York Teaching Hospital
NHS Foundation Trust

Referral to Treatment

Access Policy

COVID-19 Response

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Publisher:	Healthcare Governance Team
Date of first issue:	January 2007
Version:	v.7.2
Date of version issue:	11th December 2020
Approved by:	Executive Board via Risk & Oversight Committee
Date approved:	14th July 2020
Review date:	2 years from approval date or in the event of legislation or guidance changes.
Target audience:	All staff who are engaged in managing, administering or treating patients.
Relevant Regulations and Standards	• Referral to Treatment Consultant-led Waiting Times Rules Suite: October 2015 • Recording and Reporting Referral to Treatment (RTT) Waiting Times for Consultant-led Elective Care: October 2015 • Recording and Reporting Referral to Treatment Waiting Times for Consultant-Led Elective Care: Frequently Asked Questions • NHS Constitution July 2015 • Diagnostics Waiting Times and Activity: Guidance on Completing the 'Diagnostic Waiting Times & Activity' March 2015 • Equality Act 2010 June 2015

	• Overseas Visitor Guidance April 2016 • Cancer Waiting Times Guidance v10 April 2019 • Armed Forces Covenant July 2015 • NHSI Elective Care Model Access Policy
Links to Organisational/Service Objectives, business plans or strategies	• Our objective is to be trusted to deliver safe, effective healthcare to our community
Executive Summary This policy reflects the overall expectations of the Trust for the management of patients' referral to treatment pathway and defines the principles on which the policy is bases. All staff are expected to understand and apply this policy.	

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Version History Log

This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

Version	Date Approved	Version Author	Status & location	Details of significant changes
v.2	August 2010	L Watson	Head of Patient Access	• NHS Constitution (April 2010) • Implementation of right to access services within maximum waiting times - March 2010 – (pg 4 & App B)
v.2	August 2010	L Watson	Head of Patient Access	• Update to new policy format
v.3	15 May 2013	L Watson	Head of Patient Access	• Reformatted as per Trust guidelines • Update to include reference to 'Everyone Counts: Planning for Patients 2013/14' • Update to patient unavailability. Reduction of the length of time patients can make themselves unavailable for social reasons (pg 7 Clock Pauses) • Addition of a paragraph on copying letters to patients (pg 13) • Addition of a paragraph on operations cancelled on the day (pg 8) • Addition of flow diagram for diagnostic DNAs/CNAs (App C)
v.4	19th November 2014	L Watson	Head of Patient Access	• Updated to include feedback from the Intensive Support Team (IST): • Add sentence on redirecting referrals in paragraph**3.1.8**

Version	Date Approved	Version Author	Status & location	Details of significant changes
				• Reference DNAs of urgent 2 Week Wait (2WW) patients in paragraph**3.1.9** and update Yorkshire Cancer Network guidance for management of Urgent suspected cancer patients (2ww) • Add contact points within paragraph**3.1.11** • Refresh patient exceptions section within paragraph**3.6** to mirror NHS Constitution Handbook • Detail added on the information given to patients on their right to access NHS services within maximum wait times within paragraph**3.7** • Revise timeframe for agreeing another offer date when patients operations are cancelled for non-clinical reason on the day of admission from 72 hours to 24 hours within paragraph**3.8** • Sentence added to section **3.22** to explain that in many instances patients' diagnostic tests will form part of their 18 week pathway. • Sentence added to paragraph**3.25** clarifying redirection of referrals • Additional sentence added on patients switching to NHS treatment paras **3.26 & 3.27**
V.5	18/1/17	L Watson	Systems & Network Manager	• National update of the Referral to Treatment Consultant-led Waiting Times Rules Suite: October

Version	Date Approved	Version Author	Status & location	Details of significant changes
				2015 • Update incorporated from National Cancer Waiting Times Guidance: October 2015 • Update section on Armed Forces Covenant & Access for Military Veterans as per NHS Constitution & Armed Forces Covenant • Exceptions to the Policy as per NHS Constitution Handbook (paragraph3.3) • Reference to Choose & Book replaced with NHS e-referral • Refreshed detail around DNAs and safeguarding
v.6	25th October 2018	L Watson	Systems & Network Manager	• Updated in line with the NHS Improvement Model Elective Care Access Policy • Integration of DNA Policy into RTT Policy • Safeguarding flow diagrams updated
v.7	9th January 2019	A Hurren	Deputy Head of Operational Planning & Performance	• Updated Appendix F; Process for Child not Brought to an Appointment • Updated Appendix H; Management of Maternity DNAs
v.7.1	31st July 2020	A Hurren	Deputy Head of Operational Planning & Performance	• Added Flow chart for COVID-19 RESPONSE; Patient Flow – Patients who are unable or unwilling to commit to a Treatment Date or Decline Treatment. (Appendix L). • Change from Directorates to

Version	Date Approved	Version Author	Status & location	Details of significant changes
				Care Groups reflected. • Added references to 28 Day Faster Diagnosis Cancer Standard. • Reordered Non-Admitted and Admitted Pathways sections. • Added section on Pre-Operative Assessment (POA). • Added section on Patient Initiated Follow-Up (PIFU). • In Reasonable Offer section reference added that the offer can be at any of the Trust's sites. • In OP DNA sections reference to virtual appointments added. • Reformatted contents table.
v.7.2	11th December 2020	A Hurren	Deputy Head of Operational Planning & Performance	• Incorporated P5 – Patient wishes to defer surgery for COVID reasons or, P6 – Patient wishes to defer surgery for Non-COVID reasons into COVID-19 RESPONSE; Patient Flow – Patients who are unable or unwilling to commit to a Treatment Date or Decline Treatment. (Appendix L).

Contents

1. Introduction

The policy is aimed at all staff with responsibility for clinically managing or administering patients' access to services within the hospital. All staff are expected to understand and apply the appropriate rules and principles, including: patients' right of access to services within the maximum waiting times and diagnostic waiting times guidance. Copies of Trust policies are available electronically via Staff Room under Policies and Procedures.

2. Definitions/Terms used in policy

Definitions are outlined at **Appendix A.**

3. Policy Statement

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

4. Impact upon individuals with Protected Characteristics

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at an unreasonable or unfair disadvantage over others. In the development of this policy, the Trust has considered its impact with regard to equalities legislation.

5. Accountability

Whilst overall accountability rests with the Board of Directors, responsibility for adhering to the Policy sits with all staff that have access to and responsibility for administering and/or managing patient waiting lists within the Trust

6. Overarching Principles

The purpose of this Policy it to ensure all patients requiring access to our elective services are managed equitably and consistently in line with the NHS Operating Framework and the NHS Constitution. Patients have the right to access certain commissioned services within maximum wait times unless they choose to wait longer or it is clinically appropriate to wait longer.

This Policy:

- Sets out the rules and principles under which the Trust manages elective access to outpatient appointments; diagnostics and elective inpatient and/or day case treatments

- Outlines directions for staff on application of the NHS Constitution in relation to elective waiting times

- Demonstrates how elective access rules should be applied consistently, fairly and equitably.

The following points highlight the general principles governing the Trust's position on access to its services:

6.1 Access to the Trust's commissioned services will be available for all patients who require those services. Patients have the right not to be unlawfully discriminated against in the provision of NHS services, including on grounds of gender, race, religion or belief, sexual orientation, disability, age or mental illness.

6.2 The Trust will publish all consultant-led 1st outpatient services on the NHS e-referral system; ensuring that all outpatient appointment slots are available on the NHS e-referral system within agreed polling ranges and will not accept paper referrals to consultant-led services after March 2018.

6.3 Paper referrals into the Trust will not be accepted into consultant-led services after March 2018.

6.4 In most circumstances patients should not be referred for elective services unless they are fit, ready and willing to access services within the maximum waiting times. The exception will be in cases of urgent patient pathways.

6.5 Patients have the right to start consultant-led treatment within 18 weeks from referral; be seen by a specialist within 2 weeks of GP referral for suspected cancer; wait no longer than 6 weeks for a diagnostic test.

6.6 The Trust's Core Patient Database (CPD) will be used to record and administer all referrals, advice and guidance requests and waiting lists in the Trust. (Diagnostic investigations may be on local systems)

6.7 The process of referral and admission management will be transparent to the public and external organisations.

6.8 Consultants may refer onward directly to other consultants for non-urgent conditions which are directly related to patients' complaint/condition which caused the original referral. Onward referral is also permitted in urgent cases (e.g. cancer, other urgent conditions). Re-referral back to GP is only required for onward referral of non-urgent, unrelated conditions. It should be noted however, that where new referrals are received into the wrong specialty these referrals should be redirected to the correct specialty and not returned to the GP.

6.9 Waiting lists will be managed chronologically according to clinical urgency in line with patient choice, national and local targets.

6.10 Accuracy of all waiting lists and diagnostic information is the responsibility of staff within the Trust involved in administration or management of patient information.

6.11 All staff with responsibility for administering or managing elective patients within the Trust will be expected to understand and apply the rules associated with patients accessing services within the maximum waits times.

6.12 All staff with responsibility for administering or managing patients will ensure that the Trust's Accessible Information Policy is adhered to in line with the national Accessible Information Standard; ensuring that our patients have access to and understand the information they are given as well as the appropriate communication support. (Although not part of the Standard, the Trust policy will also include access to translation and interpretation services).

6.13 All staff must be aware of the need to use the NHS number throughout a patient's episode of care: from registration of referral through clinic consultations and ward stays and final coding procedures.

7. Trust Roles & Responsibilities/staff competency & compliance

All staff with responsibility for clinically managing or administering patients are responsible for understanding and applying the 'rules' associated with patients accessing our elective services within the maximum wait times.

- Care Group Directors are accountable for ensuring compliance with the policy within their Care Groups.

- Care Group Managers are accountable for implementing, monitoring and ensuring compliance within their Care Groups.

- The Head of Information is responsible for the timely producing of Patient Tracking Lists (PTLs) which support the Care Groups in managing RTT waiting lists.

- Waiting List clerks, Medical Secretaries and booking teams are responsible for compliance with all aspects of the Access Policy and Standard Operating Procedures underpinning the Policy.

- Head of Patient Access is responsible for ensuring that the Trust's e-RS Directory of Services (DoS) is accurate and up-to-date.

As part of their induction all new starters to the Trust will receive training applicable to their role enabling them to demonstrate their competency and compliance with the Trust's Access Policy.

All existing staff will receive annual contextual training to enable them to demonstrate ongoing competency and compliance with the Trust's Access Policy.

This Policy along with underpinning Standard Operating Procedures will support the training programme.

Staff will be performance managed against key performance indicators applicable to their role.

The process for monitoring compliance is attached at Appendix B.

8. Patients' Responsibilities

As outlined in the NHS Constitution, patients can make a significant contribution to their own, and their families, 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.

9. Patients Moving between NHS and Private Care

Patients can choose to move between NHS and private care at any point during their treatment without prejudice.

Where a patient is being seen privately and then decides to move from private to NHS care, those patients should be referred back to their GP for referral into the NHS. (It is not always necessary for these patients to have another outpatient appointment). The clock starts for these patients when we (the provider) receive the referral.

The exceptions to this are for those patients who need to access services urgently. In these circumstances the clinician who transfers the patient from Private to NHS care, or their secretary, should inform the private patient team by phone (internal extensions 7715382; 7715383 or 7715385). This will allow the necessary alterations to be made to CPD so that the appropriate charges can be made for the services we provide.

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

10. Commissioner Approved Procedures

Procedures of limited clinical value (POLCV) are contained within the CCG contract documentation (2017/19), highlighting the exact commissioning position for individual procedures, together with the position regarding elective intervention on patients who have a BMI over the outlined threshold or patients who are recorded as current smokers. Funding will **only** be considered where criteria are met. Clinicians must ensure that the patient fulfils all the criteria. All other cases need to be referred for consideration by the Individual Funding Request (IFR) Panel, with evidence about clinical exceptionality.

11. Armed Forces Covenant & Access for Military Veterans

In line with the Armed Forces Covenant, we must ensure that those in the armed forces, reservists, their families and veterans should not face disadvantage when accessing health services in the area they reside. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment.

Special consideration is appropriate in some cases and, therefore, all military veterans are entitled to **priority** access to NHS hospital care for any condition, as long as it is related to their service within the armed forces; and subject to clinical need of others. In practice this means that when secondary care clinicians agree that a veterans condition is likely to be service related we are required to prioritise their treatment over other patients with the same level of clinical need; but not over other patients with a more urgent clinical need. GPs should make it clear in their referrals that the patient is a war veteran and requires treatment for condition(s) relating to their period of service, however, it is our responsibility to ensure that prioritisation occurs. (Armed Forces Healthcare NHS Choices and **Armed Forces Covenant 2015** refers).

NB: Military veterans do not need to have applied and become eligible for a war pension before receiving priority treatment.

12. Healthcare Travel Costs Scheme (HTCS)

For some patients, travel to receive healthcare can present difficulties. HTCS is part of the NHS Low Income Scheme to provide assistance to patients who do not have a medical need for ambulance transport, but do still require assistance with their travel costs. A quick reference guide for patients' eligibility is attached at **Appendix C.** Members of staff within the Cashiers Office are able to advise patients and/or staff further.

13. Prisoners (Choice and 18 weeks)

Prisoners are included in the right to be treated within 18 weeks but are excluded from choice of provider and appointment due to safety and security issues. (The NHS Choice Framework: April 2016 refers).

The Trust will work with the prison service to minimise delays.

National Service Standards

14. National Referral to Treatment & Diagnostic Standards

Whilst the aim is to treat all elective patients within 18 weeks, the national standards are set at less than 100% to allow for scenarios such as:

- Clinical exceptions: when it is in the patient's best interest to wait more than 18 weeks for their treatment.

- Choice: when patients choose to extend their pathway beyond 18 weeks by declining reasonable offers of appointments; rescheduling agreed appointment dates/admission offers.

- Not attending: when patients do not attend previously agreed appointment dates/admission offers (Did Not Attend) and this prevents Trusts from treating patients within 18 weeks.

Referral to Treatment	
Incomplete	92% of patients on an incomplete pathway (i.e. still waiting for treatment) to be waiting no more than 18 weeks (or 127 days)
Diagnostics	
Applicable to diagnostic tests	99% of patients to undergo the relevant diagnostic investigation within 5 weeks and 6 days (41 days) from the date of decision to refer to appointment date

NB: Cancer waiting time standards are outlined at paragraph 62.

15. Access for Patients to Services within Maximum Waiting Times

Patients have the right to access certain services commissioned by NHS bodies within maximum waiting times; or for the NHS to take all reasonable steps to offer patients a range of suitable alternative providers if this is not possible. This means that patients have the right to:

- Choice of hospital and consultant.
- Start their consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions; and
- be seen by a cancer specialist within a maximum of two weeks from GP referral for fast track referrals where cancer is suspected and; wait no longer than 6 weeks for a diagnostic test.

Detailed guidance for applying these rules is contained within the relevant departmental standard operating procedures that underpin this Policy.

Patients' right to start treatment within 18 weeks from referral will include treatments where a consultant retains overall clinical responsibility for the service or team, or for patients' treatment. This means the consultant will not necessarily be physically present for each appointment, but will take overall responsibility for patients' care.

16. Exceptions to the right to be seen within Maximum Waiting times

Exceptions to the right to be seen within maximum waiting times do not apply where:

- Patients choose to wait longer;
- Delaying the start of patients' treatment is in their best clinical interests, for example where smoking cessation or weight

management is likely to improve the outcome of the treatment;

- It is clinically appropriate for patients' conditions to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage;

- Patients' fail to attend appointments which they had chosen from a set of reasonable options; or the treatment is no longer necessary.

(Extracted from the NHS Constitution Handbook October 2015).

17. Clock Starts

The RTT clock starts when any healthcare professional (or service permitted by an English NHS commissioner) refers to a consultant-led service. The RTT clock start date is the date the Trust receives the referral. For referrals received via the NHS e-Referral Service, the RTT clock starts the day the patient's unique booking reference is converted.

A clock also starts when a referral is received into an interface or referral management assessment centre which may result in an onward referral to a consultant-led service.

Clock starts commence as follows:

NHS e-referral service	From the date the patient converts their unique booking reference number (UBRN) (i.e. the date they book their appointment)
Hard copy referral	From the date received by the provider
Referrals received via the national appointment line (TAL)	From the date the provider receives the e-mail communication from TAL

Inter-provider transfers	From the date the referral was received at the original provider
RTT & Diagnostic Clock (many patients referred for a diagnostic test may also be on an open RTT pathway)	• RTT clock starts the date patient converts their unique booking reference number (i.e. the date they book their appointment). If hard copy the date received by provider • Diagnostic clock starts at the point of the decision to refer for test
Cancer clock starts	• See paragraph 63

18. Exclusions to Clock Starts

A referral to most consultant-led services starts an RTT clock but the following services and types of patients are excluded from RTT:

- Obstetrics and midwifery.
- Planned patients (see paragraph21).
- Referrals to non-consultant led services.
- Referrals for patients from non-English commissioners.
- Genitourinary medicine (GUM) services.
- Emergency pathway non-elective follow-up clinic activity.

19. New Clock Starts for the same Condition

Following Active Monitoring: 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 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.

Following a Decision to Start a Substantively New Treatment Plan: If a decision is made to start a substantively 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 shall receive their first definitive treatment within a maximum of 18 weeks from that date.

For Second Side of a Bilateral Procedure: A new RTT clock should be started when a patient becomes fit and ready for the second side of a consultant-led bilateral procedure.

20. Clock Stops

The clock stops at the start of first definitive treatment. Start of first definitive treatment is described as the start of the first treatment that is intended to manage a patient's condition. The clock stops if the treatment that is started is intended to avoid further intervention. This could be:

- Treatment provided within an interface service.
- Treatment provided by a consultant-led service.
- Therapy or healthcare science intervention provided in secondary care if this is what is decided as the best way to manage the patient's condition.
- A clinical decision is made and has been communicated to the patient and their GP that they have been added to the transplant list.

A waiting time clock also stops when it is communicated to the patient, that:

- It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care.
- A clinical decision is made not to treat.
- A patient did not attend and is discharged (with clinical input).
- A decision is made to start the patient on a period of active monitoring.
- A patient declines treatment having been offered it.

21. Patients on Planned Waiting Lists

Patients should be added to a planned waiting list where clinically they need to undergo a procedure at a specific time. The due date for their planned procedure will be included in the planned waiting list entry. Patients on planned waiting lists will be scheduled for admission at the clinically appropriate time and they should not have to wait after this time has elapsed.

22. Active Monitoring

Active monitoring is where a decision is made that the patient does not require any form of treatment currently, however, should still be monitored in secondary care. When a decision to begin a period of active monitoring is made and communicated to 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 matter of days, but it is appropriate if a longer period of active monitoring is required before further action is needed.

23. Patient Unavailability (Patient Initiated Delays: Cancelling, Declining or Delaying Appointment and Admission Offers)

Whilst periods of unavailability are applicable to both non-admitted and admitted stages of the pathway, they tend to be more applicable to admitted pathways. See paragraph 55 for **Diagnostics**.

Patients can choose to postpone their appointment, treatment or TCI date if they wish. Such cancellations or delays have no impact on reported RTT waiting times. This period of unavailability must be recorded on our Core Patient Database (CPD). Clinicians will be informed of patient-initiated delays to ensure that no harm is likely to result from the patient waiting longer for 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. However, we must not apply 'blanket' rules outlining maximum length of patient initiated delays. Clinicians should review patients' cases individually to determine whether:

- The requested delay is clinically acceptable (RTT clock will continue).

- Clinically unsafe length of delay: clinician to contact patient with a view to persuading patient not to delay (RTT clock will continue).

- Contact the patient to review their options – this may result in agreement to the delay (RTT clock will continue); or to begin a period of active monitoring (RTT clock will stop).

- The patient's best clinical interest would be served by discharging them to the care of their GP (RTT clock stops).

- Declined and cancelled TCIs do not stop the clock. Again, no 'blanket' rules can be applied and only the clinician can make the decision on an individual patient basis.

The general principle of acting in the patient's best clinical interests at all times is paramount. It is generally not in the patient's best interest to be left on a waiting list for an extended period, therefore, where long delays (i.e. months) are requested by patients a clinical review should be carried out, and 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 removed from the waiting list, without clinical input. See paragraph 52 for **Diagnostics.**

For patient declined TCIs related to COVID-19 and the requirement to self-isolate 14 days prior to surgery, please refer to Appendix L "COVID-19 RESPONSE; Patient Flow – Patients who Decline Treatment or are Unable to Commit to a Treatment Date".

24. Copying Letters to Patients

Patients have the right to receive copies of letters sent between clinicians about their care. Copies of letters are available to patients on request. This includes communications between different health professionals, for instance those from and to GPs, hospital doctors, nurses, therapists and other healthcare professionals. Patients may inform their consultant/healthcare professional at the time of their consultation that they want to receive copy letters and this information can be captured as part of the outcome recording.

25. Patient Choice

Patients have the right to make choices about their NHS care and are entitled to choice of provider. This means that the majority of patients in England have the right to choose any hospital they wish to attend for their first outpatient appointment in a service led by a consultant; if that organisation provides clinically appropriate care for their condition. In order to facilitate the offer of choice it is mandatory that all our consultant led services are published and available on the NHS E-referral service. NHS E-referral is the Trust's referral method for consultant-led services for patients' first outpatient appointments.

26. Patient Choice & Military Personnel

Military personnel will continue to be excluded from choice of provider, but not appointment because of the need to maintain operational availability. Families of military personnel are still eligible to choose their hospital when being referred for a first outpatient appointment. (The NHS Choice Framework: Published 29 April 2016)

27. Patients who may not be entitled to free NHS treatment

The Trust will check every patient's eligibility for treatment to help the Trust assess 'ordinarily resident status' in line with standard

operating procedures. Anyone who is deemed to be ordinarily resident in the UK is entitled to free NHS hospital treatment in England. Anyone who is not ordinarily resident is subject to the National Health Service (Charges to Overseas Visitors) Regulations 1989. The Overseas Visitor Team (internal extension 7725627 – York) and (internal extension 7715008 – Scarborough) should be informed of any patient(s) that staff feel may not be entitled to free NHS treatment. The Overseas Visitor Team can provide more detailed information.

Local Service Standards

28. Local Service Standards

Key standards for implementation are described in more detail within the standard operating procedures which underpin the RTT Policy and are available on the Trust's Intranet on Staff Room under Policies & Procedures.

Operational teams will regularly monitor levels of capacity for patient pathways to ensure any shortfalls are addressed to avoid poor patient experience and breaches of the standards.

29. Governance

The Governance structure is as follows:

- Planned Care Board
- Cancer Board
- Operational Steering Group
- Operational Performance Meetings

(See Appendix B)

30. Reasonable Notice of Appointment

Outpatients & Diagnostics

Patients on an outpatient or diagnostic pathway will be offered 2 dates with reasonable notice. A local agreement has been reached that an offer is deemed reasonable when either a verbal or written offer of a minimum of 2 appointments on different days, with at least 1 weeks' notice, is given. Please note the reasonable offer can be at any of the Trust's sites.

Inpatients & Daycases

Patients on an inpatient or day case waiting list will be offered 2 dates with reasonable notice. An offer is deemed reasonable when either a verbal or written offer of a minimum of 2 appointments on different days, with at least 3 weeks' notice given. Please note the reasonable offer can be at any of the Trust's sites.

For patient declined TCIs related to COVID-19 and the requirement to self-isolate 14 days prior to surgery, please refer to Appendix L "COVID-19 RESPONSE; Patient Flow – Patients who Decline Treatment or are Unable to Commit to a Treatment Date".

31. 6 Weeks' Notice of Leave by Clinicians

The Trust leave policy requires a minimum of 6 weeks' notice of annual or study leave (including notification of planned meetings) where a consultant or other medical staff requires a clinic to be cancelled or reduced.

32. Inter-Provider Transfers

When clinical care of patients on an 18-week pathway is transferred between organisations, the data items pertaining to the patient's 18 week clock must be transferred securely via NHS net from the referring organisation to the receiving organisation within 48 hours of decision to refer (DSCN 44/2007 refers). The Patient Access Teams on the Scarborough and York sites will register receipt and ensure the 18-week clock information is recorded

accurately on CPD. Please note; an IPT is not required if referring to another organisation for a diagnostic test/procedure if intention is for the care of the patient to continue at YTHFT once the result is received.

For those patients who need to be onward referred from us to another hospital as part of their care pathway, patient details will be sent to the Data Quality Team by secretaries, and the Data Quality Team will onward refer to the appropriate IPT NHS.net mailbox.

33. Data Quality

All staff have a responsibility for data quality and must ensure that data is recorded accurately, and as close to the event as possible, adhering to Trust policies and procedures.

Non-Admitted Pathways

34. Receipt of Referral Letters into the Trust

The process for receipt of referral letters into the Trust is shown at Appendix E Referrals into consultant-led services will only be accepted via the national electronic referral system (e-RS). Paper based referrals are only accepted for services that are not available via e-RS and these should be directed to the Patient Access Team within the Trust.

More detailed information on the process is contained within the Standard Operating Procedures.

35. NHS E-Referral Appointment Slots

The Trust will ensure that outpatient appointment slots are available on the NHS E-referral system, within agreed polling ranges. In instances where services have no available slots within the polling range the Trust will receive notification of the patients who have chosen us as their provider. Staff managing the receipt of these notifications must follow best practice by making contact with the patients within a maximum of 4 days. Patients should

then be offered a suitable appointment date and Care Groups informed of the appointment slot issues to ensure that sufficient capacity is made available via NHS E-referral.

36. Outpatient Fast Track Referrals (14 day rule)

The exception to the standard referral pathways are referrals made under the 2 week rule. These patients must be given an appointment within 14 days. The 2 week standard is monitored from the date of the receipt of these referrals, or from the date the appointment is booked via e-RS.

37. Consultant to Consultant Referrals (onward referral of patients)

Consultants may refer onwards directly to other consultants for non-urgent conditions which are directly related to the patients' complaint/condition which caused the original referral. Onward referral is also permitted in urgent cases (e.g. cancer, other urgent conditions). Re-referral back to GP is only required for onward referral of non-urgent, unrelated conditions.

It should be noted, however, that where new referrals are received into the wrong specialty these referrals should be redirected to the correct specialty and not returned to the GP.

38. Outpatient Clinic Template Management Procedure

Template management is critical in terms of understanding our capacity and demand. There is a formal process for all changes to either increase or decrease activity. Intended changes must fit in with our contracted plans and access target management. All template change requests must be submitted to the email box: CommissioningGroup@york.nhs.uk, detailing proposed changes in volume, case mix or other adjustment, with a brief supporting narrative. Please use the appropriate pro-forma. Outpatient Clinic Managers can advise on this process.

39. Outpatient Clinic Outcomes

Outcomes will be captured electronically on CPD during/following patients' clinic consultations. Every patient, new and follow-up, whether they have attended or not, will have a status and outcome recorded on CPD. Outcomes will then be promoted to an electronic worklist and picked up by the appropriate administrative staff for action.

40. Patient Initiated Follow-Up (PIFU)

Instead of being offered regular follow-ups, appropriate patients can be followed up on PIFU which allows patients to make their own appointment when they need it e.g. when experiencing a 'flare-up' in their condition. Further details can be found in the Patient Initiated Follow-Up SOP on Staff Room.

Patients who decline treatment and deemed suitable for Patient Initiated Follow-Up by their responsible clinicians can be removed from active RTT list and listed under PIFU with timescale set for review (not applicable for 1st appointments). PIFU timescale should be set at 6 months for any Covid related listings. Patients can access the service directly if any issues arise within this timescale as per Patient Initiated Follow-Up SOP on Staff Room. If no patient contact after 6 month timescale, details will be passed to responsible clinician for review and decision regarding discharge or further input.

41. Patients who Do Not Attend 1st Outpatient Appointment

The RTT clock is stopped and nullified, as long as we can demonstrate the appointment was booked in line with our reasonableness criteria (see paragraph 30). 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 agreed with the patient.

Patients who do not attend their first outpatient appointment following their initial referral may be discharged back to their GP (or referrer) and their clock stopped. The process for discharging patients must be based on clinician review. Where patients are

discharged as a result of their DNA the GP/referrer and patient must be notified. This relates to face to face, telephone or virtual appointments.

The procedure for management of children (under 18) who have not been brought to appointments is shown at Appendix F. Clinicians should review the records and assess the risk to a child's welfare of not being brought to their appointment.

The procedure for management of vulnerable adults is shown at Appendix G.

The procedure for management of maternity patients is shown at Appendix H.

The general principle of acting in the patient's best clinical interest is paramount.

42. DNA of Subsequent Outpatient Appointments

If a patient DNAs any subsequent (i.e. follow up) appointment (face to face, telephone or virtual) and the clinician indicates that a further appointment should be offered then their RTT clock will continue to tick. The patient may be discharged but any discharge must be based on clinician review.

For the management of children (under 18) who have not been brought to appointments please see Appendix F.

Patients who are referred in at 16+ years can be seen in adult clinics. However, where they are existing patients in a paediatric service (and in full-time education) they are generally seen up until 18 years of age and the correspondence in these cases usually addressed to the parent/guardian.

The procedure for management of vulnerable adults is shown at Appendix G.

The procedure for management of maternity patients is shown at Appendix H.

Where patients are discharged as a result of their DNA the GP/referrer will be notified.

The general principle of acting in the patient's best clinical interest is paramount.

43. Patients who Cannot Attend (CNA) Outpatient Appointments

The definition of a CNA is when a patient informs us that they wish to cancel their appointment (even if this is at short notice). National guidance dictates that if a patient cancels their appointment (regardless of whether this is on the day) the 18 week clock will continue to tick.

Patients can choose to postpone or amend their appointments. Such cancellations/delays have no impact on reported RTT waiting times. The RTT clock will stop if the patient is discharged. All discharges must be based on clinician review. The general principle of acting in the patient's best clinical interest is paramount.

For patient declined appointments related to COVID-19, please refer to Appendix L "COVID-19 RESPONSE; Patient Flow – Patients who are Unable to commit to a Treatment Date or Decline Treatment".

44. Management of Urgent Suspected Cancer Patients (2ww)

These patients should not be referred back to their GP after a single DNA or cancellation.

Patients may only be referred back to their GP after multiple (two or more) DNAs, but not after multiple appointment cancellations unless this has been agreed with the patient. By cancelling an appointment a patient has shown a willingness to engage with us.

Patients that choose an appointment outside of 2 weeks do not exempt themselves from the standards. The operational standards for the 2 week wait commitments take account of the volume of patients that are likely to be seen outside of 2 weeks due to patient choice. For further detail please refer to the Trust's Cancer

Operational Policy and the National Cancer Wait Times (CWT): A Guide.

The general principle of acting in the patient's best clinical interest is paramount.

Admitted Pathways

45. Adding Patients to waiting list

The Trust's Core Patient Database (CPD) will be used to capture and monitor all waiting list entries. Ideally, patients will be fit, ready and available before being added to the admitted waiting list. Patients should be added without delay following the decision to admit. The active waiting list includes all patients who are awaiting admission at a clinically defined time. Adding a patient to the inpatient or day case waiting list will either:

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

46. Patients requiring more than one procedure

If more than one procedure is to be performed at one time by the same surgeon, 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 same) surgeon(s):

- The patient will be added to the active waiting list for the primary (1st) procedure.

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

47. Patients Requiring Thinking Time

Patients may sometimes require time to think about the recommended treatment options before confirming they would like to proceed. It is not appropriate to stop their RTT clock where thinking time amounts to only a short span of time. Therefore, patients should be asked to make contact within an agreed period with their decision.

It sometimes may be appropriate for the patient to enter into active monitoring (and the RTT clock stopped) where they state that they do not anticipate making a decision for a matter of months. This decision must be made by the clinician on an individual patient basis with their best clinical interests in mind. Where active monitoring is applied then a follow-up appointment/contact should be made with the patient as appropriate. A new RTT clock would commence from the date of the decision to admit if the patient decides to proceed with the surgery.

48. Scheduling Patients for Admission

Clinically urgent patients should be scheduled first, followed by routine patients using the Trust's PTL in chronological order of their RTT wait.

If the patient does not make contact, the demographic details of the patient should be checked either via our Data Quality Team or with the GP direct.

Patients will be offered a choice of at least 2 admission dates with three weeks' notice. Admission dates can be offered with less than 3 weeks' notice and if the patient accepts, this can be defined as 'reasonable'. Any admission offers declined should be recorded on CPD.

For patient declined TCIs related to COVID-19 and the requirement to self-isolate 14 days prior to surgery, please refer to Appendix L "COVID-19 RESPONSE; Patient Flow – Patients who are Unable to Commit to a Treatment Date or Decline Treatment".

If there is insufficient capacity to offer dates within the required timeframe this should be escalated to the appropriate service manager.

49. Patients who Do Not Attend Admission

Patients who do not attend (DNA) for their admission will have their pathway reviewed by their consultant. If the consultant decides that they should be offered a further admission date, the RTT clock will continue. If the consultant decides that it is in the patient's best clinical interest to be discharged back to their GP, the RTT clock will stop.

We cannot apply 'blanket' rules on the discharge of patients linked to how many times they DNA.

50. Patients who are Unfit for Surgery

If the patient is identified as unfit for the procedure, the nature and duration of the clinical issue should be ascertained:

<u>Short-term illness</u>

If the clinical issue is to be short-term and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold etc.), the RTT clock continues.

<u>Longer-term illnesses</u>

If the clinical issue is of a more serious nature and the patient requires optimisation and/treatment the clinician should indicate to administration staff:

- If it is clinically appropriate for the patient to be removed from the active waiting list and put on active monitoring. (RTT

clock stop).

- If the patient should be optimised/treated within secondary care or if they should be discharged back to the care of their GP (RTT clock stop).

51. Elective On-the-Day Cancellations

It is the expectation that no patient will be cancelled by the hospital on the day of admission for non-clinical reasons. However, in those extreme circumstances patients must be booked a new date either within 28 days (as per the national standard) or before their 18 week breach date, if this is shorter than 28 days. This offer date must be agreed within a reasonable timeframe from the cancellation and preferably before they leave the trust or within 24 hours. Where an offer of appointment cannot be made within 28 days then the patient is entitled to be offered an alternative provider and the cost of the treatment paid for by the original provider. (Escalation flow diagram is shown at Appendix D). This must be approved with the Care Group Manager or representative of that specialty. All other avenues for treatment must be explored and documented and subsequently discounted before agreement to transfer is approved.

Diagnostics

52. Diagnostic Clock Rules

- **Diagnostic clock start**: the clock starts at the point of the decision to refer for a diagnostic test by either the GP or the consultant.
- **Diagnostic clock stop**: the clock stops at the point at which the patient undergoes the test.

More detailed information on appointment booking is available in the departmental standard operating procedures.

53. Patients with a Diagnostic & RTT Clock

A large proportion of patients referred for a diagnostic test may also be on an open RTT pathway. In these circumstances the patient will have both types of clock running concurrently:

- Their RTT clock which started at the point of receipt of the original referral.
- Their diagnostic clock which started at the point of the decision to refer for diagnostic test.

54. 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.

55. Diagnostic 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 starts on receipt of the referral.

56. Patients who Do Not Attend (DNA) and Can Not Attend (CNA) Diagnostic Appointments

If a patient DNAs their diagnostic appointment, their diagnostic wait time is set to zero and started again from the date of the appointment that the patient did not attend.

If a patient CNAs their appointment, their diagnostic wait time is also set to zero and started again from the date of the appointment that the patient cancelled.

The above is based on patients being given reasonable notice. See paragraph 30 for terms of reasonable notice. Patients should also be advised via their confirmation appointment letters of the consequences of DNAs/CNAs.

This guidance is taken from the DH's "Diagnostics Waiting Times and Activity" March 2015. A flow diagram is attached at Appendix J outlining clock starts/stops, DNAs and CNA rules.

It should be noted that in many instances patients' diagnostic tests will form part of their 18 week pathway and it is not appropriate to reset a patient's RTT clock in these instances.

57. Diagnostic Planned Appointments

Planned patients are not included in the clock rules. Patients should be added to a planned waiting list where clinically they require a diagnostic test to be carried out at a specific time. The due date for their planned procedure should be included in the planned waiting list entry. Patients on planned waiting lists will be scheduled for admission at the clinically appropriate time and they should not have to wait after this time has elapsed.

58. Therapeutic Procedures

Where a patient is solely waiting for a therapeutic procedure, for example in the Radiology Department, there is no 6 week diagnostic standard. However, for many patients there is also a diagnostic element to their appointment, and in these instances, patients would still be required to have their procedure within 6 weeks.

59. Acute Therapy Services

Referrals to therapy services, for example, physiotherapy, dietetics, orthotics and surgical appliances can be:

- Directly from GPs where an RTT clock would not be applicable.

- During an open RTT pathway where the intervention may be intended as first definitive treatment or interim treatment.

Depending on the pathway, therapy interventions can constitute an RTT clock stop. Equally, the clock can continue to tick. It is

therefore important that staff understand if the referral to them is intended as first definitive treatment. For example:

- Physiotherapy: Patients referred for physiotherapy as a first definitive treatment – RTT clock stops when the patient begins the physiotherapy.

- Patients referred for physiotherapy as an interim treatment (surgery required); the RTT clock continues when the patient begins physiotherapy.

- Dietetics: If patients are referred to dieticians and receive dietary advice with no other form of treatment, this would constitute an RTT clock stop. Equally, patients could receive dietary advice as an important step of a particular pathway where other treatment is required and the clock would continue to tick.

- Surgical Appliances: Where patients are on a pathway referred for a surgical appliance with no other form of treatment; the fitting of the appliance constitutes first definitive treatment and the clock would stop.

60. Pre-Operative Assessment (POA)

Patients with a decision to admit (DTA), who require general anaesthetic will need to attend for pre-operative screening and may need to attend for a full pre-assessment led by the Trusts dedicated Nurse Specialist.

Patients with a DTA will be advised to attend the walk-in pre assessment screening service, either immediately after their outpatient appointment, or at the time they are given a date for their surgery depending on the surgery they scheduled for.

- At the pre-assessment screening the patient will be advised whether they will require a full pre-operative assessment (POA), led by the nurse specialist, prior to their surgery.

- Patients with complex health conditions will be booked in for their POA at the same time as the surgery date is booked, by the admissions team. Ideally the patient will be booked in for their POA six weeks prior to the surgery date; however this may not be possible for short notice surgery dates.

Patients who do not attend (DNA) their POA appointment will be contacted and a further appointment agreed if necessary. Should they DNA again, they will be returned to the responsible consultant. The RTT clock continues to tick throughout this process.

If the patient is identified as unfit for the procedure, the nature and duration of the clinical issue should be ascertained. If the clinical issue is short-term and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold, UTI), the RTT clock continues.

However, if the nature of the clinical issue is more serious for which the patient requires optimisation and/or treatment, clinicians should indicate to administration staff if it is clinically appropriate for the patient to be removed from the waiting list, and if so, whether the patient should be:

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

When 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.

Cancer Pathways

61. Cancer Operational Policy

Please refer to the Trust's Operational Cancer Policy for detailed information, which is available on Staff Room under Policies &

Procedures. A summary of the waiting time standards and clock starts is shown below.

62. Cancer Waiting Time Standards

The table below outlines the key cancer waiting time standards that must be adhered to:

Service Standard	Operational Standard
Maximum 2ww from urgent GP referral for suspected cancer to first appointment	93%
Maximum 2ww from referral of any patient with breast symptoms (where cancer is not suspected) to first hospital assessment	93%
Maximum 28 days referral to communication of diagnosis or all clear	75%
Maximum 31 days from decision to treat first definitive treatment	96%
Maximum 31 days from decision to treat/earliest clinical appropriate date (ECAD) to start of subsequent treatment(s) where the subsequent treatment is surgery	94%
Maximum 31 days from decision to treat/ECAD to start of subsequent treatment(s) where the subsequent treatment is drug treatment	98%
Maximum 31 days from decision to treat/ECAD to start of subsequent treatment(s) where the subsequent treatment is radiotherapy	94%
Maximum 62 days from urgent GP referral for suspected cancer to first treatment	85%
Maximum 62 days from urgent referral from an NHS cancer screening programme for suspected cancer to	90%

Service Standard	Operational Standard
first treatment	

63. Clock Starts (Cancer Pathway)

2ww	The date the patient converts their unique booking reference number (UBRN) (i.e. the date they book their appointment) or date of receipt if received in hard copy.
28 Day Faster Diagnosis	The date the patient converts their unique booking reference number (UBRN) (i.e. the date they book their appointment) or date of receipt if received in hard copy.
62 day	A 62-day cancer clock can start following the below actions: • Urgent 2ww referral for suspected cancer • Urgent 2ww referral for breast symptoms (where cancer is not suspected) • A consultant upgrade • Referral from NHS cancer screening programme • Non NHS referral (and subsequent consultant upgrade
31 day	A 31-day cancer clock will start the following: • A Decision to Treat (DTT) for first definitive treatment • A DTT for subsequent treatment • An earliest clinically appropriate date following a first definitive treatment for cancer

64. Clock Stops (Cancer Pathway)

28 Day Faster Diagnosis	Clock will stop following: • Communication of diagnosis or all clear
62-day	Clock will stop following: • A deliver of first definitive treatment • Placing a patient with a confirmed cancer diagnosis onto active monitoring • Making a decision not to treat • Patient declining all diagnostic tests • Confirmation of a non-malignant diagnosis
31-day	Clock will stop following: • Delivery of first definitive treatment • Placing a patient with a confirmed cancer diagnosis onto active monitoring • Confirmation of a non-malignant diagnosis

In some cases where a cancer clock stops, the 18-week RTT clock will continue, i.e. confirmation of a non-malignant diagnosis.

Please refer to the Trust's Cancer Operational Policy available via Staff Room: Policies and Procedures for more detailed information.

Appendix A - Definitions

2ww	Two-week wait: the maximum wait time for a patient's first outpatient appointment or 'straight to test' appointment if they are referred as a 62-day pathway patient.
18 weeks Rule Suite	The 18 Weeks Rules Suite sets out the rules and definitions for 18 weeks The suite provides a framework within which decisions can be made and how to apply the rules.
28 Day Faster Diagnosis	28 days wait: The maximum wait time from referral to communication of diagnosis or all clear if a patient is referred as a 62-day pathway patient.
31-day pathway	The starting point for 31-day standard is the date a patient agrees a plan for their treatment or the date that an earliest clinically appropriate date is effected for subsequent treatments.
62-day pathway	Any patient referred by a GP with a suspected cancer on a 2ww referral pro-forma; referral from a screening service; referral from healthcare professional for breast symptoms or where a routine referral has been upgraded by a hospital clinician, must begin treatment within 62 days from receipt of referral.
Access to Services within maximum wait times	Guidance outlining the duties placed on PCTs and Providers of patients' rights in accessing services within 18 weeks (Gateway 13676 refers).
Accessible Information	Information which is able to be read and/or received and understood by the individual or group for which it is intended.
Active Monitoring (sometimes known as watchful wait)	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures. An 18 week clock may be stopped where it is clinically appropriate to start a period of monitoring without clinical intervention. A new 18 week clock will start when a decision to treat is made.
ASI	Appointment Slot Issue.
Bilateral Procedures	Where a procedure is required on both the right and left sides of the body.
Choice	Patients have the right to choice of provider for their NHS care when referred for their first outpatient appointment to a service led by a consultant
Chronological Booking	Refers to the process of booking patients for appointments, diagnostic procedures and admissions in date order of their clock start.

Consultant-led service	A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse-led clinics which come under the umbrella of the consultant-led service
Clock Start	An 18 week clock starts when any care professional (in England) makes a referral to a consultant led service regardless of setting.
Clock Stop	A clock stops when first definitive treatment starts
CNA	Could not Attend. Patients who have had reasonable notice of their appointment date and who do notify the hospital in advance of their appointment to say they cannot attend the appointment (even if this is at short notice).
Direct access	Where GPs refer patients to hospital for diagnostic tests only. These patients will not be on an open RTT pathway
DNA	Did not Attend. Patients, who have had reasonable notice of their appointment date and who, without notifying the hospital, do not attend their appointment. (Please also see WNB: Was Not Brought as this relates to children who have not been brought to their appointment and who have not 'DNA'd')
E-referral Service (E-RS) *Formerly known as Choose & Book*	National electronic referral service.
First Definitive Treatment	An intervention intended to manage a patient's condition, disease or injury and avoid further intervention. What constitutes first definitive treatment is a matter for clinical judgement in consultation with the patient.
Follow up	A Follow Up patient is one who attends as a follow up either after a 1st attendance or after being admitted for inpatient treatment which relates to the outpatient attendance.
Incomplete Pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage.
Inter Provider Transfer (IPT)	Method of transferring a Minimum Data Set of 18 week clock start details and clinical information where a patient's care transfers between provider organisations. The information is transferred via secure email.
New Patient	A New Patient is a patient who is new to the consultant for the

	purpose for which they have been referred.
NHS Constitution	The Constitution (Everyone Counts: Planning for Patients 2013/14) establishes principles and values of the NHS in England and sets out rights to which patients, public and staff are entitled.
Nullified	Where the RTT clock is discounted from any reporting of RTT performance.
Patient Initiated Delay	Where the patient cancels, declines offers or does not attend appointments or admission. This in itself does not stop the clock. A clinical review must take place.
Polling Range	Range of appointments that are offered up to NHS e-referral service from our Core Patient Database.
Planned Waiting List	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked at the clinically appropriate time.
PTL	Patient Tracking List.
Reasonable Offer	<u>Inpatients/Daycase</u> An offer is deemed reasonable when either a verbal or written offer of a minimum of 2 appointments on different days, with at least 3 weeks' notice given. <u>Outpatients & Diagnostics</u> A local agreement has been reached that an offer is deemed reasonable when either a verbal or written offer of a minimum of 2 appointments on different days, with at least 1 weeks' notice given.
RTT	Referral to Treatment.
TAL	The Appointment Line - National appointment line for the booking of choose & book appointments.
TCI	To Come In (date).
UBRN	Unique Booking Reference Number.
WNB	Was Not Brought – this term refers to children who are not brought to appointments.

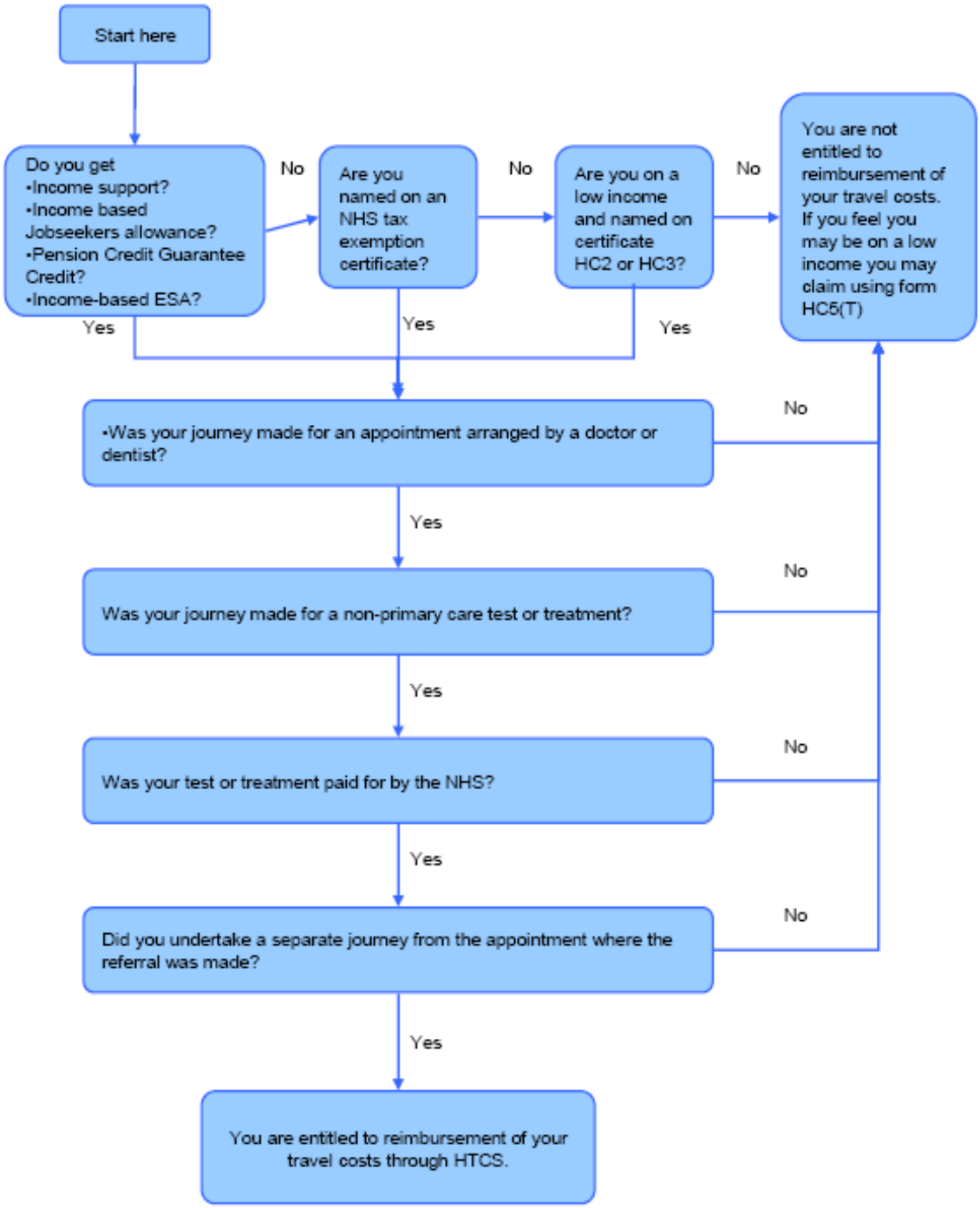
Appendix B - Process for Monitoring Compliance and Effectiveness

Minimum Requirement to be monitored	Process for Monitoring	Responsible Individual, Committee or Group	Frequency of Monitoring	Responsible Individual, Committee or Group for review of results	Responsible Individual, Committee or Group for developing action plan	Responsible Individual, Committee or Group for monitoring action plan
a. Quality & Oversight committee	Quality & Oversight committee	Quality & Oversight committee	Quality & Oversight committee	Quality & Oversight committee	Quality & Oversight committee	Quality & Oversight committee
b. Cancer Delivery Group	Compliance assurance	Cancer Delivery Group	As required by escalation	Cancer Delivery Group	Cancer Delivery Group	Cancer Delivery Group
c. Operational Performance Meetings	Non-Compliance	Operational Performance Meeting	As required by escalation	Head of Operational Performance/Corporate Performance Meeting	Head of Operational Performance/Corporate Performance Meeting	Head of Operational Performance/Corporate Performance Meeting

Appendix C - Healthcare Travel Costs Scheme

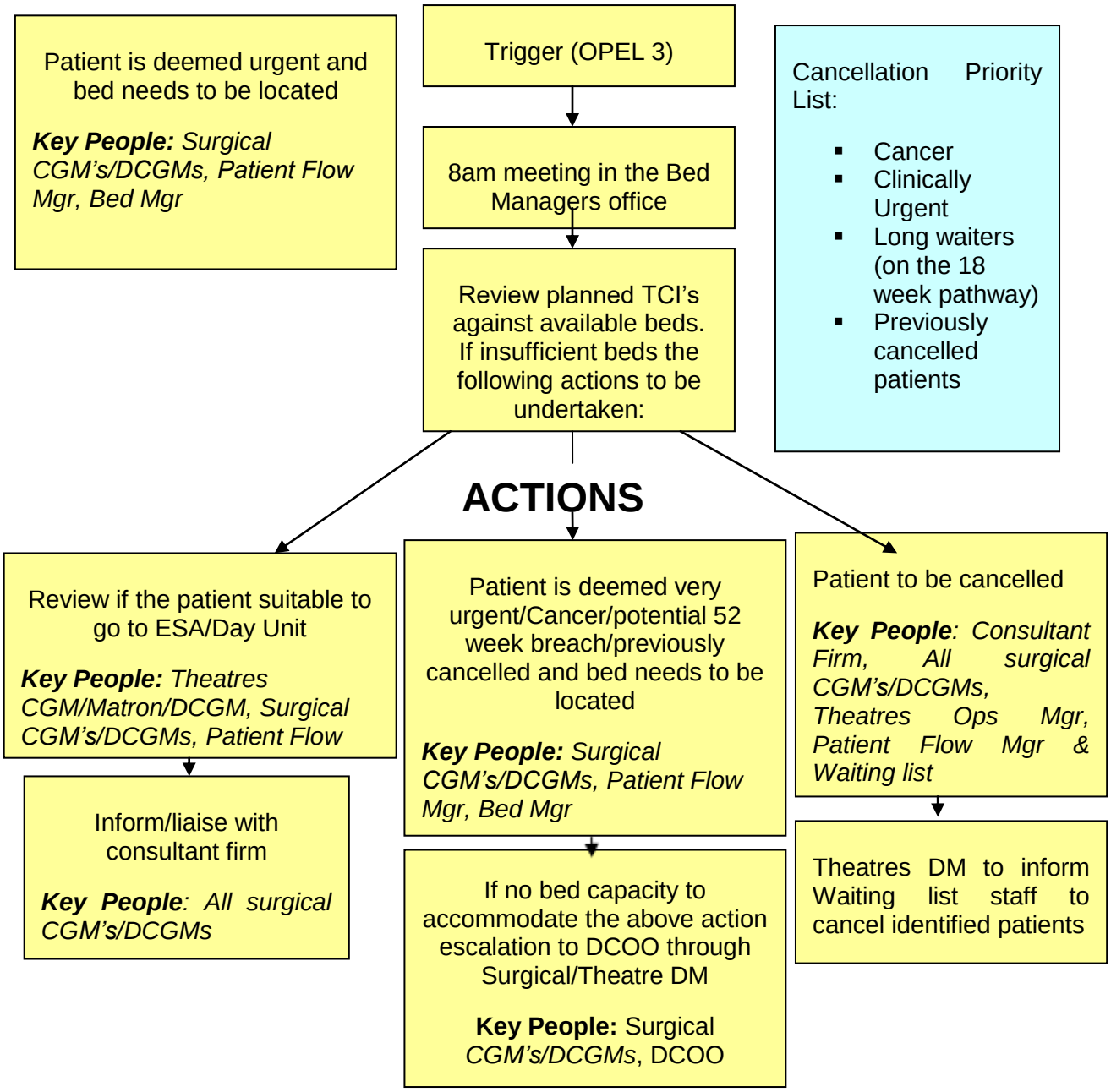
Extract from Healthcare Travel Costs Scheme (Gateway Ref 14322)

Quick Reference Guide (Patients Eligibility for Assistance with HealthCare Travel Costs)



Appendix D - Elective On-Day of Surgery Cancellation Guidance

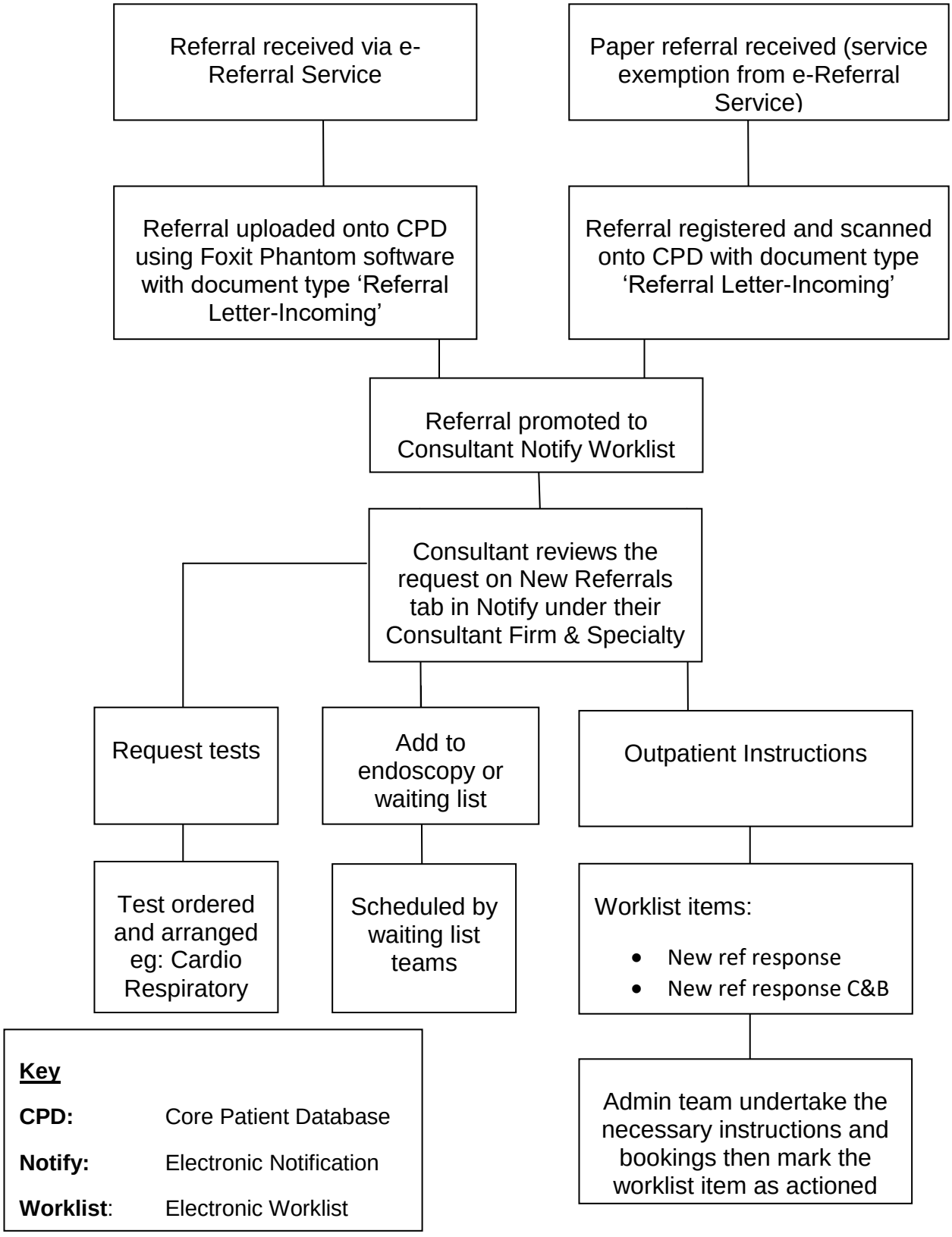
Where escalation is required the following flow chart should be followed



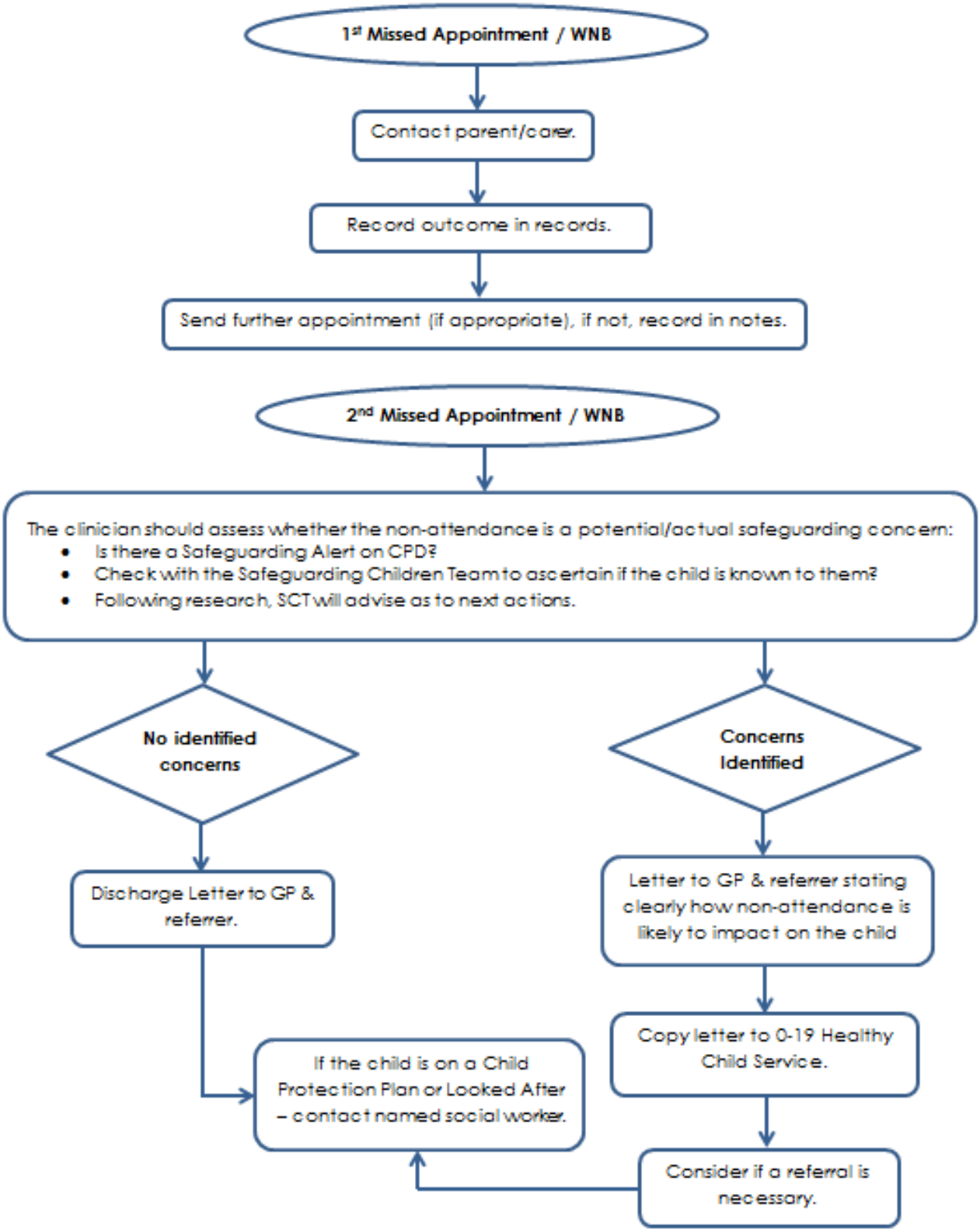
In addition the daily operational meetings will review the week ahead when OPEL 3 is activated. Information to be brought to the meetings at this time is:

- List of all planned TCIs for week
- Forecast 18 week position

Appendix E - Process Flow: Receipt of Referrals into Trust

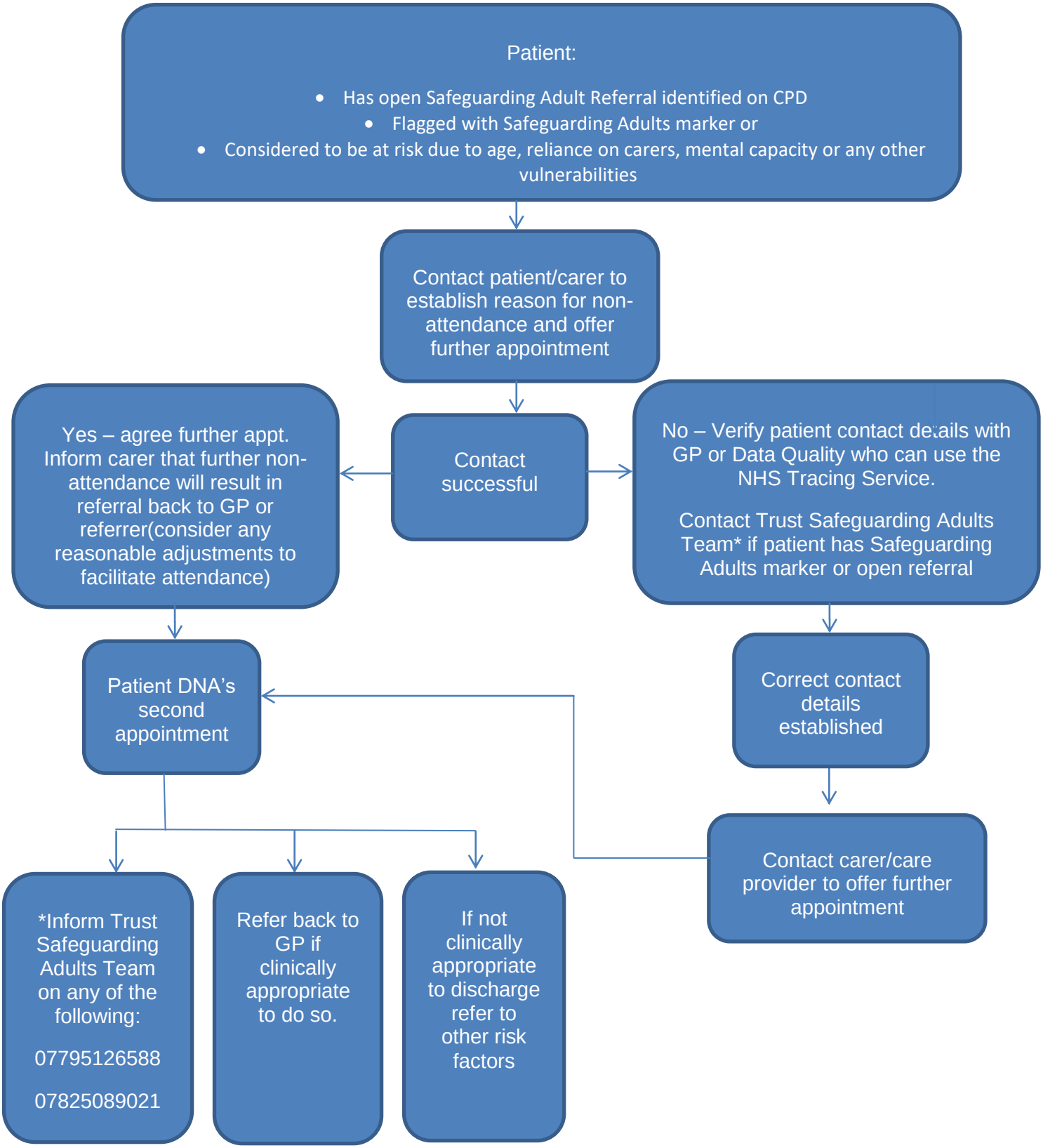


Appendix F - Process for Child not Brought to an Appointment

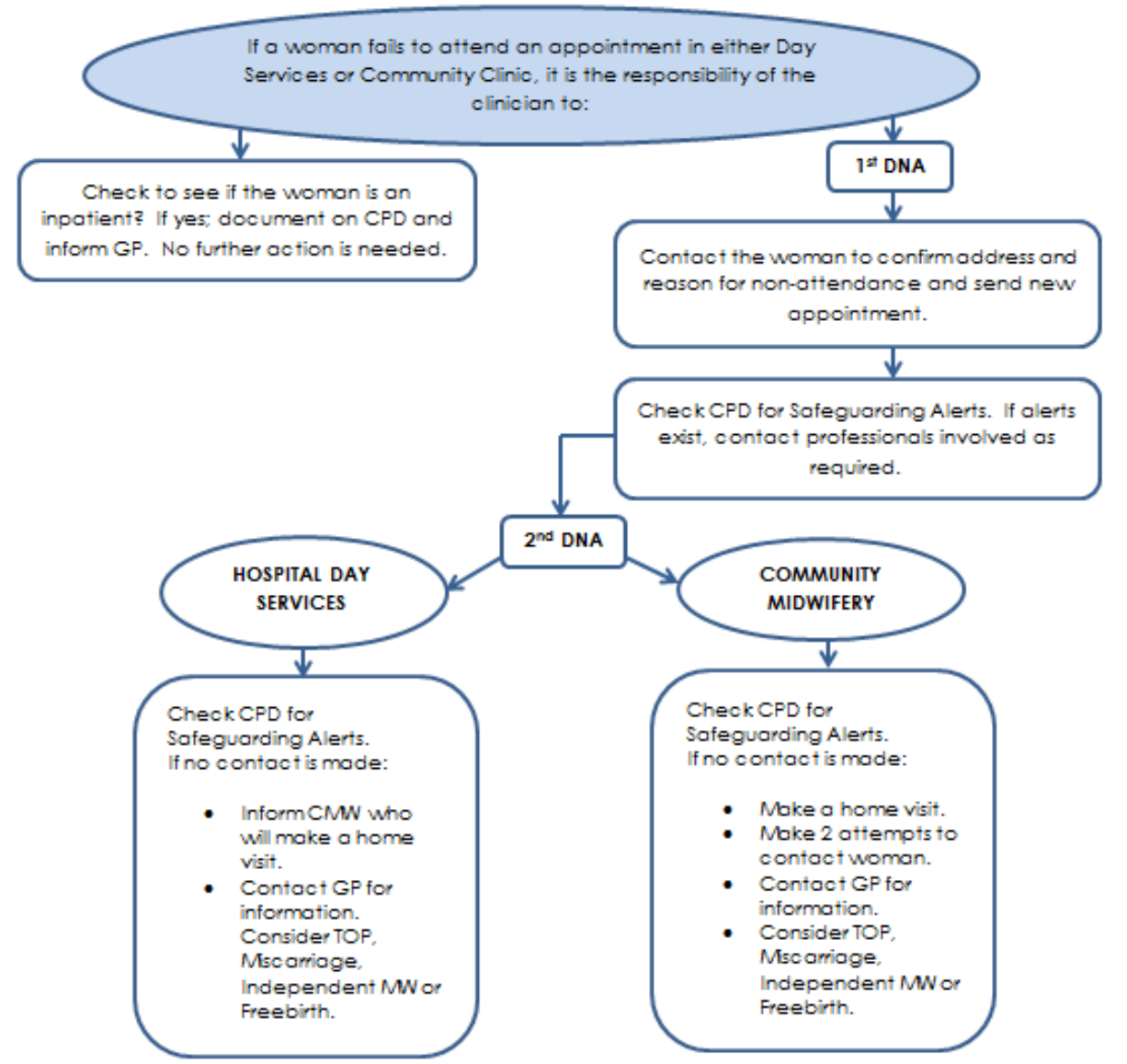


Process for Child not Brought to an appointment v2 FM Nov 2018

Appendix G - DNA for Vulnerable Adults



Appendix H - Safeguarding Maternity DNA Process



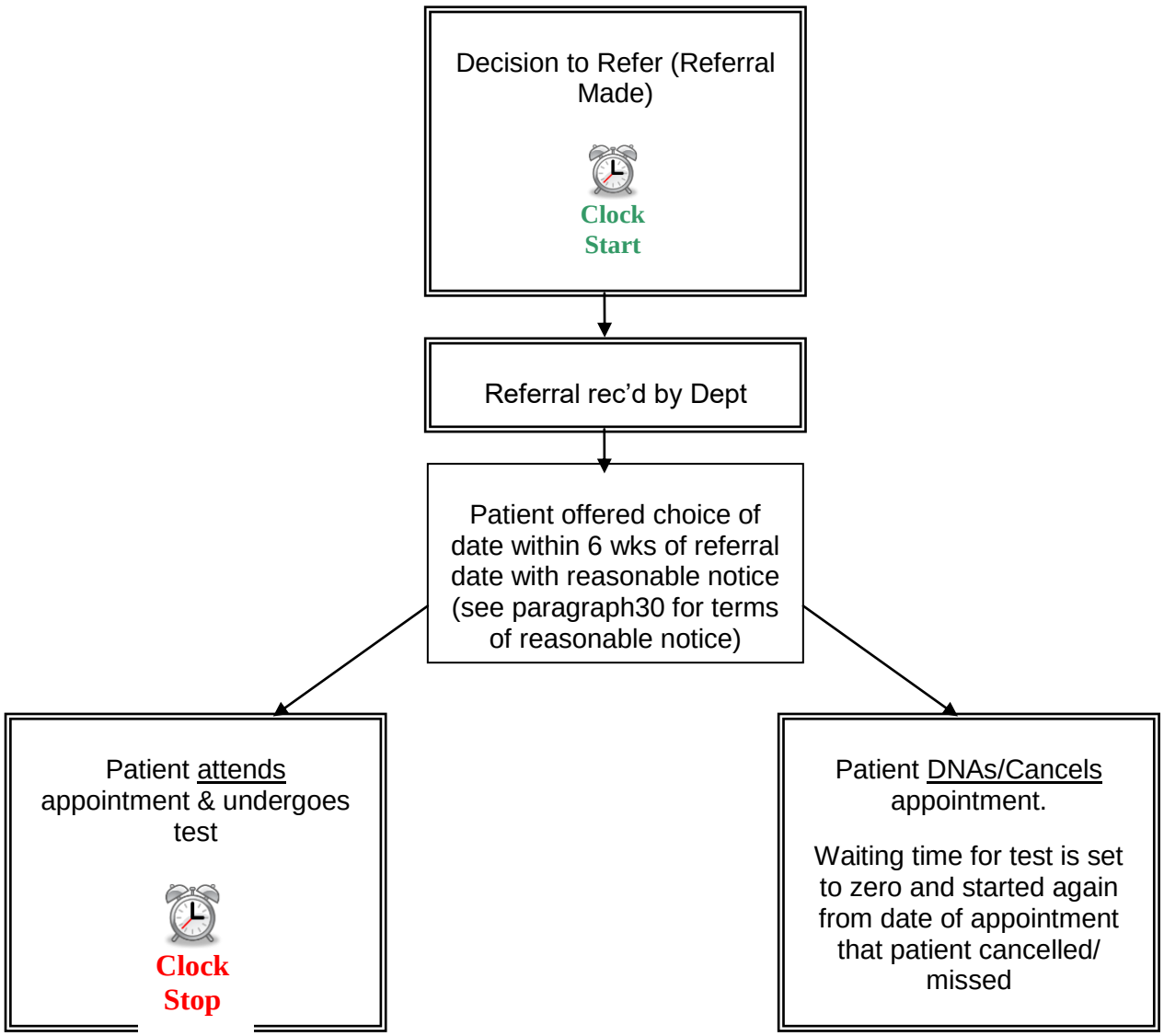
Though we would ideally like women to attend for their antenatal care, it remains the woman's informed choice whether she chooses to access care. Careful assessment of any safeguarding issues should be made and escalated appropriately where applicable.

Consider

- What are the health implications for the unborn?
- Are there historical concerns?
- Are other agencies involved? If so, inform them of concerns/non-attendance.
- Discuss concerns with the Safeguarding Children Team.
- Is a referral to Childrens Social Care required? Document details in records.

- If contact is still unsuccessful, or the woman declines antenatal care; document and update hospital and community systems.
- Inform GP of actions taken.

Appendix J - DNA/CNA Flow Diagram for Diagnostic 6 week target



This guidance is taken from the DH's "Diagnostics Waiting Times and Activity" March 2015

Appendix K - Policy Management

Consultation

Consultation has taken place with CCGs, Trust's Care Groups, including Clinical teams, Corporate Directors and approved by the Executive Board via the Clinical Risk and Oversight Committee.

Quality Assurance

Consultation has taken place with Care Group and Corporate Directors as well as ensuring the Policy is in line with national guidance on referral to treatment management. The policy has been proof read and checked prior to being submitted for approval.

Approval Process

The approval process for this Policy complies with that detailed in Trust Policy Guidance. The Executive Board is the approving group for this Policy.

Review and Revision Arrangements

This policy will be reviewed every 2 years or with legislation changes. The Healthcare Governance Team will notify the author of the policy of the need for its review six months before the date of expiry.

On reviewing this policy, all stakeholders identified will be consulted as per the Trust's Stakeholder policy. Subsequent changes to this policy will be detailed on the version control sheet at the front of the policy and a new version number will be applied.

Subsequent reviews of this policy will continue to require the approval of the Executive Board.

Dissemination and Implementation

Dissemination

Once approved, this policy will be brought to the attention of Corporate Directors, Clinical Directors, Care Group Managers, Deputy Care Group Managers, Heads of Service and Senior Managers

It will be published on the Trust's Staff Room under Policies & Procedures and a communication sent out to ensure that all staff are aware of, and understand that they are required to comply with, this policy.

This policy is available in alternative formats, such as large print as set out in the Staff Guide for accessing Interpreting Services for patients which is available on the Trust's Intranet site 'Staff Room'.

Implementation

This policy will be implemented throughout the Trust by the Policy Manager to all staff with responsibility for managing the care of or administering patients' access to services within the hospital.

Managers will ensure the day to day adherence of the policy.

Document Control including Archiving

The register and archiving arrangements for policies will be managed by the Healthcare Governance team. To retrieve a former version of this policy the Healthcare Governance team should be contacted.

Monitoring Compliance and Effectiveness

This policy will be monitored for compliance to ensure the minimum requirements of the NHSLA Risk Management Standards are met (Appendix B).

Training

Training is undertaken by staff on all systems and processes to apply the procedures that underpin this policy.

Trust Associated Documentation

- Trust Cancer Operational Policy
- Data Quality Policy
- Child Protection & Safeguarding Policy
- Access Procedures
- 18 Weeks RTT: Roles & Responsibilities
- External References
- Referral to Treatment Consultant-led Waiting Times Rules Suite: October 2015
- Recording and Reporting Referral to Treatment (RTT) Waiting Times for Consultant-led elective care
- Recording and Reporting Referral to Treatment (RTT) Waiting Times for Consultant-led elective care: Frequently asked Questions
- The NHS Constitution (July 2015)
- Implementation of the right to access services within maximum wait times (Gateway Ref 13676)
- Diagnostics Waiting Times & Activity. Guidance on completing the 'Diagnostic Waiting Times & Activity' monthly data collection (March 2015)
- Diagnostics Frequently asked Questions (FAQs) on completing the 'Diagnostic Waiting Times & Activity' monthly data collection (February 2015)

- Choice at Referral: The Guidance Framework
- Delivering Cancer Waiting Times (March 2015)
- Cancer Waiting Times Guidance v10 April 2019
- DSCN 44/2007 – Inter Provider Transfer Administrative Minimum Dataset
- Equality Act 2010
- Overseas Visitor Guidance (April 2016)
- Armed Forces Covenant (July 2015)
- Healthcare Travel Costs Scheme (Gateway Ref 14322).

Appendix L - COVID-19 RESPONSE; Patients who are unable or unwilling to commit to a Treatment Date or Decline Treatment.

Patient contacted and offered a choice of TCI/Appointment (virtual or face to face) dates (1st, FU or Diagnostic). Patient should be informed of the measures the Trust has put in place to mitigate the risks of COVID.

Patient accepts COVID safety measures &/or agrees a TCI/Appointment date – standard booking process to be followed.

Patient advises they no longer wish to remain on the waiting list for their surgery/treatment/test.

Patient declines all TCI/Appt dates offered/Is NOT able/prepared to follow COVID safety measures/wishes to defer inpatient surgery for a non-COVID reason.

Patient details are passed on by Waiting List, Patient Access, Radiology Administration Team or Administration Teams to the responsible/referring (if Radiology) clinician to review patient record

YTHFT Clinician to contact patient to discuss patient's care to include but not limited to the following;

- Reiterate to the patient the steps the Trust has taken to protect the patient from risk of COVID during their admission/appointment or the reasons why they should not defer treatment.
- Outline the risks to the patient of declining or deferring surgery/treatment; balanced between the risks of contracting COVID and the benefits of surgery/treatment
- Explain to the patient what may happen next, i.e. put on active monitoring and be followed up in outpatients, or removed from waiting list with an option to contact us for relisting when ready for surgery/treatment, remain on the waiting list and be reviewed within 6 months or removed from the waiting list.

FOR CHILDREN, MATERNITY OR VULNERABLE ADULTS PLEASE REFER TO APPENDICES F, G AND H

Patient who choose they no longer wish to remain on the waiting list
Letter sent to patient agreeing to their request to be removed from the waiting list. Patient discharged from secondary care. Letter is to be sent to GP (and referrer).

Patient decides to proceed with treatment – details passed back to Waiting List, Patient Access, Radiology Administration Team or Administration Teams for booking of TCI/Appointment.

Patient declines offer of surgery/treatment, but still requires treatment in the future. Clinician is to complete risk assessment and confirm next step.

HIGH RISK

Patient is to remain on active RTT waiting list. If on the Inpatient Waiting List for surgery/treatment Patient to be marked as either:
P5 – Patient wishes to defer surgery for COVID reasons or,
P6 – Patient wishes to defer surgery for Non-COVID reasons

POTENTIAL RISK

INPATIENTS: If on the Inpatient Waiting List for surgery/treatment Patient to be marked as either:
P5 – Patient wishes to defer surgery for COVID reasons or,
P6 – Patient wishes to defer surgery for Non-COVID reasons
OUTPATIENTS: Patient is to be placed on active monitoring. Patient removed from active RTT list and date confirmed for review (not applicable for 1st appointments). PIFU 6months option can be used so patient can access the service directly if any issues arise (referral remains open). See Patient Initiated Follow-Up (PIFU) SOP on StaffRoom.

LOW RISK

Patient is to be removed from all waiting lists and discharged, with open offer to come back directly to the Trust within the following 12 months.

Clinical template is required to be completed for every individual patient (see overleaf). To be sent to Patient & Referrer (& GP if not referrer) to include;

- Summary of conversation.
- Risk Assessment.
- Follow-up advice for referrer and patient.
- Option for GP to contact Trust to discuss patient.

If patient re-presents within the following 12 months.

Clinician is required to re-assess and relist according to clinical priority.

CLINICAL TEMPLATE FOR PATIENTS WHO DECLINE TREATMENT

Patient Details

Diagnoses	
Problems and Issues	
Procedure(s) Listed For	
Risk Stratification Category (Circle one)	HIGH | POTENTIAL | LOW
Reason for declining offered dates, treatment etc.	
Clinical risk factors	
Information and advice given to Patient	
Requested Actions	

Outcome;

☐ **Patient has decided against treatment at the present time, the risks have been explained to the patient. Patient to remain on the waiting list as either a P5 or P6.**

☐ **Patient has decided against treatment at the present time, the risks have been explained to the patient. If Outpatient patient to be placed on active monitoring, and will be regularly reviewed. If on Inpatient Waiting List, Patient to remain on the waiting list as either a P5 or P6.**

☐ **Patient has decided against treatment at this time. Patient is to be removed from all waiting lists and discharged, with the option to self-refer back into the Trust within the next 12 months.**