The Royal Wolverhampton NHS Trust

OP39

Patient Access Policy

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1.0 Policy Statement (Purpose / Objectives of the policy)

The purpose of this policy is to ensure all patients requiring access to outpatient appointments, diagnostics and elective inpatient or day case treatments are managed equitably and consistently, in line with national waiting time standards and NHS Constitution. The policy is designed to:

1.1 ensure the management of elective patient access to services is transparent, fair, equitable and managed according to clinical priorities,

1.2 set out the principles and rules for managing patients through their elective care pathways,

1.3 ensure that the patient's best interests and wishes, according to clinical priority, are at the forefront of the way in which the Trust operates, and

1.4 protect the clinical interests of vulnerable patients (e.g., children).

The policy has been agreed with clinicians, commissioners, and other relevant stakeholders.

The Royal Wolverhampton NHS Trust is committed to delivering high quality and timely elective care to patients, and to promote and provide services which meet the needs of individuals and do not discriminate against any employee, patient, or visitor. The policy is intended to be of interest to and used by those individuals within the Trust and wider, who are responsible for referring patients, managing referrals, and adding to and maintaining waiting lists for the purpose of organising patient access to secondary care.
The principles of the policy apply to clinical and non -medical healthcare such as physio etc as well as administrative waiting list management.
It is underpinned by a comprehensive suite of detailed standard operating procedures. All clinical and non-clinical staff must ensure they comply with both the principles within this policy and the specific instructions within the standard operating procedures.
The policy was developed in collaboration with Access Leads from each of the provider Trusts and the Black Country and West Birmingham Integrated Care Board (ICB) and adopted in line with NHSEI model access policy.

2.0 Definitions

2.1 **Active Monitoring -** also known as 'watchful wait'. An 18-week clock may be stopped where it is clinically appropriate to start a period of active monitoring in secondary care without clinical intervention.

2.2 **Active Waiting List** - patients awaiting elective admission who are fit, able and available to be called for admission.

2.3 **AHP** - Allied Health Professionals (e.g., physiotherapists).

2.4 **Appointment Slot Issues (ASI)** - this list within the Electronic Referral System shows referral details of where there was no capacity available for the chosen speciality at the time of booking.

2.5 **Bilateral Procedures -** where a procedure is required on both the right and left sides of the body.

2.6 **Booked Admission** - a patient agrees a date for admission on the day the decision to admit was made.

2.7 **Chronological Booking -** refers to the process of booking appointments, diagnostic procedures and admissions in date order of the clock start date.

2.8 **Consultant-led Service -** a service where a consultant retains overall responsibility for the care of the patient.

2.9 **Daycase** - a patient admitted electively for up to 23 hours with the intention of receiving care that does not require the use of a hospital bed overnight.

2.10 **Decision to Admit -** where a clinical decision is made to admit the patient for either day case or inpatient treatment.

2.11 **Directory of Services (DOS) -** a published list within the Electronic Referral System (e-RS) which shows the range of outpatient services offered to patients by the Trust.

2.12 **Elective Care** - any prescheduled care which doesn't come under the scope of emergency care.

2.13 **Electronic Referral System (e-RS**) - the national electronic system used by GPs to refer, make and co-ordinate patient first outpatient appointments.

2.14 **First Definitive Treatment -** an intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes 'First Definitive Treatment' is a matter for clinical judgment, in consultation with others as appropriate, including the patient.

2.15 **Fast Track** - to be referred to as 'Two Week Wait'.

2.16 **Incomplete Pathways** - patients who are waiting for treatment on an open pathway, either at a non-admitted or admitted stage.

2.17 **Inpatient/ Admitted Pathway -** a patient admitted electively or by other means with the intention that they will remain in hospital for at least one night, including any patient admitted who leaves hospital for any reason without staying.

2.18 **Inter Patient Transfer (IPT) -** where a consultant sends a referral to another hospital. The IPT is a mechanism which shares data on the 18-week pathway to manage and monitor performance for the continuing waiting time of the patient.

2.19 **Nullified RTT clock** - where the RTT clock is discounted from any reporting of RTT performance.

2.20 **Outpatient** / N**on-Admitted Pathway** - a patient referred by a GP or other health care professional for clinical advice or treatment within an outpatient setting.

2.21 **Patient Tracking List (PTL) –**a list of all patients (inpatients, daycases, patients waiting for diagnostic tests or other, and outpatients (new and review) waiting for an appointment or admission.

2.22 **Planned Admission** - a subsequent, planned non-referral to treatment (RTT) sequence of clinical care following an initial operation or procedure (e.g., check cystoscopy or a surveillance endoscopy).

2.23 **Referral to Treatment (RTT) -** the period from when a referral is made to when first definitive treatment takes place.

2.24 **Waiting List Admission** - a patient who is admitted electively from a waiting list having not been offered a date of admission at the time the decision to admit was made.

3.0 Accountabilities

TRUST RESPONSIBILITIES

Although responsibility for achieving standards lies with the Trust board, all staff with access to and a duty to maintain elective care information systems are accountable for their accurate upkeep of standards within this policy.

3.1 The Chief Executive has overall responsibility for performance regarding waiting times within the Trust and to ensure appropriate mechanisms are in place to support service delivery.

3.2 The Chief Operating Officer is accountable for ensuring that the waiting time targets specified within the policy are delivered.

3.3 The Deputy Chief Operating Officers are accountable for implementing, monitoring, and ensuring compliance with the policy within their divisions.

3.4 Clinical Directors & Group Managers are responsible for ensuring that waiting lists are managed appropriately within their group. It is the responsibility of groups to ensure that their patients are managed in accordance with this policy and the procedural guidelines which underpin it. The clinical management of individual patients on the waiting lists is the responsibility of the clinician in charge of the patient's' care. ·
In addition, Clinical Directors and Group Manager must ensure the NHS e-referral service directory of services (DOS) reflects the services provided in conjunction with Patient Access Services.

3.5 Operational and Line Managers have a responsibility to ensure that robust systems are in place to ensure effective implementation of this policy with all staff within their remit.

3.6 The Head of Patient Access Services is responsible for monitoring compliance against the policy and to escalate areas of non-compliance to Directorate or Group Managers and to the Deputy Chief Operating Officers and the Chief Operating Officer.

3.7 The Trust Performance Group is responsible for reviewing performance levels across the Trust and to act as necessary.

3.8 The Performance Team is responsible for reporting performance levels across the Trust.

3.9 Information Services is responsible for the timely production of patient tracking lists (PTLs) which support the divisions in managing waiting lists and RTT standards.

3.10 The Deputy Director of Strategic Planning and Performance acts as guardian for referral to treatment (RTT).

3.11 Administration Staff including ward clerks, patient access clerks, outpatient staff, admissions staff, medical secretaries, and all other staff are responsible to their line manager for booking and scheduling patient care. They are responsible for the day-to-day management of patient pathways and adherence to the policy, ensuring compliance with Trust processes, procedures, and administration tools.

GENERAL PRACTITIONERS & ICB RESPONSIBILITIES

3.12 General Practitioners (GP's) and other referrers play a pivotal role in ensuring patients are fully informed during their consultation of the likely waiting times for a new outpatient consultation and of the need to be contactable and available when referred.

3.13 The Black Country and West Birmingham ICB is responsible for ensuring all patients are aware of their right to treatment within an alternative provider if their RTT wait goes beyond 18 weeks or if it is likely to do so.
If RTT waits go beyond 18 weeks, the ICB must take all reasonable steps to offer a suitable alternative provider, or if there is more than one, a range of suitable alternative providers able to treat or see the patient more quickly than the provider to which they were referred. A suitable alternative provider is one that can provide clinically appropriate treatment and is commissioned by the ICB or NHS England.
The ICB is responsible for ensuring there are robust communication links for feeding back information to GP's. GPs should also ensure quality referrals are submitted to the appropriate provider or service first time.

3.14 PATIENT RESPONSIBILITIES

The NHS Constitution recommends the following actions patients can take to help in the management of their condition.

- Patients can make a significant contribution to their own, and their family's good health and wellbeing and should take personal responsibility for it.
- Patients should be registered with a GP practice as this is the main point of access to NHS care as commissioned by NHS bodies.
- Patients should provide accurate information about their health, condition, and status.
- Patients should keep appointments or cancel within a reasonable timeframe.

4.0 Policy Detail

The principles are supported by detailed local protocols indicated below:

Attachment 1	General Elective Access Principles and Standards
Attachment 2	Referral to Treatment (RTT) National Standards
Attachment 3	Standards for Managing Outpatient Referrals
Attachment 4	Outpatient Waiting List
Attachment 5	Booking Outpatient Appointments
Attachment 6	Partial Booking for Review Appointments
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Attachment 14	Acute Therapy Services
Attachment 15	Tertiary Referrals and Inter-provider Transfers (IPT)

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation revenue resources of this policy require additional	No
3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments	None

6.0 Equality and Diversity Risk Assessment

Tick	Options
	A. There is no impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.
	B. There is some likely impact as identified in the equality analysis. Examples of issues identified, and the proposed actions include:

7.0 Maintenance

The responsibility for review of this policy lies with the Head of Patient Access Services. The detail of the policy will be reviewed and ratified every 3 years or earlier if there are any changes to national elective access rules or locally agreed principles.

8.0 Communication and Training

This policy will be made available on the Trust's Intranet site under Organisational Policies.

The policy should be read in full by all applicable staff with specific roles responsible for referring patients, managing referrals, and adding to and maintaining waiting lists for the purpose of organising patients access to secondary care. All staff with specific roles and responsibilities associated with this policy should receive training on the requirements as part of their role. This should be undertaken within the service areas.

Advice and support will be provided by Patient Access Services.

9.0 Audit

Criterion	Lead	Frequency	Committee / Group	Monitoring Method
Monitoring of waiting times for first Outpatient Appointments	Head of Patient Access	Weekly	Trust Performance Group	Information report
Monitoring of Clinic utilisation for Outpatients	Head of Patient Access	Weekly	Trust Performance Group	Information report
Monitoring of Inpatient waiting times	Head of Patient Access	Weekly	Trust Performance Group	Information report
Monitoring of Diagnostic waiting times	Performance team / Directorate & Group Managers	Weekly	Trust Performance Group	Information report
Monitoring of 'clinics not cleared' within 3 days.	Head of Patient Access	Weekly	Trust Performance Group	Information report
Monitoring of no RTT outcomes within OP clinic	Head of Patient Access	Weekly	Trust Performance Group	Information report

Monitoring of DNA compliance	Head of Patient Access	Weekly	Trust Performance Group	Information report
Monitoring of Patient Initiated Follow UP (PIFU)	Head of Patient Access	Weekly	Trust Performance Group	Information report

Part A – Document Control

Reference Number and Policy Name. OP39 – Patient Access Policy	**Version:** 6.0 April 2023		**Status:** Final	**Author Responsible:** Head of Patient Access Services **Director Sponsor:** Chief Operating Officer
Version / Amendment History	**Version**	**Date**	**Author**	**Reason**
	1.0	November 2003	Head of Patient Access Services	Original Policy
	2.0	January 2008	Head of Patient Access Services	Review
	3.0	May 2012	Head of Patient Access Services	Minor amendments to cancer definitions (as agreed at Performance)
	3.1	February 2015	Head of Patient Access Services	Changes to outpatient sources of referral codes and minor update on DNA notifications to GPs and updates to Cancer services section Audit and references also added
	4.0	February 2017	Head of Patient Access Services	Full Review of Policy
	4.1	May 2019	Head of Patient Access Services	Review by Chief Finance Officer – extended to September 2019 pending full review
	4.2	September 2019	Head of Patient Access Services	Review by Chief Finance Officer – extended to December 2019 pending full review
	5.0	January 2020	Head of Patient Access Services	Full Review of Policy
	5.1	December 2020	Head of Patient Access Services	Review following updates to RTT waiting times relating to Covid-19

	6.0	April 2023	Head of Patient Access Services	Full Review following: • Introduction of Patient Initiated Follow Up (PIFU) • Recommendations from external audit carried out by RSM. • Harmonisation of Access Polices across Sandwell & West Birmingham Group

Intended Recipients- This policy is aimed at all staff who are involved in scheduling or managing Outpatient appointments or Inpatient waiting lists.

Consultation Group / Role Titles and Date:
Trust Performance Group – January 2023
Group and Directorate Managers-January 2023
Clinical Directors – January 2023 via Directorate Managers
ICB Ops Group - December 2022

Name and date of Trust level group where reviewed	Trust Policy Group - April 2023
Name and date of final approval committee	Trust Management Committee - April 2023
Date of Policy issue	May 2023
Review date and Frequency (standard review frequency is 3 years unless otherwise indicated)	April 2026

Training and dissemination – The Patient Access Policy will be available on the Trust Intranet site**.** Advice available as and when required from Patient Access Services.

Publishing Requirements: Can this document be published on the Trust's public page:
No?
If yes you must ensure that you have read and have fully considered it meets the requirements outlined in sections 1.9, 3.7 and 3.9 of OP01, Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines, as well as considering any redactions that will be required prior to publication.

To be read in conjunction with –

OP07 – Health Records Policy
OP91 – Data Quality Policy
OP101 – Children 'Did not Attend' No Access Policy
CP06 - Consent for Treatment Policy
OP10- Risk Management & Patient Safety Reporting Policy
NHS Accessible Information Standards
Overseas Patient Procedure

OP03 - Cancer Operational Policy Consultant-led Referral to Treatment Waiting Times Rules and Guidance Introduction to the NHS Constitution	
Initial Equality Impact Assessment completed YES **Full Equality Impact Assessment** NO If you require this document in an alternative format e.g., larger print please contact Head of Patient Access Services.	
Monitoring arrangements and Committee:	Trust Performance Group
Document summary / key issues covered: This policy details the standards and processes relating to the management and effective monitoring of both the Outpatient and Inpatient waiting list.	
Key words for intranet searching purposes	
High Risk Policy? **Definition:** •Contains information in the public domain that may present additional risk to the public e.g. contains detailed images of means of strangulation. •References to individually identifiable risk cases. •References to commercially sensitive or confidential systems. If a policy is considered to be high risk, it will be the responsibility of the author and chief officer sponsor to ensure it is redacted to the requestee.	**No**

VALIDITY STATEMENT This document is due for review on the latest date shown above. After this date, policy and process documents may become invalid. The electronic copy of this document is the only version that is maintained. Printed copies must not be relied upon to contain the latest updates and amendments.

Part B **Ratification Assurance Statement**

Name of document: Patient Access Policy

Name of author: Gail Langston Job Title: Head of Patient Access

I, Gail Langston the above named author confirm that:

- The Policy presented for ratification meet all legislative, best practice and other guidance issued and known to me at the time of development of the said document.
- I am not aware of any omissions to the said document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known.
- The document meets the requirements as outlined in the document entitled Governance of Trust- wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines (OP01).
- The document meets the requirements of the NHSLA Risk Management Standards to achieve as a minimum level 2 compliance, where applicable.
- I have undertaken appropriate and thorough consultation on this document, and I have detailed the names of those individuals who responded as part of the consultation within the document. I have also fed back to responders to the consultation on the changes made to the document following consultation.
- I will send the document and signed ratification checklist to the Policy Administrator for publication at my earliest opportunity following ratification.
- I will keep this document under review and ensure that it is reviewed prior to the review date.

Signature of Author:

Date:

Name of Person Ratifying this document (Chief Officer or Nominee):
Job Title:
Signature:

- I, the named Chief Officer (or their nominee) am responsible for the overall good governance and management of this document including its timely review and updates and confirming a new author should the current post-holder/author change.

To the person approving this document:

Please ensure this page has been completed correctly, then print, sign and email this page only to: The Policy Administrator

IMPLEMENTATION PLAN

To be completed when submitted to the appropriate committee for consideration/approval.

Policy number and policy version	**Policy Title** **OP39- Patient Access Policy**	
Reviewing Group	**Trust Policy Group**	**Date reviewed:**
Implementation lead: Gail Langston – Head of Patient Access Services		
Implementation Issue to be considered (add additional issues where necessary)	**Action Summary**	**Action lead / s (Timescale for completion)**
Strategy; **Consider** (if appropriate) Development of a pocket guide of strategy aims for staff Include responsibilities of staff in relation to strategy in pocket guide.		
Training; Consider 1. Mandatory training approval process 2. Completion of mandatory training form		
Development of Forms, leaflets etc.; Consider 1. Any forms developed for use and retention within the clinical record **MUST** be approved by Health Records Group prior to roll out. 2. Type, quantity required, where they will be kept / accessed/stored when completed		
Strategy / Policy / Procedure communication; Consider 1. Key communication messages from the policy / procedure, who to and how?		
Financial cost implementation Consider Business case development	N/A	
Other specific Policy issues / actions as required e.g. Risks of failure to implement, gaps or barriers to implementation		

Attachment 1

Protocol Title: General Elective Access Principles & Standards.

1.0 The NHS has set maximum waiting time standards for elective access to healthcare.
In England, waiting time standards for elective care (including cancer) come under two headings:

- the individual patient rights (as in the NHS constitution) and
- the standards by which individual providers and commissioners are held accountable by NHS improvement and NHS England.

It is expected that before a referral is made to the Trust, the patient is clinically fit for assessment and, or treatment and would be available within 18 weeks of the referral. The Trust must work with General Practitioners (GPs), Integrated Care Board (ICB) and other primary care services to ensure patients have a full understanding of this prior to a referral being made.

2.0 Individual patient rights

The NHS Constitution 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 the following:

- choice of hospital and consultant,
- 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 two weeks from a GP referral for urgent referral where a cancer is suspected.

If this is not possible, the NHS must take all reasonable steps to offer a range of alternatives.
The right to be seen within the maximum waiting time does not apply:

- if the patient chooses to wait longer,
- if delaying the start of treatment is in the best clinical interests of the patient (note that in both scenarios the patient's RTT clock continues to tick), and
- If it is clinically appropriate for the patient's condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at this stage.

All patients must be treated fairly and equitably regardless of race, sex, religion or sexual orientation.

3.0 Vulnerable Adults & Patients with disabilities

The Trust will work to ensure fair and equal access to services for all patients ensuring it meets its obligations towards vulnerable patients and those who had or have disabilities under the Equality Act 2010.

4.0 Patient eligibility to NHS Treatment

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 guidelines and rules.
All staff have a responsibility to check every patient's eligibility for treatment at the first point of entry in the Trust. All patients should be asked the baseline questions to help assess resident status. Patients identified as overseas visitors should be referred to the overseas visitor's team for clarification of status regarding entitlement to NHS treatment before their first appointment is booked or date to come in (TCI) agreed.

SOP18, Overseas Visitors Procedure

5.0 Patients Transferring between NHS and Private Care

Patients can choose to move between NHS and private status at any point during their treatment without prejudice. Where it has been agreed, for example, that a surgical procedure is necessary, the patient can be added directly to the elective waiting list if clinically appropriate. The RTT clock starts at the point the GP or original referrer's letter arrives in the Trust.
The RTT pathways of patients who notify the Trust of their decision to seek private care will be closed with a stop clock applied on the date of this being disclosed by the patient.

6.0 Procedures of low clinical value (POLCV)- (commissioner approved only)

Patients referred for specific treatments that are included in the list of procedures of limited clinical value, can only be accepted with the prior approval of the relevant ICB.

7.0 Health Services for Military Veterans

In line with the Armed Forces Covenant, published in 2015, all veterans and war pensioners should receive priority access to NHS care for any conditions related to their service, subject to the clinical needs of all patients. Military veterans should not need first to have applied and become eligible for war pension before receiving priority treatment.
GPs will notify the Trust of the patient's condition and its relation to military service when they refer the patient, so the Trust can ensure it meets the current guidance for priority service over other patients with the same level of clinical need. In line with clinical priority, patients with more urgent clinical needs will continue to receive priority.

8.0 Prisoners

All elective standards and rules are applicable to prisoners. Delays to treatment incurred as a result of difficulties in prison staff being able to escort patients to appointments or for treatment do not affect the recorded waiting time for a patient.

The Trust will work with staff in the prison service to minimise delays through clear and regular communication channels and by offering a choice of appointment or admission date in line with reasonableness criteria.

9.0 Reasonableness

'Reasonableness' is a term applicable to all stages of the elective pathway. Reasonableness refers to specific criteria which should be adhered to when offering routine appointments and admission dates to patients to demonstrate that they have been given sufficient notice and a choice of dates. A reasonable offer is defined as a choice of two dates with at least three weeks' notice.

10.0 Chronological booking

Patients will be selected for booking appointments or admission dates according to clinical priority. Patients of the same clinical priority will be appointed or treated in RTT chronological order, i.e., the patients who have been waiting longest will be seen first. NHSEI Prioritisation Criteria and 'P' category listing will also apply as per national guidance for managing elective backlog. Patients will be selected using the trust's patient tracking lists (PTLs) only. They will not be selected from any paper-based systems.

11.0 Communication

All communications with patients and anyone else involved in the patient's care pathway (e.g., a 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.

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

Attachment 2

Protocol Title: Referral to Treatment (RTT) National Standards.

1.0 National Targets

Referral to Treatment	92% of patients on an incomplete pathway (i.e., still waiting for treatment) to be waiting no more than 18 weeks (or 126 days).
Diagnostic tests	99% of patients will not wait longer than 5 weeks and 6 days (41 days) from the date of decision to refer to their appointment date.

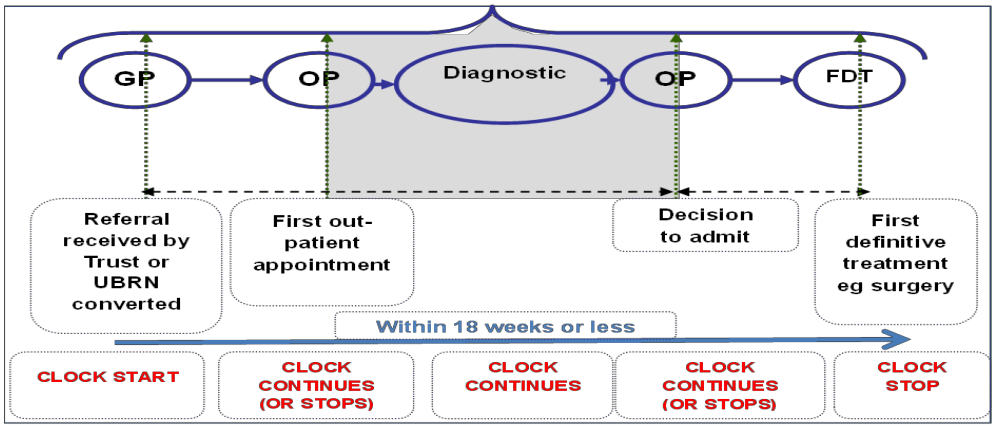
In addition to the elective care standards above, there are separate cancer standards which must be adhered to (Refer to Cancer Operational Policy-OP03).

While the aim is to treat all elective patients within 18 weeks, the national elective access standards are set less than 100% to allow for the following scenarios.

- **Clinical exceptions**: where it is in the patient's best interest to wait more than 18 weeks for their treatment.
- **Choice**: when the patient chooses to extend their pathway beyond 18 weeks by declining reasonable offers of appointments, rescheduling previously agreed appointment dates or admission offers, or by specifying a future date for appointment or admission.
- **Co-operation**: when patients do not attend previously agreed appointment dates or admission offers (DNA) and this prevents the Trust from treating them within 18 weeks.

2.0 Overview of national referral to treatment rules

The diagram below provides a visual representation of the chronology and key steps of a typical RTT pathway.



3.0 Clock starts

The RTT clock starts when any healthcare professional or a service permitted by an English NHS commissioner to make such referrals refers to any one of the following.

3.1 A consultant-led service, regardless of setting with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or GP.

3.2 An interface, referral management or assessment service, which may result in an onward referral to a consultant-led service before responsibility is transferred back to the referring health professional or GP.

3.3 A self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional permitted to do so.

4.0 Exclusions to New Clock starts

A referral to most consultant led services starts an RTT clock with the following exceptions:

- Obstetrics and midwifery,
- Planned patients, (a subsequent, planned non-referral to treatment (RTT) sequence of clinical care following an initial operation or procedure) (e.g., check cystoscopy or a surveillance endoscopy).
- Referrals to a non- consultant led service,
- Referrals for patients from non – English commissioners,
- Genitourinary medicine services (GUM), and
- Emergency pathways non-elective follow up activity.

5.0 New Clocks starts for same condition

5.1 Active Monitoring / Watchful Wait.

Some clinical pathways require patients to undergo regular monitoring or review diagnostics as part of an agreed programme of care. These events would not in themselves indicate a decision to treat or a new clock to start. If a decision is made to treat after a period of active monitoring (watchful wait), a new RTT clock would start on the date of the decision to treat (DTT).

5.2 Following a decision to start a substantively new treatment plan

If a decision is made to start a substantially new or different treatment that does not already form part of that patient's agreed care plan, this will start a new RTT pathway clock

and the patient will receive their first definitive treatment within the maximum 18 weeks from that date.

5.3 For second side of a bilateral procedure

A new RTT clock should be started when a patient becomes fit and ready for a second side bilateral consultant-led procedure.

5.4 For a rebooked new Outpatient appointment

Where a patient DNA's their 1st Outpatient appointment, the RTT clock will be nullified, and a new clock will start on the day a rebooked appointment is made if required.

5.5 Planned Patients

All patients added to a planned waiting list will be given a due date by when their planned procedure or test should take place.

6.0 Clock Stops for 'first definitive treatment'

An RTT clock stops when 'First definitive treatment' starts and includes the following.

- Treatment provided by an interface service.
- Treatment provided by a consultant-led service.
- A clinical decision is made to add a patient to a transplant list and has been communicated to the patient, their GP and, or the referring practitioner without undue delay.
- An Allied Health Professional (AHP), e.g., a physiotherapist or a dietician, or healthcare science intervention provided in secondary care or at an interface, if this is what the consultant-led or interface service decides is the best way to manage a patient's condition and avoid further intervention.

7.0 Clock stops for non-treatment

An RTT clock stops for non-treatment when the patient and subsequently their GP are informed without delay that:

- It is clinically appropriate to return the patient to primary care,
- A clinical decision is made not to treat,
- A patient did not attend (DNA) which results in patient being discharged,
- A clinical decision is made to start a period of active monitoring, or
- A patient declines treatment having been offered it.

8.0 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 few 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.

9.0 Patient Initiated Delays

9.1 Non-attendance of appointment / did not attend (DNA's)

Other than at first attendance, DNA's have no impact on the reported waiting times. Every effort should be made to minimise DNA's and it is important that a clinician reviews every DNA on an individual basis.
The decision to discharge a patient must be made by the clinician and be in the best clinical interest of the patient and can demonstrate that the appointment was clearly communicated in line with reasonableness criteria to the patient.

9.2 'FIRST' appointment DNA

The RTT clock is stopped and nullified in all cases, (if it can be demonstrated that the appointment was booked in line with reasonableness criteria). If the clinician indicates that another first appointment should be offered, a new RTT clock will be started on the day the new appointment is booked.

9.3 Subsequent (follow up) appointment DNA

The RTT clock continues if the clinician indicates that a further appointment should be offered. If patients wait more than 18 weeks as a result of such delays, the 8% tolerance is in place to account for this. The RTT clock stops if the clinician indicates that it is in the best clinical interests to be discharged back to the GP or referrer.

9.4 Cancelling, declining, or delaying appointment or admission offers

Patients can choose to postpone or amend their appointment or treatment if they wish, regardless of the resulting waiting time. Such cancellations or delays have no impact on the reported RTT waiting times. However, clinicians will be informed of patient-initiated delays to ensure that no harm is likely to result from the patient waiting longer for diagnosis or treatment (clinicians may indicate in advance, for each specialty or pathway, how long it is clinically safe for patients to delay their treatment before their case should be reviewed).
The general principle of acting in the patient's best clinical interest at all times is paramount. It is generally not in a patient's best interest to be left on a waiting list for an extended period, and so where long delays (i.e., of many months) are requested by patients, a clinical review should be carried out, and preferably the treating clinician should speak with the patient to discuss and agree the best course of action. Patients should not be discharged to their GP or otherwise removed from the waiting list

unless it is for clinical reasons.

9.5 Patients who are unfit for surgery
If a patient is identified as unfit for a procedure, the nature and duration of the clinical issue should be ascertained.

9.6 Short term illness
If the clinical issue is short term (i.e., up to 4 weeks) and had no impact on the original decision to undertake the procedure (e.g., cough or cold), the RTT clock continues.

9.7 Long term illness
If the clinical issue is more serious and the patient requires optimalisation and, /or treatment for it, the clinician should indicate:

- if it is clinically appropriate for the patient to be removed from the waiting list
  (this will be a clock stop event in line with active monitoring or /watchful wait) and

- if the patient should be optimised or treated (active monitoring clock stop) or if they should be discharged back to the care of their GP (clock stop).

10.0 Orthodontic Pathways

Due to the nature of orthodontic pathways, they will be managed separately within the service. A standard operating procedure will apply locally to manage orthodontic pathways.

11.0 Patients who have appointments cancelled because a service has been suspended

Where a clinical assessment has been made and the provider considers it is safe to temporarily suspend a service for some patients, the usual rules on provider-initiated cancellations will apply and the RTT waiting time clock should continue to tick.

12.0 18 weeks Referral to Treatments codes

National Codes	Local RWT codes	Local codes description	Status Code	Patient Status
10	DTNX DTOH	Diagnostic Test New Cross Diagnostic Test at other hospital	First activity in RTT period	Not yet treated (awaiting test results / add to waiting list, refer for outpatient treatment or diagnostics)

	OUT WL	Decision to Treat at further OPA appointment. Add to waiting List		
11	FT	Future Treatment	Active monitoring end	First activity at the start of a new RTT period following active monitoring.
12	RCDC	Consultant to Consultant different condition	Consultant referral	First activity at the start of a new RTT period following a decision to refer directly to a new consultant for separate condition
20	RCSC	Consultant to Consultant referral for same condition	Transfer to another RWT Consultant	Subsequent activity during RTT period – further activity anticipated same condition
21	RHSC	External Referral for same condition	Transfer to another provider	Not yet treated, subsequent RTT period anticipated by another Health Care Provider
30	FTG	First Treatment given	First definitive treatment given	Patient has received first definitive treatment that is intended to manage their disease, condition, or injury
31	WWP NRWP	Watchful Wait patient Not ready for surgery patient	Active monitoring (Patient initiated)	Start of active monitoring initiated by the patient
32	WWD NRWD	Watchful Wait consultant	Active monitoring / watchful waiting	Start of active monitoring initiated by the clinician

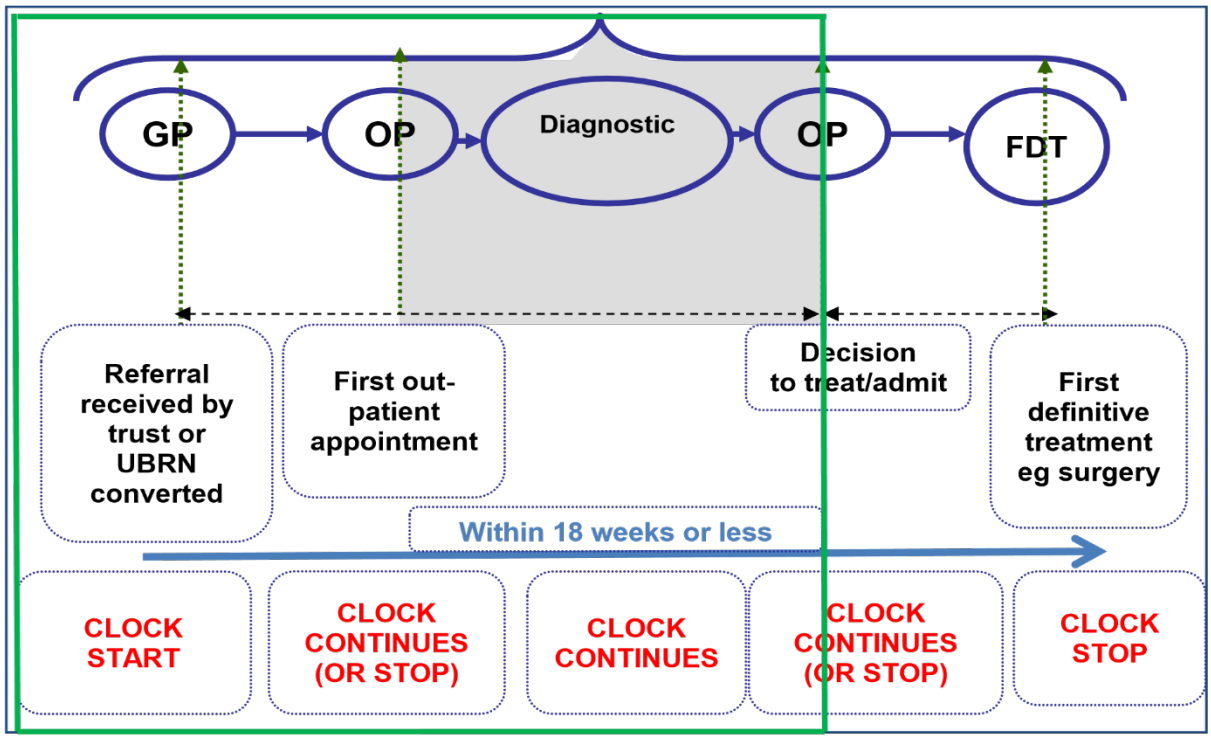
		Not ready for surgery consultant		
33	DNAN DNAO NDNT FAR	Did Not attend first appointment. Did Not attend FUP discharged no treatment. No Attend decision not to treat. Did Not attend further appointment required	DNA (Did Not Attend)	Patient failed to attend an appointment or admission
34	DNT	Decision Not to treat	Decision not to treat	Patient does not require treatment
35	NTDP	No Attend patient declined treatment	Treatment declined by patient	Patient not treated but discharged
36	D ND	Patient Died before treatment. No Attend patient died before treatment	Deceased	

Attachment 3

Protocol: Standards for Managing Outpatients Referrals

1.0 Non-Admitted Pathways

The non-admitted stages of the patient pathway (see below) comprise both outpatients and the diagnostic stages, as highlighted by the section with the green border around it in the diagram below. It starts from the clock start date (i.e., the date the referral is received) and ends when either a clock stop happens in outpatients (this could be the first, second or a further appointment) or when a decision to admit is made and the patient transfers to the admitted pathway.



2.0 Referral standards from Primary Care

Referrals made to the Trust must be legible, follow agreed referral protocols and provide appropriate details to register the patient. Information regarding referral guidance is available on the Trust Directory of Services.

Where clinically appropriate, referrals should be made to a service rather than a named clinician. Each service has agreed clinical criteria to support triage and vetting, and patients will be allocated to the most appropriate clinician, taking into account waiting times. Referring to services is in the best interest of the patients, as pooling referrals promotes equity of waiting times and allows greater flexibility in booking appointments.

Referrals not accompanied by the appropriate clinical information required to triage will be rejected and returned to the referrer. When making a referral, GPs must attach the referral letter at the time of booking or within a maximum of 3 working days.

A daily list is produced of outstanding letters, and if not received, the GP must be contacted by the administration team to obtain the referral letter.
Where patients' first language is not English, or the patient communicates non-verbally, their referral must state the exact type of interpreter required.
Referrals must also clearly state if the patient has learning disabilities, mental health problems or is in anyway a vulnerable adult and will include information on any preferences of requirements for the patient, or if the condition is a result of any military service.
Referrals should only be made to the Trust if the patient is fit, ready and willing to be treated within maximum waiting times. If this is not the case, the referral should not be made until such time as the patient is fit and available.

3.0 Directory of Services (DOS)

The directory of services is a published list which shows the range of services offered to patients by the Trust. GPs can access the list via the National E-referral system (ERS) to choose, in conjunction with the patient, the best possible option for the patient's needs.
To ensure appropriate referrals are made, it is important that Clinicians and Group and Directorate Managers work closely with Patient Access Services to update the DOS as and when changes take place, including when Consultants join or leave the Trust, or where there is a service change.
An overall annual review of the DOS will take place to ensure its accuracy. This will be carried out directly in conjunction with the Patient Access Team and service leads.

4.0 Referral administration

4.1 National E-referrals system (ERS) (for GPs)

The NHS e-Referral Service is the preferred method of receiving referrals from GPs.
This is a national electronic system which GPs use to offer a secure method of booking a first outpatient appointment. By using this service, the patient can choose the provider to whom they are referred as well as agreeing the date and time of the appointment. In doing so, a unique booking reference number (UBRN) will be generated which will follow the referral and ultimately enable the process of recording the activity.
The RTT clock starts from the point of conversion of the Unique Booking Reference Number (UBRN) within NHS e-Referrals.

4.2 Paper referrals

Referrals made by paper must not be accepted unless the reason is one stated within the agreed exclusion criteria (refer to section 7.0)
All routine, urgent pooled and consultant specific referral letters received directly within a specialty must be date stamped on receipt and returned within one working day to the central booking team where it will be returned to the GP requesting that the referral is made via e-RS.
If a paper referral is accepted as part of the exclusion criteria, or is to a non-consultant led service, it must be date stamped on the day of

receipt and registered onto the Patient Access System (PAS) within 3 working days by either the appointments team or service area where referrals are managed separately.
The RTT clock for paper referrals starts on the date that the referral is received by the Trust.

5.0 Trust Document Management System (DOCMAN)

Referrals made via ERS will be transferred to the Trust document management system. This creates a worklist for consultants to read and process referrals and allows them to either reject or accept the referral to ensure patients are booked appropriately at the beginning of their pathway. Where a paper referral is accepted (as part of agreed exclusions), an electronic copy of the referral must be created, by scanning the referral onto the Docman system so that it can be processed in line with electronic referrals.

6.0 Referrals from Welsh Health Boards.

If a patient has not been through the prior approval process (for example referrals from some Welsh Health Boards) the 18-week clock starts ticking from the date the referral is received, and the clock continues ticking while approval is sought.

7.0 Exclusions

There are some exceptions which have been contractually agreed between the Trust and ICB where a paper referral may be accepted and processed.

Urgent and Emergency Clinic Activity including:

- Referral made via any emergency portal, i.e., Hot Clinic,
- Rapid Access Cardiology,
- Stroke and TIA clinics,
- Fracture Clinics,
- Urgent OP appointment resulting from adverse diagnostic tests,

- Obstetrics,
- All prison referrals,
- Patients with no NHS number (e.g., asylum seekers, overseas visitors etc.),
- Sensitively marked patient (such if the patient is part of a witness protection scheme), and
- Temporary residents.

8.0 Prioritisation of Referrals

All NHS e-referrals must be reviewed and accepted or rejected by clinical teams within two working days for urgent referrals or five working days for routine referrals. If this is delegated, it will remain the responsibility of the consultant for any clinical consequences of the decision. Each specialty must ensure there are agreed arrangements for reviewing and prioritising referrals if the consultant or responsible clinician is away from the Trust.
Referrals will be prioritised as ‘urgent’ or ‘routine’, unless the clinician reviewing the referral suspects a cancer diagnosis – in which case the referral

will be upgraded to Cancer 2-week wait (fast-track) (refer to Cancer Operational Policy –OP03).
Where there are delays with the process for reviewing referrals, this will be escalated to the relevant Directorate or/ Group Manager to address.

9.0 Rejected Referrals

Referrals should not routinely be rejected. The directory of services should accurately reflect the services offered to ensure the appropriateness of referrals. If a referral is received for a service not provided by the Trust, it will be rejected back to the referring GP advising that the patient needs to be referred elsewhere. The patient will then be removed from the Outpatient waiting list and the RTT clock will be stopped. The reason for the rejection must be clearly stated so that the GP is able to take appropriate action to review the best option for the patient.

10.0 Redirected Referral

If a referral has been incorrectly made it can be redirected to the correct service. The GP will be advised of the redirection through their worklist within ERS. The patient's RTT clock will continue to tick from the original date when they converted their UBRN.

11.0 Types of Referrals

11.1 Pooled Referral - is a referral made to a service and an appointment is allocated according to clinical need and capacity to any consultant within the service.

11.2 Named Referral - is a referral made to an individual named consultant. Where it is clinically appropriate, referrals should be made to a service rather than a named consultant to minimise outpatient waits. This also is in the best interests of the patient as it promotes equity of waiting times and allows greater flexibility in booking processes. There are circumstances where 'named referrals' are considered appropriate such as:

- referral back to a consultant who had previously managed a patient condition'
- as a follow on from advice and guidance request, and
- The consultant may specialise in the patient's condition.

11.3 Open Referral – is where a patient has previously seen and been discharged by a consultant but agreed with the consultant that should the same condition reoccur within a maximum of 3 months; the patient can be offered another review appointment. This appointment must be recorded as a review appointment and the previous referral must be re-opened. A new 18-week pathway **must not** be started.

11.4 Consultant to Consultant Referral

These referrals must follow the strict referral protocol agreed with the local ICB. Acceptable reasons for a consultant-to-consultant referral are where they are part of the continuation of investigation treatment of

the condition for which the patient was referred – this includes referrals to pain management where surgical Is not intended.

12.0 Urgent referrals for a new condition

Suspected cancer referrals – this will be vetted and dated by the receiving consultant and upgraded if deemed necessary. Once upgraded, the patient should be treated within 62 days of the date the referral was received by the consultant.

Where the condition is not related to the original referral, the patient will be referred to their GP. The GP should be informed by letter with a clinical opinion on options for further management of the patient's condition.

At the point where a consultant, or nurse specialist, makes the decision to refer an existing patient on to another consultant within the Trust or to another service provider, the patient's registered GP must receive notification and details of the nature of the referral within five working days of the referral. Consultant to consultant referrals for related conditions will be included within the 18-week pathway, with the wait continuing from the original referral.

Consultant to consultant referrals for a different condition will start a new patient pathway with a new 18-week pathway clock. The original referral wait will continue concurrently until the patient is discharged or treated by the original consultant.

13.0 Referrals to Clinical Assessment Services (CAS)

These services provide intermediate levels of clinical triage, assessment and treatment between primary and secondary care. The Trust currently offers this service for gastroenterology and renal patients. A referral to 'CAS' starts an 18-week RTT clock. A 'virtual' appointment is made on PAS for such a referral, usually after midnight. The patient therefore should not be aware of this, and an actual appointment will be made following the triage process.

14.0 Referrals to 'Referral Assessment Service' (RAS)

This service offers a triage service prior to an appointment being made. It allows a referral to be triaged by a consultant, who will then assess the priority and need for an appointment, after which an appointment will be made, or the referral may be returned to the GP. This service is mainly used for reviewing 'urgent' referrals to ensure that patients are appropriately reviewed, and that urgent capacity is effectively utilised.

15.0 Inter provider Referrals.

All referrals for other Trusts or intermediate services must be agreed and accepted by the receiving specialty. They must be accompanied by a minimum data set (MDS) form clearly showing the patients position relative to their 18-week pathway. The Trust cannot reject a referral based on a non-receipt MDS.

16.0 Dental Electronic Referral Management System (Rego)- (for Dentists only)

As of 1st April 2018, all dental referrals in respect of Oral Surgery, Orthodontics and Oral Medicine must be made via DERMS.

17.0 Cancer Fast Track Referrals (2 Weeks Waits)

Refer to the Cancer Operational Policy –OP03.

18.0 Advice and guidance

A GP can, via e-RS, request advice; there is no intention to refer the patient for an appointment. It is a system which allows the GP and consultant to undertake a two-way electronic discussion on the condition and appropriate treatment for the patient. If the outcome is that the patient needs to be seen in clinic, this can be converted into a referral and processed accordingly, The RTT clock starts on the date the UBRN is converted. The patient may at this point decide that they wish the appointment to be made with another provider.

19.0 Expedite Referrals

Once a referral has been triaged by a consultant, the GP may send further correspondence requesting that an appointment is brought forward or upgraded. This must only be agreed by the consultant or clinician on the grounds of clinical urgency.

Attachment 4

Protocol: Outpatient Waiting List

1.0 Recording Referrals on PAS

All referrals must be recorded on the PAS system. This must include the source of referral to denote where the referral originated from.

The codes that must be used on Patient Administration System (PAS) are in the table below.

CODE	DESCRIPTION
1	Following an Emergency Admission
2	Following a domiciliary visit
3	General Practitioner
3	Referral from a prison
3	Referral from Private General Practitioner
5	Hospital Consultant to another hospital
6	Referral from the patient / self-referral
7	Referral from Prosthetic
10	Referral from Emergency Department
11	Referral from Private hospitals same Consultant
12	Referral from GP with special interests
13	Referral from Specialist Nurse
14	Referral from Therapy services
14	Referral from an Orthotics
15	Referral from Optometrist
16	Referral from Orthoptist
17	Following National screening e.g. Cytology, bowel, breast, diabetic eyes
92	Dentists
93	Community Dentists
97	Referral from the Forces (i.e. Navy, Army, Royal Air Force)
97	Referral from School Nurse/Health Visitor

2.0 Patients waiting for an appointment

Once a patient has been referred and is awaiting the date of an appointment, they will appear on either the ERS worklist or internal PTL on the information portal. The list that the patients appear on would depend on the way in which they were referred, or if they have previously had an appointment and it had been cancelled by either the Trust or the patient. The worklists would also include where a patient 'Did Not Attend' their appointment, and for clinical reasons, the consultant requires the patient to be rebooked.

3.0 Patient Tracking List (PTL)

The PTL is a list of all patients (inpatients, day case, patients waiting for diagnostic test or other, and outpatients (new and review)) waiting for an appointment or admission. It is used to ensure that the correct patients are selected in line with clinical priority and the 18-week pathway. For outpatients, this would include patients referred outside of ERS (i.e., via paper) as part of the exclusion list. It would also include internal referrals and those which could not be booked within ERS and have been transferred to the PTL.

4.0 Appointment Slot Issues (ASI)

Patients who have been referred from their GP via e-RS should be able to choose, book and confirm their appointment before a referral is received and accepted in the Trust.

If there are insufficient slots available for the selected service at the time of attempting to book (or convert their Unique Booking Reference Number 'UBRN'), the patient will appear on the appointment slot issue (ASI) worklist. The RTT clock starts from the point at which the patient attempted to book. The appointment must not be left on this worklist beyond 180 days. If, due to capacity reasons there is still no available capacity, the appointment would be cancelled from the ERS system and transferred to PAS, where the appointment would be reviewed as part of the PTL. The UBRN number must be recorded in PAS, to ensure the activity is captured.

5.0 Appointment for booking (AFB)

This worklist within ERS shows patients who have been referred via RAS, DNAs, and patients whose appointment has been cancelled by either themselves or by the Trust.

6.0 Referrals for Review Worklist

This list within ERS is for patients awaiting triage of their referral by the consultant. Once vetted, they need to be actioned within ERS as accepted, rejected, or change of service.

Attachment 5

Protocol Title: Booking Outpatient Appointments

1.0 Standards for booking

All patients will be offered outpatient appointments within the guidelines for patient choice and in line with national guidance for waiting times. That is in order of clinical priority (urgent before routine) and then in chronological order of the date the referral was received using the PTL.

2.0 Maximum waiting times for first Outpatient Appointment

To ensure 18-week RTT targets are met, patients should not wait more than 13 weeks for a first outpatient appointment and this should only exceed 8 weeks by exception.

Outpatient waiting lists must be managed and validated by the central appointments team in conjunction with service leads or within the service where waiting times are managed separately.

The Trust Performance team will also validate and monitor compliance for waiting times in line with RTT national guidance.

Patients must be listed promptly, and the list must not contain patients who no longer require an appointment.

Patients have the right to request to be referred to another hospital if they have to wait more than 18 weeks before starting treatment for a physical or mental health condition if the treatment if not urgent. There is no consequence to the patient if they choose to not to change.

3.0 Booking via ERS

Patients who have been referred via ERS should be able to choose, book and confirm their appointment before the Trust receives and accepts the referral (directly bookable services). The exception to this will be referrals received to a referral assessments service (RAS).

4.0 Reasonable offer of Appointment

A “reasonable offer” is one made for a time and date of 3 or more weeks’ notice from the date the offer is made by letter.

If an offer is made with less than 3 weeks’ notice it is only considered reasonable if the patient accepts it. The patient cannot, however, be penalised for declining an offer made with less than 3 weeks’ notice.

The offer is not considered reasonable if the patient has advised that they would be unavailable during a period of time.

Patients who decline one reasonable offer should be informed that they will only be offered one further appointment. If a second reasonable offer is declined, clinical advice should be sought to ensure that discharging the patient is not contrary to their best clinical interest (to protect the clinical interests of vulnerable patients).

5.0 Waiting Time Reset (Patient or Hospital)

The waiting time will be reset in the event of the following:

- patient declines a reasonable offer more than once'
- patient cancels or reschedules an appointment on **2 consecutive occasions after accepting it, or**
- the patient DNAs first OP appointment.

The waiting time cannot be reset if the hospital cancels or reschedules an appointment of if the patient turns down an offer that was unreasonable.

6.0 Patient Choice

Where possible the Trust will endeavour to provide an NHS appointment at the hospital site of the patient's choice. If this is not possible, the patient will be offered an appointment at any of the sites within the Trust.

7.0 Patients requiring outpatient appointment following an inpatient stay.

Patients who require an outpatient appointment with the consultant or team that was responsible for their care during an inpatient stay will be booked as a 'follow up or review' appointment. These patients do not need to be placed on an 18-week pathway. Patients who require an outpatient appointment with a different specialty or new consultant team or as a result of the admission from Emergency Department will be booked as a 'new' appointment.
Where possible, the appointment date should be given to the patient before leaving the ward. Where this is not possible, the patient should be advised that an appointment will be forwarded by post.

8.0 Capacity issues when making an appointment.

In all cases, where requests are made for an appointment by a consultant, a timeline will be given as to when the patient should be seen. It is important for patient care that the time period requested is adhered to. Where, due to capacity issues, this is not possible and it is unlikely that an appointment is available for a further 6 weeks, this must be escalated to the consultant in order that a clinical judgement can be made as to when the patient should attend.

9.0 Patient Treatment List (PTL) Meetings

Weekly performance meetings must be undertaken where appropriate between Directorate Leads and Patient Access Services to monitor all patient bookings and compliance. Patient Access Services should generate a report from the Information Portal showing current booking timescales and review capacity requirements. Directorates must act upon the information and ensure capacity is provided as appropriate.

Attachment 6

Protocol Title: Partial Booking for Review Appointments

1.0 Introduction

The outpatient follow up waiting list is used to keep a record of patients who require a review appointment more than six weeks from their last attendance. The date of the next appointment could be 12 months or more in the future. Partial booking is used within some specialties, whereby instead of routinely making an appointment and running the risk that the patient could DNA or cancel, the patient receives a letter to contact the Trust in order to mutually agree the date and time.

2.0 Process to follow

- Using the Information Portal and PAS, a list is created of the patients due their next review appointment in six to eight weeks' time.

- A letter is produced and sent to the patient informing them of this and they are provided with a telephone number to contact the Trust to arrange their appointment over the telephone.

- If after 14 days the patient does not make contact, a further reminder letter will be sent giving the patient a further seven days to make contact**.**

- If the patient still does not make contact, they will be discharged back to the care of the GP. A list of the patients discharged will be generated and forwarded to the consultant informing them of the outcome. A further appointment may be arranged if there is a clinical reason to do so.

Attachment 7

Protocol Title: Outpatient Clinic Changes by Hospital

1.0 Introduction

In order to offer an efficient service and avoid inconvenience to our patients, it is important that outpatient clinics run as planned. To do this, any clinic cancellation or change must be kept to a minimum. Not only do clinic changes inconvenience our patients, but it may also affect compliance with the RTT waiting times as patients will have to wait longer for their appointment.

2.0 Clinic Cancellation or Reduction

The legitimate reasons for cancelling a clinic include annual leave, professional leave and study leave as well as on-call activities in certain directorates (e.g., General Surgery, Orthopaedics etc). These should all be planned in advance. A minimum of eight weeks' notice of annual or study leave is required for clinic cancellation or reduction of a consultant-led clinic. Junior doctors and nursing staff are required to provide a minimum of six weeks' notice.

The only acceptable reason for a clinic to be cancelled at short notice is due to the unplanned absence of medical staff.

Sick leave is often unplanned, but compassionate leave and attendance at inquests and court hearings (not always planned in adequate time) are also acceptable reasons for short-notice cancellations.

Clinic cancellations must only be authorised by the appropriate Directorate Manager Clinical Director or Clinical Lead.

3.0 Cancellations with more than 8 weeks' notice

Clinics will only be cancelled where leave has been approved by Clinical Director, Clinical Lead or Group or Directorate Manager.

The request must be forwarded to the clinic management team where it will be processed within five working days.

Where possible, patients who have previously been cancelled should not be cancelled a second time.

4.0 Cancellations with less than 8 weeks' notice

Clinics must not be cancelled with less than eight weeks' notice unless under exceptional circumstances and if there is no alternative; the request must be authorised by Directorate Manager, Clinical Director or Clinical Lead.

For cancellations of less than five working days, it will be the responsibility of the individual service to contact patients directly to arrange an alternative appointment. The outpatient nursing team must also be advised. Where clinics are held in Outpatients 1, the clinic room booking system 'Bookwise', must also be updated to reflect the cancellation so that the clinic rooms can be reallocated.

5.0 Patient Communication

All patients to be cancelled must be contacted as soon as possible when it is known that a clinic is to be cancelled. Where capacity allows, an alternative date should be offered that will allow patients on an open RTT pathway to be treated within 18 weeks. Equally this will allow patients not on open pathways to be reviewed as near to the clinically agreed timeframe as possible.

Attachment 8

Protocol Title: Running an Outpatient Clinic for New and Follow up Patients

1.0 Patients Attending Clinic

All patients attending an outpatient appointment must have their demographic details checked and updated on the Patient Administration System (PAS) (refer to Health Records Policy – OP07, & Data Quality Policy OP91).

2.0 Walk in Patients

On occasions, patients may attend clinic without having a booked appointment. In such cases, the consultant or most senior doctor in the clinic should be advised and if they agree to see the patient, the patient must be recorded on PAS or ERS as a walk-in attendance.

3.0 Making a Review Appointment

Where possible, follow up appointments for patients on an open pathway should be avoided, by discussing likely treatment plans at the first outpatient appointment and, or use of telephone or written communication where a face-to-face consultation is not clinically required. Where this is unavoidable, such appointments must be booked to a timeframe that permits treatment by 18 weeks (unless the patient chooses a later date)

If a further appointment is required within six weeks, this should be booked and agreed with the patient before they leave the department. This provides the best opportunity for patient choice to be accommodated within the required timescale. Where insufficient capacity is available, the receptionist must escalate to the clinical teams.

If an appointment is required for more than six weeks, the patient should be advised that the appointment will be made closer to the time and a letter will be sent to them. The patient should then be added to the Outpatient Waiting List (OWL).

For separately managed services, local procedures may apply for booking review appointments.

4.0 Patient Initiated Follow Up appointments (PiFU)

A Patient Initiated Follow Up (PIFU) allows a patient to take control of their outpatient appointments rather than having them regularly or routinely scheduled. Patients meeting the clinical criteria will be given a set period in which they can contact the hospital if they have any worries or concerns relating to the condition for which they have agreed a PIFU pathway and will be able to arrange a follow up appointment.

At the end of the PIFU period, if the patient has made no contact, they will be discharged to the care of their General Practitioner (GP) or in some cases the original referrer (refer to appendix 1).

5.0 RTT / 18 weeks status

Where applicable, the outcome of the RTT status must also be captured as part of the cashing up process and updated on PAS to denote the clinical outcome. This will provide vital information on the patient pathway and will be used to ensure further intervention is carried out within the national waiting times. If there is an open clock, and an outcome is not recorded, this must be raised with the consultant before the end of the clinic so that the status can be updated.
It is possible for patients to be assigned any one of the following RTT statuses at the end of their outpatient attendance.

Patients on an open pathway

- Clock stops for treatment.
- Clock stops for non-treatment.
- Clock continues if requiring diagnostic tests, therapies or being added to the inpatient waiting list.

Patients already treated or with a decision not to treat

- New clock start if a decision is made regarding a new treatment plan.
- New clock start if the patient is fit and ready for second side of a bilateral procedure.
- No RTT clock if the patient is to be reviewed following first definitive treatment.
- No RTT clock if the patient is to continue under active monitoring.

Accurate and timely recording of the RTT status at the end of clinic is critical to supporting RTT performance.

6.0 Cashing clinics up

It is important that the outcome of all patients booked on to a clinic is captured on the day of the clinic, or where this is not possible by 10am the following working day.
It is the responsibility of the clinician to ensure that all outcomes are recorded on either the electronic outcome form or the yellow paper form and available for the receptionist so that PAS can be updated. This includes if the patient has attended, did not attend or cancelled the appointment as well as if the patient requires a further appointment, requires adding to the inpatient waiting list, discharged etc. If any of this information is missing, it is important to liaise with the relevant nurse immediately in clinic to ensure the information is captured.
A daily report is available to show where clinics have not been cashed and if not cashed within three days, a report is produced and is escalated to the Trust Performance Team on a weekly basis.

7.0 Suspensions (unknown reason)

If, in exceptional circumstances an outcome is not provided, the appointment must be added as a suspension using ‘unknown reason’ so that the clinics can be cashed up. This ensures that the patient appointment remains visible on PAS and can be actioned following clinic when the actual outcome is known. This option **should** only be used by exception.

Attachment 9

Protocol Title: Patient 'DNA' changes or Cancellation of Outpatient appointments

1.0 Patient Did Not Attend (DNA) either 'new' or 'follow up'

Patients who fail to attend their outpatient appointment, must be recorded as a 'DNA' on PAS.

If the patient is on an RTT pathway, as in the case of New Patients, their RTT clock should be reset in PAS to reflect that by not attending the appointment, the patient has nullified the referral pathway.

All DNAs should be clinically reviewed at the end of clinic and discharged back to the care of the GP unless it is considered that discharging the patient would be contrary to their best clinical interest.

Clinical interests of vulnerable patients are best protected by offering a further appointment.

- (Refer to OP101 Children's 'Did Not Attend' Policy.)
- (Refer to OP03 Cancer Operational Policy.)

If the decision is made not to rebook, the patient will be removed from the Outpatient waiting list and a letter will be sent from the consultant to the GP advising them of the decision.

If a further appointment is required, the RTT pathway will restart from the date of the re-booked appointment.

2.0 Appointment changes and cancellations initiated by the Patient.

Where the patient gives prior notice that they cannot attend their arranged appointment (even if it is on the day of clinic) this should be recorded as a cancellation and not a DNA. The patient should be offered an alternative date and time which is more convenient to them.

Where the request was made following receipt of a text message reminder, an alternative appointment should be made as soon as possible.

If the patient is on an RTT open pathway, the clock will continue to tick.

If the patient advises they wish to cancel and not rearrange the first appointment, they will be removed from the waiting list and a clock stop and nullified applied. The patient should be advised that their consultant and GP will be informed.

Where a patient cancels on a second consecutive occasion, they should be discharged back to their GP unless following a review by medical staff, it is considered that discharging the patient would be contrary to their best clinical interest.

Clinical interests of vulnerable patients are best protected by offering a further appointment.

- (Refer to OP101 Children's 'Did Not Attend' Policy).
- (Refer to OP03 Cancer Operational Policy).

Attachment 10

Protocol Title: Diagnostic Tests

1.0 Definition of a Diagnostic Test

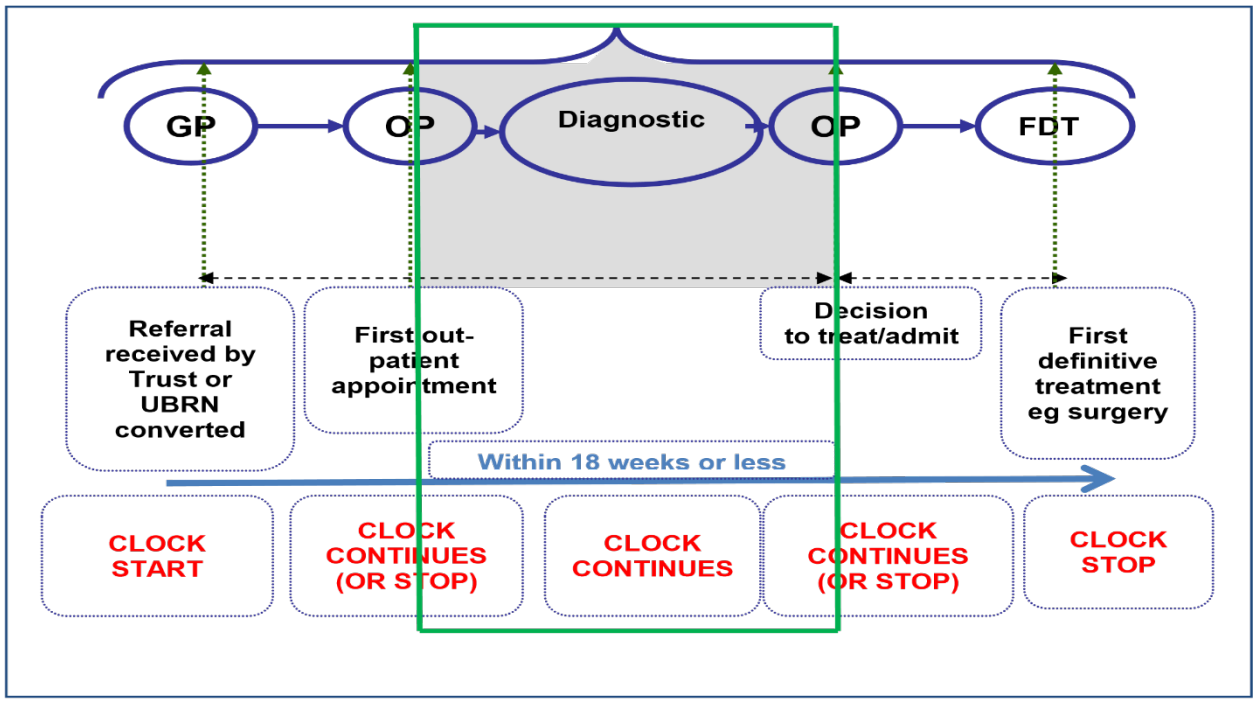
A “diagnostic” test is defined as a test or procedure used to identify and monitor a patient’s disease or condition with the intention of enabling a medical diagnosis to be made.

Diagnostics are an integral part of the patient pathway and cover imaging, endoscopy, audiology, cardiology, respiratory and urodynamics.

2.0 RTT pathways for diagnostic tests

The section within the green border on the diagram below represents the diagnostic stage of the RTT pathway which forms part of the non-admitted pathways. It starts at the point of a decision to refer for a diagnostic test and ends on the results or report from the diagnostic procedure being available to the requester.

It is important to note, however, that patients can also be referred for some diagnostic investigations directly by their GP where they might not be on an 18-week RTT pathway. This will happen where the GP has requested the test to inform future patient management decisions, i.e., has not made a referral to a consultant-led service at this time.



3.0 Patients with a diagnostic and RTT clock

The diagnostics section of an RTT pathway is a major pathway milestone. A large proportion of patients referred for a diagnostic test will also be on an open RTT pathway. In these circumstances, the patient will have both types of clocks running concurrently:

- their RTT clock which started at the point of receipt of the original referral and
- their diagnostic clock which starts when the request for a diagnostic test or procedure is made (often at the first outpatient consultation).

4.0 Straight to Test arrangements

For patients who are referred for a diagnostic test where one of the possible outcomes is review and, if appropriate, treatment within a consultant-led service (without first being reviewed by their GP), an RTT clock will start on receipt of the referral. These are called straight-to-test referrals.

5.0 Patients with a diagnostic clock only

Patients who are referred directly for a diagnostic test (but not consultant-led treatment) by their GP, i.e., clinical responsibility remains with the GP, will have a diagnostic clock running only. These are called 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.

6.0 National Diagnostic clock rules

The Trust should provide details on the diagnostic clock rules, including clock start, clock stop, reasonableness, DNA, cancellations, and any impact on the patient's RTT clock.

Diagnostic clock start: the clock starts when the request for a diagnostic test or procedure is made.

Diagnostic clock stop: the clock stops at the point at which the patient undergoes the test.

7.0 Waiting Times

Patients should not wait more than six weeks for a diagnostic test. For the purposes of RTT recording, this does not include waits for diagnostic tests or procedures where:

- the patient is waiting for a planned (or surveillance) diagnostic test or procedure, i.e., procedure or series of procedures as part of a treatment plan which is required for clinical reasons to be carried out or repeated at a specific time or frequency (e.g., 6 monthly check cystoscopy),
- the patient is waiting for a procedure as part of a screening programme (e.g., routine repeat smear test etc),
- the patient is an expectant mother booked for confinement, or.
- the patient is currently admitted to a hospital bed and is waiting for an emergency or unscheduled diagnostic test or procedure as part of their inpatient treatment.

7.0 Booking diagnostic appointment

If a patient declines, cancels or does not attend a diagnostic appointment, the diagnostic clock start can be reset to the date the patient provides notification of this. However, the Trust must be able to demonstrate that the patient's

original diagnostic appointment fulfilled the reasonableness criteria for the clock start to be reset. Resetting the diagnostic clock start has no effect on the patient's RTT clock. This continues to tick from the original clock start date.

8.0 Diagnostic cancellations, declines and, or DNAs for patients on an open pathway

Where a patient has cancelled, declined and, or not attended their diagnostic appointment and a clinical decision is made to return them to the referring consultant, the RTT clock should continue to tick. Only the referring consultant can make a clinical decision to stop the RTT clock, if this is deemed to be in the patient's best clinical interests, by discharging the patient or agreeing a period of active monitoring.

9.0 Active diagnostic waiting list.

All patients waiting for a diagnostic test should be captured on an active diagnostic waiting list, regardless of whether they have an RTT clock running, or have had a previous diagnostic test. The only exceptions are planned patients (see below).

10.0 Planned diagnostic appointments.

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 identified.

11.0 Therapeutic procedures

Where the patient is solely waiting for a therapeutic procedure, for example in the radiology department, there is no six-week diagnostic standard. However, for many patients there is also a diagnostic element to their admission or appointment, and so these patients would still be required to have their procedure within six weeks.

12.0 Patients waiting for more than one diagnostic test or procedure.

Patients waiting for two separate diagnostic tests or procedures concurrently should have two independent waiting time clocks (e.g., patient presenting with breathlessness could have a heart and lung condition and therefore may need both cardiology and respiratory tests concurrently).

Alternatively, a patient may need test 'X' initially and once carried out, a further test 'Y'; in this scenario, the patient would have one waiting time clock running for test 'X'. Once test 'X' was completed, a new clock would be started to measure the waiting time for test 'Y'

Protocol Title: Elective Inpatient Waiting List

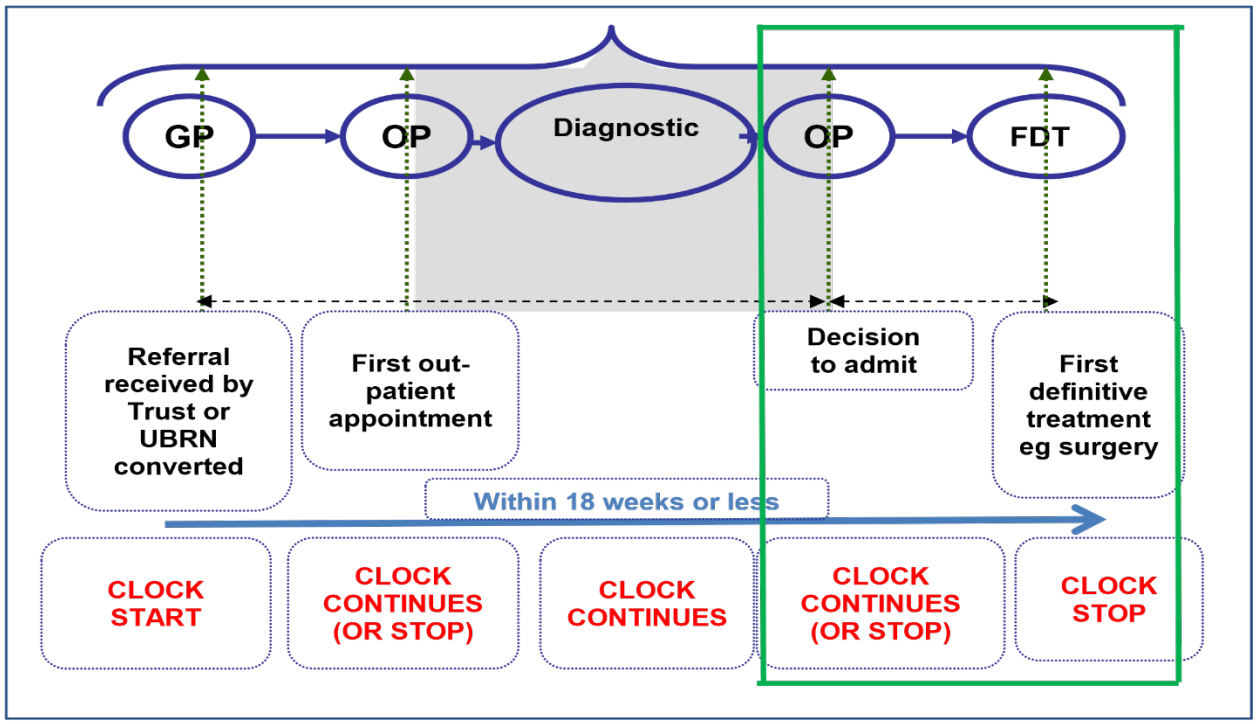
1.0 Principles of Elective Inpatient Waiting List Management

The decision to add patients to a waiting list will be made by the clinician following discussion with the patient and, or their carers (if the patient lacks capacity).

Patients will only be added to the waiting list if there is an expectation of being treated and that the patient accepts and agrees. Patients will not be added if:

- the patient is medically unfit for the procedure,
- the procedure is not currently available or funded within the Trust,
- the patient is unable to accept a date within the reasonable offer period, or
- the patient does not meet the criteria for a procedure of limited clinical value (POLCV) that is restricted, or the consultant feels that the patient would benefit from a POLCV which is excluded. An individual funding request for must be completed by the consultant and approval received from the appropriate ICB.

2.0 Stages in the Management of Admitted Patients.



3.0 The Active Waiting List (Inpatient PTL)

The national standard is that no patient should wait longer than 52 weeks for an inpatient admission.

The active waiting list should only include patients who are fit and ready to accept an offer for admission. However, they will be added to the admitted waiting list without delay following a decision to admit, regardless of whether they have undergone a preoperative assessment, or if the patient has confirmed a period of unavailability at the point of decision to admit.

The active inpatient or daycase waiting list PTL includes all patients who are awaiting elective admission. The only exceptions are planned patients who are awaiting admission at a specific clinically defined time The PTL is used to select the correct patients in order of their 18-week pathway and clinical priority.

The PTL must be validated and kept up to date by the Patient Access waiting list coordinators in conjunction with service leads.

Where there are concerns with waiting times, this should be escalated to the Directorate and Group Managers in a timely manner. This would include instances where patients were approaching 40 weeks wait, and there is no plan in place to offer a date for admission.

In terms of the patients RTT clock, adding a patient to the inpatient or daycase waiting list will either:

- continue the RTT clock from the original referral received date or
- start a new RTT clock if the surgical procedure is a substantively new treatment plan which did not form part of the original treatment package, providing that either another definitive treatment or period of active monitoring had already occurred. The RTT clock will stop upon admission.

4.0 Planned Waiting List

Patients should only be added to a Planned Waiting List where they clinically need to wait for a planned period of time. This includes planned diagnostic tests (e.g., check cystoscopy) 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 at the clinically appropriate time and they should not have to wait a further period after this time has elapsed. For example, a patient scheduled for a re-test in January must have the appointment sent in December and the procedure must be done in January.

There should be no open pathway for patients on a Planned Waiting List.

5.0 Adding patients to an Inpatient Waiting list.

All patients added to an inpatient or day-case waiting list must have given consent (see Consent for Treatment Policy–CP06) and stage one of the consent form completed agreeing to the procedure or surgery. This should be recorded on the TCI card. Where no consent has been completed, the TCI card should be returned to the consultant and the patient must not be added to the waiting list until stage one consent has been completed. A patient must not be added to a waiting list unless all relevant tests that enable consultants to make a fully informed decision are available and have been reviewed. All patients added to a waiting list must receive written confirmation within five working days confirming

the intention for admission. This will only apply following receipt of a TCI card and relevant documentation by the waiting list co-ordinator (i.e., consent form and, if appropriate, POLCV form).

6.0 Prioritisation Codes ('P' codes)

When a clinical decision is made to add a patient to a waiting list, the consultant must highlight the clinical priority of the patient when completing the waiting list card. This is to ensure that all patients are offered a date in order of their clinical priority.

P2 - this denotes the patient requires 'urgent' treatment and should be offered a date within 1 month of the decision being made.

P3 - patients with a P3 code are relatively urgent and should be offered a date within 3 months.

P4 – patients with this code are considered to be non-urgent and may be offered a date over 3 months in line with their RTT clock status.

7.0 Patients requiring more than one procedure.

In some instances, patients may be waiting for more than one procedure at the same time. The patient should be added to the waiting list with 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) surgeons, the following applies.

- The patient should be added to the active waiting list for the primary (first) procedure.
- The patient should not be added to the waiting list for any unrelated procedures if they are not 'fit or willing' to proceed with any additional treatment at that stage.
- When the patient's first treatment is complete and the patient is fit, willing and able to undergo the second procedure, the patient may then be added to the waiting list. A new clock will start when the patient becomes ready for the second procedure.

Examples of this are:

bilateral procedures – such as procedures on the same part of the body on both left and right sides (i.e., both hips, or both eyes etc.),

joint procedures – where a main procedure is undertaken by one consultant, but another consultant may assist or perform another specialist procedures at the same time, and

unrelated procedures – where a patient is to undergo procedures on different parts of the body (i.e., requires hip operation and cataract surgery) at different times.

8.0 Patients requiring thinking time.

Patients may wish to spend time thinking about the recommended treatment options before confirming they would like to proceed; it would not be appropriate to stop their RTT clock where the thinking time amounts to only a few days. Patients should be asked to make contact within an agreed period with their decision.

It may be appropriate for the patient to be entered into active monitoring (and the RTT clock stopped) where they state they do not anticipate making a decision within the next 12 weeks.
This decision can only be made by the clinician and on an individual basis with the patient's best clinical interest 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. If the patient does not wish to proceed, they would be discharged back to the care of their GP.

9.0 Procedure of Low Clinical Value (POLCV)

Where a procedure is considered to be of low clinical value, the eligibility for funding for the treatment must be established before the patient is added to the waiting list. When a decision to treat is made, a request form must be completed and attached to the waiting list card. If an application for individual funding is required, the IFR (Individual Funding Request) form must be completed by the consultant.

10.0 Selecting Patients for Admission

When selecting patients for admission, the following must be considered:

- clinically urgent patients must have priority,
- planned admissions must be admitted at the clinically appropriate time, and
- all other patients will be admitted in order of the 18 weeks pathway.

All patients will be identified from the Trust PTL and subject to the clauses above will be scheduled for admission in chronological order of RTT wait.
To review capacity requirements, it is recommended, where possible, that operating lists are selected at least four weeks in advance. Exceptions to this would be for surgeons who treat cancer patients.

11.0 Offer dates for Admission

All elective cases will be booked following a telephone call with the patient to ensure they are ready and available to accept an admission date.
A "reasonable offer" is one made for a time and date of three or more weeks' notice from the date the offer is made.
If an offer is made with less than three weeks' notice it is only considered reasonable if the patient accepts it. The patient cannot, however, be penalised for declining an offer made with less than three weeks' notice.
The offer is not considered reasonable if the patient has advised that they would be unavailable during a period of time.
Once a reasonable date for admission has been agreed, patients who choose to delay treatment may be allowed to cancel booked TCI dates up to a maximum of two separate occasions.
If there is insufficient capacity to offer a date, it must be escalated to the directorate managers for the service.
It is considered good clinical practice that all offers declined by the patient are recorded on PAS. This information can be used later to understand the reasons for any delays in the patient's treatment, e.g., hospital or patient initiated.

12.0 Unable to contact patients.

Every effort must be made to contact the patients at various times of the day by telephone or text.

You should also consider contacting their GP to ensure the patients correct contact details are recorded.

If all attempts fail to make contact with the patient, this must be escalated to the consultant.

13.0 Patient declaring periods of unavailability while on the inpatient / day case waiting list.

If a patient contacts the Trust to communicate periods of unavailability for social reasons (e.g., holidays, exams etc.) this period should be recorded on PAS.
If the length of the period of unavailability is equal to or greater than a clinically unsafe period of delay (as indicated in advance by consultants for each specialty), the patient's pathway will be reviewed by the consultant.
If it is deemed clinically safe for the patient to delay, the RTT clock would continue.
If it would be clinically unsafe, the clinician should contact the patient with a view to persuading the patient not to delay. The RTT clock continues. In exceptional circumstances if a patient decides to delay their treatment it may be appropriate to place the patient on active monitoring (clock stop) if the clinician believes the delay will have a consequential impact of the patient's treatment plan.

14.0 Patient who decline or cancel TCI offers.

If patients decline TCI offers or contact the Trust to cancel a previously agreed TCI date, this will be recorded on PAS. The RTT clock continues to tick. If as a result of the patient declining or cancelling, a delay is incurred which is greater than the potentially clinically safe period (as indicated in advance by the consultants for each specialty), the patients pathway will be reviewed by their consultant.
Patients who decline all reasonable offers for a TCI date should be recorded as **P6** on PAS to denote that all attempts have been made to offer a date, but the patient declined.

15.0 Removals from the Waiting List

There are occasions when a patient should be removed from the waiting list, such instances include the following.

- Patient decides not to proceed with the treatment.
- Patient is removed following DNA for admission.
- Patient not fit at preoperative assessment and will not be ready within three months.
- Patient is removed following a clinical decision not to proceed.
- If a patient is not available for treatment for longer than 12 weeks, the patient is removed from the waiting list and the clock is stopped until they are ready and able to receive treatment, when they can be placed back on the waiting list with a new clock started.
- If the patient is unavailable for less than four weeks, they must stay on the waiting list.

- Change of medication that requires more than six weeks monitoring period.
- More than two declined reasonable offers.
- When a patient requests a certain date past the 18 weeks date, due to personal reasons.
- The patient cancels booked TCI date on more than 2 occasions.

15.1 Clinically urgent patients

Should the patient be deemed clinically urgent, the clinician must contact the patient to discuss the risks and benefits of attending for admission. Should the patient subsequently agree to the admission, due process for recording on PAS should be followed.
If, following discussion with the clinician, the patient is still not willing to accept a date, the clinician should contact the patient's GP to advise of the patients' decision and why they have made this decision.
If the patient is to remain on the waiting list, the patient must be reviewed regularly by the relevant clinical team until a date can be mutually agreed. This information must be recorded within the patient health record.
If the decision is to remove the patent from the waiting list, a letter must be sent to the patient and the GP advising them of the decision to either remove the patient from the active waiting and place them on active monitoring or to discharge the patient back to their GP's care.

15.2 Non-urgent patients

Following clinical review, if the patient is deemed as not clinically urgent, agreement will be sought from the clinician to agree whether it would be in the best clinical interests of the patient for them to remain on the RTT waiting list, and the patient's RTT clock would continue to tick, or to discharge the patient back to the care of their GP, and this would stop the patient's 18 week pathway.
It is not acceptable to refer patients back to their GP simply because they wish to delay their appointment or treatment. However, it would be acceptable where referring patients back to their GP is in their best clinical interests. Such decisions should be made by the treating clinician on a case-by-case basis.
If following clinical review the clinician determines it is in the best interests of the patient to remain on the waiting list, the 18-week pathway will continue. These patients will require regular review until a date of admission can be agreed. The patient's record should be updated to reflect the decision not to discharge the patient back to their GP.

Attachment 12

Protocol Title: Preoperative Assessment for Elective Admissions

1.0 Introduction

All patients with a decision to admit requiring a general anaesthetic must attend a pre-operative assessment to ensure they are fit for the surgery or procedure to take place.

Patients on a waiting list are invited to attend pre-operative assessment when a date for surgery or procedure has been agreed. In some cases, patients may be offered a preop date prior to the offer of a TCI date so as they could be admitted as short notice.

Patients attending for outpatient appointment where surgery is agreed may be offered a one-stop preoperative assessment on the day to ascertain fitness before being added to waiting list.

In all cases, a patient may still be added to the waiting list prior to a pre-op assessment taking place.

2.0 Patient attending for Preoperative Assessment

When the patient arrives, their demographic details must be checked and updated on PAS.

The patient must be booked into clinic and following the assessment should be 'discharged to waiting list' on PAS. The RTT pathway **must not** be closed at this point. At the end of the clinic, all patients must be 'cashed up', that is that they are either marked as attended or DNA and an outcome recorded.

3.0 Patients who DNA Preoperative Assessment

Where a patient does not attend their preoperative assessment, the pre-op assessment team will contact the patient by telephone to arrange a further appointment. If the patient decides they no longer wish to undergo the surgery, they will be removed from the waiting list and the consultant will be informed.

4.0 Patient assessed as fit to proceed with surgery.

Where a patient is assessed and considered fit to continue with the surgery or procedure, the previously agreed date will go ahead in line with their 18-week pathway.

5.0 Patient assessed as not fit for treatment to proceed.

If the patient is not fit for the planned procedure and the clinical reason is short term (i.e., less than four weeks) and has no impact on the original clinical decision to undertake the procedure (i.e., cough or cold), confirmation that the clinical issue is resolved must be obtained by clinical preoperative staff before a patient is considered fit to proceed. The clock will continue running during this time and the patient must be offered a new date within their 18-week breach date.

If the clinical issue is a serious one and expected to last more than three months and the patient requires optimisation or treatment, the clinician must indicate that it is clinically appropriate to remove the patient from the waiting list.

- Optimised or treated within secondary care: active monitoring clock stop for the existing pathway and potentially a new clock starts for optimisation treatment.
- Discharged back to the care of their GP (clock stop – discharged).

Where the patient becomes fit and ready to be treated for the original condition, a new RTT clock would start on the day this decision is made and communicated to the patient. The patient will be relisted, and a new clock started when confirmation is received that the patient is fit to undertake the procedure.

6.0 Patients who test positive for Covid 19

The Royal College guidance is that where a patient has tested positive for Covid 19, their admission date should be delayed for seven weeks (90 days). However, clinical prioritisation can overrule this guidance if the consultant feels it is in the best interest of the patient.

Attachment 13

Protocol Title: Patients Admission and Discharge

1.0 Patients Attending for Admission.

On arrival, the patient's demographic details must be checked and updated on PAS.

The patient must be admitted using the recorded TCI episode on PAS for that admission. This will automatically update and close the 18-week pathway.

2.0 Admission Methods

When a patient is admitted into hospital, the correct method of admission must be selected according to the list given.

3.0 Cancellations on day of surgery (by hospital for non-medical reasons)

It is the expectation that no patient will be cancelled by the hospital on day of surgery. However, in extreme circumstances when this is unavoidable, patients must be booked a new date either up to and including 28 calendar days (as per the national standard) or before their 18-week breach date if this is shorter than 28 days, unless the patient chooses a later date.

These cancellations must be authorised by Divisional or Directorate level only.

A new admission date following a cancellation must be agreed with the patient, and wherever possible must not be cancelled a second time.

If it is not possible to offer the patient a date within 28 days of the cancellation, the Trust will offer to fund the patient's treatment at the time and hospital of the patient's choice where appropriate.

4.0 Cancellations on day of surgery (by patient)

If a patient cancels on the day of admission, they must be added back to the waiting list if their admission was routine or referred to the consultant if it was clinically urgent. Where the patient has cancelled on two occasions, they should be removed from the waiting list.

If the patient cancels due to a positive Covid result, the patient must not be offered a further date for seven weeks (90 days) following the date of the positive test.

5.0 Patient DNAs on day of admission

Patients who do not attend for admission will have their pathway reviewed by their consultant. If the patient's consultant decides that they should be offered a further admission date, the RTT clock continues to tick. Should the patient's consultant decide that it is in their best clinical interests to be discharged back to the GP, the RTT clock is stopped. It is the clinician's responsibility to inform the referrer and the GP if a patient fails to attend an appointment.

6.0 Planned Outpatient Appointments during an Inpatient Stay

On occasions, patients may be an inpatient but also have a planned outpatient appointment within the period of admission for either the same specialty or a

different one. It is important that if the patient is not able to attend the appointment, then must be cancelled or rearranged.

7.0 Ward, Consultant or Hospital Transfers

Where a patient transfers their ward, consultant or hospital during an inpatient episode, PAS must be updated in a timely manner to reflect the changes.

8.0 Discharging a patient.

On day of discharge, it is vital that patients are discharged on PAS in a timely manner. All patient documentation created during the inpatient stay must be forwarded to the scanning team to ensure it is available on Clinical Web Portal (CWP) for future review appointments (see Health Records Policy – OP07, attachment 6 scanning patient documentation and information).

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ADMISSION METHOD CODES / DESCRIPTIONS

Elective Admission, when the DECISION TO ADMIT could be separated in time from the actual admission:

11	Waiting list
12	Booked
13	Planned

Note that this does not include a planned transfer from another Trust (Hospital Provider) (see 81 below).

Emergency Admission, when admission is unpredictable and at short notice because of clinical need:

21	Emergency or dental casualty department of The Royal Wolverhampton NHS Trust (admitted via ED/Dental Casualty Department)
22	GENERAL PRACTITIONER: (GP) after a request for immediate admission has been made direct to the Trust (Hospital Provider), i.e. not through a Bed bureau, by a GENERAL PRACTITIONER or deputy (Admission at request of GP)
23	Bed bureau
24	Consultant Clinic, of this or another Trust (From an Outpatient Clinic)
25	Admission via Mental Health Crisis Resolution Team
2A	Emergency Department of **another** Trust (Hospital Provider) where the PATIENT had not been admitted *
2B	Emergency Transfer - Transfer of an admitted PATIENT from another Trust (Hospital Provider) in an emergency *
2C	Baby born at home as intended * **- to be recorded against baby record only**
2D	Other emergency admission *
28	Other means, examples are: ** - admitted from the Emergency Department of another Trust (provider) where they had **not** been admitted - transfer of an admitted PATIENT from another Trust (Hospital Provider) in an emergency - baby born at home as intended

Maternity Admission, of a pregnant or recently pregnant woman to a maternity ward (including delivery facilities) ***except when the intention is to terminate the pregnancy, see below guidance***.

31	Admitted ante-partum (Before Delivery)
32	Admitted post-partum (After Delivery)

Termination of Pregnancy

11/12/13	When the termination is arranged then an admission code from Elective Admission is to be used as appropriate (11,12 or 13)
31	If the termination is not planned (patient is admitted to a maternity ward i.e., for observation etc. and following this a termination of pregnancy occurs Admission Method code 31 would remain
21	Pt admitted via ED to a maternity ward and has a termination of pregnancy – Emergency Admission 21 code or other relevant Emergency Admission code to be used.

Other Admission not specified above

82	The birth of a baby in this Trust (Health Care Provider)
83	Baby born outside the Trust (Health Care Provider) except when born at home as intended.
81	Planned Transfer - Transfer of any admitted PATIENT from other (Trust) Hospital Provider other than in an emergency

Note: The classification has been listed in logical sequence rather than alphanumeric order. **Note - National Codes 2A, 2B, 2C and 2D have been introduced to replace National Code 28 *'Other means'*. National Code 28 will be retired in the next version of the Commissioning Data Set.**

If unsure regarding the use of the most appropriate Admission Method, Please contact The Data Quality Team

rwh-tr.dataquality@nhs.net

Protocol Title: Acute Therapy Services

1.0 Introduction

Acute therapy services consist of physiotherapy, dieticians, orthotics and surgical appliances.

Referrals to these services can be:

- directly from GP's where an RTT clock would not be applicable or
- during an open pathway where the intervention is intended as first definitive treatment of interim treatment

Depending on the pathway or patient, therapy interventions could constitute an RTT clock stop. Equally the clock could continue to tick. It is critical that staff in these services know if patients are on open pathways and if the referral to them is intended as first definitive treatment.

2.0 Physiotherapy

For patients on an orthopaedic pathway referred for physiotherapy as first definitive treatment, the RTT clock stops when the patient begins physiotherapy.

For patients on an orthopaedic pathway referred to physiotherapy as an interim treatment (as surgery will be required), the RTT clock continues when the patient undergoes physiotherapy.

3.0 Surgical Appliances

For patients on an orthopaedic pathway referred for a surgical appliance with no other form of treatment agreed, the fitting of the appliance constitutes first definitive treatment and therefore the RTT clock stops when the appliance is fitted.

4.0 Dietetics

If patients are referred to the dietician and receive dietary advice with no other form of treatment, this would constitute a RTT clock stop. Equally, patients could receive dietary advice as an important step of a particular pathway (e.g., bariatric): in this pathway, the clock would continue to tick.

Attachment 15

Protocol Title: Tertiary Referrals and Inter-Provider Transfers (IPT)

1.0 Introduction

Inter-provider Transfer is a critical mechanism to manage and monitor performance and performance-sharing on the 18-week pathway. It also allows equitable attribution of breaches of that pathway. When clinical responsibility for a patient is transferred, there is a danger that the administrative data on the patient does not pass to the new organisation and subsequent responsibility for breach sharing lacks clarity.

2.0 Minimum Data Set

The IPT minimum data set is designed to support the transfer of administrative data from the referring provider to the receiving provider, thus allowing the receiving provider to report on the 18-week patient pathway. By sharing information via the minimum data set for inter provider transfers all parties involved can be fully aware of the patient's pathway. All services that refer onwards into provider services must use the IPT process.

All IPT minimum data sets (IPTMDS) will be completed and sent to the receiving provider within 48 hours (DSCN 44/2007). It is the referring organisation's responsibility to ensure the IPTMDS is sent and that an NHS.net address is used as the secure email service. A Performance Sharing report will be completed by the Provider where the 18-week clock stop event occurs. This will only be completed for breaches of the 18-week pathway. It is therefore essential that the IPT process is adhered to.

Appendix 1

Protocol Title:

Patient Initiated Follow Up Appointments

1.0 INTRODUCTION

A Patient Initiated Follow Up (PIFU) allows a patient to take control of their outpatient appointments, rather than having them regularly or routinely scheduled.
Patients meeting the clinical criteria will be given a set period in which they can contact the hospital if they have any worries or concerns relating to the condition for which they have agreed a PIFU pathway and will be able to arrange a follow up appointment.
At the end of the PIFU period, if the patient has made no contact, they will be discharged to the care of their General Practitioner (GP) or in some cases the original referrer.
PIFU pathways can be offered to patients from either an outpatient appointment or in some instances from another administrative event.
Although the expectation is that the patient's RTT (Referral to Treatment) period will have ended with a clock stop, placing a patient on PIFU will result in a clock stop (i.e., active monitoring).
A patient can only be offered a PIFU if that is the expected primary outcome. For example, a patient cannot be offered PIFU and put on to a waiting list or be put on a list for annual review.

2.0 PURPOSE OF THE SOP

This SOP will help to ensure that patients receive a consistent high quality of care when on a PIFU pathway, and that patient experience standards are maintained.
A standardised process is followed for patients with a PIFU appointment.
There is a seamless process for patients on a PIFU pathway to rebook a follow up appointment should this be required.
The correct RTT status is used when requesting a PIFU appointment.

3.0 IDENTIFYING PATIENTS FOR WHOM PIFU IS SUITABLE

Clinicians will be supported to identify for which patients PIFU is suitable through specialty specific guidance. In general, for PIFU to be suitable for a patient, the following conditions must be met.
The patient is at low risk of urgent follow-up care and satisfies criteria established by the specialty.
The patient understands and accepts the risks and implications of going on a PIFU pathway.
The patient is confident and able to take responsibility for their care for the time while they remain on the PIFU pathway, e.g., they do not have rapidly progressing dementia, severe memory loss or a severe learning disability.

The patient understands which changes in their symptoms or indicators mean they should get in touch with the service, and how to do so.
The patient has the tools they need to understand the status of their condition (e.g., devices, leaflets, apps etc.), and understands how to use them.
The patient has sufficient health literacy and knowledge, skills and confidence to manage their follow up care (Patient Activation).
The patient understands how to book their follow up appointments with the service directly, and how long this option will apply for.
If any of the following criteria are met, careful consideration should be given to assess whether PIFU is appropriate for the patient.

- The patient's health issues are particularly complex or if the patient is deemed to lack capacity for making decision in line with the Mental Capacity Act 2005.
- The patient takes medicines that require regular and robust monitoring in secondary care.
- The patient is not able to contact the service easily (e.g., lack of access to telephone).
- The patient has low levels of knowledge, skills and confidence to manage their follow up care.
- There are clinical requirements to see the patient on a fixed timescale (timed follow ups). In these cases, consider offering a blend of PIFU and timed follow ups (e.g., for cancer pathways).
- The clinician has concerns about safeguarding for the patient.

For paediatric patients, safeguarding triage criteria that will override the clinical selection of children and young people being put onto PIFU are as follow.

- The child or young person (a young person is someone aged 16-17) must be considered in line with the Mental Capacity Act 2005 for the decision-making process.
- A child or young person who has an active social service involvement due to safeguarding, care provision concerns or a child-protection plan.
- Travelling children and young people.
- Children and young people with mental health issues.
- The child or young person's health issues are particularly complex and cannot be safely monitored without the need for specialist (hospital) intervention.
- Children who are known to need further active treatment or treatment changes within the PIFU follow-up window.
- There are clinical requirements to see the child or young person within a fixed timescale.
- The child or young person takes medicines that require regular and robust monitoring in secondary care.
- The child or young person or family is unable to contact the service easily (e.g., lack of access to a telephone) or have access to 24hour communication means.
- The clinician has safeguarding concerns for the child or young person.

- The child or young person is in Local Authority care, or subject to a child protection plan.
- There is parental disagreement in the treatment or management of the child or young person either between themselves or with the medical team.
- There is evidence or suspected poor parental communication or parental discourse over treatment and care.
- The child or young person has previously had an unexplained DNA or was not brought without attempted parental contact.
- Conditions where a potential differential is NAI or abuse.

4.0 DISCUSSING PIFU WITH THE PATIENT DURING A CONSULTATION

During the consultation, the clinician offers PIFU to the patient for whom they assess it is suitable and has a shared decision-making conversation. The patient has the option to decline to move to the PIFU pathway if it is does not meet their individual needs or circumstances. The discussion and decisions must be clearly documented within the patient record. For patients who agree that PIFU is appropriate for them, the clinician must:

- explain the symptoms to watch out for,
- explain to the patient how to manage their care at home,
- explain the process on how to contact the hospital to arrange an appointment within a specified timescale,
- where appropriate, develop a personalised care and support plan with the patient and shares a copy with them; the plan will include a section on the patient management plan and whether the patient will have timed follow-up appointments in conjunction with PIFU appointments (based on clinical need),
- explain to the patient what will happen at the end of the specified timescale, i.e., patient will be discharged or have a clinical review,
- explain to the patient that they have the option to go back on to the traditional timed follow up pathway at any stage if PIFU is not working for them,
- provide the patient with the appropriate verbal and, or written information, and
- instruct the recording of PIFU on the hospital PAS by completing the clinic outcome form, if agreed, within an outpatient consultation.

5.0 COMMUNICATION

The clinician must write to the patient and the GP with guidance on the symptoms and how and when the patient should request a follow-up including alternative access points, including full phone numbers, where appropriate.
The service sends a condition-specific information leaflet, letter, SMS and, or email with advice on the symptoms and signs indicating the patient should contact the service. For some conditions, this can be a standardised information leaflet.

6.0 Patients who contact the service during their PIFU timescale

If the patient wishes to have a follow up appointment within the specified period before the PIFU expires, they contact the service to request an appointment via the agreed route for the relevant specialty. The booking team will check that they are PIFU patients for the specialty and are within timescales.
NB a PIFU ordered by one specialty should not be used to book a follow up with a different specialty.
The booking team either books an appointment with the specialty that the patient wishes to see or arranges a call-back from the specialty team (as per the agreed criteria and process for each speciality).
If a triage is indicated, a member of the specialty team calls the patient to understand the symptoms or issues the patient is having within the agreed specialty level response times.
Following the triage, if required, the service or booking team will arrange an appointment with the appropriate clinician within the agreed maximum waiting time as defined by the specialty.
At the appointment, the clinician takes the clinical decision to restart the PIFU clock for the patient or mark them for automatic discharge or review at the end of their PIFU timescale.
(If a patient's query is resolved at clinical triage stage, then the clinician responsible for triage should make this decision.)

7.0 RECORDING PIFU

PATIENT ACCESS SERVICES

DATE: July 2021

PIFU (Patient Iniated Follow Up) Procedure

A Patient Initiated follow up (PIFU) allows a patient to take control of their outpatient appointments, rather than having them regularly or routinely scheduled.

Patients meeting the clinical criteria will be given a set period of time in which they can contact the hospital if they have any worries or concerns relating to the condition for which they have agreed a PIFU pathway and will be able to arrange a follow up appointment.

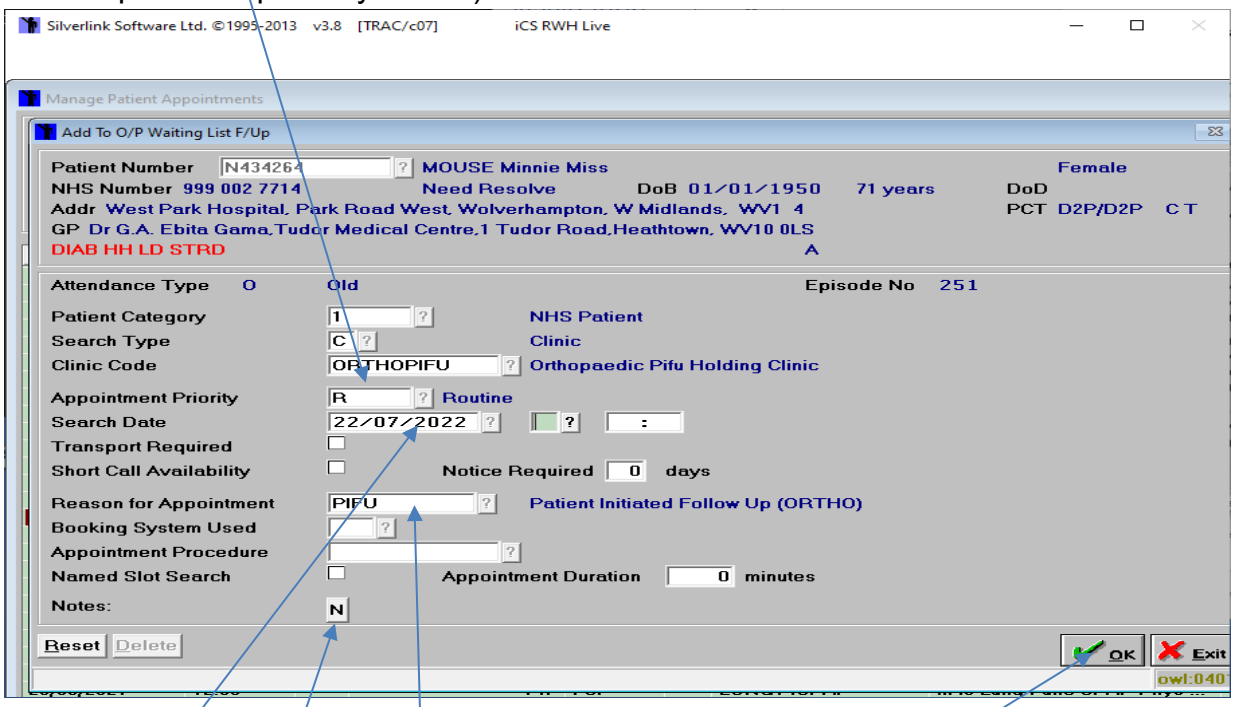
At the end of the PIFU time period, if the patient has made no contact, they will be discharged to the care of their General Practitioner (GP) or to the original referrer.

Following an Outpatient attendance, the consultant will indicate using the Clinic Outcome Form that the patient should be added to the Outpatient Follow Up Waiting List as part of a PIFU pathway and the period of time to be added.

1 ADDING A PATIENT TO A PIFU PATHWAY

- From the attended Outpatient appointment select Add to O/P Waiting List F/Up

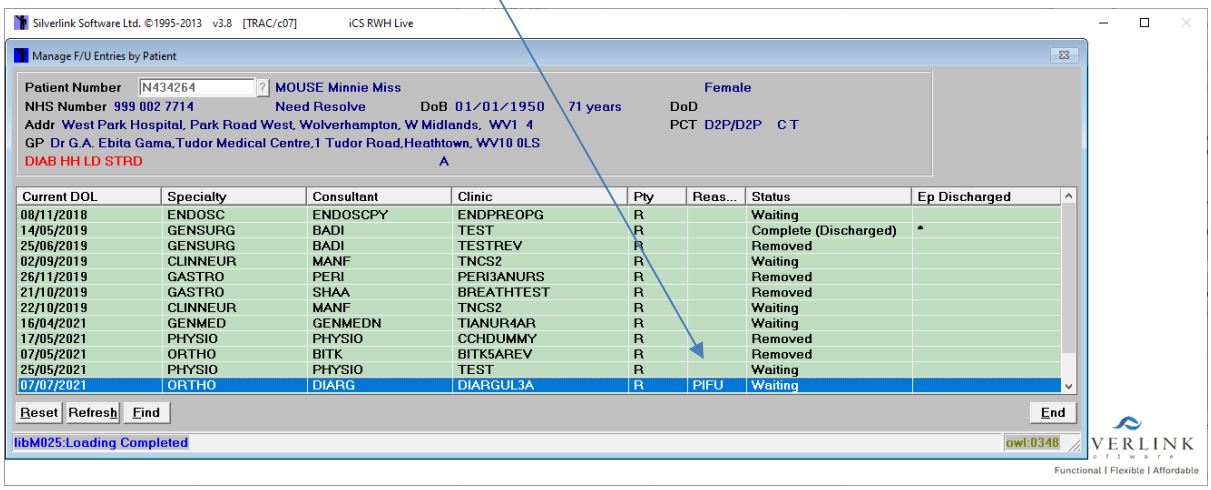
- Enter the PIFU Clinic Code for the specialty of attendance (All codes will be set up as the speciality +PIFU)



- Enter the end date of the agree PIFU Period in the search field
- Enter Reason for Appointment **PIFU** and click **OK**
- Add the clinic code in the notes section to denote future clinic code

2 BOOKING AN APPOINTMENT FOLLOWING A PATIENT REQUEST

- From Manage F/U Entries by Patient Select the entry that is for the specialty in question. You will see an entry in the **reason for Appointment Screen** PIFU. Highlight this entry and then:

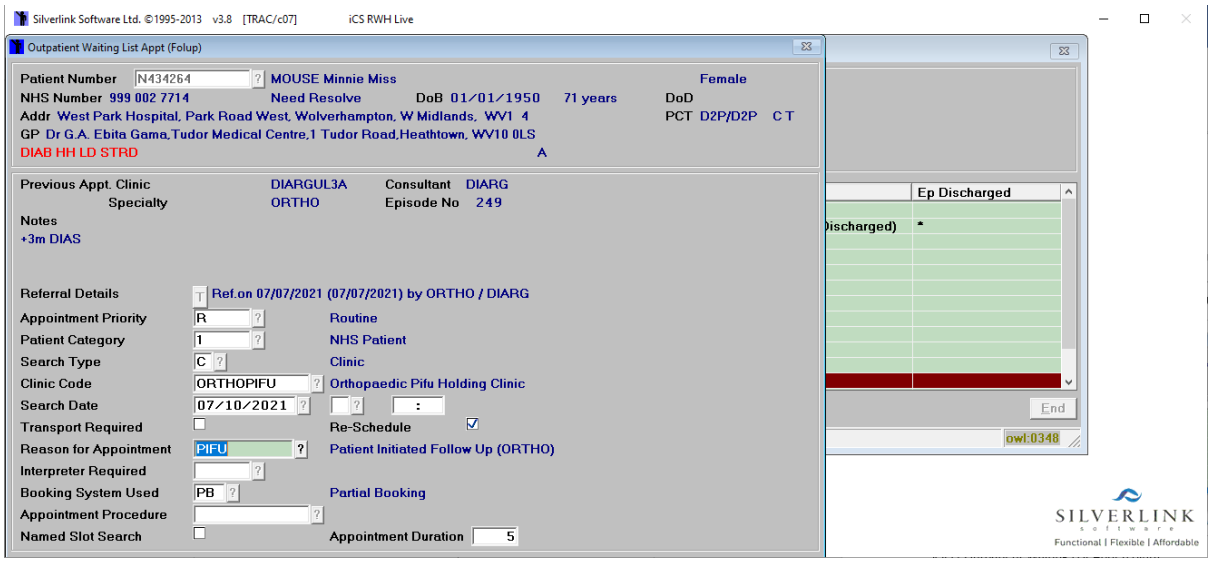


- Select Outpatient Waiting List Appt (Follow up)
  (You will need to change the clinic code from the PIFU CINIC code to the actual Clinic Code the appointment is to go on)

- Enter the Search Date you require for the appointment.

- Reason for Appointment will already be populated **DO NOT REMOVE**

- Then continue with the screen as normal



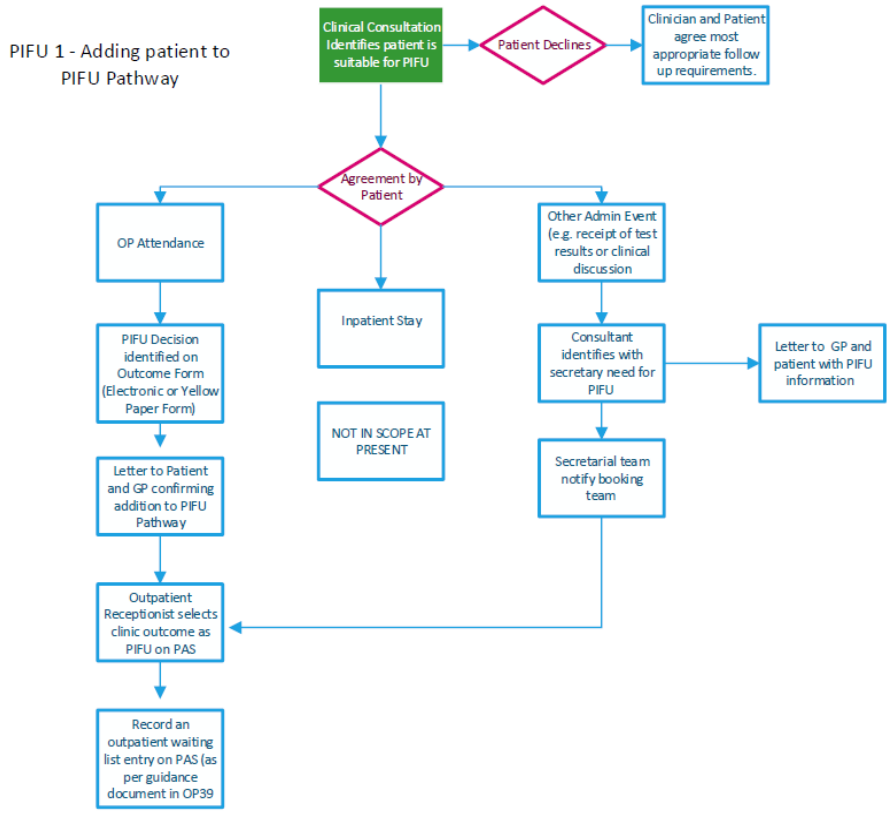
3 NO CAPACITY TO BOOK AN APPOINTMENT

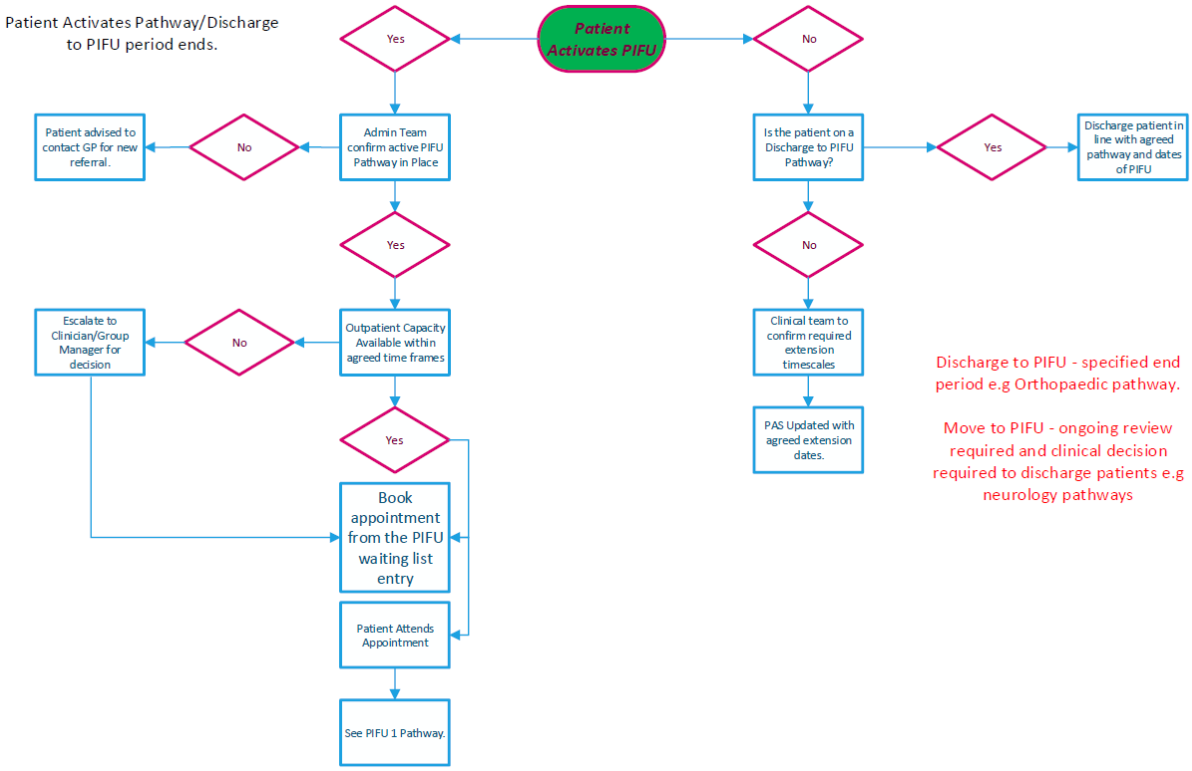
If a patient requests an appointment during the PIFU period, a date must be arranged within 6 weeks of the request. If there is no capacity within 6 weeks you must:

- change the PIFU entry to reflect the actual FUOWL clinic code and note that the patient has requested to be seen
- Raise with the Group Manager /Consultant for a clinical decision to be made

4 NO CONTACT MADE BY THE PATIENT

If there has been no contact made by the patient at the end of the PIFU period, the patient should be discharged from PAS





8.0 RESPONSIBILITES

Clinicians

- Agree a clinical protocol that includes clear criteria and follow up timescales for the patient cohort identified as suitable.
- Have a shared decision-making conversation with the patient explaining the options, risks and benefits
- Ensure that the patient understands the PIFU process and agrees to being on the PIFU pathway, and what will happen at the end of it.
- Educate the patient about self-management, develop a personalised care and support plan and share it with the patient.
- Provide information about symptoms to watch for, patient information leaflet and a completed guide card to the patient.
- Indicate correctly on the clinic outcome form that the patient should be placed on a PIFU pathway and for how long.
- Explain patient is on a PIFU pathway in the clinic letter and how the patient can activate a follow up appointment within the specified timescale.
- Agree with operations manager the maximum waiting time for appointment following a patient initiating contact.
- Share information about PIFU with the patient's GP. Triage the patients when they call for a PIFU appointment.
- Take the clinical decision to restart the PIFU clock; or mark the patient for automatic discharge or review at the end of their timescale, at their PIFU consultation.
- Decide on further management if a patient does not attend their appointment, such as discharge the patient or rebook a further follow up appointment.

Outpatient Reception Team:

- Record the PIFU entry on PAS as instructed by the Consultant following an Outpatient attendance.

Appointment Booking Teams

- Ensure that patient requests for an appointment during the PIFU period are processed and accurately booked into the appropriate clinic as per defined criteria for each service.
- Booking team will confirm expiry date on system and if PIFU has expired, inform patients that they require a new referral through the GP.
- Check that the PIFU order is open and within the agreed period when a patient makes contact to request an appointment to allow booking to commence.
- Identify if a follow up appointment is available with the original clinician, where possible. Send a confirmation letter after booking an appointment.
- Book a follow up appointment within the agreed maximum time of contact. If this is not possible, obtain the patient's contact details and advise that the patient will be called back later the same or the following day to arrange an appointment. In such cases, communicate the patient request to the relevant service lead for identification of an appointment. Escalate any lack of capacity to the relevant service leads to ensure capacity can be found.

- Contact the patient to book an appointment when capacity has been identified.

Medical secretaries

- Ensure the offer of a PIFU appointment is included in the transcribed letter to the patient's GP and patient.
- Ensure the patient information leaflets are included in the communication to patients.
- Record the offer of a PIFU appointment on PAS on instruction from the treating clinician following an admin review.

Directorate and Group Managers

- Ensure there is a clear process for patient to contact the service for a PIFU appointment.
- Ensure that there is a designated PIFU lead or contact for the service.
- Ensure responsibilties are agreed with the Booking Team.
- Have a clear plan in place to manage capacity so that PIFU appointments can be accommodated in clinic within the agreed

maximum waiting time, and PIFU appointments are prioritised in line with other waiting list targets.

- Ensure any clinic template changes have been made on how patients will be logged into the system, and all staff have been sighted on and understand the process.
- Ensure that the clinical protocol has been signed off by the service lead clinician.
- Ensure the PIFU information on the website.
- Provide the appointment booking team and PALS with up-to-date contact details for the service PIFU lead contact.
- Monitor the Follow Up Owl to ensure that patients referrals are discharged at the point they reach the end of their PIFU pathway.
- Set up a system for capturing staff and patient feedback; monitor it regularly so that any issues can be addressed and process refined.
- Ensure there is flexibility in clinic capacity to book patients who request PIFU.
- Respond to matters escalated to them in line with the Outpatient Standard Operating Procedure.
- Ensure that all their staff are fully aware of their obligations around PIFU – this includes ensuring that patients are discharged from the service once the PIFU follow up period has expired by the nominated member of staff.
- Ensure that errors are monitored and addressed.
- Ensure that all operational procedures are regularly reviewed and updated where required.

Team leader or delegated admin

- Monitor the Follow Up Owl to ensure that patients referrals are discharged at the point they reach the end of their PIFU pathway.
- Ensure that all PIFU patients are made appointments or discharged from the request list.
- Order replacement Guide Cards and Patient Information leaflets.
- Remotely monitor patients on the PIFU pathway, close referrals and discharge patients.
- Where appropriate (including when a clinician decides to discharge a patient following a DNA) send a letter to the patient and the GP.
- Escalate any lack of capacity to the relevant operation managers to ensure capacity can be found.
- Monitor patients with management plan reviews and arrange telephone review appointments as required.

Service Checklist

- Identify suitable clinical pathways.
- Agree inclusion and exclusion criteria ensuring safeguarding issues are clearly understood and documented.
- Identify contact details to share with patient.
- Agree pathway for managing calls from patients e.g., initial nurse led triage to assess needs.

- Develop and identify supporting patient information.
- Add contact details and information to Trust website for ease of access by patients.
- Agree booking criteria and share with relevant teams.
- Build in pathway review processes to ensure PIFU pathways remain up to date.