You matter most

Harrogate and District NHS Foundation Trust

PATIENT ACCESS POLICY

Version	Date	Purpose of Issue/Description of Change	Review Date
6	13/05/2019	Review of the Patient Access Policy	May 2020
Status		Open	
Publication Scheme		Our Policies and Procedures	
FOI Classification		Refer to author before release	
Function/Activity		N/A	
Record Type		Policy	
Project Name		N/A	
Key Words		Waiting lists, waiting times, admissions, inpatient, outpatient, diagnostic, referral to treatment, 18 weeks, DNA, cancellation, access	
Standard		N/A	
Author		Rachel McDonald and Yasmin Higgins	**Date/s**
Approval and/or Ratification Body		Performance Group and Senior Management Team	March 2019

Contents

1. INTRODUCTION & OVERARCHING PRINCIPLES

1.1 Introduction

Harrogate & District NHS Foundation Trust is committed to delivering high quality and timely elective care to patients, in both acute and community care.
This policy reflects the overall expectations of the Trust and local commissioners on the management of referral to treatment and diagnostic referrals, appointments and admissions into and within the organisation, and defines the principles on which the policy is based.

The policy sets out the rules and principles under which the Trust manages elective access to outpatient appointments, diagnostics, elective inpatient or day case treatment.

It supports staff by giving them clear direction on the application of the NHS Constitution in relation to elective waiting times.

This policy should be read in full by all clinical and non-clinical staff, who must ensure that they comply with both the principles within this policy and any specific instructions within standard operating procedures (SOPs).

The Trust is committed to providing services which meet the needs of individuals and does not discriminate against any employee, patient or visitor.

1.2 Purpose

The purpose of this policy is to ensure all patients requiring access to outpatient appointments, diagnostics and elective inpatient or day case treatment are managed in line with national waiting time standards and the NHS Constitution. A copy of the NHS constitution can be found at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf

1.3 Scope

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 a reference document for patients and is supported by a patient facing abridged version.

1.4 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 that, during the course of their work, have access to and responsibility for the upkeep of systems that hold referral and waiting list information.

- All staff with access to and a duty to maintain elective care information systems are accountable for their accurate upkeep.
- The Chief Executive is the organisation's Responsible Officer for the Trust's Patient Access policy and its associated procedures, waiting list accuracy and probity.
- 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.
- 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.
- 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 Patient Access Policy. They are also responsible for ensuring that all clinical staff are aware of the guidance on best practice contained in this policy.
- Waiting list Administrators, including clinic staff, secretaries or booking clerks are responsible to their respective managers with regard to compliance of all aspects of the Trust's Patient Access Policy.
- Waiting List Administrators for outpatients, diagnostics and elective inpatient or day care services are responsible for the day-to-day management of their lists and are supported in this function by their Managers and Operational Directors who are responsible for achieving access standards.
- The Information Services team are responsible for producing and maintaining regular reports to enable clinical directorates to accurately manage elective pathways, and ensure compliance with this policy.
- GPs and other referrers play a pivotal role in ensuring patients are fully informed during their consultation of the likely waiting times for a new outpatient consultation and of the need to be contactable and available when referred.
- CCGs are responsible for ensuring robust communication links are in place to feedback information to GPs. GPs should ensure quality referrals are submitted to the appropriate provider first time.
- 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.

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

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

1.5 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 RTT Manager, Inpatient Access Manager and Outpatient Access Manager in conjunction with Internal Audit

1.6 General Elective Access Principles

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

- The individual patient rights (as per the NHS Constitution).
- The standards by which individual providers and commissioners are held accountable by NHS Improvement and NHS England. All patients are to be treated fairly and equitably regardless of race, sex, religion or sexual orientation.

1.7 Individual Patient Rights

The NHS constitution clearly sets out a series of pledges and rights stating what patients, the public and staff can expect from the NHS. A patient has the right to the following:

- The choice of hospital and consultant.
- To commence their treatment for routine conditions following a referral into a consultant-led service, within a maximum waiting time of 18 weeks to treatment.
- To be seen by a cancer specialist within a maximum of two weeks from a GP referral for urgent referrals where cancer is suspected.
  If this is not possible, the NHS must take all reasonable steps to offer a range of alternatives.

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

- If the patient chooses to wait longer (the patient's RTT clock continues to tick).
- If delaying the start of the treatment is in the best clinical interests of the patient (the patient's RTT clock continues to tick).

- If it is clinically appropriate for the patient's condition to be actively monitored in secondary care

1.8 Patient Eligibility

The Trust will check every patient's eligibility for NHS care and ensure that any charges are received upfront for treatment that is not immediately necessary or urgent, in line with the Overseas Visitor Policy.

1.9 Patients Moving Between NHS & Private Care

Patients can choose to move between NHS and private status at any point during their treatment without prejudice. Where it has been agreed, for example, that a surgical procedure is necessary the patient can be added directly to the elective waiting list if clinically appropriate. The RTT clock starts at the point the GP or original referrer's letter arrives in the hospital.

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

1.10 Commissioner Approved Procedures

Patients referred for specific treatments where there is limited evidence of clinical effectiveness, or which might be considered cosmetic can only be accepted with the prior approval of the relevant CCG.

If a procedure is not currently available or funded within the Trust, the patient will be returned back to the care of their GP with the expectation that they will be referred back to the Trust once the funding request has been approved by the CCG. There is however a small number of procedures/treatments that need to be requested by a secondary care Consultant. In these cases the 18 week RTT clock will continue to tick whilst funding is sought.

1.11 Military Veterans

In line with the Armed Forces Covenant, published in 2015, all veterans and war pensioners should receive priority access to NHS care for any conditions which are related to their service, subject to the clinical needs of all patients. Military veterans should not need first to have applied and become eligible for a war pension before receiving priority treatment.

GPs will notify the Trust of the patient's condition and its relation to military service when they refer the patient, so the Trust can ensure it meets the current guidance for priority service over other patients with the same level of clinical need. In line with clinical policy, patients with more urgent clinical needs will continue to receive priority.

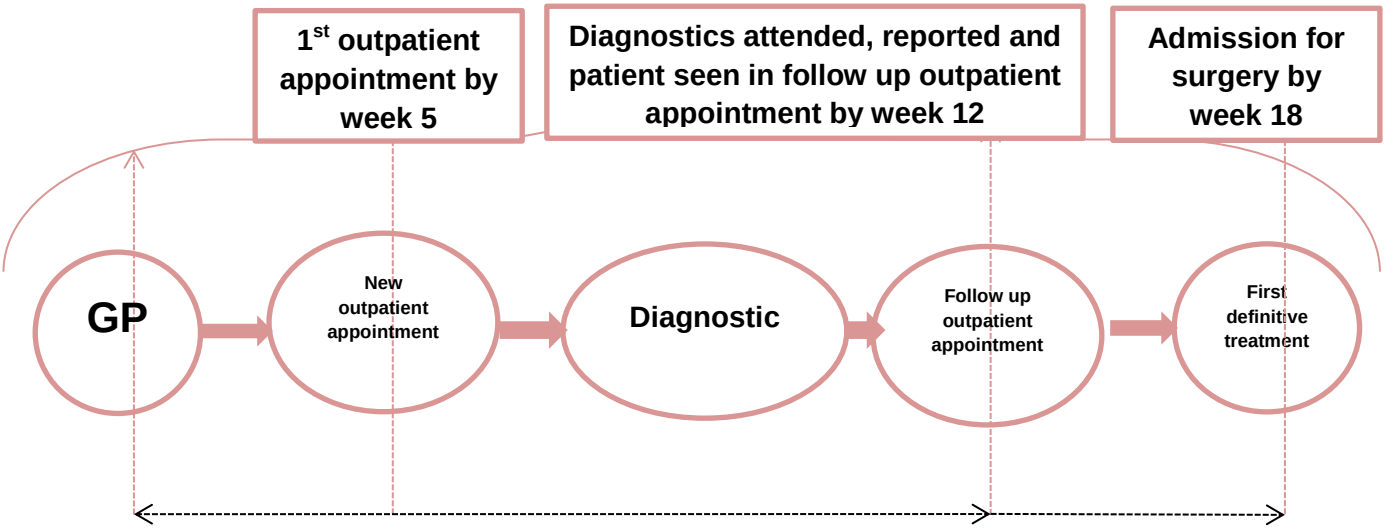
1.12 Prisoners

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

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

1.13 Pathway Milestones

In order to achieve treatment within 18 weeks of receipt of referral, pathways should be designed with key milestones and sufficient capacity agreed with clinicians and commissioners. As an example, a surgical pathway could be broken down into the milestones shown below.



1.14 Locally defined waiting times standards

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 and 6 days of referral
- Elective admissions within 9 weeks and 6 days of a decision to treat

1.15 Monitoring

Operational teams will monitor levels of capacity for each pathway milestone to ensure any shortfalls are addressed in advance, thus avoiding a poor patient experience, resource intensive administrative workarounds and ultimately breaches of the RTT standard.

1.16 Reasonableness

'Reasonableness' is a term applicable to all stages of the elective pathway. Reasonableness refers to specific criteria which should be adhered to when offering routine appointments and admission dates to patients, to demonstrate that they have been given sufficient notice and a choice of dates.

An offer for an outpatient appointment can be defined as reasonable if the patient has been given seven days' notice. An appointment with less than seven days' notice can be offered to a patient, however it can only be deemed reasonable if a patient accepts it.

An offer for surgery can be defined as reasonable if the patient has been given three weeks' notice. An appointment with less than three weeks' notice can be offered to a patient, however it can 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. There is no national definition of reasonable for cancer patients. For such urgent referrals, two days' notice would be deemed reasonable.

1.17 Chronological Booking

Patients will be selected for booking appointments or admission dates according to clinical priority. Patients of the same clinical priority will be appointed / treated in RTT chronological order according to the length of time they have been waiting since their original referral.

1.18 Communication

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

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

2. NATIONAL REFERRAL TO TREATMENT AND DIAGNOSTIC STANDARDS

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

In addition to the elective care standards above, there are separate cancer standards which the Trust must adhere. Information on cancer standards can be found in the Trust's Cancer Access Policy.

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

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

3. OVERVIEW OF NATIONAL REFERRAL TO TREATMENT (RTT) RULES

3.1 Clock starts

The RTT clock starts when any healthcare professional (or service permitted by an English NHS Commissioner to make such referrals) refers to a consultant-led service. The RTT clock start date is the date that the trust receives the referral. For referrals received through NHS e-Referral, the RTT clock starts on the day the patient converts their unique booking reference number (UBRN)

Examples include:

- A referral is received into a consultant led service, regardless of setting, with the intention that the patient will be assessed and if appropriate, treated before clinical responsibility is transferred back to the referrer.
- A referral is received into an interface or referral management assessment centre which may result in an onward referral to a consultant led service before clinical responsibility is transferred back to the referrer.
- A patient self refers into a consultant led service for pre-agreed services agreed by providers and commissioners.

3.2 Exclusions

Most referrals to consultant-led services will start an RTT clock; however, the following services and types of patients are excluded from RTT:

- Obstetrics and midwifery
- Planned patients
- Referrals to a non-consultant led service
- Non-English commissioners
- Genitourinary medicine services
- Emergency pathway non-elective follow-up clinic activity
- Non-consultant led community services

3.3 New clock starts for the same condition

<u>Following active monitoring</u>

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

<u>Following a decision to start a substantively new treatment plan</u>

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

clock and the patient shall receive their first definitive treatment within a maximum of 18 weeks from that date.

For Second Bilateral Procedure

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

For a Rebooked New Outpatient Appointment

See point 3.8.1 First Appointment DNAs on page 14.

3.4 Planned Patients

All patients added to the planned list will be given a due date by which their planned procedure/test should take place. Where a patient, requiring a planned procedure, goes beyond their due date, they will be transferred onto the active waiting list and a new RTT clock will be started. The detailed process for management of planned patients is described in the relevant departmental procedures.

3.5 Clock stops for first definitive treatment

An RTT clock stops when:

- First definitive treatment starts. This could be:
  - Treatment provided by an interface 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 or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions.

- A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

3.6 Clock Stops for Non-Treatment

A waiting time clock stops when it is communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay that:

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

3.7 Active monitoring

Clinically led active monitoring

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

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

Patient led active monitoring

If a patient wishes to delay their investigations or treatment for an extended period of time, they can enter into a period of active monitoring. For example if a patient wishes to delay their treatment for a number of months. The patient's case will be reviewed, at the time that the delay is communicated to the Trust, by the patient's consultant to determine if the delay is clinically acceptable. If the delay could result in potential harm this should be communicated clearly to the patient and every effort should be made to encourage the patient to attend.

3.8 Patient Initiated Delays

Non-attendance of appointments/did not attend (DNAs)

Every effort should be made to minimise DNAs, and it is important that a clinician reviews each and every DNA before making a decision to discharge the patient back to their GP/referrer or offer the patient another appointment.

First appointment DNAs

The RTT clock is stopped and nullified in all cases (as long as the appointment was booked in line with the Trust's reasonableness criteria). If the clinician indicates that another first appointment should be offered, a new RTT clock will be started on the day the new appointment is agreed with the patient**.**

Subsequent (follow up) appointment DNAs

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

3.9 Cancelling, declining, or delaying appointments

Patients who re-schedule/ cancel their first or subsequent appointment will be offered an alternative date, within current waiting time and reasonableness guidelines. If a patient cancels their appointment for a second time their case will be reviewed using the below guidelines;

First appointment

The patient's case will be reviewed by Medical Records to determine whether it is appropriate to;

- Discharge the patient back to their GP/Referrer
- Offer a further appointment within current waiting time guidelines

Follow up appointment

The patient's case will be reviewed by their Consultant / Senior Clinician to determine whether it is appropriate to;

- Discharge the patient back to their GP/Referrer
- Offer a further appointment within current waiting time guidelines

The decision will then be recorded on ICS, and where appropriate a new appointment will be booked. If a decision is made to discharge the patient, they will be informed in writing of the reason for their removal by a letter sent from Medical Records.

3.10 Patients Who Are Unfit for Surgery

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

Short-Term Illnesses

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

Longer Term Illnesses

If the nature of the clinical issue is more serious for which the patient requires optimisation and / or treatment, clinicians should indicate to administration staff:

- If it is clinically appropriate for the patient to be removed from the waiting list. This will be a clock stop event via the application of active monitoring.
- If the patient should be treated within secondary care (active monitoring clock stop)
- If they should be discharged back to the care of their GP (clock stop).

4 NON-ADMITTED PATHWAYS

The non-admitted stages of the patient's pathway comprise both outpatients and the diagnostic stages. It starts from the clock start date (i.e. the date the referral is received) and ends when either a clock stop happens in outpatients (this could be the first, second or a further appointment) or when a decision to admit is made and the patient transfers to the admitted pathway.

4.1 Receipt of Referral Letters

Paper-based referrals are still currently accepted, but the trust discourages this route. The NHS e-Referral (e-RS) is the preferred method of receiving referrals from GPs and Referral Management Centres (RMCs). Paper- based referrals will be sent to a central point and all referrers will be informed of this requirement and its location.

Where clinically appropriate, referrals will be made to a service rather than a named clinician, services have agreed clinical criteria to support triage and vetting, and patients will then be allocated to the most appropriate clinician, and in consideration of waiting times. Referring to services is in the best interests of patients as pooling referrals promotes equity of waiting times and allows greater flexibility in terms of booking appointments.

4.2 Methods of Receipt

<u>NHS e-Referrals (e-RS)</u>

- All NHs e-referrals must be reviewed and accepted or rejected by clinical teams within one working day for urgent referrals and two working days for routine referrals.
- Where there is a delay in reviewing e-referrals this will be escalated to the relevant clinic / management team and actions agreed to address it.
- If an NHS e-referral is received for a service not provided by the Trust, it will be rejected back to the referring GP advising that the patient needs to be referred elsewhere. This will stop the patient's RTT clock.

<u>Paper-Based Referrals</u>

- All routine and urgent pooled and consultant-specific referral letters should be sent to the trust's centralised booking office.
- Referrals must be date stamped upon receipt at the Trust. Should a paper-based referral be received directly into a specialty, the specialty must date stamp the referral and forward to the centralised booking office within one working day of the receipt. For patients referred by paper, the referrals received date is the point that the Referral to Treatment (RTT) clock starts.

4.3 Referral types

Rapid Access Chest Pain Clinic (RACPC) Referrals

RACPC patients must be seen by a specialist within 14 days of the Trust receiving the referral. To ensure that this is achieved;

- RACPC referrals should be made via e-RS only
- GPs should ensure that appropriate information regarding the RACPC referral is provided to the patient.

Transient Ischaemic Clinic (TIA) Referrals

TIA referrals are immediately triaged by the Appointment Centre staff and the Clinician in charge.

- Patients that are classified as 'high risk' will be assessed and investigated within 24 hours of the referral.
- Patients that are classified as 'low risk' will be assessed and investigated within 7 days of the referral.

Consultant to Consultant Referrals

These are referrals that are part of the continuation of investigation / treatment of the same condition for which the patient was referred. This includes referrals to pain management where surgical intervention is not intended.

- Urgent referrals for new condition
- Suspected cancer referral. The referral will vetted and dated by the receiving consultant and upgraded if deemed necessary. To upgrade the referral the Information Analyst Cancer Specialist must be informed. Once upgraded the patient will be treated within 62 days of the date the referral was received by the consultant.

Community services

Referrals to non-consultant led community services will be processed and appointed in accordance with local service arrangements.

4.4 Inter-Provider Transfers (IPTs)

Incoming IPTs

All IPT referrals will be received electronically via the Trust's 18 Week RTT Team NHS net email account (hdft.rttmail@nhs.net)

The Trust expects an accompanying Minimum Data Set (MDS) pro-forma with the IPT, detailing the patient's current RTT status (the Trust will inherit any RTT wait already incurred at the referring trust if they have not had their clock stopped) and if the patient has been referred for a new treatment plan for the same condition (where a new RTT clock will start upon receipt at this trust). The patient's pathway identifier

should also be provided. If the IPT is for a diagnostic test only, the referring trust retains responsibility for the RTT pathway.

If any of the above information is missing, the referral should be recorded on PAS and the information actively chased by the 18 Week RTT Team.

Outgoing IPTs

The trust will ensure that outgoing IPTs are processed within 48 hours of the referral letter being issued to avoid unnecessary delays.

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

Referrals and the accompanying MDS will be emailed securely from the 18 Week RTT Team NHS.net account. The 18 week team will verify (and correct if necessary) the RTT status for the patient.

4.5 Booking New Outpatient Appointments

e- Referral Service

Patients who have been referred via e-RS should be able to choose, book and confirm their appointment prior to the Trust receiving and accepting the referral.

If there are insufficient slots available for the selected service at the time of attempting to book (or convert their UBRN), the patient will appear on the Appointment Slot Issue (ASI) work list. The RTT clock starts from the point at which the patient attempted to book. Patients on the ASI list will be contacted the following working day to inform them that the Trust is aware of their referral and will be making an appointment as soon as available.

If a patient's appointment has been incorrectly booked on e-RS into the wrong service at the Trust by the referrer, the referral should be electronically re-directed in the e-RS to the correct service. A confirmation letter of the appointment change will be sent to the patient. The patient's RTT clock will continue to tick from the original date when they converted their UBRN.

Paper-Based Referrals

The Trust will ensure that all paper-based referrals are imputed onto PAS and reviewed by the relevant consultant for vetting within a timely manner.

Appointments will be booked in order of clinical priority (urgent before routine) and then in chronological order of referral received date.

Where there is insufficient capacity to offer an appointment within the required milestone, this should be escalated to the relevant service manager.

Any appointment offers declined by patients should be recorded on PAS. This is important for two reasons; full and accurate record keeping is good practice and the information can be used at a later date to understand the reasons for any delays in the patient's treatment, e.g. hospital or patient initiated.

4.6 Clinic Attendance & Outcomes (New & Follow-Up Clinics)

Every patient, new and follow-up, whether attended or not, will have an attendance status and outcome recorded on PAS at the end of the clinic. Clinics will be fully cashed up within one working day of the clinic taking place. Any delay in cashing up will be highlighted to the Medical Records manager.

Clinic outcomes (e.g. discharge, further appointment) will be recorded by clinicians on the agreed cashing up sheet and sent back to Medical Records once the clinic has finished.

Upon attendance in clinic, patients may be on an open pathway (i.e. waiting for treatment with an RTT clock running) or they may already have had a clock stop due to receiving treatment or a decision not to treat being agreed. It is possible for patients to be assigned any one of the following RTT statuses at the end of their outpatient attendance, depending on the clinical decisions made or treatment given/started during the consultation:

<u>Patients on an Open Pathway</u>

- Clock stop for treatment
- Clock stop for non-treatment
- Clock continues if requiring diagnostics, therapies or being added to the admitted waiting list

<u>Patients already treated or with a decision not to treat</u>

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

Accurate and timely recording of these RTT statuses are critical to supporting the accurate reporting of RTT performance.

4.7 Booking Follow-up Appointments

Patients on an Open Pathway

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

Patients Not on an Open Pathway

Patients who have already been treated or who are under active monitoring and require a follow-up appointment may be entered on to a follow up waiting list. This process will be clearly explained to the patient.

4.8 Did Not Attends (DNAs)

Did not attend

All DNAs (new and follow-up) will be reviewed by the Consultant / Senior clinician at the end of clinic in order for a clinical decision to be made as to whether the appointment should be rebooked or the patient returned to the care of their GP/referrer. If a decision is made not to re-appoint the patient, the same Consultant / senior clinician should write to the GP (or referrer) explaining the reasons for not re-appointment.

Was not brought

Paediatric patients, adults with health and support needs or patients referred on an urgent cancer pathway should be managed separately in accordance the Trusts procedures.

4.9 Appointment Changes & Cancellations Initiated by the Patient

If the patient gives any prior notice that they cannot attend their appointment (even if this is on the day of clinic), this should be recorded as a cancellation and not a DNA.

If the patient requires a further appointment, this will be booked with the patient at the time of the cancellation.

If the patient is on an open RTT pathway, the clock continues to tick. If there are insufficient appointment slots within the agreed pathway milestones, the issue must be escalated to the Service Manager.

If the patient has never been seen and advises they do not wish to progress their pathway, they will be removed from the relevant waiting list and a clock stop and nullification applied. A letter will be sent to the GP/referrer informing them of the patient's decision.

Full guidance on how patient appointment cancellations should be managed is found in section 3.9.

4.10 Appointment Changes Initiated by the Hospital

Hospital initiated changes to appointments will be avoided as far as possible, as they are poor practice and cause inconvenience to patients.

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.

Patients will be contacted immediately if the need for the cancellation is identified and offered an alternative date(s) that will allow patients on open RTT pathway to be treated within 18 weeks. Equally, this will allow patients not on open pathways to be reviewed as near to the clinically agreed timeframe as possible.

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 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.

5. DIAGNOSTICS

The following sections cover patients with an RTT and diagnostic clock, straight to test and diagnostic only patients.

5.1 Patients with a Diagnostic & RTT Clock

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

- Their RTT clock which started at the point of receipt of the original referral.
- Their diagnostic clock which starts at the point of the decision to refer for diagnostic test (often at the first outpatient consultation).

5.2 Straight to Test Arrangements

For patients who are referred for a diagnostic test which will possible result in an outpatient review and treatment within a consultant led service (without first being reviewed by their GP) an RTT clock will start on receipt of the referral. These are called straight to test referrals.

Examples of such services include:

- Straight to test endoscopy.
- Radiology services

5.3 Patients with a Diagnostic Clock Only

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

5.4 National Diagnostic Clock Rules

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

5.5 Booking diagnostic appointments

Appointments will be booked in line with the Trusts locally agreed reasonableness criteria (as outlined in section 1.14).

If a patient declines, cancels or does not attend a diagnostic appointment, the diagnostic clock start can be reset to the date the patient provides notification of this.

However:

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

5.6 Diagnostic Cancellations, Declines and / or DNAs for Patients on Open RTT Pathways

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

5.7 Active Diagnostic Waiting List

All patients on an active diagnostic waiting list are monitored daily by the administration teams to ensure they are appointed within the required timeframes. Any capacity or demand issues should be highlighted to the Management teams promptly to avoid undue delay for the patient.

5.8 Planned Diagnostic Appointments

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

5.9 Therapeutic Procedures

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

6. PRE-OPERATIVE ASSESSMENT (POA)

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

- Patients with a DTA will be advised to attend the walk-in pre assessment screening service immediately after their outpatient appointment. However, if this is not possible patients should ensure they attend pre-operative screening as soon as they are able.

- At the pre-assessment screening the patient will be advised whether they will require a full pre-operative assessment (POA), led by the nurse specialist, prior to their surgery.
- Patients with complex health conditions will be booked in for their POA at the same time as the surgery date is booked, by the admissions team. Ideally the patient will be booked in for their POA six weeks prior to the surgery date, however this may not be possible for short notice surgery dates.

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

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

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

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

When the patient becomes fit and ready to be treated for the original condition, a new RTT clock would start on the day this decision is made and communicated to the patient.

7. ACUTE THERAPY SERVICES

Acute therapy services consist of Physiotherapy, Dietetics, Orthotics and Surgical Appliances. Referrals to these services can be:

- Directly from GPs where an RTT clock would NOT be applicable
- During an open RTT pathway where the intervention is intended as first definitive treatment or interim treatment.

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

7.1 Physiotherapy

For patients on an open pathway referred for physiotherapy as first definitive treatment, the RTT clock stops when the patient commences physiotherapy.
For patients on an orthopaedic pathway referred for physiotherapy as interim treatment (as surgery will definitely be required), the RTT clock continues while the patient undergoes physiotherapy.

7.2 Surgical Appliances

For patients on an open pathway referred for a surgical appliance as first definitive treatment, it is only once the fitting of the appliance takes place that the patients RTT clock will stop.

7.3 Dietetics

If patients are referred to the dietician and receive dietary advice with no other form of treatment, this would constitute an RTT clock stop.

7.4 Speech and Language Therapy

If patients are referred to the speech and language therapist and receive advice with no other form of treatment, this would constitute an RTT clock stop.

8. NON-ACTIVITY RELATED RTT DECISIONS

Where clinicians review test results in the office setting and make a clinical decision not to treat, the RTT clock will be stopped on the day this is communicated in writing to the patient.

Administration staff should update PAS with the clock stop. The date recorded will be the day the decision not to treat is communicated in writing to the patient.

9. ADMITTED PATHWAYS

9.1 Adding Patients to the Active Inpatient or Day Case Waiting List

Ideally patients will be fit, ready and available before being added to the admitted waiting list. The active inpatient or day case waiting lists/PTLs includes all patients who are awaiting elective admission. The only exceptions are planned patients, who are awaiting admission at a specific clinically defined time.

In terms of the patient's RTT clock, adding a patient to the inpatient or day case waiting list will either:

- Continue the RTT clock from the original referral received date
- Start a new RTT clock if the surgical procedure is a substantively new treatment plan which did not form part of the original treatment package, providing that

either another definitive treatment or a period of active monitoring has already occurred. The RTT clock will stop upon admission.

9.2 Patients Requiring More Than One Procedure

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

- The patient will be added to the active waiting list for the primary (1st) procedure.
- When the first procedure is complete and the patient is fit, ready and able to undergo the second procedure, the patient will be added (as a new waiting list entry) to the waiting list, and a new RTT clock will start.

9.3 Patients Requiring Thinking Time

Patients may wish to spend time thinking about the recommended treatment options before confirming they would like to proceed. It would not be appropriate to stop their RTT clock where this thinking time amounts to only a short period i.e. a few weeks and the patient has been asked to make contact within that period with their decision.

It may be appropriate for the patient to be entered into active monitoring (and the RTT clock stopped) where they state they do not anticipate making a decision within a short period of time i.e. a month. In this scenario, a follow-up appointment must be arranged around the time the patient would be in a position to make a decision. A new RTT clock should start from the date of the decision to admit if the patient decides to proceed with surgery.

9.4 Scheduling Patients to Come in (TCI) for Admission

Clinically urgent patients will be scheduled first, followed by routine patients. All patients will be identified from the Trust's PTLs, and subject to the clause above about clinical priorities, will be scheduled for admission in chronological order of RTT wait.

Patients will be offered a choice of at least two admission dates with three weeks' notice within the agreed milestone for the specialty concerned. Admission dates can be offered with less than three weeks' notice and if the patient accepts, this can then be defined as 'reasonable'.

If there is insufficient capacity to offer dates within the required milestone, this issue will be escalated to the relevant service manager. Any admission offers declined by patients will be recorded on PAS. This is important for two reasons:

1. Full and accurate record keeping is good clinical practice.

2. The information can also be used at a later date to understand the reasons for any delays in the patient's treatment, e.g. hospital or patient initiated.

9.5 Patients Declaring Periods of Unavailability

If a patient declares a period of extended unavailability their case should be reviewed by the clinician to determine if;

- The delay could result in patient harm – The clinician should contact the patient and every effort should be made to encourage the patient to attend. If this is unsuccessful the patient can choose to enter into a period of patient led active monitoring (clock stop) and a follow up appointment/ phone call will be arranged for when they are available.
- The delay is clinically acceptable but the patient's condition/ treatment plan may change during the delay. The patient can choose to enter into a period of active monitoring (clock stop) and a follow up appointment/ phone call will be arranged for when they are available.
- The delay is clinically acceptable (clock continues). For example, a patient who wishes to delay their hip replacement for a few weeks due to social reasons.

9.6 Patients Who Decline or Cancel TCI Offers

Should patients decline TCI offers or contact the Trust to cancel a previously agreed TCI, this will be recorded on iCS. The RTT clock continues to tick. If a patient cancels two TCI offers, the patient's pathway will be reviewed by their Consultant. Upon clinical review, the patient's Consultant will indicate one of the following:

- Clinically safe for the patient to delay - continue progression of pathway. The RTT clock continues.
- Clinically unsafe length of delay – clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues.
- Clinically unsafe length of delay – in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP.
- The requested delay is clinically acceptable, but the clinician believes the delay will have a consequential impact (where the treatment may fundamentally change during the period of delay) on the patient's treatment plan – active monitoring.

9.7 Patients Who Do Not Attend Admission

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

9.8 On the Day Cancellations

Where a patient is cancelled on the day of admission or day of surgery for non-clinical reasons, they will be rebooked within 28 days of the original admission date

and the patient must be given reasonable notice of the rearranged date. The patient may choose not to accept a date within 28 days.

9.9 Planned Waiting Lists

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

When patients on planned lists are clinically ready for their care to commence and reach their due date for their planned procedure, they will either be admitted for the procedure or be transferred to an active waiting list and a new RTT clock will start. For some patients (e.g. surveillance endoscopies) a diagnostic clock would also start.

10. APPENDICES

10.1 Appendix 1: Consultation Summary

List Groups and/or Individuals Consulted
Medical Director
Organisation Delivery Group
Senior Leadership Team
Harrogate and Rural District CCG
NHS Improvement
Communications and Marketing Manager