# Patient Access Policy

This policy was formerly called the Referral to Treatment Access Policy.

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1. INTRODUCTION

1.1 Purpose
This Policy reflects the overall expectations of the Trust and local commissioners on the management of referrals, appointments and admissions into and within the organisation, and defines the principles on which the policy is based.

1.2 Scope
This policy covers all services within Harrogate & District NHS Foundation Trust that patients may be referred into as an elective (waiting list) patient. This includes hospital based and community based services.

This Policy is intended to be of interest to and used by all those individuals within the Trust or other partnership organisations, who are responsible for referring patients, managing referrals, adding to and maintaining waiting lists for the purpose of organising patient access to hospital treatment.

The policy is also made publically available via the Trust’s website: https://www.hdft.nhs.uk/patients/our-commitment/.

1.3 Principles
This policy highlights the key principles that govern effective and reliable referral and admission management throughout the local health community:

- The processes of referral, appointment and admission management will be transparent to the public and external organisations.

- The Trust will give priority to clinically urgent patients and treat everyone else in turn, according to the length of time they have been waiting since referral, at a time convenient to them and in line with current national waiting times standards.

- The Trust adheres to the principle that all waiting lists should be managed equitably with no preference shown on the basis of purchaser, source of referral or whether the patients are to be treated under the NHS or privately. Where possible the Trust will work with its health partners in developing equity of access across all provider sites in the health community.

- At any point on a patient pathway where the patient would have a choice of provider, the Trust will not provide or produce any publication material that may influence the patient’s choice or unfairly favour one provider over another. Patients requesting information on choice of provider should be referred to the NHS Choices website or their GP for further information.

- All referrals, additions and removals from the waiting list will be made in accordance with this policy.
• Accuracy and reliability of waiting list information is the responsibility of all staff in the local health community who are involved in referral, appointment and admission management or have access to the administration and upkeep of patient administration systems.

• Patients (and parents / carers) will receive clear explanations regarding proposed inpatient and day surgery treatment including benefits and potential risks. Agreement to proceed with treatment will take the form of written consent signed by the patient in accordance with the Trust's policy on informed consent.

• Patients (and parents / carers) will be made aware of their role in ensuring the Trust's waiting list processes are efficient and are expected to attend appointments (or notify the Trust in advance if they are unable to attend) and to keep the Trust informed of changes to personal circumstances.

• The Trust will ensure that all patients requiring treatment by the Trust will be treated within national waiting time standards.

• Patient information will be provided, in the appropriate format, to patients explaining the waiting list process, and in particular pointing out the potential consequences of not attending an appointment. This information will be shared when all appointments are agreed with the patient.

• All rules within this policy should be applied pragmatically. The consultant in charge of the patient’s care can request exceptions to the rules contained within this policy if it is in the clinical best interests of the patient. When in doubt, the spirit of the policy should be applied, which is to see all patients in a timely manner, clinically urgent patients first and all other patients in turn.

1.4 Serving personnel, their families and Veterans

• Serving personnel, their families and Veterans have specific requirements as set out by the National Armed Forces Covenant. Specifically, the Trust must fulfil the following commitments:

  • The Armed Forces Community¹ should enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in the area they live
  • Serving personnel and their families² should retain their relative position on any NHS waiting list if moved around the UK due to the Serving person being posted
  • Veterans³ should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need.

Further guidance of the covenant can be found at the following link https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/49470/the_armed_forces_covenant_today_and_tomorrow.pdf
Footnote: ¹ Serving personnel, their families and veterans  
²Families are defined as a member of immediate family living with the Serving person such as their spouse or children  
³Veterans are defined as any person who has served with the Army, Navy or RAF for at least one day and is no longer in active service

2. NATIONAL WAITING TIMES TARGETS AND GUIDANCE

The Trust is required to achieve the following nationally defined waiting times targets:

2.1 18 weeks Referral to Treatment (RTT)

Patients on a consultant led pathway should be treated within 18 weeks of initial referral, unless it is clinically inappropriate or the patient chooses to wait longer than 18 weeks. This is also referred to as the “Referral to Treatment” (RTT) standard.

Consultant-led pathways are where a consultant retains overall clinical responsibility for the pathway. The pathway may include appointments and treatments provided by the service or team led by the consultant. The setting of the consultant-led appointment or treatment, whether hospital-based or community-based, does not affect the patient’s right to start treatment within 18 weeks.

The national RTT standards are:

- 92% of incomplete pathways to be within 18 weeks;
- No patient should wait longer than a maximum of 52 weeks.

2.2 Cancer waiting times standards

The following national waiting times standards apply to patients with confirmed or suspected cancer:

- Two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals;
- Maximum waiting time of 31 days from decision to treat to treatment for all cancers;
- Maximum waiting time of 62 days from urgent referral to treatment for all cancers;
- Maximum waiting time of 38 days from urgent referral to tertiary referral for all urgent suspected cancer referrals.

Appendix 1 provides further information on each cancer waiting times target.

While nationally the current target is for a two week maximum wait, there is a local cancer network aim for patients to be seen within one week of GP referral to ensure better compliance with the 62 day target.
Patients who need to transfer to Leeds or other hospitals should be referred over as soon as possible and by no later than day 38 of the pathway.

In addition, the following national waiting times standards applies to patients referred in with breast symptoms (cancer not initially suspected):

- Two-week maximum wait from urgent GP referral to first outpatient appointment for patients with breast symptoms.

The MDT (multi-disciplinary team) co-ordinators monitor or track all patients on a cancer pathway. All members of the MDTs as well as the directorate managers should work to ensure that patients move smoothly and in a timely manner along their pathway. Monthly cancer waiting times breach analysis meetings will occur with representation from these areas to ensure that challenges are addressed and continual improvement is achieved.

### 2.2.1 Process for Stepping a Patient down from a cancer pathway

A patient is removed from the 62 day cancer pathway following:

- A benign diagnosis
- Downgraded referral (patient referred in as a 2ww and following discussion between the consultant and GP, the GPs agrees to the patient being downgraded)
- Patient dies before treatment
- No suspicion of malignancy following clinic review and/or investigations
- Patient declines offered diagnostic or therapeutic intervention
- First definitive treatment given
- Start of a period of active monitoring/watchful waiting

If the Patient Pathway Co-ordinator is in any doubt as to whether a patient can be removed from the cancer pathway, they will discuss with the clinician to check whether the patient has been reassured they are not being investigated for cancer.

If a patient is stepped down from a 62 day cancer pathway, this does not affect their 18 weeks status.

### 2.3 Other national waiting times standards

The following national waiting times for specific patient groups also apply:

- Urgent referrals for patients with TIA (Transient Ischaemic Attack) should be seen and any treatment started within 24 hours;
- All diagnostic tests to be carried out within 6 weeks of referral for the test;
- Patients referred to the Rapid Access Chest Pain Service should be seen within two weeks of referral.
2.4 Locally defined waiting times standards

In addition, the Trust has defined the following local waiting times standards to support the delivery of the national 18 week standard:

- First outpatient appointments within 4 weeks 6 days of referral;
- Elective (waiting list) admissions within 9 weeks 6 days of a decision to treat.

2.5 The NHS Constitution

The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

The NHS Constitution states that patients have the right to access certain services commissioned by NHS bodies within maximum waiting times. Where this is not possible, the NHS should take all reasonable steps to offer a range of suitable alternative providers. This promise was made a legal right by NHS England and Clinical Commissioning Groups (CCGs) in the responsibilities and standing rules regulations 2012.

It is therefore now a legal right for patients to start their NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate that they wait longer.

If the patient cannot be seen within the maximum waiting time, the NHS Constitution states that the patient may contact the commissioner who is funding the treatment (CCGs or NHS England). In these circumstances, the commissioner must investigate and offer the patient a range of suitable alternative hospitals or community clinics that would be able to see or treat the patient more quickly.

For more information on the NHS Constitution, please click on the link below: http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

2.6 18 weeks clock rules and definitions

There are specific nationally defined waiting times rules for patients on an 18 week pathway. Where these are referenced within this policy, a clock symbol will appear at the beginning of the section and text will be shown in italics.

It is the responsibility of all members of staff to understand the 18 Week principles and definitions. They must be applied to all aspects of individual specialty pathways, and referrals and waiting times will be managed and measured accordingly.
2.6.1 Start of the 18 Week pathway

An 18 week clock starts when any health care professional or service permitted by the CCG to make such referrals, refers 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 health professional or general practitioner;

- 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;

An 18 week clock also starts upon a self referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a health care professional.

Upon completion of an 18 week referral to treatment period, a new 18 week clock only starts:

- Upon the decision to start a substantively new or different treatment that does not already form part of that patient’s agreed care plan
- When a patient requiring a bilateral operation (e.g. cataract removals) becomes fit and ready for the second consultant – led procedure
- Upon a patient being re-referred to a consultant – led service; interface; or referral management or assessment service as a new referral
- When a decision to treat is made following a period of active monitoring.
- When a patient rebooks their appointment following a first appointment DNA

The e Referral System (eRS) will be the primary referral method. The start of the RTT period is the date of conversion of the Unique Booking Reference Number (UBRN). This may be in the clinician’s practice, through eRS Telephone Appointments Line (TAL) or via the internet. (If the patient is referred via TAL, the clock will start on the date that the patient appears on the Appointment Slot Issue (ASI) work page within eRS).

Where eRS is not in place, the 18 week clock starts at the point at which the provider receives the referral letter.

Consultant to consultant referrals for conditions not related to the original referral should usually be made via the patient’s GP. At the point where a consultant makes the decision to refer an existing patient onto another consultant within the Trust or to another service provider, the consultant will notify the GP in line with this policy.

Any such referral would start a new patient pathway with a new 18 week pathway clock. The original 18 week pathway will continue concurrently until the patient is discharged or treated by the original consultant.
Consultant to Consultant referrals for patients with the same underlying condition will be included within the 18 week pathway, with the wait continuing from the original referral. For example, a patient referred to neurology with pins and needles is found to have carpal tunnel syndrome and is referred to orthopaedics for treatment.

2.6.2 End of the 18 Week pathway

A Clock will stop for treatment when first definitive treatment starts. This could be:

- Treatment provided by an interface service; (e.g. MSK Service)
- Treatment provided by a consultant-led service
- Therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led service decides is the best way to manage the patient’s disease, condition or injury
- A clinical decision is made and has been communicated to the patient, and their GP (or other referring practitioner) to add a patient to a transplant waiting list.

A Clock will stop for non-treatment when it is communicated to the patient and their GP (or other referring practitioner) that:

- It is clinically appropriate to return the patient to primary care for non-consultant-led treatment in primary care.
- A clinical decision is made to start a period of active monitoring
- A patient declines treatment after having been offered it
- A clinical decision is made not to treat
- A patient DNAs their first appointment following the initial referral that started their 18 week clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient.
- A patient DNAs any other appointment and is subsequently discharged back to the care of their GP, provided that:
  - The provider can demonstrate that the appointment was clearly communicated to the patient
  - Discharging the patient is not contrary to their best clinical interests
  - Discharging the patient is carried out according to local, publicly available policies on DNAs
  - These local policies are clearly defined and specifically protect the clinical interest of vulnerable patients (e.g. children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders.
- The death of a patient would also end the 18 week pathway.
3. WAITING TIMES GUIDANCE FOR APPOINTMENTS – INCLUDES OUTPATIENTS, DIAGNOSTIC, ALLIED HEALTH PROFESSIONAL AND COMMUNITY BASED SERVICES

The Trust will give priority to clinically urgent patients and treat everyone else in turn, according to the length of time they have been waiting since referral, at a time convenient to them and in line with current national waiting times standards.

3.1 Failure to attend first appointment (DNA)

Where a patient does not attend (DNA) their first new appointment the patient will not normally be offered another appointment, but will be removed from the waiting list and discharged back to the care of their GP/referrer. The patient and GP/referrer should be informed in writing of the reason for their removal by a letter sent from Medical Records(Appendix 3). As the patient has not yet been seen within the Trust, the consultant does not normally need to be made aware of this. The patient may be re-referred at the GP/referrer’s discretion. The Trust will take into account extenuating patient circumstances and act in the spirit of reasonableness when deciding whether to discharge back to the GP / referrer. This information should be recorded as free text on the PAS.

For 18 weeks pathways, patients who DNA their first new appointment nullify the RTT clock (i.e. the pathway is removed). Where patients are re-appointed following a DNA for a first new appointment, the original RTT clock is nullified and a new 18 week pathway starts with effect from the date the patient agrees the new appointment date.

Exceptions to the DNA discharge rules are:

- At risk babies/Children up to the age of 16 years (see section 3.3)
- Two week wait referrals (cancer referrals)
- Rapid access chest pain referrals
- TIA (Transient Ischaemic Attack) urgent referrals
- Further clinical exceptions as agreed at Directorate level

For urgent two week cancer referrals and rapid access referrals, the appointment should be re-booked within 14 days of the DNA. If an urgently referred patient subsequently DNA’s a second appointment, the consultant and the patient’s GP/referrer should be made aware of this so that options for ongoing management of the patient can be considered. For all other exceptions to the DNA discharge rule, the appointment should be booked again within 21 days of the DNA.

All patients should have the opportunity to negotiate their new appointment, and all verbally agreed appointments should also receive a confirmation letter, unless the patient has specifically stated that they do not require a confirmation letter.

If a patient does not attend a new appointment and a subsequent appointment is arranged, the calculation of the outpatient stage of treatment wait is made from the date of the DNA’d appointment, providing that reasonable notice has been adhered to.
3.2 Failure to attend follow up appointments (DNA)
Patients who fail to attend (DNA) their follow up appointment will not be offered a further appointment unless it is contrary to their best clinical interests – this will be the decision of the consultant. Medical records staff should notify the consultant’s secretary that the patient has DNA’d. If it is decided that the patient will be discharged back to their GP / referrer for subsequent management, a letter should be sent by the consultant’s secretary to the patient and their GP / referrer and their 18 Week Referral To Treatment clock will stop.

For patients who have their appointment re-booked, the 18 week clock continues to tick.

3.3 Children (under 16 years) failure to attend (DNA)
When children under the age of 16 fail to attend for a new or follow up appointment, their case should be reviewed by the consultant in charge of the clinic. A decision should be made as to whether another appointment is offered. If the child is known to have a child protection plan, the child’s social worker as well as the health visitor / school nurse must be notified by letter with a copy to the patient / carer / GP / referrer requesting further referral if necessary. Advice is available from the named doctor and the named nurse for child protection in the Trust.

Children with diabetes under the Paediatric Diabetes Team are not discharged from secondary care if they fail to attend appointments. Repeated DNAs will raise concerns of safeguarding and will follow the process described in the Operational Policy for the Harrogate Children’s Diabetes Multi-disciplinary Team, section 2.5.1.

3.4 Patients who re-schedule a first appointment
Patients who re-schedule / cancel their first appointment will be offered an alternative date at the time of cancellation within current waiting time guidelines. Any patients not available within 4 weeks 6 days of the first cancellation will be referred back to the GP / referrer.

If the patient cancels their first appointment twice, they should normally be removed from the outpatient waiting list and referred back to their GP/referrer for further management. The patient and GP/referrer should be informed in writing of the reason for their removal by a letter sent from Medical Records (Appendix 3). As the patient has not yet been seen within the Trust, the consultant does not normally need to be made aware of this. The patient may be re-referred at the GP / referrer’s discretion. Patients who cancel and re-book their new appointment via eRS will be monitored by the Trust. Any patient who cancels and re-books more than twice will be reviewed and where clinically appropriate discharged back to their GP / referrer who may re-refer at their own discretion.

If a patient cancels a new appointment, the RTT clock will continue to tick if the patient is being re-booked. The RTT clock will stop if the patient is referred back to their GP.
3.5 Patients who re-schedule a follow up appointment

Patients who cancel their follow up appointment will be offered an alternative date at the time of cancellation, this will be within current waiting time guidelines.

If the patient cancels their follow up appointment twice consecutively, they should normally be discharged and removed from the waiting list. This will be at the discretion of the consultant. Medical records staff should notify the consultant’s secretary that the patient has cancelled two or more consecutive appointments. If it is decided that the patient will be discharged back to their GP / other Referrer for subsequent management, these patients will be informed verbally by the consultant’s secretary and asked to contact their GP for further management. The patient may be re-referred at the GP’s discretion.

If a patient cancels and re-books a follow up appointment appropriately, the RTT clock continues.

3.6 Referral management

There are 3 main types of referral for a new outpatient appointment that the Trust will receive:

- Consultant named referrals – this is a referral to a named Consultant (i.e. Dear Mr. Smith) which include 2 week rule and tertiary referrals

- Generic referrals – this is often a referral to a specialty (i.e. Dear ENT Surgeon, Dear Doctor, Dear Podiatrist), which include 2 week rule and rapid access chest pain referrals and also referrals to services provided by a consultant-led multi-disciplinary team.

- Direct Access and straight to test referrals – this referral is directly to a service such as endoscopy.

If the Trust receives an inappropriate referral, (a referral that is outside of specific referral protocols (where they exist) or for a service that the Trust does not provide), these will be returned to the GP/referrer. If an inappropriate referral is received via the urgent cancer referral route, the referral should be discussed with the patient’s GP/referrer prior to rejection.

Referral letters should be treated as important confidential documents. Losing or unnecessarily delaying a referral can potentially put a patient at risk. In this eventuality, the Trust and / or individual members of staff may be considered to have failed in their duty of care.
The following guidance on the management of referrals must be adhered to:

- Referrals should only ever be in one of four locations; Medical Records, Consultant’s Office, within the patient’s health record on the respective hospital or community site, or the 18 Weeks RTT office if the referral is an Inter-Provider Transfer.

- Under no circumstances should a referral leave the organisation unless its removal has been noted and recorded by the Medical Records Team. Tracking of referral from receipt to outpatient appointment is essential to ensure this is managed.

- Copies should only be made if absolutely necessary and the copy clearly marked as such.

- Within offices robust filing procedures must be put in place to reduce the risk of misplacement and to comply with national guidance on data protection. For example referral letters should be kept in well-defined locations (e.g. marked trays).

- When it is necessary for referrals to be clinically graded by a consultant, the appointment clerk must hand deliver these to the relevant consultant. Patient referral letters must never be transferred via the internal mail or left on unattended desks.

3.7 Process of referrals

e Referral System (eRS)
1. GP records referral electronically
2. Provisional appointment made by GP, patient or Referral Support service, CSU.
3. Referral printed from eRS by Appointment Centre Team – Patient’s demographics checked, referral updated and provisional appointment recorded on referral within one working day or receipt.
4. Referral passed to Consultant for prioritising.
5. If Consultant accepts referral, patient is sent a letter to confirm appointment by Medical Records Team.
6. If the Consultant rejects the referral and an appropriate alternative consultant is available, the referral will be re-directed and appointed. Any inappropriate referrals will be returned to the GP. If an inappropriate referral is received via the urgent cancer referral route, the referral should be discussed with the patient’s GP/referrer prior to rejection.
7. If the clinician upgrades the referral to a suspected cancer, Medical Records must be notified that an appointment needs bringing forward and Medical Records must contact Information Services for the patient to be added to the cancer tracker. The patient should be seen within 2 weeks from the upgrade request.
8. If after onward transmission to clinicians for prioritisation referrals are not received back in Medical Records after 5 working days such breaches will be the subject of an exception report completed by the Team Leaders and forwarded to
the Outpatient Access Manager and the Operational Directorate Management Team.

Referrals received via the eRS Telephone Appointment Line (TAL)
1. Where patients are unable to electronically book an appointment through eRS because there are no appointment slots available online, the patient is added to the Telephone Appointment Line (TAL) list within eRS.
2. The TAL list is available to the Appointment Centre Team and is downloaded from eRS on a daily basis.
3. A letter is sent to the patient within 1 working day to say that the Trust has received notice of their referral and is aware that they are waiting for an appointment.
4. Patients from TAL are then booked (in chronological order) into appointment slots on eRS as they become available by the Appointment Centre Team. This should normally happen within 5 working days of the patient being added to TAL.
5. Once an appointment has been booked for the patient, the Appointment Centre Team will contact the patient to notify them and confirm that the appointment date and time is suitable.

GP referrals not received via eRS
Appointment Centre staff receive referrals and the following process should ensue:

1. Receipt by Safe Haven and stamped with ‘date received’
2. Referral registered and put on outpatient waiting list on PAS within one working day of receipt. Referral tracking initiated.
3. Referral passed to a named consultant to be prioritised.
4. Collected by Medical Records Team and priority entered on the iCS Outpatient Waiting List module (OWL).

If after onward transmission to clinicians for prioritisation referrals are not received back in Medical Records after 5 working days such breaches will be the subject of an exception report completed by the Team Leaders and forwarded to the Head of Patient Systems and Health Records.

Consultant to consultant referrals
Consultants will only refer directly to other consultants in urgent cases or for related conditions (e.g. a patient requiring cardiology input during a surgical procedure). Referrals for conditions not related to the original referral should be made via the patient’s GP / referrer. At the point where a consultant makes the decision to refer an existing patient onto another consultant within the Trust or to another service provider, the consultant will notify the GP in line with this policy.

3.8 Arranging appointments
Appointments will be made in one of three ways:

- Electronically via eRS with a provisional appointment
- Full booking
- Partial booking
Selection of patients for appointments must be in line with Royal College guidance. Therefore patients should be selected for appointments as follows:

- In order of clinical priority
- Patients with the same clinical priority to be selected in chronological order according to the length of time they have been waiting since their original referral;

This will mean the patients that consultants have prioritised as “urgent” must be seen first and in date order of their 18 week target date, then “routine” patients in date order of their 18 week target date.

It should be noted that some fixed appointments are made in certain specialities, however national guidance on reasonableness must be followed in issuing these appointments.

There may be some instances when a routine patient is seen ahead of an urgent patient to allow good utilisation of clinics (for example - if a routine patient is the only patient able to come at very short notice to fill a slot that has been cancelled by another patient) but the general principles detailed above should apply.

The consultant will prioritise each referral and will return the referral to Medical Records within the respective timescales for urgent and routine referrals. Within 1 working day of receipt of the prioritised referral the Medical Records Team will check the details of the patient on the Outpatient Waiting List (OWL) and amend the priority if required.

If the priority is urgent, the referral will be the responsibility of the relevant Medical Records Team. A member of the team will make an urgent appointment.

**3.9 Reasonableness of appointment offers**

National 18 weeks guidelines on reasonableness state “it is for local commissioners and providers to agree on reasonableness rules that make sense in the context of the way services are commissioned and provided”.

The Trust has previously agreed the following local definition of reasonableness for appointments with the local commissioner:

For an appointment offer (either written or verbal) to a patient to be deemed reasonable, the following should be followed:

- The patient is to be offered an appointment with a minimum of 5 days’ notice;

- An appointment with less than 5 days’ notice can be offered to a patient. However this offer is only deemed reasonable if the patient accepts it. If the appointment offer is rejected by the patient, then this will not affect the patient’s date on list.

Urgent referrals (e.g. for suspected cancer) need to be appointed as soon as possible and this is likely to mean that the patient is offered an appointment which
may not meet the above reasonable offer criteria. For such urgent referrals, two days’ notice would be deemed reasonable.

3.10 Booking appointments for urgent referrals
For urgent referrals not booked electronically via eRS, patients will be contacted by the Medical Records teams by telephone to agree an appointment date and time. If a patient cannot be contacted by telephone an appointment letter must be posted first class or hand delivered in order to arrive at the patient’s home address by the following day.

3.11 Booking appointments for non-urgent referrals
For non-urgent referrals not booked electronically via eRS, an appointment will be booked by the Medical Records Teams and a letter sent inviting the patient to the appointment.

- If a patient is unavailable for the appointment within 4 weeks 6 days, the clerk will discuss the referral with the consultant with a view to returning the referral under cover of a letter to their GP/referrer. In such circumstances, a letter would be sent to the GP/referrer and patient advising the GP/referrer to re-refer the patient when they are fit and able to attend the appointment. They will then be removed from the waiting list;

- There is no facility to suspend patients waiting for an outpatient appointment for medical or social reasons;

- Patients who accept an appointment at less than 5 days’ notice and then subsequently cancel are deemed to have self-deferred and their local stage of treatment waiting time should be calculated from the date of the cancelled appointment.

3.12 Clinic profiles
Clinic profiles set the type and number of slots available within each clinic and are crucial to determining the operational capacity of the service by identifying the ability of each clinic to see a certain number and type (e.g. new, follow up) of patients. They also govern the length of each type of appointment slot.

Clinical Directors and Operational Directors will have agreed annual activity levels by speciality and consultant / clinic manager. It will be their responsibility to ensure these are delivered. Clinical Directorate Management Teams will liaise with the Outpatient Access Manager and Medical Records Team Leaders to ensure that sufficient capacity is available to deliver agreed activity plans and Outpatient Waiting Time guarantees.

It is the responsibility of the Clinical Directorate Management Teams to ensure significant changes in clinic profiles are notified in writing to the Outpatient Access Manager and Medical Records Team Leaders at least 6 weeks before the proposed change. In relation to annual leave and any other reasons for significant changes to the profile, 6 weeks’ notice is also required. Consultants should not change the clinical profile unless there is good reason to do so.
3.13 Clinic cancellation / reduction

The only reason that clinics should be cancelled is due to the absence of clinical staff. This can be the result of planned annual leave, study leave, planned audit sessions or unplanned sickness absence.

In accordance with best practice, the following framework should be followed:

- Clinical Directorate Management Teams must be given a minimum of 6 weeks’ written notice of planned annual leave or study leave which identifies when a clinician requires a clinic to be cancelled or reduced;

- If the notice period is less than 6 weeks’ due to unplanned leave (e.g. sickness/bereavement etc.), all efforts should have been made by the respective medical team to cover the clinic to prevent/minimise cancellations;

- If this is not possible, the respective clinician must work with the appropriate Operational Director to ensure that those patients whose appointments will be cancelled, and where such action may jeopardise the Trust’s ability to treat them within the respective waiting time standards, are seen before the waiting time target is breached but within existing Trust resources. This is especially pertinent for patients who are identified as urgent referrals;

- When clinics have to be unavoidably cancelled, liaison with the Outpatient Access Manager, appropriate admissions and /or booking staff and the respective nursing staff is essential;

- When clinics are partially cancelled, patients with shorter waiting times since their original referral should be cancelled before patients with longer waiting times since their original referral;

- It is the responsibility of the medical records team leader to ensure that patients whose appointments are cancelled are re-booked with an appointment date within the relevant waiting time, subject to available capacity. If there is no available clinic capacity, the responsibility rests with the Clinical Directorate Management Teams;

- No patient will be issued with an appointment date that is in breach of a waiting time standard;

- There will be no changes to the start point of the calculation of a patients waiting time due to clinic cancellation;

- All clinic cancellation/changes must be reported to the Clinical Directorate Management Teams and the Outpatient Access Manager by the relevant medical records team leader on the date received.
3.14 Validation of waiting lists
Medical Records Team Leaders are responsible for validating their own waiting lists to ensure no new patient breaches the Trust’s waiting times standards. Any potential breaches must be reported to the Clinical Directorate Management Teams.

When removing a patient from the waiting list, the date and the reason for cancellation / removal must be recorded on the Patient Administration System and on the referral letter which is then filed in the patient’s case notes. Where case notes do not exist, the referral letter should be filed in a ‘removals folder’.

3.15 18 weeks clinical exceptions
National 18 weeks guidance states that patients should start their consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate that they wait longer.

Where it is not clinically appropriate for a patient’s treatment to begin within 18 weeks of referral, because the patient is either temporarily unfit for treatment or there is genuine clinical uncertainty about the diagnosis, these patients should remain on an 18 week pathway and their 18 weeks waiting time still be reported. These patients will fall under the operational tolerances already built into the national target.


3.16 CCG clinical threshold document
The local commissioner’s clinical threshold document should be adhered to and any referrals received that do not meet the criteria should be returned to the GP.

Further information on this document can be found at:

3.17 e Referral System (eRS)
Patient referrals received via eRS will be processed in line with the booking process shown below:

• The centralised Medical Records Teams led by Specialty Team Leaders will be responsible for clinic management on a daily basis. Clinicians will be able to amend the make-up of their clinics by working with these teams to refine their Directory of Services in order to ensure that capacity is available to meet contracted demand.

• Reviewing referrals – a time limit of 1 working day will be set to review referrals and change the priority set by GP, if required. The time limit will extend to a maximum of 5 days in extraordinary cases.
• Rejected referrals – referrals are not expected to be routinely rejected. The Directory of Service held within eRS will be regularly updated and refined to ensure that referrers have the information they need to refer to the correct service. If a referral is rejected, information will be provided to the GP/referrer explaining the reasons why. The Information Governance Manager will audit rejected referrals on a regular basis and provide solutions for thematic issues.

• Redirected referrals – where appropriate, referrals received into the incorrect pathway/service will be redirected into the correct service, on the advice of the Consultant, by the Specialty Team Leader and the CCG/GP practice will be advised on a weekly basis of any redirections.

The polling range on eRS should usually be no longer than five weeks in order to support the delivery of 18 Weeks, however to cope with unforeseen increases in demand, polling ranges may occasionally be flexed out and then reduced back to five weeks over an agreed time period in agreement with the Director of Performance and Delivery.

4. ELECTIVE INPATIENT AND DAY CASE WAITING TIMES GUIDANCE

4.1 Types of elective inpatient and day case waiting lists

Active waiting lists - The Active Waiting list identifies all patients who are currently waiting to undergo an elective inpatient or day case procedure and are fit, willing and able to come into hospital for their procedure.

Planned waiting lists - The Planned Waiting list identifies all patients who are waiting for a planned/scheduled procedure, i.e. a procedure or series of procedures as part of a treatment plan which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency, e.g. 6 month check endoscopy. Patients on planned waiting lists are not included in any calculation of the waiting list size because their procedures would not be done any sooner if resources were not a constraint.

4.2 Adding patients to an inpatient / day case waiting list

For those patients requiring admission for treatment, this is the final stage of the 18 week RTT pathway. On the date of admission, the clock stops for that RTT pathway. The patient will have waited no longer than 18 weeks from the point of referral unless it is clinically appropriate or the patient has chosen to do so and this will be recorded on the PAS. It is the expectation that only patients who are fit and available for potential surgery will be referred to the Trust.

The decision to add patients to the inpatient/day case waiting list will be made by the Consultant or a member of the Consultant Team under an arrangement agreed with the Consultant and after discussion with the patient. Patients will only be added to the inpatient/day case waiting list if there is an expectation of treating them, and
when the patient has accepted the clinicians advice on elective treatment. The patient will be added to the waiting list within one working day of the Decision to Admit (DTA). Patients will not be added if:

- They are unfit for the procedure (e.g. they need to lose weight);
- They are not ready for the surgical phase of treatment;
- There is no serious intention to treat them;
- The procedure is not currently available or funded within the Trust;
- They are not referred in line with the CCG’s Clinical Threshold Document.

4.3 Required patient information

The following information will be requested from the patient when they are placed on the waiting list:

- Confirmation of the patient’s address, postcode, contact telephone numbers (home/mobile and work) and registered GP;
- Availability to come into hospital at short notice (less than 48 hours) if a cancellation occurs and the patient has not already received an admission date. Patients must not be disadvantaged if after agreeing short notice availability they are unable to come in at short notice i.e. the waiting time will still be calculated from the original decision to admit;
- Any special circumstances requiring longer notice than usual for admission (e.g. caring for elderly relative, transport arrangements etc.);
- Any dates when the patient will not be available for admission e.g. booked holiday, etc. these dates will be recorded as patient requested self-deferral periods.

Every patient should be sent a letter confirming that he or she has been put on the inpatient/day case waiting list. A patient information leaflet for the intended procedure should be given to the patient in clinic or included with this letter.

4.4 Determining priority - selection of patients for admission

Patients should be prioritised as follows:

- In order of clinical priority;
- Patients with the same clinical priority to be selected in chronological order according to the length of time they have been waiting since their original referral.

With urgent patients, Consultants may also stipulate that the patient should be admitted within a specific time span. This must be taken into account when scheduling a patient to come in.

4.5 Reasonableness of offers of inpatient or day case admission dates

National 18 weeks guidance on reasonableness for written and verbal offers of admission states that a patient should be offered a minimum of two different admission dates with a minimum of three weeks’ notice. Patients can be offered
shorter notice dates but these are only deemed “reasonable” if the patient accepts the date. If the patient declines a short notice date, they must still be given the opportunity of a minimum of two different admission dates with a minimum of three weeks’ notice.

Prior to admission:

- Patients will have their TCI (to come in) date confirmed in writing by the Trust, whether this agreement has been reached at the pre-op assessment clinic or via a telephone consultation;
- The agreed TCI date will be recorded on PAS within 1 working day of confirmation of acceptance of an admission offer;
- Patients should attend the appropriate pre-operative assessment clinic prior to admission;
- Patients will be asked to confirm their acceptance of the admission date in the week prior to admission or at pre-operative assessment clinic;
- Patients who fail to respond to an offer of an admission date, will, at the discretion of the consultant, be removed from the waiting list and the reason recorded on PAS. A letter will be sent to the Patient and GP / referrer informing them of the removal from the inpatient/day case waiting list.

4.6 Patients who are not fit for surgery

In most circumstances patients should not be referred for acute services unless they are fit, willing and able to access services and be treated within a maximum of 18 weeks. However some patients may become temporarily unfit for treatment after they have been referred. With patients who are deemed unfit for surgery the following pathways can be applied:

*If it is likely that the patient will be unfit for a significant period of time, the patient should normally be referred back to their GP / referrer. This would stop their 18 week clock.*

*If the patient will only be unfit for a short period of time (e.g. chest infection), they can remain on the inpatient waiting list. In this scenario, their 18 week clock would continue to tick.*

4.7 Patients suspended from the active waiting list

Patients suspended from the Active Waiting List are patients that for medical or personal reasons are temporarily unable to accept a date to come in for their procedure.

Patients can only be suspended in one of two ways:

- They are temporarily medically unfit or their current medication prevents them from having their procedure. The patient’s medical unfitness can be assessed by the GP / referrer, consultant or the patient themselves.
- They are socially unavailable for their procedure e.g. holidays, work commitments, and therefore they may request their admission to be delayed.
The following rules must also be adhered to regarding the suspension of patients:

- The Trust will work to ensure that no patient will be suspended for more than 10 weeks. If the patient’s total period of suspension will exceed 10 weeks then the Inpatient Access Manager must bring this patient to the attention of the appropriate Consultant and Head of Patient Systems and Health Records for a decision on whether or not the patient should be referred back to their GP / referrer with appropriate guidance on re-referral when fit and available for admission.
- Patients who are not fit for the procedure should not be added to the waiting list.
- Patients can be suspended immediately when added to the Waiting List providing that the suspension is no longer than 10 weeks.
- If the suspension period requested is in excess of 10 weeks, but no longer than 6 months, the patient will be advised to contact their GP when they wish to return to the active waiting list. The patient’s GP will then use the appropriate guidance to refer them straight on to the waiting list when they are fit and available for admission.
- If the suspension period requested is longer than 6 months, the patient will be discharged back to the care of their GP with appropriate guidance on re-referral when fit and available for admission.
- When staff are informed of a short period of suspension, it is best practice to agree a new TCI date with the patient at the time of notification of the suspension. This should ensure that offers of appointments to patients will adhere to national guidance of reasonableness and the Trust does not breach national waiting time standards.
- If the patient is not ready to return to the active waiting list and their period of suspension does not exceed 10 weeks the suspension may continue until such time as 10 weeks is exceeded.

The Inpatient Access Manager and Head of Patient Systems and Health Records are responsible for ensuring that the suspended waiting list is accurate, appropriate and does not disadvantage patients.

Care should be taken to ensure that patients on the suspended list are included in all validation and review processes.

Following a period of suspension, there will be no adjustment to the original date on the waiting list when the patient is brought back to the active list, but the suspended days do not count as part of the patient’s inpatient waiting time.

A patient should not be suspended once an admission date has been agreed, unless the date is later than normal due to the need to resolve other medical problems prior to treatment.

4.8 Failure to attend an admission date

Where a patient fails to attend on their admission date the patient will be removed from the waiting list and discharged back to the care of the
GP / referrer unless it is demonstrated by the consultant that doing so will be detrimental to the patient care. If the patient is discharged, a letter should be sent by the consultant’s secretary to the patient and their GP / referrer and their 18 Week clock will stop.

If the patient accepts a further TCI date and goes on to DNA again, they will be removed from the waiting list and discharged back to the care of the GP / referrer. The patient and GP / referrer will be informed by letter and their 18 Week Referral To Treatment clock will stop.

Exceptions to this rule are:

- Patients undergoing cancer treatment;
- Urgent conditions based upon consultant clinical judgement;
- Children under the age of 16 years old.

In the above cases, patients should be contacted and another appointment made.

**4.9 Patients who re-schedule an admission date**

Patients who cancel / re-schedule their first date for an operation, after originally accepting it should be offered an alternative date at (or as soon as possible after) the time of cancellation. This will not stop the 18 week clock.

If a patient cancels more than once then they should be removed from the waiting list. This will stop the 18 week clock. The patient will be informed verbally at the time of cancellation. In addition a letter will be sent to the GP / referrer explaining the decision and their 18 week clock will stop.

**4.10 Cancellations on day of surgery**

It is the expectation that no patient will be cancelled for non-clinical reasons by the hospital on day of the surgery or day of admission. However in extreme circumstances when they occur, patients must be given a new TCI date either within 28 days of the cancellation (as per the national standard) or before their 18 week breach date if this is shorter than 28 days.

**4.11 Patients listed for bilateral, multiple stage surgery or for more than one procedure**

Where a patient requires a bilateral operation, e.g. cataract removal procedures on both eyes, they should be added to the elective waiting list for the first operation only. After the first procedure, the patient may be added to the waiting list for the second operation once they are fit, willing and able to have the second stage of their treatment.

If this is carried out within a clinical optimum timescales, they should be classified as ‘planned’, if not they should be added to the active waiting list.
4.12 Patients treated in the private sector or alternative NHS provider

If the Trust is unable to treat a patient within 18 weeks, the patient will be offered treatment at an alternative provider, either within the NHS or private sector.

In all such instances, the Trust’s Access Policy will continue to apply. At no time should the patient be removed from the Trust’s waiting list until the procedure is completed at the alternative provider.

The following should be noted:

- Transfer to alternative providers must always be with the consent of the patient and their GP / referrer;

- If a patient does not wish to be transferred, they will remain on the waiting list with the original decision to admit date and be admitted under normal arrangements ensuring compliance with NHS waiting times standards;

- In the event that cases are transferred by the Trust under a subcontract arrangement to another provider (e.g. private provider), the dates for completion of the work must be agreed in advance. The patient will be given an admission date on PAS as the completion date. On the date of the admission date, the alternative provider will be contacted to verify that the patient has been admitted and recorded on PAS as such. If the patient has not been admitted then the procedure described in previous sections must be followed. The patient must not be penalised by being offered treatment at another provider.

4.13 Patient exclusions under waiting list management

There are some referrals that state that for clinical reasons intervention must not commence for a specified period (e.g. therapy input post heart attack). The 18 week referral clock will have already stopped for these patients and they are considered as exceptions in terms of waiting list management.

4.14 Internal referrals

When a patient is referred for a particular service and requires a referral to another service for the same condition, an internal referral is made.

*If the patient has already received a treatment in the first service then the referral may initiate the start of a new 18 week pathway. However if the patient hasn’t received a form of treatment, the 18 week clock will continue.*

4.15 Patient unable to complete a course of treatment

Where a patient has been referred or commenced a course of therapy for a particular condition and is unable to attend due to illness or hospital admission, they will be discharged if they are unable to forecast when they will be fit and able to attend. A letter will be sent to the patient and to the referrer recommending re-referral when fit and able to attend.
4.16 Tertiary / inter-provider referrals

If a patient needs to be referred to another provider for the same condition, the 18 week clock is still running until treatment has taken place, irrespective of where that treatment takes place.

All clinical transfer information (including the original date of the clock start) must be forwarded to the receiving provider within a maximum 48 hours. The Inter-Provider Transfer Minimum Data Set (IPTMDS) will be printed automatically in the 18 Week RTT Team’s office when the patient’s 18 Week pathway is updated with the code 21 on PAS. The 18 Week RTT Team will then take on the responsibility for sending the IPTMDS along with a copy of the referral letter to the receiving provider via a secure NHS.net email address.

4.17 Maintaining waiting lists

Waiting lists will be kept up to date using data from various sources. It is essential that data is entered onto the PAS within 48 hours of an action in order to maintain accuracy of data collection and waiting list management. Patients who no longer need their operations / procedures will be removed from the waiting list.

Amendments to admission dates on PAS are only acceptable if a date is entered in error and corrected on the same working day. If this timeframe is exceeded the TCI date should be cancelled as an administrative error and a correct TCI date allocated.

The maintenance of the waiting list for a particular specialty is the responsibility of the Operational Director of the relevant directorate. The Operational Director (or their representative) must ensure that specialty waiting lists do not contain patients who no longer need their operation.

Typically it will be the consultant or their secretary who will first be aware of a patient’s change in circumstances (e.g. patient treated privately, procedure no longer required). It is vital that this information is immediately relayed to the Waiting List staff so that an up to date, accurate waiting list can be maintained, and that details are amended on PAS within 1 working day of receipt of notification of change.

4.18 Quality assurance

In order to establish that the policy and procedures are appropriately carried out, and reflect current standards, an audit of the processes will be undertaken as appropriate. This process will be led by the Information Governance Manager in conjunction with Internal Audit, and compliance will be assessed against national benchmarks. For further details, see Appendix 1.

Waiting lists will also be subject to rolling validation programmes according to current best practice.

4.19 Education and training

All grades of staff who use PAS as part of their daily work requirements will undergo education and training in the use of PAS, and in the management of waiting list processes. The arrangement of this training is the responsibility of the appropriate line manager. Staff will not be given access to the system until they have been
trained and staff responsible for updating PAS will be expected to complete an annual refresh training exercise. New changes in processes will be managed by ad hoc training.

4.20 Security and confidentiality
All staff engaged in the application of this policy are bound by the Trust’s IM&T Security and Confidentiality policies. 
https://www.hdft.nhs.uk/patients/our-commitment/

5. ROLES AND RESPONSIBILITIES

Good practice determines that a clear distinction is drawn between the roles of staff responsible for meeting targets, and those responsible for reporting on performance (Audit Commission, 2003). Having up to date policies and procedures in place, reliable, valid data collection systems and appropriate training for key staff is essential to the accuracy of referrals and waiting list information and management.

Responsibility for achieving quality and performance indicators lies with the Directorates. The accuracy of the referral and waiting list information is the responsibility of all staff who, during the course of their work, have access to and responsibility for the upkeep of systems that hold referral and waiting list information.

5.1 All staff
Waiting List Management and associated data quality is the responsibility of all Trust Staff. Staff who will implement this Access Policy will have an obligation to follow the policies and procedures recommended and to attend all training.

5.2 The Chief Executive
The Chief Executive is the organisation’s Responsible Officer for the Trust’s Access policy and its associated procedures, waiting list accuracy and probity.

5.3 The Chief Operating Office
The Chief Operating Officer (or their deputy) has direct operational responsibility for ensuring that the Trust adopts best practice and new guidance and has the IT infrastructure to support implementation.

5.4 The Head of Performance and Analysis
The Head of Performance and Analysis is responsible for ensuring that this policy adheres to the most recent Department of Health / NHS England Guidance on waiting list management and is available to all Trust staff.

5.5 Clinical Directors / Operational Directors / General Managers
Clinical Directors, Operational Directors and General Managers are key to ensuring that all administrative staff are aware of their responsibilities in ensuring the adoption of the processes and procedures in this policy. They are responsible for ensuring that the appropriate staff within their directorate are fully trained to implement the Access Policy.
They are also responsible for ensuring that all clinical staff are aware of the guidance on best practice contained in this policy.

5.6 Consultants and GP/ referrers
Consultants and GPs / referrers will have shared responsibility for the management of individual patients that is dependent on clear and timely communication between both parties regarding a patient’s clinical condition and personal circumstances.

6. CONSULTATION, APPROVAL AND RATIFICATION PROCESS

6.1 Consultation process
Consultation on this policy will be through the Trust’s key internal stakeholders, including approval via the Performance Management Group, as well as the local commissioner.

6.2 Ratification process
This Policy will be approved by the Senior Management Team (SMT).

7. DOCUMENT CONTROL

7.1 Publication
All Trust documents unless classified as NHS confidential or NHS protect (see protective marking section 7.4 of the Policy Development Manual), once approved and ratified must be published in the Trust electronic document library.

7.2 Access
Copies of policy documents should not be printed unless it is absolutely necessary, to reduce the risk that out of date copies may be in circulation. Requests for this policy in an alternative language or format (such as Braille, audiotape, large print etc) will be considered and obtained whenever possible.

7.3 Review process
This policy will be reviewed every two years.

8. DISSEMINATION AND IMPLEMENTATION

8.1 Dissemination and communication
This policy, when ratified will be stored as an electronic document on the Trust’s intranet site. It will also be made publically available via the Trust’ website.

The policy will be referred to in the Child Protection Strategy. It will be shared with the Child Protection Strategic Group.

8.2 Training and support
All staff who are involved in the 18 week referral to treatment process will receive appropriate training to ensure that they are fully aware of their responsibilities.
8.3 Consultation summary

Initial consultation – January-March 2014 – circulated to internal stakeholders
Review period – April-July 2014
Second consultation – August-September 2014
Final draft prepared October 2014
Approved by Performance Management Group – 14th October 2014
Approved by Senior Management Team – 19th November 2014

Appendix 1 – National Cancer Waiting Times Standards

<table>
<thead>
<tr>
<th>Standard</th>
<th>National Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>All referrals from GP/GDPs that are marked ‘urgent suspicious of malignancy’ must be seen by a specialist within the target days</td>
<td>14 days</td>
</tr>
<tr>
<td>All symptomatic breast referrals where cancer is not suspected must be seen by a specialist within the target days</td>
<td>14 days</td>
</tr>
<tr>
<td>All referrals from GP/GDPs that are marked ‘urgent suspicious of malignancy’ where the diagnosis of cancer is confirmed receive their first definitive treatment with the target days from the date the referral is received</td>
<td>62 days</td>
</tr>
<tr>
<td>All symptomatic breast referrals where cancer is not suspected must receive their first definitive treatment with the target days from the date the referral is received</td>
<td>62 days</td>
</tr>
<tr>
<td>All other patients with cancer who require treatment must receive that treatment within the target days from the decision to treat being made</td>
<td>31 days</td>
</tr>
<tr>
<td>All patients will wait no more than target days from decision to treat to the start of treatment for second and subsequent treatment (surgery, radiotherapy, chemotherapy and other treatments)</td>
<td>31 days</td>
</tr>
<tr>
<td>Rare Cancer Target (Paediatric, testicular and acute leukaemia) must be treated within the target days</td>
<td>31 days</td>
</tr>
<tr>
<td>All patients with suspected cancer, detected through national screening programmes must not wait more than the target days from referral to treatment</td>
<td>62 days</td>
</tr>
<tr>
<td>Any patients where cancer is suspected during their hospital care can be upgraded to a 62 day cancer pathway. They must not wait more than the target days for treatment from the date that is decided that cancer is a possible diagnosis</td>
<td>62 days</td>
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### Appendix 2 – Audit and Quality Assurance of Waiting List Data

<table>
<thead>
<tr>
<th>KPIs</th>
<th>Audit / Monitoring required</th>
<th>Audit / Monitoring performed by</th>
<th>Audit / Monitoring frequency</th>
<th>Audit / Monitoring reports distributed to</th>
<th>Action plans approved and monitored by</th>
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<td>Outpatient Data Collection Audit</td>
<td>Information Governance Manager</td>
<td>Quarterly</td>
<td>Information Governance Working Group</td>
<td>Data and Information Governance Steering Group</td>
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<td>Therapy Services Data Collection Audit</td>
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<td>Daily</td>
<td>Information Governance Working Group</td>
<td>Data and Information Governance Steering Group</td>
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Appendix 3 - Text for First Outpatient DNA letter

Dear Patient Name

You were offered an appointment on [insert Clinic date]. Unfortunately you failed to attend this appointment and in accordance with the Trust’s Patient Access Policy, you have been discharged back to the care of your GP. Please contact your GP to discuss any further treatment.

Yours sincerely,

Catherine Howard
Head of Patient Systems & Health Records

cc. GP Address
Appendix 4 - Text for First Outpatient Cancellation / Re-schedule discharge letter

Date

Patient Name
Patient Address

Dear Patient Name

You were offered appointments on [insert clinic dates] which you cancelled. In accordance with the Trust’s Patient Access Policy as you have now rescheduled 2 or more appointments, you have been discharged back to the care of your GP. Please contact your GP to discuss any further treatment.

Yours sincerely,

Catherine Howard
Head of Patient Systems & Health Records

cc.  GP Address
Appendix 5 - Text for Patient Letter – patient unavailable for 6 months or longer

Date

Patient Name
Patient Address

Dear Patient Name

You were offered to be placed on the inpatient waiting list. Unfortunately you are unable to attend for the agreed procedure within 6 months, therefore, in accordance with the Trust’s Patient Access Policy, you have been discharged back to the care of your GP. Please contact your GP for further information.

Yours sincerely,

Catherine Howard
Head of Patient Systems & Health Records

cc. GP Address
Appendix 6 - Text for GP letter – patient unavailable for 6 months or longer

Date

GP Name
GP Address

Dear GP Name

Your patient (Insert patient name and d.o.b) was offered to be placed on the inpatient waiting list. Unfortunately they are unable to attend for the agreed procedure within 6 months, therefore, in accordance with the Trust’s Patient Access Policy; they have been discharged back to your care. Please find attached the most recent clinic letter for further information.

Yours sincerely,

Catherine Howard
Head of Patient Systems & Health Records
Appendix 7 - Text for patient letter – patient unavailable for between 10 weeks and 6 months

Date

Patient Name
Patient Address

Dear Patient Name

You were offered to be placed on the inpatient waiting list. Unfortunately you are unable to attend for the agreed procedure within the next 10 weeks, therefore, in accordance with the Trust’s Patient Access Policy; you have been referred back to the care of your GP. Please contact your GP within 6 months if you wish to be placed on the waiting list and we will endeavour to do this once we have received your GP’s request, providing that you are fit and available for admission.

Yours sincerely,

Catherine Howard
Head of Patient Systems & Health Records

cc. GP Address
Appendix 8 - Text for GP letter – patient unavailable for between 10 and 6 months

Date

GP Name
GP Address

Dear GP Name

Your patient (insert patient name and d.o.b) was offered to be placed on the inpatient waiting list. Unfortunately they are unable to attend for the agreed procedure within the next 10 weeks. Therefore, in accordance with the Trust’s Patient Access Policy; they have been referred back to your care. The patient has been advised to contact you within 6 months if they wish to be placed on the waiting list and we will endeavour to do this once we have received your request, providing that they are fit and available for admission.

Yours sincerely,

Catherine Howard
Head of Patient Systems & Health Records