procedures, standards and checks are fully implemented for their systems that support accurate waiting list information. They are responsible for recognising and acting upon actual or potential waiting list data quality issues, specifically:

- Reviewing the Policy and ensuring themselves and their teams are kept up to date with any national changes.
- Ensuring staff receive adequate training in the use of systems related to the processing of patient waiting list data, e.g. CareFlow, CADIS and associated Business Intelligence and Waiting List Management solutions.

4.3 *Policy Author* and *Policy Implementation Lead(s)*

Responsibility for identifying the need for a change in this Policy as a result of changes in practice, changes to statutory requirements, revised professional / clinical standards or revised local / national directives, and then for resubmitting the Policy for re-approval and republication if required.

4.4 *Trust Board*

Overall responsibility for assuring that the Trust's obligation to meeting the objectives set out in the **NHS Constitution for England** [20] concerning waiting list management and performance are met; the *Board* will be kept informed via a programme of internal and external audit.

4.5 *Executive Committee*

The *Executive Committee* will receive reports relevant to waiting list performance, including performance against national waiting time targets and matters relating to operational issues, associated improvement trajectories and action plans.

4.6 *Chief Operating Officer (COO)*

Executive accountability for reporting matters pertaining to waiting list performance to the *Chief Executive*, including performance against national waiting time targets. The *COO* has overall management responsibility for all operational staff who record data into the Trust's information systems and is therefore ultimately responsible for its accuracy.

4.7 *Deputy Chief Operating Officer*

Overall operational accountability for waiting list management and RTT performance across all Divisions.

4.8 *Associate Director of Business Intelligence*

Responsibility for providing regular data quality audits of the standard of data collection and the recording the submission of national returns produced by the *Informatics Team*.

4.9 *Clinicians*

All clinicians must ensure that before adding a patient to the waiting list for a cancer treatment / non-cancer treatment, the patient is fit, ready and able to come into hospital for their procedure. When assessing patients if clinicians wish to upgrade patients to the national 62-day target they should follow the guidance for upgrading Non-2WW patients to a 62 day Cancer pathway 2019. Clinicians are not able to 'step down' a patient from an Urgent 2WW referral pathway unless previously discussed with the referring GP and an agreement reached. This must be recorded in the form of a letter to GP and documented within the clinical notes.

4.10 *Divisional Director - Surgery, Women and Children's*

The lead Divisional Director for RTT and Elective Care with responsibility for the oversight of the Trust's RTT delivery performance.

4.11 *Divisional Management Teams*

Members of the *Divisional Management Teams* have a joint responsibility for the quality of data recorded within their Division / Service area. It is the responsibility of line managers to ensure that their staff comply with the Policy and are trained to use competently the appropriate information systems, including how to raise waiting list concerns. Managers must ensure that staff within their team, who have any involvement with the management of patient waiting lists, fully understand the content of the Policy and that the principles within the Policy apply to all information systems that are covered within its scope. Furthermore, *Operational Management Teams* through their *Divisional Director* and *Associate Medical Director* are responsible for achieving the elective access standards and are always striving for improvement by ensuring that appropriate capacity is in place to meet demand.

4.12 *Informatics Team*

Responsibility for reporting the Trust's position nationally concerning patient waiting times for 18-week RTT, diagnostics and cancer.

4.13 *Access Team*

Responsibility for monitoring and managing performance against the RTT standards, monitoring the implementation of the Policy and acting as subject matter experts in RTT and Access. They are also responsible for validation and data quality issues.

4.14 *Fast Track Team*

Responsibility for ensuring that the data entered into systems accurately reflects the information provided by the GP upon referral, in order that patients can be tracked within the relevant national cancer pathway timeframe. The *Outpatient administrative clerks / receptionists* have a responsibility to ensure that the data entered onto CareFlow accurately reflects the information provided by the clinical teams on the clinic-outcome pro-forma. Validation of 2WW data is the responsibility of the *Outpatient administrative teams*.

4.15 *All Employees*

All employees are personally responsible for the quality of data used to support waiting lists entered by themselves, or on their behalf, into the Trust's systems. This responsibility will be clarified in their job description and monitored via on-going supervision and appraisals. It is essential that any alterations or updated information is amended as soon as possible on the Trust's Patient Administration System and / or other systems to provide up-to-date information to support the delivery of care and reduce any associated risk to patient safety.

4.16 Community Responsibilities

Meeting the 18-week RTT target is the responsibility of the entire healthcare community. Each section of the community has responsibilities it needs to follow to ensure that the 18-week target can be met.

4.17 General Practitioners / Referrers

GPs play a pivotal role in ensuring that patients are fully informed of the likely waiting times of a new Outpatient appointment and of the need to be both contactable and available for an appointment when they are referred. They should also ensure that patients are clinically fit for assessment and have been made aware that they are being referred for possible treatment of their condition. These are the responsibilities of the referring clinician:

- Referrers must provide accurate, timely and complete information within their referral.
- Wherever possible, referrals should be made electronically through the e-RS.
- After a referral has been made, the referrer must inform the hospital if the patient no longer wishes or requires to be seen.
- The referrer must appropriately manage any patients who are discharged by the Trust following a DNA or cancellation of their appointment(s).

4.18 Clinical Commissioning Groups (CCG)

The CCG is responsible for ensuring good lines of communication between GPs and the Trust.

4.19 Patients

Patients should be aware of the following responsibilities:

- Attending their hospital appointment or ensuring that they contact the hospital beforehand to cancel it.
- Ensuring that they inform their healthcare provider of any changes to personal circumstances, particularly contact details and their registered GP.
- Providing as much notice as possible if they are unable to attend.
- Managing their health where possible.
- Telling their Health Care Professional when they feel they have not been treated promptly and are unhappy with their care.

5 Training

5.1 E-learning

All staff involved in any elements of the elective care pathway (admitted / non-admitted / diagnostic) will complete the RTT Awareness online training as part of mandatory training.

All of the following staff will complete the NECSU RTT Introduction Module:

- *Outpatient Administration Team*
- *Fast Track Team*
- *Medical Secretaries*

All of the following staff will complete the NECSU RTT Advanced Module:

- *Elective Admissions Team* including *AQP Booking Clerks*
- *Operations Team* including *DDs / DDDs / Heads of Service / Operations Managers*
- *Access Team*
- *Informatics Team*

5.2 Face-to-face Training

The *RTT Trainer* within the *Access Team* will provide face-to-face training sessions for any staff groups identified as requiring additional training. Face-to-face training packages will be developed for specific staff groups involved in any elements of the elective care pathway.

There will be bi-monthly *Heads of Service* / *Operations Managers* RTT Training Sessions which will be co-ordinated by the *Divisional Director - Surgery. Women and Children's*. They will focus on local processes and tools e.g. the introduction of the RTT Forecasting Tool.

There will also be a dedicated RTT session as part of the Trust's Head of Service Development Programme.

At least 2x Deputy Divisional Directors (including the *Deputy Divisional Directors within Surgery, Women and Children's)* and a *Senior Informatics Analyst* will complete formal demand and capacity modelling training to support RTT performance.

6 Further Reading and Consultation

6.1 References

Ref No.	Document Title	Location (URLs intentionally included)
1	**Academy of Medical Royal Colleges – Clinical Guidance: Onward referral – A working group report**	https://www.aomrc.org.uk/wp-content/uploads/2018/05/AOMRC-Guidance-on-onward-referral_210518-v3.pdf
2	**Allied Health Professional Referral to Treatment Revised Guide 2011**	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215248/dh_131969.pdf
3	**Armed Forces Covenant**	https://www.armedforcescovenant.gov.uk/
4	**BSW CCG Clinical prioritisation of waiting lists for endoscopy and diagnostic procedures**	https://bswccg.nhs.uk/for-clinicians/primary-care-documents/primary-care-bulletin-documents/1941-guidance-prioritisation-of-waiting-lists-for-endoscopy-and-diagnostic-procedures/file
5	**Charging of Overseas Visitors at the GWH Policy**	T:\Trust-wide Documents\Finance\Charging of Overseas Visitors at the GWH Policy.docx
6	**Clinical validation of surgical waiting lists: framework and support tools**	https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/10/C0760-Clinical-validation-of-surgical-waiting-lists-1-2.pdf
7	**Confidentiality: NHS Code of Practice**	https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice
8	**Consultant-led Referral to Treatment Waiting Times Data 2021-22**	https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2021-22/
9	**Consultant-led treatment: right to start within 18 weeks**	https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks
10	**Data Protection Act 2018**	https://www.gov.uk/data-protection
11	**Equity and excellence: Liberating the NHS**	https://www.gov.uk/government/news/equity-and-excellence-liberating-the-nhs
12	**Going Further on Cancer Waiting Times**	https://www.england.nhs.uk/wp-content/uploads/2015/03/going-further-cancer-waits.pdf
13	**Great Western Hospital Acute Adult Cancer Services Operational Policy**	T:\Trust-wide Documents\Chemotherapy, Cancer and Oncology\Great Western Hospital Acute Adult Cancer Services Operational Policy.docx
14	**Guide to NHS waiting times in England**	https://www.nhs.uk/nhs-services/hospitals/guide-to-nhs-waiting-times-in-england/
15	**Managing Child Missed Health Appointments Policy and Guideline**	T:\Trust-wide Documents\Safeguarding\Managing Child Missed Health Appointments Policy and Guideline.docx
16	**Medical Leave Policy**	T:\Trust-wide Documents\HR & Workforce - Leave, Conduct, Absence, Sickness, CPD, Performance, Induction, Bank, etc\Medical Leave Policy.docx
17	**Monthly Diagnostic Waiting Times and Activity**	https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/
18	**National Cancer Breach Allocation Guidance**	https://www.england.nhs.uk/publication/national-cancer-breach-allocation-guidance/
19	**National Cancer Waiting Times Monitoring Dataset Guidance**	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/09/national-cancer-waiting-times-monitoring-dataset-guidance-v11-sep2020.pdf
20	**NHS Constitution for England**	https://www.gov.uk/government/publications/the-nhs-constitution-for-england

21	**NHS Data Model and Dictionary**	https://datadictionary.nhs.uk/index.html
22	**NHS Standard Contract**	https://www.england.nhs.uk/nhs-standard-contract/
23	**Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care**	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/05/Recording-and-Reporting-guidance-April_2021.pdf
24	**Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care: Frequently Asked Questions**	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2017/10/Accompanying-FAQs-v7.32-ASI-FAQ-update.pdf
25	**Referral to treatment**	https://www.england.nhs.uk/rtt/
26	**Referral to treatment consultant-led waiting times - Reviewing the pathways of patients who have waited longer than 18 weeks before starting their treatment**	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Reviewing-pathways-over-18-weeks-January-2012-Final.pdf
27	**Referral to treatment consultant-led waiting times - Rules Suite**	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/464956/RTT_Rules_Suite_October_2015.pdf
28	**Referral to treatment measurement and COVID-19**	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/03/C0009-RTT-measurement-and-COVID-19.pdf
29	**Safeguarding Children and Young People at the Great Western Hospital Policy**	T:\Trust-wide Documents\Safeguarding\Safeguarding Children and Young People at the Great Western Hospital Policy.docx
30	**The Operating Framework for the NHS in England 2012-13**	https://www.gov.uk/government/publications/the-operating-framework-for-the-nhs-in-england-2012-13
31	**NHS entitlements: migrant health guide**	https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide
32	**Action required to tackle health inequalities in latest phase of COVID-19 response and recovery**	https://www.england.nhs.uk/about/equality/equality-hub/action-required-to-tackle-health-inequalities-in-latest-phase-of-covid-19-response-and-recovery/

6.2 Consultation Process

This Policy has been developed in consultation with the Trust's *Operations Team* and the Trust's *Access Team*.

The following is a list of the consultees involved in the review of this Policy and the date that they approved it for publication:

Job Title / Department.	**Date of Approval**
Chief Operating Officer	14/12/2021
Deputy Chief Operating Officer	21/12/2021
Associate Director of Business Intelligence	26/10/2021
Director of Improvement & Partnerships	15/12/2021
Divisional Director – Surgery, Women and Children's	14/12/2021
Divisional Director – Unscheduled Care	21/12/2021

Job Title / Department.	Date of Approval
Divisional Director – Integrated and Community Care	21/12/2021
Deputy Divisional Director – Planned Care	N/A
Deputy Divisional Director – Women and Children's	19/11/2021
Deputy Divisional Director – CS&SS	18/11/2021
Deputy Divisional Director – Outpatients	12/11/2021
Deputy Divisional Director – Cancer Services	05/11/2021
Head of RTT Performance and Data Quality	14/12/2021
Deputy Head of Access	04/11/2021

7 Equality Impact Assessment

An Equality Impact Assessment (EIA) has been completed for this document and can be found in Appendix A.

A STAGE 1: Initial Screening For Equality Impact Assessment

At this stage, the following questions need to be considered:		
1	What is the name of the policy, strategy or project? **Elective Patient Access, Booking and Choice of Date Policy**	
2.	Briefly describe the aim of the policy, strategy, and project. What needs or duty is it designed to meet? **To ensure that the Trust has a robust Access Policy meeting the requirements of the NHS Constitution for England [20] and best practice in relation to Access and patient choice**	
3.	Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any of the nine protected characteristics (as per Appendix A)?	**No**
4.	Is there evidence or other reason to believe that anyone with one or more of the nine protected characteristics have different needs and experiences that this policy is likely to assist i.e. there might be a *relative* adverse effect on other groups?	**No**
5.	Has prior consultation taken place with organisations or groups of persons with one or more of the nine protected characteristics of which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address?	**No**

Signed by the manager undertaking the assessment	*Mark Dalling*
Date completed	**22/11/2021**
Job Title	***Head of RTT Performance & Data Quality***

On completion of Stage 1 if you have answered YES to one or more of questions 3, 4 and 5 above you need to complete a STAGE 2 - Full Equality Impact Assessment.

Equality Impact Assessment

Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

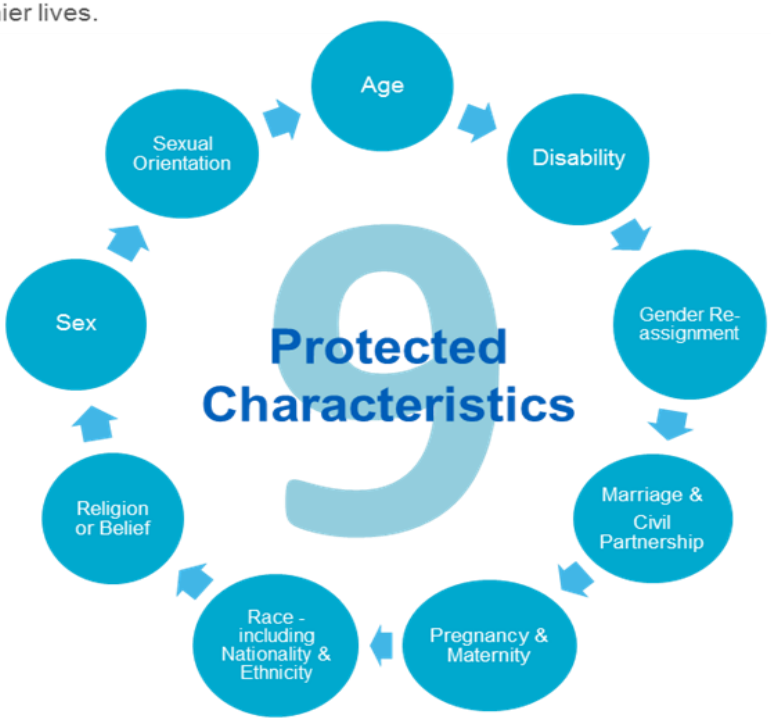
If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Trust Equality and Diversity Objectives

Better health outcomes for all	Improved patient access & experience	Empowered engaged & included staff	Inclusive leadership at all levels

Our Vision

Working together with our partners in health and social care, we will deliver accessible, personalised and integrated services for local people whether at home, in the community or in hospital empowering people to lead independent and healthier lives.



B National Standards – RTT and Diagnostic Standards

As defined in **The Operating Framework for the NHS in England 2012-13** [30]:

"…trusts will need to ensure that 92 per cent of patients on an incomplete pathway should have been waiting no more than 18 weeks."

RTT - Referral to Treatment	92% of all patients must be treated within 18-weeks.

"We also expect less than 1 per cent of patients to wait longer than six weeks for a diagnostic test."

Diagnostics	99% of diagnostic tests must be completed within 6-weeks.

C National Standards – Cancer Waiting Times Standards

As defined in the **National Cancer Waiting Times Monitoring Dataset Guidance** [19]:

Maximum two weeks from:		**Operational Standard**
Receipt of urgent referral for suspected cancer to first outpatient attendance		93%
Receipt of referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment		93%

Maximum 28 days from:		
Receipt of two week wait referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of two week wait referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer		75%

Maximum one month (31 days) from:		
Decision to treat to first definitive treatment		96%
Decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is:	surgery	94%
	drug treatment	98%
	radiotherapy	94%

Maximum two months (62 days) from:	
Urgent referral for suspected cancer to first treatment (62-day classic)	85%
Urgent referral from a NHS Cancer Screening Programme (breast, cervical or bowel) for suspected cancer to first treatment	90%

No separate operational standards set:
Consultant upgrade of urgency of a referral to first treatment Maximum one month (31 days) from urgent referral to first treatment for rare cancers: acute leukaemia, testicular cancer and children's cancers

D Consultant-led Services – the 19 RTT Treatment Functions

As defined in the **Consultant-led Referral to Treatment Waiting Times Data 2021-22** [8]:

"RTT waiting times are measured within 19 treatment functions, which have been chosen to capture the main treatment areas. Treatment functions are based on specialties."

General Surgery Service
Urology Service
Trauma and Orthopaedic Service
Ear Nose and Throat Service
Ophthalmology Service
Oral Surgery Service
Neurosurgical Service
Plastic Surgery Service
Cardiothoracic Surgery Service
General Internal Medicine Service
Gastroenterology Service
Cardiology Service
Dermatology Service
Respiratory Medicine Service
Neurology Service
Rheumatology Service
Elderly Medicine Service
Gynaecology Service
Other - Medical Services
Other - Mental Health Services
Other - Paediatric Services
Other - Surgical Services
Other - Other Services

E Diagnostics – the 15 DM01 Diagnostic Tests

As defined in the **Monthly Diagnostic Waiting Times and Activity** [17]:

"Data should be collected on 15 key tests. These are:"

Imaging - Magnetic Resonance Imaging (MRI)
Imaging - Computer Tomography (CT)
Imaging - Non-obstetric ultrasound (NOUS)
Imaging - Barium Enema
Imaging - DEXA Scan
Physiological Measurement - Audiology – Audiology Assessments
Physiological Measurement - Cardiology - echocardiography
Physiological Measurement - Cardiology - electrophysiology
Physiological Measurement - Neurophysiology – peripheral neurophysiology
Physiological Measurement - Respiratory physiology - sleep studies
Physiological Measurement - Urodynamics - pressures & flows
Endoscopy - Colonoscopy
Endoscopy - Flexi sigmoidoscopy
Endoscopy - Cystoscopy
Endoscopy - Gastroscopy

F Action Cards

Appendix F lists the Action Cards and their status, and is filed externally to this Policy to facilitate the regular updating required in the early stages of their development.