Totally

Patient Access Policy

Totally

Document Control

Document Control Sheet Title		Patient Access Policy	
Policy Area (delete as appropriate)		Elective Care	
Target Audience (who/which division/directorate/subsidiary is this policy applicable to?)		All	
Consultation with stakeholders (Provide details of who has been consulted during the development of this policy)			
Dissemination Date		**Implementation Date**	
Method of Dissemination			
Essential Reading For		All	
Information For		All	

Policy Owner (the "owner" of a policy is the office, department, division responsible for carrying out or oversight of that policy)	**Name**	**Role**
	Nicola Salkeld	Director of Operations
Policy Editor (who wrote/edited the policy)	**Name**	**Role**
Policy Approver (which Board/committee/group has approved this policy – in line with policy for approval of policies)		
Version Number	1	
Supersedes Version Number		
Summary of Changes from Previous Version		
Approval Date		

Next Review Due (policies should be reviewed at 3 yearly intervals as a maximum)	

Contents

Patient Access Policy 1

1. Overview 5
2. Scope 5
3. Background 5
4. Policy 6
5. Referrals 6
6. Management of Outpatients 11
7. Management of Diagnostics 18
8. Management of Inpatient and Day Case Waiting List 20
9. Children and Young People 24
10. Vulnerable Patients and Inequalities in Heath Care 24
11. RTT Rules Suite 26
12. Standards and Principles 34
13. Effective Communication with Patients 35
14. Roles and Responsibilities 36
15. Monitoring Document Effectiveness 37
16. Abbreviations and Definitions 38
17. References 41
18. Equality Impact Assessment Tool (EqiA) 41

1. Overview

This policy details how patients will be managed administratively at all points of contact within Totally. The policy has been developed to ensure Totally provides a consistent, equitable and fair approach to the management of patient referrals and admissions that meets the requirements of the NHS Operating Framework and the commitments made to patients in the NHS Constitution (See section 5.11 for detail of the standards).

The NHS Constitution states that patients can expect to start their consultant led treatment within a maximum of 18 weeks of referral for a non-urgent condition.

2. Scope

This policy sets out the overall expectations of Totally for the management of referrals and admissions into and within the organisation and defines the principles upon which the policy is based.
Totally staff have a key role in managing waiting lists effectively. Treating patients and delivering a high quality, efficient and responsive service ensuring prompt communications with patients is a core responsibility of the hospital and the wider local health community. Totally staff will promote a safe, clean, and personal service.

3. Background

This overarching policy is intended to be used by all individuals working for Totally hospital and community services who organise patient access for secondary or community treatment, with a responsibility for:

- referring patients
- managing referrals
- adding to and maintaining waiting lists
- the tracking and validation of elective pathways

4. Policy

4.1.1 This policy sets out the way in which Totally will manage patients who are waiting for treatment on admitted, non-admitted, and diagnostic pathways. This includes the management of all patients, irrespective of the site where they receive care.

4.1.2 Every process in the management of patients who are waiting for treatment must be clear and transparent to both the patients and to partner organisations and must be open to inspection, monitoring, and audit.

4.1.3 Totally will give priority to clinically urgent patients and treat everyone else in turn subject to the exceptions described.

4.1.4 Totally will work to meet and improve on the maximum waiting times set by NHS England for all groups of patients.

4.1.5 Totally will aim to negotiate appointment and admission dates and times with patients.

4.1.6 In accordance with a training needs analysis, staff involved in the implementation of this policy including, clinical, clerical, and managerial will undertake training provided by Totally with regular annual updates. Policy adherence will form part of staff goals and objectives.

4.1.7 Totally will ensure that management information on all waiting lists and activity is recorded on the appropriate systems.

5. Referrals

5.1.1 Referrals

- Must be clear and concise stating the clinical priority.
- Be addressed to a specialty/service wherever possible
- Where it is explicit that the patient needs to see a particular member of the specialty/service (through patient choice or sub speciality expertise), this must be written in the referral request with the reason for this clearly stated.
- Must include up to date demographics, Name, Address, Date of Birth, Contact Telephone Number, NHS Number, Parent/Guardian

5.1.2 E-Referral System (e-RS)

The E-Referral System is the national electronic solution for clinicians to refer a patient for a first outpatient appointment. It is a mainstream source of receiving referrals within Totally and all GP referrals into consultant led services must be received via this system. From 1st October 2018, the NHS Standard Contract provides for a

commissioner to decline to pay for GP to consultant first outpatient activity, undertaken by an Acute Provider which did not originate with a referral through e-RS. Non-compliance with the guidance will result in the referral being rejected and returned to the original referrer. To do this each service on e-RS will have a Directory of Services (DOS). This template does the following:

- It holds information that describes the services that care organisations offer.
- It enables referring clinicians to search for appropriate services to which they can refer patients.
- It provides a window through which providers can display their services.

When a referral is generated the referral letter must be electronically attached by the referrer either:

- On the same working day for Suspected Cancer referrals
  or
- 3-5 working days of the request (decision to refer) and where the appointment is more than 5 days in advance.

For e-RS referrals, the RTT pathway start date is the UBRN conversion date or the deferred to provider date if there are no appointment slots to book to. All referrals booked under a generic consultant or have previously been deferred to provider must be altered within one working day to the named consultant under whose care the patient will remain.

The best practice for polling ranges with slot availability on e-RS should not exceed 6 weeks.

They will be managed by the Service Management teams supported by the patient administration teams.

5.1.3 Specialist Advice and Guidance

The E-Referral Service (e-RS) supports the concept of one clinician asking advice from another and receiving a reply, this allows a dialogue between clinicians over the best management options for the patient.

A GP may create a request for advice and guidance via the e-RS system, images and attachments can be added. This request will appear on the provider clinician's worklist to be reviewed and a response is returned within 48 hours with either advice, a request for further information or with authorisation this can be converted into a referral. If the request is converted, it will appear on the Appointments for Booking list which will be managed by Patient Access and Administration Services. See the link below for further information.
NHS England » Advice and Guidance

5.1.4 Referral Management Centres

A referral management centre or assessment service is a specific type of interface service that does not provide treatment but accepts referrals and provides advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient. Referrals to Referral Management Centres are covered by RTT rules. The clock starts on the date that the patient rings to make an appointment and the UBRN is activated. An onward referral should be received within 3 days of receipt of the original referral in the Referral Management Centre.

5.1.5 Referral Assessment Service (RAS)

The Referral Assessment Services (RAS) triages referrals from the referrer daily and decides on the most appropriate onward clinical pathway. If it is an elective referral the patient is contacted to discuss and arrange an appointment where needed. The clock starts on the date that the patient rings to make an appointment and the UBRN is activated. If necessary, the referral will be returned to the original referrer with advice if an onward referral is not required.

5.1.6 Clinical Assessment Service (CAS)

The Clinical Assessment Service (CAS) is an intermediate service. It allows greater clinical expertise in assessing a patient, more than expected of a referring clinician. This expertise ensures patients go on the most appropriate onward care pathway. Referrals are triaged by a clinician in the service and tests can be requested prior to 1st appointment. Triage should be completed within 48 hours of receipt.

5.1.7 Duplicate Referrals

If a patient has already been referred into a service and has not yet received an appointment, the waiting list will be managed appropriately by the booking team. Referrers should not re-refer the patient. If symptoms change and the referral is now deemed urgent, the referrer must follow the expedite process. See 5.1.15 Expedited referrals.

5.1.8 Self-Referral

Clinicians should not advise patients or staff to self-refer.

5.1.9 Internal referrals (Consultant to Consultant)

Where a hospital consultant believes a patient would benefit from a non-urgent opinion from a specialist for a condition that is unrelated to the presenting complaint,

this information should be provided back to the referrer and patient for a decision as to whether a referral is progressed and to which provider.

This will cover:

- non-urgent referrals for conditions not related to the presenting complaint.
- non urgent referrals from A&E
- all other non-urgent consultant to consultant referrals not covered by the exceptions below.

Exceptions include:

- clinical urgent referrals
- referrals from medical specialities to surgical specialities for the same condition
- referrals from a generalist to a sub speciality
- referral for the assessment and suitability of patients for surgery or interventions
- Referral for anaesthetics for Cardiac or Respiratory medicine
- Transplant receipt or doner
- Thrombophilia screening
- Hyperglycaemia

Where an internal referral takes place, for either a further opinion or a transfer of care, this patient will be placed on the same RTT pathway with the RTT clock starting from the original referral date.

Where an internal referral is received for a different condition, from an 'incidental finding' this patient will have a separate new RTT Pathway created, and the clock start date will be from the date the decision was made to refer. E.g., the clinic appointment date where this was communicated to the patient.

5.1.10 Tertiary /Inter-Provider Referrals

A completed Inter-provider Minimum Data Set pro-forma (IPTMDS) must be sent with all inter- provider transfers (IPT). If a Clinician is referring to another NHS Organisation outside of Totally, and/or for internal transfers within Totally, from patient centre A to patient centre B, then an IPTMDS form must be fully completed, including all the RTT pathway details and sent with the referral letter. This will ensure a patient's pathway is created or continued accurately with the correct clock start date.

If a referral is received and does not have a fully completed IPTMDS form, then the referral must be added to the system and where possible, the patient given an appointment in order not to delay any further treatment. The incomplete IPTMDS form must then be chased up with the referring trust/ clinician, any pathways that are

a potential breach over 32+ weeks must be escalated to the management team for review and acceptance.

5.1.11 Paper referrals

Internal referrals are submitted and are received at various entry points.

Email - various accounts.

Letter - via post

These referrals may be from GPs at sites where the patients are temporarily residing, and e-RS is not in use. Examples of this would be HMP Prisons, Cygnet Mental Health Hospitals.

All referrals on receipt must be registered and scanned onto the relevant system to allow appropriate management and next steps i.e., triage/booking. The clock start date will commence on receipt of the referral.

5.1.12 Rejected Referrals (ERS)

Where a clinician deems a non-cancer referral as clinically inappropriate then the referral must be rejected on e-RS with a clear reason and possible alternative action to be taken by the referrer. If an appointment has been booked, then a cancellation of appointment letter will be sent to the patient informing them of the decision and requesting that they discuss this with their original referrer. A referral should not be rejected if it relates to a subspecialty of the existing speciality, it has been attached to.

Totally staff will contact GP surgeries where referral letters have not been attached in the agreed timeframe. However, and by exception, if there is no clinical information added for 4 weeks despite one attempt for the first two weeks to contact and two attempts the following 2 weeks via the Practice Manager, the referral will be rejected as it cannot be clinically assessed as appropriate, and the patient will be informed.

5.1.13 Expedited referrals

Expedite referrals can be sent by a referrer when a referral has been received for a condition and the referrer deems appropriate that the condition has worsened, and the patient requires to be seen sooner. On receipt of an expedite referral/letter the administrator will check the PAS system and e-RS for the original referral and will send both referral and expedite to the Service Manager to arrange for a clinical review.

An expedite referral/letter does not replace the original clock start date of the existing referral regardless of urgency.

5.1.14 Redirection of referral

Where a clinician decides a referral has been booked into an inappropriate clinic or service then the referral must be redirected to the appropriate clinic. A letter will be sent to the patient informing them of the decision.

5.1.15 Appointment Slot Issues (ASI's)

If there are no appointment slots for a referrer or patient to book into, they will fall onto the ASI list. Where it is not possible to book an appointment due to capacity patients must be managed appropriately. The RTT clock start date will be the same as the UBRN conversion date.

Patients' referrals are only visible on the ASI list for 180 days, if at that point they have not yet been booked, they will "drop off" the e-RS ASI list. To keep visibility of the patient's referral, and to be able to book them an appointment once there is capacity, they must be transferred from e- RS to the correct waiting list on patient centre. Those specialities currently with a waiting list exceeding 23 weeks for a 1st appointment, will need to transfer their patients on to patient centre at weeks zero (0) to ensure the referrals do not drop off the ASI list at 180 days. Where the waiting list is less than 23 weeks for a 1st appointment, then the patient will remain on the ASI list and be managed through the usual e-RS process.

When transferring a patient from an ASI list the administrator is responsible for ensuring the RTT clock start date is altered to reflect the date the UBRN was attempted to be converted (UBRN received date). The request must be manually cancelled by the administrator on e-RS with a comment to reflect the transfer over to patient centre.

ASI waiting lists should be monitored and managed by each service via their weekly PTL meetings.

5.1.16 Appointments for Booking worklist (AFB)

The appointment for booking list within e-RS will contain patients that have been triaged by a RAS with the decision to refer them on for an appointment. It will also contain patients that have had an appointment booked which has since been cancelled either by us as the provider or by the patient themselves, any patients that have failed to attend or DNA'd their appointment will also be on the worklist.

The administrator is responsible for managing the AFB worklist similarly to the ASI list, as the UBRN will drop off after 180 days.

6. Management of Outpatients

6.1 Management of New and Follow–up Outpatient Appointments

To deliver and recover elective activity and ensure that Totally meets the targets for offering "patient choice" at first outpatient appointment and at all stages of a patient's journey, several booking processes have been adopted as best practice. These include:

- Face to face outpatient clinics
- Telephone appointments
- Virtual clinics (via digital application)
- PIFU Patient initiated follow up appointments.

It is the clinician's responsibility to ensure that patients that require a follow up appointment following first attendance are recorded accurately in their clinical outcome record and the appropriate next steps are clearly documented.

6.2 Private Patients

Where a patient opts to pay for private care, their entitlement to NHS services remains and may not be withdrawn. Any situations where patients receive additional private care alongside NHS care should be handled with the highest standards of professional practice and clinical governance.

Any patient who changes between NHS and private status should not be put at any advantage or disadvantage in relation to the NHS care they receive.

Patients who are referred from the private sector can be added direct to the NHS waiting list on the referral received date. They do not necessarily need an NHS appointment prior to addition. The 18-week clock will start from referral receipt in the Referral Management Centre.

6.3 Capacity Management

GP's and/or referral centres will ensure that patients are offered a full range of choices for providers of treatment.

Where the current capacity available within a service is not adequate to meet the numbers of patients referred to it within the pre-agreed timescales, the Service Manager together will take action to ensure all patients are treated in accordance with the RTT standards.

6.4 Outpatient Booking Processes

Fully Booked – when a patient confirms their appointment date or admission. A patient can do this either via e-RS or directly with a booking clerk to agree a mutually convenient date and time for their appointment or admission. Full booking must always be used in circumstances when an appointment is to be made with less than 3 weeks' notice.

Fixed Booked – where we have been unable to contact the patient an appointment or admission date is booked and sent to the patient without choice. Fixed booked appointments must be made by letter when full booking has not been possible, e.g., no contact telephone number is available. A fixed booked appointment must be offered with more than 3 weeks' notice.

Recording of dates offered - All patients appointments must be recorded in the PAS. When applying the rule of reasonable notice, the first date must be offered with a minimum 3 weeks' notice (21 calendar days). If the patient declines the offered date, this must be recorded in Patient Centre/PAS and a further date offered to the patient again with a minimum 3 weeks' notice (21 calendar days). If no capacity is available to rebook the appointment, following patient declining the first date offered the patient must be added to the relevant Outpatient Waiting List, pending capacity clarification from the service. Where the patient is declining 2 dates, offered with reasonable notice, for a new appointment they must be advised that they will be discharged back to the care of the original referrer. See 5.2.15 Patient Cancellations

Partial Booking 1st Invites process.

Where the process of Partial Booking is used requesting patients to contact the Booking department to arrange an appointment, the first letter sent gives the patient a period of 14 days in which to contact to arrange a suitable date. If the patient does not contact by the end of the 14-day period a second reminder letter is sent, giving a further 7 days' notice to 'get in touch' from the date of the letter. If the patient fails to contact after both letters have been sent, the patient is returned to the referrer and a letter of correspondence must be sent to both the patient and the original referrer informing them of the discharge.

6.5 Chronological Booking

Clinically urgent patients will be booked as a priority and within 4 weeks from the referral received date.

Routine patients (non-clinically urgent) with no other factors for consideration such as named clinician, choice, and or complexity will be booked in chronological order based upon the length of wait. Where an RTT pathway is ongoing the overall wait time of the patient must be considered.

All patients on an active waiting list for a procedure/treatment must be reviewed every 12 weeks following the National Validation guidance. Refer to RTT Rules suite 5.9.15. for National Validation Guidance

6.6 Reasonable notice

Reasonable notice is defined as, a minimum of 3 weeks (21 calendar days) for both outpatient appointments and IP/Day case procedures and diagnostics.

6.7 Patient Initiated Follow UP (PIFU) applicable to outpatients only.

Patients who are placed on a PIFU waiting list are done so in agreement with a clinician. This will enable patients to manage their own conditions working to a personalised care and support plan, these patients can choose to request appointments only when they need them.

The clinicians will provide all the relevant information to the patient at clinical consultation so that the patient is fully aware of the process should they require a follow up appointment. From the outcome at clinic the patient will be added to a PIFU outpatient waiting list with a specified timescale in which the patient, if required can contact the service to request an appointment. If at the end of the specified timescale the patient has not requested a follow up, they will be discharged back to the care of the referrer with no need for a clinical review. The administrator responsible for the outpatient waiting list will monitor and manage this list accordingly.

6.8 Outpatient Appointment DNAs (Did Not Attend)

Clinicians are expected to review all the patients on the clinic that have DNA'd their appointments as part of the clinic cashing up process, whether this is a virtual, telephone or face to face appointment. The outcome of the clinical review may be a decision to discharge the patient back to their referrer or offer a further appointment and should be noted on the clinical outcome record and returned to reception or relevant clerk to action. If the decision is to discharge, the receptionist/administrator will be responsible for discharging the patient, closing the RTT pathway, and sending a letter to both the patient and the referrer informing them of the decision.

New routine patients (except for those with safeguarding issues for children and identified vulnerable adults/groups) who do not attend their first outpatient appointment, when they have been given a minimum of 3 weeks' notice and have been clinically reviewed may be discharged back to the original referrer.

If the DNA is being processed in a post clinical setting, following a clinical review the clinician will dictate a discharge letter which will be sent to the patient and their referrer informing them of the outcome.

All clinically urgent patients (including patients safeguarding issues for children and identified vulnerable adults) will automatically be offered a further outpatient appointment to avoid any further delays in their care. The patient will be telephoned to agree the appointment date.

6.9 Follow up appointments (including Pre-op)

Where a patient has DNA'd their follow up appointment, these will be clinically reviewed and if the clinician agrees that there is no contra-indication, the patient may be discharged back to their original referrer. A letter will be dictated by the clinician and a copy sent to the patient and referrer. The RTT Clock will stop when the letter has been sent. If a further appointment is required, this will be completed as part of the clinic cashing up process and the administrator will book the appointment if required within 6 weeks or will add to the Waiting List if there is no capacity. If there is a delay in the cashing up process by the clinician, they may instruct the secretary or booking teams to make a further appointment. The RTT clock stops if there is a decision to discharge otherwise the RTT clock will continue ticking.

Patients should not be penalised where exceptional circumstances prevent them from attending an appointment, e.g., extreme weather conditions, or where public transport has stopped running. In these circumstances staff should seek guidance from their line manager.

6.10 Patients that DNA their appointment multiple times on the same referral

In these scenarios it is extremely important that a clinical review be provided by the clinician and checks done to understand why the patient may have DNA'd, to determine the next steps.

Following this review, if they deem it appropriate and there are no contra-indications the clinician will discharge the patient back to the referrer due to engagement issues. The clinician may conclude that a further appointment is clinically necessary and if there are concerns, they should dictate correspondence to the patient's referrer around any clinical worries and/or offer a management plan where needed. The RTT Clock will stop from the date when the letters have been sent.

6.11 Patients that DNA 2 consecutive appointments on the same referral

As with multiple DNA's the need for a clinical review is paramount as the patient may be discharged back to their referrer due to engagement issues and the impact on their clinical care if they are not being reviewed at the clinically appropriate intervals. It may be concluded that a further appointment is necessary, and concerns should be dictated in a letter to the patient's referrer. If the patient is discharged the RTT clock will stop when the letters have been sent.

6.12 Patient Cancellations New Appointments

If a patient accepts an appointment, either by full or partial booking rules and cancels their appointment, they are to be re-booked for a further appointment.

NOTE: A patient cannot be penalised where exceptional circumstances prevent them from attending.

When a patient cancels a new appointment for a second consecutive time and reasonable notice of the appointment was given, or patient confirmed the date and time, they will be discharged back to the care of the referrer, a standard letter of correspondence must be sent by the administrator to both the patient and referrer.

6.13Follow-up appointments.

When a patient cancels a follow up appointment for a second consecutive time a clinical review will be required. The clinician will review and if deemed appropriate the patient will either be given a further appointment, or be discharged back to their referrer and a letter dictated by the clinician and sent back to the referrer providing that: -

- The provider can demonstrate that the appointments were clearly recorded and communicated to the patient with either choice and or reasonable notice.
- The clinical interests of vulnerable patients are protected and are agreed with clinicians, patients, and other relevant stakeholders.
- The patient has not been penalised where exceptional circumstances prevent them from attending an appointment, e.g., extreme weather conditions, or where public transport has stopped running. In these circumstances staff should seek guidance from their line manager.
- The above process can only be followed for consecutive patient cancellations, if there is a hospital cancellation between the 2 patient cancellations, the patient cannot be discharged. If they are discharged, this will stop the RTT clock from the date of the letter.

6.14Discharging patients

New appointments (PDWA Patient does not wish to attend)

If a patient cancels their first new appointment prior to being seen, and no longer requires the appointment, they can be discharged back to the care of the referrer. A standard letter of correspondence must be sent by the administrator to both the patient and the referrer.

NOTE: This only applies with New first appointments where the patients have never been seen.

6.15Outpatient Follow up appointments. (No longer required)

If a patient is choosing to be discharged after they have had a first appointment and are on a follow up outpatient waiting list, the clinician responsible for their care must be notified. A clinical review must be sought prior to discharge. The administrator is responsible for fully completing the discharge, closing the RTT pathway and sending the appropriate letter to both the patient and GP/referrer.

6.16Inpatient Waiting lists/Diagnostics

If a patient is choosing to be removed from the Waiting list and discharged midway through their pathway, a clinical review must be sought as it may not be in the patients' best interests to decline treatment. Once a decision to discharge is received as above the administrator is responsible for fully completing the discharge, closing the RTT pathway and sending a letter to both the patient and their referrer.

6.17Clinical decision to discharge (TNR Treatment not required)

6.18When the decision to discharge is a clinical one the clinician must dictate a letter informing both the patient and the patients referrer of the decision. The discharge process must be fully completed and the RTT clock stopped.

6.19Clinic Cancellation or Reduction of clinics impacting patients.

A minimum of six weeks' notice is required for clinic cancellation or reduction/appointment time changes impacting patients (except for sickness where alternative options cannot be sourced).

Clinic cancellations with less than six weeks' notice i.e., short term sickness can only be authorised by a designated Senior Manager.

All patients who have their appointment cancelled by Totally for any reason will be contacted by the organisation either by telephone and/or letter to rebook their appointment ensuring that no waiting time is breached. If there is no capacity to rebook the patient must be added to the relevant outpatient waiting list (OWL)

Any patients that are affected by a hospital cancellation which will impact patients with less than 3 weeks' notice, it is the responsibility of the service to manage the rebooking of the patient and not the booking service.

6.20Results Review

Where a patient has been seen in clinic and sent for diagnostic tests, they should only be brought back to clinic if necessary. If the patient does not require a further appointment, a letter must be dictated to the patient and their referrer informing them of the results of the diagnostic tests and the next steps. If at this point the patient is discharged, the referrer is requested to give medication or the patient is to be actively monitored, then the RTT clock can stop on the date the letter was sent to the patient informing them of the decision. If a patient is to return to clinic for further review the RTT clock continues.

6.21Arrivals late for clinic

If a patient arrives late for their appointment time and the delay is the responsibility of the Patient Transport Service every effort will be made to see the patient for their consultation. Patients who arrive late may have to be seen last or it may be that they are seen by another member of the clinical team.

If the patient arrives late and the delay is not the responsibility of the Patient Transport Services and cannot be accommodated within the scheduled time of the clinic, their appointment should be cancelled and another appointment should be made. This will be treated as a patient cancellation and as such follow that part of the policy, details of this action and reason for the delay should be recorded on the PAS.

7. Management of Diagnostics

7.1 Diagnostic Tests/Procedures

Diagnostic tests are defined as being used to identify and monitor a patient's disease or condition. Therapeutic procedures are defined as a procedure which involves actual treatment of a patient.

Diagnostics waiting times are monitored and reported on through the DM01 monthly return with a number of diagnostic procedures that should be included. Therapeutic procedures should be excluded however, in some cases, diagnostics will become a therapeutic procedure, where at a point during the diagnostic the healthcare professional decides to perform a therapeutic treatment at the same time. These procedures should still be reported in the waiting time return.

7.2 The DM01 monthly submission.

There are 15 key diagnostic tests that are reported on as part of the monthly submission. It is used to measure performance against the operational standard, that less than 1% of patients should wait more than 6 weeks (over 41 days) for a diagnostic test. Tests included are:

- Imaging - Magnetic Resonance Imaging
- Imaging –
- Imaging - Non-obstetric ultrasound Computed Tomography
- Imaging - Barium Enema
- Imaging - DEXA Scan
- Physiological Measurement - Audiology – Audiology Assessments
- Physiological Measurement - Cardiology - echocardiography
- Physiological Measurement - Cardiology - electrophysiology
- Physiological Measurement - Neurophysiology - peripheral neurophysiology
- Physiological Measurement - Respiratory physiology - sleep studies
- Physiological Measurement - Urodynamics - pressures & flows

- Endoscopy - Colonoscopy
- Endoscopy - Flexi sigmoidoscopy
- Endoscopy - Cystoscopy
- Endoscopy – Gastroscopy Exclusions from submission

Where the patient is waiting for a procedure as part of a screening programme (i.e., routine repeat smear test etc.)

Where the patient is waiting for a planned surveillance and is recorded on a planned waiting list.

The patient is an expectant mother booked for confinement.

The patient is currently admitted to a hospital bed and is waiting for an emergency or unscheduled diagnostic test/ procedure as part of their inpatient treatment.

7.3 Patient Cancellations

Where a patient cancels or misses a diagnostic test/procedure appointment the DM01 clock resets to zero and the waiting time starts again from the date of the cancelled/missed appointment. Where this presents a significant technical challenge and doing so does not adversely affect waiting times, the same clock can continue if there is still an intention to carry out a diagnostic test.

If the patient declines 2 offers of appointment with reasonable notice, then the diagnostic waiting time clock can be set to zero from the first date offered.

7.4 GP Requested Diagnostics Direct Access

Where a GP requests a Routine Direct Access Diagnostic to determine whether an onward referral to secondary care or management in primary care is appropriate, this does not start an RTT clock. The patient would be excluded from an RTT pathway, and a status code 92 would be used.

However, the patient must have the diagnostic procedure within 6 weeks of the date the test was requested. If the GP subsequently refers the patient to secondary care, the RTT clock will start upon receipt of the referral.

NOTE: it is the GP's responsibility to be clear on the referral whether they are sending the patient for treatment or requesting a diagnostic procedure. Where the diagnostic results in an onward referral to secondary care, the referrer must include all relevant test results and scans etc.

8. Management of Inpatient and Day Case Waiting List

8.1 The Decision to admit (DTA)

Patients should be fit, ready and available before being added to the IP/DC waiting list. They will be added without delay following a decision to admit, regardless of whether they have undergone a pre-operative assessment. When the patient has agreed and consented to surgery the clinician will submit an outcome form with details of the procedure. All patients should be clinically prioritised using the P code criteria. Of the 5 categories, 4 relate to the clinical prioritisation of elective care patients (P1 for emergency patients). P2- P4 relate to the period in which it is clinically appropriate for the patient to wait for their procedure.

8.2 Adding to the IP/DCWL

The administrator will be responsible for adding patients to the waiting list ensuring that the correct information is transferred onto the PAS including the clinical priority.

8.3 Selecting Patients for admission.

Clinically urgent patients must be booked first based on clinical need.

All routine elective patients must be managed chronologically in order of wait time (this includes overall RTT wait time whichever is the longest).

Cancelled theatre slots must not be given to the next “routine” referral that comes to hand. They should wherever possibly be used to bring forward the longest waiting patients.

All patients undergoing general anaesthetic will be given a preoperative assessment appointment.

8.4 Recording and monitoring of patients not on an active pathway.

Patients that are not on an elective pathway will need to be monitored from the PTL and booked accordingly in chronological order.

8.5 IP/DC Patient Correspondence

All patients, regardless of methods of booking, must be sent a letter confirming the date, time, and location of the admission within 1 working day. Also included with the letter there must be any specific speciality information regarding the procedure or advice of where this can be located.

8.6 Reasonable Offer

A reasonable offer for an elective admission is two dates with at least 3 weeks' (21 calendar days) notice.

After checking for any periods when the patient is unavailable for an appropriate date to be offered, and the patient is still unable to accept 2 dates with reasonable notice, clinical advice must be sought as to whether:

- A period of active monitoring is appropriate which would require a clinical conversation, the patient must be involved in the decision to active monitor and understand the process to follow once they become available to continue their treatment.

or

- A decision to discharge the patient back to the referrer, a letter must be dictated and sent to patient and referrer confirming this decision.

or

- A further follow up appointment is made to discuss next steps.

Active monitoring may apply at any point in the patient's pathway, but only after a decision to treat has been made and the patient is aware of any likely clinical risk of delaying their treatment.

8.7 Pre-operative assessment

Prior to being admitted into hospital for elective surgery, patients must have a pre op assessment to check that they are fit. It is a clinical investigation that precedes anaesthesia for surgical or non-surgical procedures to help reduce the risks associated.

8.8 Infection Prevention

The Infection Control Team will work closely to ensure admissions and transfers are planned effectively to guarantee the risk of cross infection is always minimised.

If the patient has diarrhoea and/or vomiting the D&V Protocol should be followed in liaison with the Infection Control team regarding other communicable infections.

In the event of an outbreak of infection in the transferring ward/hospital the Infection Control team will liaise with the relevant managers to ensure the timely transfer of patients while minimising the risk of infection to others.

All elective will be screened for MRSA according to the MRSA policy.

8.9 Patients Medically Unfit for Treatment

Short term illness approx. 4 weeks – If the patient is deemed unfit with a minor acute short-term illness, such as a chest infection, UTI, cough or cold the RTT clock will continue while the patient is given time to recover.

Long term illness - If the patient is found to be unfit for surgery, a clinical decision must be made and communicated to the administrators whether the patient is to be active monitored (clock stopped) or returned to the care of the original referrer. Re-referrals will then be made when the patient is fit to continue.

Patients on an elective waiting list identified as not fit for surgery, must be removed from the list. If the patient is removed but requires a further appointment in an outpatient setting the RTT clock must continue until the appointment has taken place and the next steps are agreed.

8.10 IP/DC Did Not Attend (DNA)

As with outpatients' appointments, patients (except for safeguarding issues for children, vulnerable adults, and dialysis patients) will be clinically reviewed and a decision made to offer another appointment or discharge back to the referrer.

Clinically urgent patients (safeguarding issues for children and identified vulnerable adults/groups) will be clinically reviewed and a decision made to offer another appointment or discharge back to the referrer.

8.11 IP/DC Patient Cancellations/Re-arrangements Routine

A patient may find that once they have agreed a TCI (to come in) date it becomes inconvenient for personal or social reasons. This should be recorded in PAS as a patient cancellation and if there is capacity, rebooked.

If a routine patient cancels their admission on 2 consecutive occasions, the clinician will be informed to undertake a clinical review and if appropriate they will be discharge back to the care of the referrer. The clinician will be responsible for ensuring a letter is sent to the patient and referrer to confirm this decision and outline the need for a re-referral if necessary.

Alternatively, if a patient is choosing to delay treatment or will be unavailable for an extended period, following a clinical conversation the decision may be to place the patient on a period of agreed active monitoring. When the patient becomes available, they will be reinstated on the waiting list at the point they were previously removed.

If an IP/DC patient contacts to decline any treatment and is requesting to be removed from the waiting list the decision to discharge must be a clinical one, the clinician should be informed of the patient request and a letter must be sent. Whether this is a standard letter or dictated letter will depend on the information that needs to go to the patient &

their original referrer, where appropriate an agreement with the clinicians must be in place. If the patient declines surgery but the next steps are unclear you would need a clinical review and the RTT pathway should not be closed by the administrator. We would need to check why the patient has declined – is it that their condition has resolved or been treated elsewhere in which case discharge may be appropriate, or do they want to discuss their condition & alternatives to surgery with their clinician. In this case the patient can be removed from the admitted waiting list, but their RTT clock continues a non-admitted pathway, and their next step (appointment or call with a clinician) should be arranged.

8.12 Cancellation of Surgery /Non-Invasive Diagnostic Procedures including those on the day

All patients who have operations cancelled on or after the day of admission (including the day of surgery) for a non-clinical reason have the right to be offered a new date for treatment within 28 days.

If a patient is rescheduled with 24 hours and remains an inpatient, this is classed as a postponement rather than a cancellation.

If a patient is offered a reasonable date within 28 days but prefers to be treated later this should not be recorded as a breach.

All patients who have their admission cancelled by Totally for any reason will be contacted by the organisation to rebook their admission ensuring that no waiting time is breached.

8.13 Patients Listed for Bilateral Procedures or More Than One Procedure

The listing of a patient for a bilateral procedure or more than one procedure must be in accordance with the following:

A bilateral procedure is one that is performed on both sides of the body at matching anatomical sites. Examples include cataract removal and hip or knee replacements.

Consultant led bilateral procedures are covered by RTT measurement with a separate clock for each procedure. The 18-week clock for the first consultant-led bilateral procedure will stop when the first procedure is carried out (or date of admission for the first procedure if it is an inpatient/day case procedure). When the patient becomes fit and ready for the second procedure, a new 18-week clock will start.

Patients waiting for a planned procedure as part of a course of treatment. This will include those waiting for appointments at specific intervals or tests as part of a screening programme.

9. Children and Young People

9.1 Parental/Guardian Responsibility

Only a person who legally has parental responsibility may agree to a child's treatment on their behalf other than clinicians acting in their best interests. Not all parents will legally have parental responsibility.

9.2 New routine outpatient appointments

Totally employees should ensure they have established who has Parental Responsibility (PR) to consent for treatment or care for anyone under the age of 18. For children under the age of 16 the person with PR will usually be one or both parents. However, when young people have reached their 16th birthday, they are able to give consent in the same way an adult can, and their consent must be sought for treatment or care. Parents still have PR until the age of 18 and can give consent if the 16/17-year-old patient was not able to due to lacking capacity for some reason. If the 16/17-year-old refuses to give consent the person with PR (usually the parent) cannot override their wishes. Children and young people who are looked after by their local authority can still give consent to their own treatment and care if over 16, for anyone under 16 PR is usually shared between a parent and the local authority or in some cases lies solely with the local authority. The local authority must provide written consent signed by a manager if PR is not shared with a parent. Children under 16 who are deemed Gillick/Frazer competent can give their own consent regardless of whether they are cared for by their local authority or living with a parent.

9.3 Was Not Brought (WNB)

Children are usually recorded as Did Not Attend (DNA) when they Were Not Brought (WNB) to hospital appointments. Children do not usually choose "not to attend" appointments themselves as they are mostly reliant on the adult responsible for their care, usually a parent/guardian.

As they cannot be held responsible for attending the appointment the following processes should be followed once a clinical review has taken place and a decision has been made.

- The referrer must be informed following every WNB by letter.
- Check we hold the correct demographics.

10. Vulnerable Patients and Inequalities in Heath Care

10.1 Vulnerable Groups and Special Requirements

- BIM Best Interest Meeting

The person determining best interests must not make assumptions about someone's best interests merely based on their age, appearance, condition, or an aspect of their behaviour. If a person has no-one who can be consulted on their behalf (other than paid workers), an independent mental capacity advocate (IMCA) must be consulted. Mental capacity assessments (and reasons / rationale behind them) should be recorded on the standard form. This completed form must then be filed in the patients' medical notes.

- IMCA Independent Mental Capacity Advocate

  If we are caring for a patient who lacks capacity, has no family or friends to speak up for them or advocate on their behalf, and we are making serious medical treatment decisions or decisions about where they will live, then we must make a referral to the appropriate IMCA service attached to the hospital they are in at the time.

- Military/War Veterans

  The term 'military veteran' refers to anyone who has served in the armed forces for at least 1 day and has received an in-service injury that requires ongoing care. Such patients should receive priority access to NHS care for any conditions which are related to their service, subject to the clinical needs of all patients.

  The referral should state if this applies, so Totally can ensure it meets the current guidance for priority service over other patients with the same level of clinical need. Patients with more urgent clinical needs will continue to receive clinical priority.

  We can record a veteran in patient centre in patient needs under the code AFVET – Armed forces vetera.

  Veterans, service leavers, and non-mobilised reservists - NHS (www.nhs.uk).

- Disabilities or Communication Needs

Totally is committed to providing, wherever possible, a booking system to support the requirements of individuals with disabilities or communication needs. We will continually work towards ensuring that individuals requiring adjustments are not disadvantaged by this policy. The referral is received via e-RS and should provide details of any adjustments/requirements which are recorded in the patient's profile on the Summary Care Record (SCR/Spine). These adjustments/ requirements must be transferred into the Patient Needs section on patient centre.

- Religious / Ethnicity

Totally is committed to providing, wherever possible, a flexible booking system to support the ethnic/ religious requirements of service users. We will continually work towards ensuring that individuals are not disadvantaged by this policy due to their ethnic/religious requirements. All ethnicities should be recorded in patient demographics

- Interpreter

Totally acknowledges that patients can face barriers that impact on accessing and effectively using health services, depending on their individual communication needs. As an organisation we are committed to reducing the barriers patients may experience and providing support to overcome those that do exist.

Totally policy is that relatives and friends cannot interpret for patients. If there is a communication barrier and you require an interpreter (including BSL (BRITISH SIGN LANGUAGE) or other sensory requirements), or a written translation then please request this using the Interpretation & Translation's online system with as much notice as possible (min 3 days) before the appointment.

Where a patient requires an interpreter for referral received via e-RS this information should be added so it is visible in the additional requirement worklist. This will be monitored and added to the patient needs field in patient centre. For paper referrals (tertiary referrals) this must be highlighted at the top of a referral and must clearly state the exact type of interpreter required.

- Prisoners

All elective standards and rules are applicable to prisoners however, all hospital appointments will need to be managed alongside the prison regimes and letters should be addressed to the Prisons Healthcare department in a windowless envelope for reasons of patient confidentiality. Totally must work with prison staff to minimise delays through clear and regular communication channels and by offering a choice of appointment or admission date in line with reasonable notice criteria.

11. RTT Rules Suite

11.1 NHS Constitution

Since 1st April 2010, NHS Constitution states patients have the right to access services within the maximum waiting times, or for the provider to have taken all reasonable steps to offer a range of alternative providers if this is not possible.

This includes:

- An 18-week time target from a referral to a consultant led service to the start of their first definitive treatment for non-urgent conditions.
- A two-week time target from referral to seeing a specialist for those who have suspected cancer or, where this is not possible, for the NHS to take all reasonable steps to offer the patient a quicker appointment at a range of alternative providers if the patient makes such a request.

The right does not apply to:

- Patients who are not on an 18-week RTT pathway
- Patients who are registered with a GP in Northern Ireland, Scotland, or Wales. This policy only applies to England and the right applies to patients referred to a service commissioned by an English Clinical Commissioning Group or NHS England
- Patients who do not attend an agreed first appointment, or rearranged appointment, without giving prior notice if the date of the original appointment offered was reasonable
- Patients who refuse treatment. The reasons for the refusal of treatment by the patient, or someone acting lawfully on their behalf, should be recorded.
- Patients for whom it is not clinically appropriate to start treatment within 18 weeks. Examples include pregnant women
- Patients who do not require treatment following clinical assessment
- Patients who need to be referred to primary care services to receive treatment
- Patients who require active monitoring following a clinical assessment
- Patients who are placed on a national transplant waiting list following assessment
- Prisoners and people detained under the Mental Health Act are NOT excluded from the right

11.2 National Targets

Patients must be treated within national waiting time targets (see below). Failure to achieve these targets and thresholds will put the organisation at risk of breaching its terms of authorisation and will also risk financial penalties within the NHS standard agreed with its commissioner.

- Maximum waiting times from referral to start of treatment -18 weeks
- Maximum Waiting Times for Cancer

11.3 Local Targets

Locally agreed stages of treatment targets will be used for ALL patients (including those that are not on an RTT pathway

Totally will operate 3 clinical priorities for outpatients: Suspected cancer- Faster Diagnosis standard (FDS 14 days); Urgent (within 4 weeks); Routine (in turn, which routinely is 6 weeks). Appointments will be booked according to clinical priority.

All referrals will be added to Patient Centre within one working day of receipt

All referrals' letters will be clinically triaged with two working days

Any cancellation to clinics and theatre sessions for planned leave, including study leave, meetings, or clinic template changes with less than 6 weeks' notice will only be authorised in exceptional circumstances

11.4 National 18 Week Referral to Treatment (RTT) Guidance

Since March 2008, the concept of waiting times for the various stages of treatment (outpatient, diagnostic, and inpatient) was replaced by the18-week Referral to Treatment pathway (RTT). The RTT pathway encompasses the patient's journey from referral to first definitive treatment rather than measuring the time spent waiting at various stages of the pathway.

The 18-week standard applies to patients referred into a consultant led service with the intention that the patient will be treated either surgically or medically for the condition they have been referred in for.

There are several key principles:

- Patients should only be referred for consultant led services if they are fit, ready and willing to access services within a maximum of 18 weeks. The exception being overriding urgent pathways or if the patient chooses to wait longer
- Patients must receive information at each step of their pathway advising them of their responsibilities regarding following medical guidance and notification periods

- Where possible and clinically appropriate, surgical lists should be pooled. In these specialties, the patient will be informed by the clinical team at their outpatient appointment that they may be operated on by a different surgeon to the one they have seen in clinic
- The organization should ensure accurate and up to date information is collected about diagnostic, outpatient and inpatient services and recorded on the appropriate system in a timely manner, and in line with national information standards.
- All patients added to the waiting list should be given a priority of either Urgent or Routine by the referring clinician
- Patient Target Lists (PTLs) and the nine protected characteristics as defined within the Equality Act 2010 will be used to support equity for non-clinically urgent patients and delivery of the Access standards

- The organisation should ensure effective two-way communication with patients and GP's
- They should also ensure robust communication between Managers, Administrative Staff and Clinicians
- Where the current capacity available in a service is not adequate to meet the volume of patients referred or in a follow up, planned or surveillance status within the pre-agreed timescales, the Service Team Managers together with Divisional Managing Directors will take action to ensure all patients are treated in accordance with their agreed treatment plan

11.5 Clock starts

An 18-week clock starts when any care professional or service make a referral to:

- 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 healthcare professional or GP.

or

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

NOTE: Referrals to a consultant led service, undertaken by Nurse Specialists/Allied Health Professionals on behalf of a consultant are included in the 18-week pathway.

All aspects of the patient pathway must be concluded within 18 weeks including investigations and diagnostics. This may also include non-consultant led services if the patient is remaining under the care of a consultant, and this is part of the patient's 18-week pathway.

11.6 Consultant to Consultant Internal Referral clock starts.

Internal consultant to consultant referrals for the same condition will not begin a new RTT clock, however when a patient is referred internally from consultant to consultant, due to a new condition being found from an "incidental finding" a new RTT pathway and clock will begin. The clock start date will be the date the decision is made to refer (date of dictation) and not the date of receipt into the receiving service. It is possible for patients to have more than 1 pathway open simultaneously for the same speciality but different conditions.

The "clock" stops at the point at which the patient receives their first definitive treatment, or a clinical decision is made that treatment is not required.

11.7 Tertiary Referrals

Tertiary referrals must be sent/received with an IPTMDS form advising the service provider of the clock start date. The information must be transferred from the IPTMDS form onto patient centre so that the patients RTT pathway is recorded accurately.

11.8 Clock stops

- First definitive treatment - the clock stops on the date that the patient receives the first definitive treatment intended to manage his or her condition without further intervention.
- For inpatient or day case admission, the clock stops on the day of admission (ensuring first definitive treatment is given, and the procedure is not cancelled for any non-clinical reason). For treatment provided in an outpatient setting, the clock stops on the day the patient attends.
- Clinical decision that treatment is not required - the clock stops on the date that the clinical decision is communicated to the patient.
- Patient choice to decline treatment - the clock stops on the date that the patient declines treatment having been offered it.
- Active monitoring - the clock stops on the date that the clinical decision to commence active monitoring is made and is communicated to the patient.
- Decision to return the patient to primary care for non-medical/surgical consultant-led treatment in primary care. The clock stops on the date that this is communicated to the patient.

11.9 Clock restarts following the previous completion of an RTT pathway

a) When a patient becomes fit and ready for the second of a consultant-led bilateral procedure
b) Upon a decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan
c) Upon a patient being re-referred into a consultant-led service as a new referral
d) When a decision to treat is made following a period of active monitoring
e) When a patient rebooks their appointment following a new appointment DNA that stopped and nullified their earlier RTT clock (see section 5.1.11)
f) When a patient is referred on internally on a pathway that already has a stopped clock

11.10 Active Monitoring

Active Monitoring may apply at any point in the patient's pathway, but only after a decision to treat has been made.

Reasons why patients may be placed on a period of hospital initiated active monitoring:

- When the most clinically appropriate option is to delay, rather than undergo any further tests, treatments, or other clinical interventions at that time.

- When a patient wishes to delay treatment at their current provider and declines 2 offers of treatment dates with reasonable notice, following a clinical conversation and agreement with the patient the hospital may decide to commence a period of active monitoring.
- When a patient declines 2 reasonable offers for earlier treatment dates at an alternative provider the hospital may decide to commence a period of active monitoring, following a clinical conversation and agreement with the patient.

When a decision to commence a period of active monitoring is made and communicated with the patient, then this stops a patient's 18-week clock.

Any instances where the clinical reason for a delay or the patient is choosing to delay that means that the patient waits over 18 weeks would constitute a clinical exception to 18 weeks and would be reflected in the 8% tolerance.

Patients may also initiate the start of a period of active monitoring themselves by choosing to decline treatment or see how they cope with their symptoms. When a patient decides to delay there should be clinical oversight and steps should be taken to ensure that the patient is fully aware of the clinical implications of the delay.

It may not be appropriate to apply active monitoring if the patient is requesting thinking time (e.g. A period of 3 weeks) and wants to delay the next stage of their pathway for a short time. However, if a longer period is agreed the patient should be advised of the process to follow should they wish to go ahead with treatment. The RTT clock will be stopped for active monitoring and once the patient wishes to go ahead with their treatment a new RTT clock will start when they are reinstated on the waiting list.

NOTE: A new proforma must be submitted by the clinician for the patient to be reinstated. The original proforma must not be used.

11.11 How to apply the national waiting time rules locally.

There are very few national waiting time rules and models of service provision vary across the country, each patient will be different. It is for the NHS locally to decide how these rules are applied to individual patients, pathways, and specialties, based on clinical judgement and in consultation with other NHS staff and patients.

The following guidance is intended to support the NHS on how to apply the national waiting times rules locally. It outlines the principles that underpin the national waiting times rules, provides explanation of and rationale behind the rules, and gives worked examples of how they may be applied locally.

Patients' experience of the NHS can be improved by ensuring they receive high quality care, in the right place, and minimising the time they wait for treatment and care. The

underlying principle in relation to consultant-led waiting times is that patients should receive high quality care without unnecessary delay.

In most cases, it will be clear how the rules should apply. However, where there is doubt, or where decisions on their application are balanced, then local decisions should be made within the framework of national rules and in line with what is in the best clinical interests of the patient and considering how the patient would perceive their waiting time.

For example: recording a decision to refer the patient back to primary care as a decision not to treat where a patient wishes to spend a few days thinking about their treatment options would not be likely to make clinical sense, nor would it make sense from the patient's perspective to stop their 18 week clock, only for a new one to start days later when they have to ask their original referrer to refer them back in. It might, however, be appropriate both clinically and from a patient's perspective to stop a waiting time clock and return to primary care where a patient asks to think about their options for several months to see how they cope with their symptoms over that period.

In summary, national waiting time rules provide a framework within which the NHS has the autonomy to make sensible, clinically sound decisions about how to apply them, in a way that is consistent with how patients experience or perceive their wait. They also ensure that waiting times are recorded and reported consistently across the NHS in England.

11.12 Referral types that do not start an RTT Pathway

- Allied Healthcare Professionals (e.g., Physiotherapy)
- Healthcare Science or Mental Health Services that are not medical or surgical consultant-led (including multi-disciplinary teams and community teams run by Mental Health Trusts) irrespective of setting.
- Direct Access Diagnostics – the patient is referred for a diagnostic and on receiving the results the referrer makes the decision whether to refer the patient on to secondary care. The onward referral would start an RTT pathway, the original diagnostic referral does not start an 18-week clock.
- Primary Care Dental Services provided by dental students in hospital settings.
- Private patients or patients under the care of a non-English commissioner
- Patients admitted as emergency admissions e.g., A&E
- Fracture Clinics
- Obstetrics/Maternity patients
- Elective patients undergoing planned procedures (e.g. check cystoscopies, surveillance endoscopies, limb lengthening procedures etc.)
- Routine dialysis patients

11.13 Activity which is not part of an 18-week RTT pathway.

Many patients continue to have ongoing treatment after their first initial treatment, sometimes for many years for the same chronic condition. 18 weeks (127 days) only applies to the time immediately following referral to the first definitive treatment, or from any new clock being started later in a patient's pathway to treatment being given.

11.14 When to re start an RTT pathway clock.

When a patient has previously received their first definitive treatment and a substantial different or new treatment is required for the patient, this will start a new RTT pathway clock at the date the decision was made for the new treatment.

11.15 Waiting list management.

Waiting lists must be monitored via appropriate governance within the care organisations. Regular patient tracking lists (PTL) meetings are expected to monitor all patient waiting lists, including:

- Referrals awaiting specialist advice
- Referrals waiting clinical triage
- Wait time to first appointment
- Follow up waiting lists
- Planned waiting lists
- Long wait management

The responsibility of who manages waiting lists will vary across services, each service is accountable for ensuring clear communication lines are in place with booking functions across Totally.

11.16 National Validation Guidance

The validation process is a three staged approach, which includes technical, administrative, and clinical validation.

- Technical validation uses data quality checks to highlight potential pathway recording errors.
- Administrative validation should be targeted and completed to ensure the correct waiting list category status. This can be carried out by multiple communication methods including text message, letter, or telephone to clarify that the patient still requires the appointment.
- Clinical validation is to identify suitability for an alternative provider and appropriate use of virtual consultations. A review that requires a clinical decision to identify a plan for next steps

12. Standards and Principles

12.1 Entitlement to NHS Treatment

Patients are eligible for free NHS treatment within Totally if they are either:

- Ordinarily a resident in the UK or,
- An Overseas visitor entitled to free NHS services under the National Health Service (Charges to Overseas Visitors) Regulations.

12.2 Patients Requiring NHS ICB Approval (Prior Approval)

Procedures not commissioned should not be carried out by providers and will not be paid for unless prior approval via an Individual Funding Request (IFR) has been agreed. The Greater Manchester Shared Services will respond to all prior approval requests within 90 operational days for non-urgent IFRs, although urgent requests will be prioritised.

For funding requests where the service is commissioned by NHS England, their IFR team will respond to all funding requests within 30 working days for routine procedures and 20 working days for urgent procedures. The IFR team will endeavour to prioritise urgent requests proportionately to their degree of urgency. The RTT pathway will stay open, and the clock will continue to tick while awaiting funding approval.

All elective activity for Scottish patients requires prior approval from the respective Scottish Board.

Treatment must not commence until the provider has received written notice of funding approval.

12.3 Low Priority Procedure (LPP) / Effective Use of Resources (EUR)

A Low Priority Procedure (LPP) is a medical procedure which is considered as not providing effective treatment and/or sufficient long-term benefits.

An LPP is either:

- a procedure which is clinically effective but only when a person meets certain criteria.
- a procedure which is potentially clinically effective but only when other alternatives, where available, have been tried first
- a procedure where not funding the treatment will not result in a significantly adverse effect on the patient's physical or mental health

12.4 Notification and recording of patient deaths.

These procedures relate to all registered patients and reflect current death notification practice. They will be reviewed as soon as automatic electronic notification is implemented and/or the implementation of new information systems across the organisation.

Up to date and accurate electronic systems will: -

- avoid information being sent to deceased patients and their families
- facilitate caseload management
- enable appropriate archiving of manual paper health records
- comply with General Data Protection Regulations
- comply with Information Governance requirements for the documentation of accurate and timely data.

Information relating to the death of a patient may become available to Totally from various sources. To ensure that the information is processed in an accurate and timely manner – the processes below apply.

It is the responsibility of all staff (including administrative, clinical/practitioners and support staff) to ensure that they maintain accurate and up to date information on both electronic and paper records systems.

13. Effective Communication with Patients

13.1 Patient Communication

- All patients regardless of booking method, will receive a letter either by post or digital, confirming the date, time, and location for their appointment.
- Where the clinics have the facility set up, all patients opted into the messaging service will receive a text reminder prior to their appointment reminding them of the date, time and location of their appointment and offering options to cancel.
- All patients that have a change to their appointment either by choice or hospital circumstance will be sent a letter to confirm.
- All patients regardless of the method of booking must be sent a letter confirming the date, time, and location of the appointment within 1 working day.
- For paper referrals the appointment should be booked with an appointment confirmation letter being sent within 5 working days of registration onto the PAS.
- For e-RS referrals a letter informing the patient of their referral must be sent within 1 working day of the booking/request being received.
- Where a patient has been discharged due to a DNA or patient cancellation, a letter informing the patient of this decision must be sent within 1 working day.
- During their time on the waiting list patients must be contacted regularly, if the wait expires the recommended wait time it is suggested that every 12 weeks contact should be made checking their preferences and access needs. This contact can be in

the form of text message, letter, or telephone to 'check in' with the patient whilst they are waiting.
- Patient can also access the while you wait NHS website for further support while awaiting treatment. While You Wait NHS | For Those Awaiting Treatment

13.2 Appointment Reminder Service

Totally offers an appointment text reminder service. Patients are automatically opted in and where clinics have the system set up a text reminder will be delivered 7 days prior to the scheduled appointment to the patient's mobile telephone in the form of an SMS message. A further reminder will be sent 48 hours prior to the appointment. Patients can also request for appointment letters to be sent by post.

The patients contact telephone number should be verified and kept up to date for the service to be effective in reducing the number of DNA's. The patient can also choose to opt out of the text messaging service, and this should be noted in the PAS.

14. Roles and Responsibilities

Patient Communication This section outlines the key responsibilities of key groups of staff within Totally in relation to this policy.

14.1 Totally's Chief Operating Officer will be responsible to the Board of Directors for ensuring the Patient Access policy is implemented and adhered to and will performance manage the implementation of the Policy.

14.2 Divisional Directors via their Service Management Teams will be responsible for ensuring all patients receive treatment within national and locally agreed targets, and that all staff adheres to the Patient Access Policy.

14.3 Service Management Teams will be responsible for ensuring all staff within their area of responsibility are aware of the access policy and how it should be implemented within their individual roles. They will be responsible for monitoring the following in line with the agreed terms of reference (TOR):

- cancelled operations / clinics
- waiting times targets
- planned waiting list
- application of the organisational annual leave policy
- completion of clinic outcome forms

14.4 Consultants and Clinical Teams

Clinicians are responsible for:

- Deciding which patients require adding to a waiting list and their clinical priority
- For the accurate and timely recording of the patient consultation outcome, via the online e- Outcome system.
- Effectively managing their waiting lists and patient waiting times in accordance with the maximum wait time guaranteed waiting times (joint responsibility with Directorate Service team)
- Ensuring patients are not listed unless medically fit and ready for their procedure
- Providing timely clinical judgement on further management of patients including following DNA or multiple patient cancellations in out-patients - this should be undertaken at the end of the clinic session. Careful consideration should be given to adults and children where there are concerns, they may be at risk of harm or where their non-attendance is sudden and/or out of character.
- Ongoing clinical review of patients that are waiting treatment or diagnosis, that have exceeded their waiting time.
- Reviewing E-referrals within two working days of receipt of the referral. During periods of leave, another clinical colleague should be asked to review referrals to prevent delays to patients.
- Provide at least six weeks' notice before the date for commencement of the leave period (i.e. planned study leave and meetings).

14.5 Patient/Service Management teams - Will be responsible for maintaining the Directory of Services (DoS) and ensuring outpatient referral processes are reviewed in line with the evolvement of E-Referral System.

14.6 OP/IP Coordinators/Medical Secretaries/Patient Administrators - Will be responsible for adding and the administration of patients to the OP/IP/DC/Diagnostic waiting list(s) as appropriate to their role.

14.7 Medical Secretaries/ Administrators must ensure all patients and referrer correspondence is typed and dispatched within 7 days of the patient event.

14.8 Medical Secretaries/Administrators must complete a minimum data set (MDS) on an Inter Provider Transfer (IPT) form for all patients being referred either internally or to another provider.

15. Monitoring Document Effectiveness

The aim of the Patient Access Policy is to improve access to services for patients. It is essential that performance against the standards within the manual are monitored and improved upon to protect patients' access to Totally services.

The Patient Access Policy is circulated and is available to all clinical and non-clinical staff in the involvement of pathway management. Training of the policy is provided in the induction process and is a continued ongoing review process. The Patient Access Policies and accompanying Standard Operating Procedures will be reviewed every year to take account of

any changes in national guidance / new directives. Necessary changes throughout the year will be issued as amendments to the Policy.

Such amendments will be clearly identifiable to the section to which they refer, and the date issued.

15.1 Training & Communication

All staff including medical and clinical staff must have appropriate training regarding RTT rules and their responsibilities as set out in the Patient Access Policy. All staff who use hospital information systems must have training and be competent before they receive access.

16. Abbreviations and Definitions

Active Waiting List	Patients awaiting elective admission for treatment and are currently available to be called for admission.
Active Monitoring	A waiting time clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage. A waiting time clock may also be stopped where it is clinically appropriate to start a period of active monitoring if a patient declines 2 reasonable treatment date offers at current or alternative providers.
Admitted Pathway	A pathway that ends in a clock stop for admission for treatment (day case or inpatient).
AFB	Appointments for booking
ASI	Appointment slot issues
CAS	Clinical assessment service
CWT	Cancer Waiting Time
CAN Could Not Attend	Patients who notify the hospital that they are unable to attend a previously agreed appointment regardless of notice period.
DC Day Cases	Patients who require admission to the hospital for treatment and will need the use of a bed/trolley/recliner but who are not intended to stay in hospital overnight.

Decision to Treat	Where a clinical decision is taken to treat the patient. This could be treatment as an IP or DC, but can also include treatments performed in other setting e.g., Outpatient clinics
DOH Department of Health	The Department of Health works to improve the quality and convenience of care provided by the NHS and social services.
DNA Did Not Attend	Patients, who have been informed or agreed their admission date (inpatients/day cases) or appointment date (outpatients) and who, without notifying the hospital, did not attend for admission/OP appointment.
DOS	Directory of Services
DTA	Decision to admit
Elective Admissions	Where a decision to admit a patient for treatment is made that is not an emergency. The patient will be placed on an elective admission waiting list.
E-Referral System	Electronic system by which GPs can refer patients directly to a service and can either book the appointment with the patient or the patient can book at their own convenience via Health space on the Internet or the National Telephone appointment line.
FDS	Faster Diagnosis Standard, a maximum 28-day target from referral to diagnosis of cancer
First definitive Treatment	An intervention intended to manage patient's disease, condition or injury and avoid further intervention. First definitive treatment is a matter of clinical judgement
Fully Booking	Patients awaiting an elective admission/appointment who have been given an opportunity to agree an appointment/admission date over the telephone following an outbound calling. These patients form part of the active waiting list. This process should be used with all patients booking, where possible.
Hospital cancellation	A cancellation of admission by the hospital
IBS Independent Booking Service	A telephone appointments service that makes the link between the referral sent using the E-Referral System but there is no IT interface with the provider units booking system.

ICB Integrated Care Board	Statutory NHS organisation which is responsible for developing plans for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in a geographical area.
IFR	Independent Funding Requests
IPT	Inter Provider Transfer
MDT	Multiple Disciplinary Team
MDS	Minimum Data Set
Mutual Aid	Shared capacity with other providers to support elective recovery
Non-Consultant led	Where a consultant does not take overall clinical responsibility for the service.
NCEPOD	National Confidential Enquiry into Patient Outcome & Death.
Outpatients (OP)	Patients referred by a general practitioner or another clinical professional i.e. another Consultant/Dental Practitioner for clinical advice or treatment not requiring admission.
OWL's	Outpatient Waiting Lists
Partial Booking	Where admission/appointment will be provisionally booked but not fully confirmed with the patient. A minimum of 3 weeks' notice must be given of the expected due date.
IFU	Patient Initiated Follow Up
PTL/Patient Tracking List/Pivot	A list of all patients whose treatment needs to be planned to meet target wait times.
Primary	Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS
RAS	Referral Assessment Service
Secondary	Secondary care services provided by medical specialists who do not have first contact with the patient
Tertiary	A level above secondary care defined as highly specialised medical care by medical specialists
TCI	To come in, the date of a patient's admission to hospital

Tolerance	The tolerance of 8% considers breaches in patient care for clinical exceptions and patient-initiated delays. Leaving a standard for compliance of 92%
UBRN	Unique Booking Reference Number
Unfit For Surgery	A list of patients awaiting elective admission who are currently unsuitable for admission due to some underlying medical reason

17. References

Department of Health (2004) A code of conduct for private practice: recommended standards of practice for NHS consultants
https://www.nhsemployers.org/~/media/Employers/Documents/Pay%20and%20reward/DH_085
195.pdf

E referral service
NHS e-Referral Service - NHS Digital
RTT Pathways
NHS England » Referral to treatment
Patients' Rights
The NHS Constitution for England - GOV.UK (www.gov.uk)

18. Equality Impact Assessment Tool (EqiA)

- The below tool must be completed at the start of any new or existing policy, procedure, or guideline development or review. For ease, all documents will be referred to as 'policy.' The EqIA should be used to inform the design of the new policy and reviewed right up until the policy is approved and not completed simply as an audit of the final policy itself.
- All sections of the tool will expand as required.
- EqIAs must be sent for review prior to the policy being sent to committee for approval. Any changes made at committee after an EqIA has been signed off must result in the EqIA being updated to reflect these changes. Policies will not be published without a completed and quality reviewed EqIA.

Part 1: Possible Negative Impacts

Protected Characteristic	Possible Impact	Action/Mitigation
Age	None	

Disability	Communication	Different Communication Techniques/Hospital Book If a patient presents themselves with a learning difficulty an assessment should be carried out so that there is a good understanding of their treatment Involve carers
Ethnicity	Language Barrier	Access to interpreter services
Gender	None	
Marriage/Civil Partnership	None	
Pregnancy/Maternity	None	
Religion & Belief	Reassurance and advice	
Sexual Orientation	None	
Trans	Inclusivity	Correct use of pronouns

Part 2: Possible Opportunity for Positive Impacts

Protected Characteristic	Possible Impact	Action/Mitigation
Age	Changes stated in section 5 of the policy benefit all patient groups	
Disability		
Ethnicity		
Gender		
Marriage/Civil Partnership		
Pregnancy/Maternity		
Religion & Belief		
Sexual Orientation		
Trans		

Other Under Served Communities (Including Carers, Low Income, Veterans)	

Part 3: Information Consulted and Evidence Base (Including any consultation)

Protected Characteristic	**Name of Source**	**Summary of Areas Covered**	**Web link/contact info**
Age	n/a		
Disability	n/a		
Ethnicity	n/a		
Gender	n/a		
Marriage/Civil Partnership	n/a		
Pregnancy/Maternity	n/a		
Religion & Belief	n/a		
Sexual Orientation	n/a		
Trans	n/a		
Other Under Served Communities (Including Carers, Low Income, Veterans)	None		

4. Have all the negative impacts you have considered been fully mitigated or resolved? *(If the answer is no, please explain how these do not constitute a breach of the Equality Act 2010 or the Human Rights Act 1998)*

5. Please explain how you have considered the duties under the accessible information standard if your document relates to patients?
As stated above in section 1

6. Equality Impact Assessment completed and signed off? *(Insert named lead from EDI Team below). Please also add this information to Section 10 Part 1.*
Name: Date: