Imperial College Healthcare NHS Trust

Trust-Wide Policy

Elective Access Policy

Key Points:

This is a controlled document. Whilst this document may be printed, the electronic version uploaded on the intranet is the controlled copy and printing is not advised. This document must not be saved onto local or network drives but must always be accessed from the intranet.

All employees must adhere to the requirements set out within this document. Any specific responsibilities or actions for particular staff or staff groups will be outlined within the main body of the document and their duties cascaded to them as required.

Promoting equality and addressing health inequalities are at the heart of Imperial College Healthcare NHS Trust's values. Throughout the processes detailed within this document the Trust has given due regard to the need to eliminate discrimination, harassment and victimisation to advance equality of opportunity and to foster good relations between people who share a relevant protected characteristic, as cited under the Equality Act 2010, and those who do not.

Current Document Status:	Final.

Contents

1. Introduction

1.1. The Trust is committed to providing high quality and timely elective care to all patients accessing our services.

1.2. This policy:

- Sets out the overarching rules and principles for managing access to outpatient appointments, diagnostics and elective inpatient or day case admissions;
- Gives staff clear direction and provides signposting to related policies and guidance; &
- Demonstrates how elective access rules should be applied to ensure provision of care is fair and equitable, in line with national waiting time standards and the NHS Constitution.

1.3. The policy is based on key principles of national referral to treatment (RTT) guidance and the processes are detailed further within standard operating procedures (SOPs) and related policies (see section 11).

1.4. Ultimately arrangements for each individual patient should be applied locally on a common-sense basis, with compassion and consideration of patient's individual circumstances.

1.5. This latest version of this policy was developed and agreed in consultation with staff, representatives from the Clinical Commissioning Group (CCG) including lay representatives, and clinical leads. It will be reviewed and ratified annually by the Trust Executive Committee, or earlier to reflect changes in national guidance or local processes.

1.6. All applicable staff should read this policy in full and complete relevant elective care training.

1.7. This Trust recognises the importance of good quality data and legal responsibilities for all NHS Hospital Trusts over data quality. As part of the False or Misleading Information (FOMI) legislation it is an offence to provide information that is false or misleading.

1.8. Staff must not carry out actions they feel may be inconsistent with this policy. If in doubt about the rules and their application, a member of staff must always check with their supervisor (including clinical lead or departmental manager) or with the Performance Support Team.

2. Scope of policy

- All elective appointments and admissions (arranged in advance) provided by the Trust;
- Does not cover patients on emergency or antenatal care/maternity pathways, although the section covering patient eligibility applies equally; &
- Applies to all clinical and administrative staff involved in managing patients referred to our elective care services.

3. Roles and responsibilities

3.1. Whilst responsibility for achieving national waiting times targets lies with the Divisional Directors and ultimately the Trust Board, all staff with access to referral and waiting list information systems are accountable for their accurate upkeep.

Divisional Directors	The Divisional Directors, with the Divisional Directors of Operations, are accountable for waiting list management and ensuring compliance with the policy within their Divisions.

Chief Information Officer	Responsible for the timely production of a patient tracking list (PTL) which supports the Divisions in managing the waiting list and RTT standards targets.
Managers	General Managers are responsible for ensuring the data is accurate and the policy is complied with. This includes ensuring staff are fully trained in RTT and associated operating procedures for this policy. Business Managers are responsible for ensuring the lists are validated, taking responsibility for ensuring treatment plans are in place for long waiters, and ensuring the NHS e-Referral Service Directory of Services is accurate and up to date.
Clinical Administrative Staff	Responsible for the day-to-day management of their lists and are supported in this function by the Business/General Managers and Divisional Directors who are responsible for achieving access targets. They are also responsible for communicating with or responding to patients appropriately and promptly. This includes liaising with booking staff in both the centralised and devolved areas as appropriate.
The Business Intelligence Team	Responsible for producing and maintaining regular reports to enable divisions to accurately manage elective pathways.
The Patient	Patients should provide accurate information about their contact details. Patients should be ready, willing and available to come to appointments and start treatment. Patients should keep appointments, or cancel as soon as possible if they cannot attend.
The patient's GP 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, of the need to be contactable and available when referred and the importance of keeping appointments, or cancelling within reasonable time. All referrals must contain the minimum referrals dataset, including highlighting any special requirements and access needs in line with the NHSE guidance on Accessible Information Standards.
The patient's CCG	The CCGs are responsible for ensuring robust communication links are in place to feedback information to GPs.

4. National elective care waiting time standards

4.1. For patients in England the maximum waiting times for elective care are set out in the NHS Constitution. The NHS Constitution sets out the following patient rights:

- to start consultant-led non-emergency treatment within a maximum of 18 weeks from referral and for the NHS to take all reasonable steps to offer a range of alternatives if this is not possible; and
- to be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.

4.2. The handbook to the NHS Constitution lists the specific circumstances where these rights do not apply and those services not covered by the rights.

4.3. All patients are to be treated fairly and equitably in accordance with The Equality Act 2010.

4.4. The current operational standards for elective care are provided below[1].

[1] Proposed new access standards (including elective care) are being piloted by NHS England and NHS Improvement during 2019/20. This includes 26-week patient choice offer to access faster treatment elsewhere in a managed way as a supporting standard. We anticipate making an in-year update to the Trust elective access policy to reflect outcomes of the national review.

RTT waiting times for non-urgent consultant-led treatment
92% of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral.
Diagnostic test waiting times
99% of patients will wait no longer than 6 weeks for a diagnostic test, investigation or image.
Cancer waits - 2 week wait
93% of patients will be seen within two weeks of an urgent GP referral for suspected cancer or where identified as breast symptomatic.
Cancer waits – 31 days
96% of patients will wait a maximum of one month (31 days) from diagnosis to first definitive treatment for all cancers.
94% of patients will wait a maximum of one month (31 days) for subsequent treatment where treatment is surgery.
94% of patients will wait a maximum of one month (31 days) for subsequent treatment where treatment is a course of radiotherapy.
98% of patients will wait a maximum of one month (31 days) for treatment where treatment is an anti-cancer drug regimen.
Cancer waits – 62 days
85% of patients will wait a maximum of two months (62 days) from urgent referral for suspected cancer to first treatment for all cancers.
90% of patients will wait a maximum of two months (62 days) from NHS cancer screening service to first definitive treatment

5. General access arrangements

Patient eligibility

5.1. The NHS provides healthcare for people who are ordinarily resident in the United Kingdom. People who are not ordinarily resident in the United Kingdom are not automatically entitled to use the NHS free of charge – regardless of their nationality or whether they hold a British passport or have lived in and paid National Insurance contributions and taxes in this country in the past.

5.2. All NHS Trusts have a legal obligation to identify patients who are not eligible for free NHS treatment and specifically:

- Ensure patients who are not ordinarily resident in the UK are identified;
- Assess liability for charges in accordance with Department of Health overseas visitor guidance[2]; &
- Charge those liable to pay in accordance with Department of Health overseas visitor guidance.

5.3. Patients registered with a GP in either Northern Ireland, Scotland or Wales are also eligible for elective treatment, subject to prior approval from their local health board.

5.4. An NHS Number does not give automatic entitlement to free NHS treatment. Therefore, at first point of entry, patients must be asked questions which will assist the Trust in assessing 'ordinarily resident status'. The only exception to this is being in an emergency.

5.5. The Human Rights Act 1998 prohibits discrimination against a person on any ground such as race, colour, language or religion.

[2] Guidance on overseas visitors hospital charging regulations

5.6. Some visitors from abroad, who are not ordinarily resident, may receive free healthcare such as those that:

- Have paid the immigration health surcharge;
- Have legally come to work or study in the UK; or
- Have been granted or made an application for asylum.

5.7. Citizens of the European Union (EU) that hold a European Health Insurance Card (EHIC) are also entitled to free emergency healthcare, although the Trust may recover the cost of treatment from the country of origin.

Contacting the overseas visitors officers

5.8. All staff are responsible for ensuring the identification of patients that are not ordinarily resident in the UK. All staff are responsible for referring to the **Overseas Visitors Officers** for determination of a patient's eligibility following the undertaking of the baseline questionnaire at the point of patient's registration to the Trust (and before their first outpatient appointment is booked).

5.9. Refer to the Trust's Overseas Visitors Policy and Procedure for further information on the process and details of who to contact.

Patients moving between NHS and private care

5.10. Patients can choose to convert between an NHS and private status at any point during their treatment without prejudice.

5.11. The NHS Constitution does not apply to private patients however should a private patient move to NHS funded services (and if the patient is yet to receive first definitive treatment and their treatment is applicable to RTT 18 week rules) then the RTT clock will start when the referral is received by the hospital.

5.12. The elective RTT pathway of a patient who notifies the Trust of their decision to seek private care will be closed as a pathway stop event on the date of this being disclosed by the patient.

Commissioner-approved procedures

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

5.14. Staff should refer to relevant guidance issued by the North West London Individual Funding Service relating to individual funding requests and planned procedures with a threshold.

Military veterans

5.15. In line with the Armed Forces Covenant published by the Ministry of Defence 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.

5.16. It is important for GPs or other referrers to notify the Trust of the patient's condition and its relation to military service when they refer the patient. This is so that 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 advice, patients with more urgent clinical needs will continue to receive priority.

Vulnerable patients

5.17. Patients who are vulnerable and/or require additional support may require additional communication between the trust clinician and the GP or other referrer. Such patients should be identified at the outset at the point of referral.

5.18. Staff should always refer to related policies and resources relating to vulnerable or at risk patients available on the Trust safeguarding policies as follows: Safeguarding children and young people and Safeguarding adults.

5.19. Patients with specific information or communication needs because of a disability, impairment or sensory loss must be identified at the outset at the point of referral and relevant details provided as part of the minimum data set, in accordance with the Accessible Information Standard.

6. Overview of RTT rules and principles

6.1. Key principles are as follows:

- Patients should be treated according to their clinical priority and then in the order in which they were added to the waiting list.
- Patients may have more than one RTT clock ticking simultaneously. Each one must be measured separately.
- RTT waiting time clocks only start or stop. There are no suspensions or pauses.
  Staff should refer to the list of Trust-approved RTT codes and descriptions to be used in the Cerner system (see appendix 1).

Clock starts

6.2. The RTT waiting time clock starts when a referral is made by any care professional or service permitted by an English NHS commissioner to make such referrals, to:

- A consultant-led service (regardless of setting) with the intention to assess and if appropriate to treat;
- An interface or assessment service which may result in an onward referral to a consultant-led service; or
- A consultant-led service where a patient self-refers as part of pre-agreed pathways.

6.3. The RTT clock start date is the date that the Trust receives the referral. For referrals received through NHS e-Referral Service, the RTT clock starts when the unique booking reference number (UBRN) is converted into an appointment.

New clock starts for the same condition

6.4. Upon completion of a consultant-led referral to treatment period, a new RTT clock may also start for the circumstances below.

Following active monitoring

6.5. In active monitoring (or watchful waiting) the patient is kept under review to undergo regular monitoring as part of an agreed programme of care. If a decision to treat is made after a period of active monitoring, a new RTT clock commences on the date the decision to treat is made.

Following a decision to start a substantively new treatment

6.6. Where further (substantively new or different) treatment may be required that did not form part of the patient's original treatment plan, a new RTT clock should start and the patient should receive their first definitive treatment within 18 weeks.

6.7. This will include situations where a previous treatment has not been successful and more aggressive treatment is required for the same condition (if the additional treatment did not form part of the patient's previously agreed care plan).

For the second side of a bilateral procedure

6.8. When the patient is medically fit and says they are available for the second bilateral procedure a new RTT clock starts. This is because bilateral procedures (carried out at both left and right sides of the body) for example cataract removals for both eyes will have separate RTT waiting time clocks. The clock for the first procedure will stop on the date that the procedure takes place.

For a rebooked new outpatient appointment

6.9. If the patient DNAs, their RTT clock can be stopped and nullified on the date of the DNA'd appointment having fulfilled the criteria in the DNA policy (see sections 8.28 to 8.46 for further details on DNAs).

Planned patients transferred to the active waiting list

6.10. All patients added to the planned list will be given a target treatment date by which is when their planned procedure/test should take place. Where a patient reaches their target treatment date without a procedure booked, they will be transferred to an active pathway and a new RTT clock started.

Clock stops - for first definitive treatment

6.11. Once a RTT waiting time clock has started it continues to tick until **first definitive treatment** starts (for the condition they were referred for), or a clinical decision is made that stops the clock or the patient declines treatment.

6.12. First definitive treatment is an intervention (including attempted intervention) intended to manage a patient's disease, condition or injury and avoid further intervention. The date that the first definitive treatment starts will stop the clock.
The key factors when determining a clock stop for first definitive treatment are:

A) What do the care professionals in charge of the patient care consider to be the start of treatment?
B) When does the patient perceive their treatment as being started?

What constitutes first definitive treatment is a matter of clinical judgement and may be in consultation with others, where appropriate, including the patient.

6.13. A clock will also stop when a clinical decision to add a patient to a transplant list is made.

Clock stops - for non-treatment

6.14. A waiting-time clock stops when it is communicated to the patient, and subsequently their GP 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 them being discharged, providing that discharging the patient is not contrary to their best clinical interests (see sections 8.28 to 8.46 for further details on DNAs);
- A clinical decision is made to start a period of active monitoring; or
- A patient declines all treatment offered. This does not include when a patient feels they have insufficient information to proceed with treatment. Patients may delay treatment while they seek further information or a clinical review; this does not stop the clock and the pathway should continue on a code 20.

Active monitoring

6.15. There are occasions when it is clinically appropriate to stop a RTT waiting time clock to monitor a patient without clinical intervention. Active monitoring is a decision jointly agreed by consultant and patient that the most clinically appropriate option is to actively monitor the condition for a period, but active treatment is still intended or may be required at a later date.

6.16. The following guidance is provided to determine if a patient should be regarded as active monitoring:

- Requirement for diagnosis. The patient must have a confirmed diagnosis or understand the clinical risk relating to the condition which is being monitored. This must be recorded as part of the clinical correspondence to both the patient and GP.
- Clinical Decision. A clinical decision / agreement is documented that the most appropriate course of action (at this point) is to monitor the condition rather than offer treatment.
- Patient awareness. The patient must know that they are not being treated at this time and why. The clinician should discuss the decision to start active monitoring with the patient in person. Once the decision to start active monitoring has been jointly agreed it must be communicated to the GP.
- Period of active monitoring. The active monitoring period is usually three months or more, however this is clinically defined on a case-by-case basis. The active monitoring period may end sooner than planned if a patient's condition changes or deteriorates.
- Booked review. When agreeing to monitor a patient's condition a follow-up appointment must be booked in the future to ensure the condition is monitored and the patient is not lost to follow-up. This may include additional investigations.
- Active monitoring can also be initiated by the patient, for example where they wish to see if they can manage symptoms without further clinical intervention or where an extended period of thinking time is requested.
- Stopping a patient's clock for a period of active monitoring requires careful consideration. Where a period of 'thinking time' is agreed with the patient, the effect on the RTT clock will depend on the individual scenario.
    - A short period of thinking time, for example where the patient would like a few days to consider proposed surgery, before confirming they wish to go ahead would not initiate active monitoring and the clock will continue.
    - If a longer period of thinking time is agreed, then active monitoring is more appropriate. This will include where the patient wants to see how their condition can be managed or progresses before making a decision as to whether to proceed with the proposed treatment (clock stop for active monitoring).
    - The use of active monitoring for thinking time should be consistent with the patient's perception of their wait. There should be a clear plan for monitoring during this period. A common sense judgement to differentiate between shorter and longer periods of thinking time should be made (Source: NHS England, Reporting RTT waiting times, October 2015).

6.17. It is important that patients are given full information about their options and supported to make an informed decision about the treatment options offered to them.

6.18. The clock is stopped on the date the decision to start active monitoring is made and discussed with the patient. A new RTT clock commences when a new decision to treat is made.

Patients who are medically unfit for surgery

6.19. The scheduler should ascertain the nature and duration of the clinical issues and whether the patient is temporarily unfit.

6.20. Where a patient is temporarily unfit (i.e. cold) the patient remains on the active waiting list and the patient's surgery is rescheduled. The RTT clock continues.

6.21. For patients identified as likely to be unfit for an extended period of time due to more serious clinical issues the patient should be clinically reviewed and considered for removal from the waiting list and possible discharge. The consultant may decide to actively monitor the patient until they become fit for treatment, or, may decide to discharge the patient back to the care of the GP / referrer; both actions would stop the RTT clock.

6.22. Ultimately patients should be clinically considered on a case by case basis and decisions will be based on the patient's best interests and what would be least detrimental to their overall pathway journey.

6.23. Clinicians must make decisions about any removal from the waiting list. Decisions must be communicated with the GP or other referrer and the patient by letter. All correspondence must be kept in the patient's electronic clinical notes on Cerner for auditing purposes.

6.24. Clock stops should not be applied when it is identified that further work up is required prior to treatment i.e. cardio review or scans; these tests should be accommodated within RTT guidance and a clock should continue to tick.

Clinical review

6.25. No patient will be automatically discharged due to patient-initiated reasons (cancelling and rearranging, not attending). Any decision to refer back to the GP / original referrer and stop the RTT clock (without treatment) are to be made on the basis of clinical review about the individual patient's circumstances.

6.26. There are many reasons of why a patient will require a clinical review during their treatment pathway. For example, if a patient repeatedly cancels their appointments and this results in extended delay to their treatment. The reviewing clinician will require relevant information to facilitate appropriate decision making about individual patient circumstances, therefore all patient and hospital initiated delays and reasons should be considered.

6.27. When requesting a clinical review involving patient choice the initiating manager should provide the clinician with relevant pathway information. A short guide to initiating clinical reviews is provided in appendix 2. The reason for referral back to the GP / original referrer should always be made clear in the patient's notes and in the letter to the GP / original referrer and to the patient.

6.28. Patients who wish to postpone treatment for an extended period of time because they wish to plan their treatment around personal or social circumstances should be managed in accordance with the policy outlined in sections 10.13 – 10.16.

Patient and GP / Referrer Communications

6.29. All correspondence with the patient and their GP / original referrer must be accurately recorded on to Cerner or other approved system. This will include correspondence / conversations about choice of dates of appointments / admissions offered to patients and the patient's response, or any requests to defer treatment for personal/social reasons where patients declare a period of unavailability.

6.30. ICHT requires copies of all clinic and referral letters to be stored on the clinical document library (CDL). In the event that an error in the GP letter already sent is identified, the original letter must be retained on the system and a new letter created clearly stating that an amendment has been made.

6.31. The NHS Contract timescale for producing and sending letters to GPs following clinic attendance is 7 calendar days (from 1 April 2018)[3].

Validation letters to contact patients

6.32. Validation letters are used to contact patients who cannot be contacted first by telephone using all available contacts and voicemails. Where telephone contact still cannot be made (two attempts on different days) the patient is to be sent a standard validation letter inviting the patient to make contact with the relevant department within 3 weeks (21 days).

6.33. If the patient does not respond within the timeframe they will be brought to the attention of the clinical team to confirm whether in the absence of any contact with the hospital, it would be appropriate to discharge the patient back to the care of their GP or other referrer. This discharge must be communicated by letter to the patient and GP in a timely manner. This decision would stop the original RTT clock.

6.34. Where individuals have specific communication needs, services and clinical staff should ensure the patients preferred method of communication is reviewed and provide information in alternative formats, or consider other specific requirements.

6.35. A separate validation process exists for contacting patients on a cancer pathway.

7. Receiving referrals and referral methods

Sources of referral

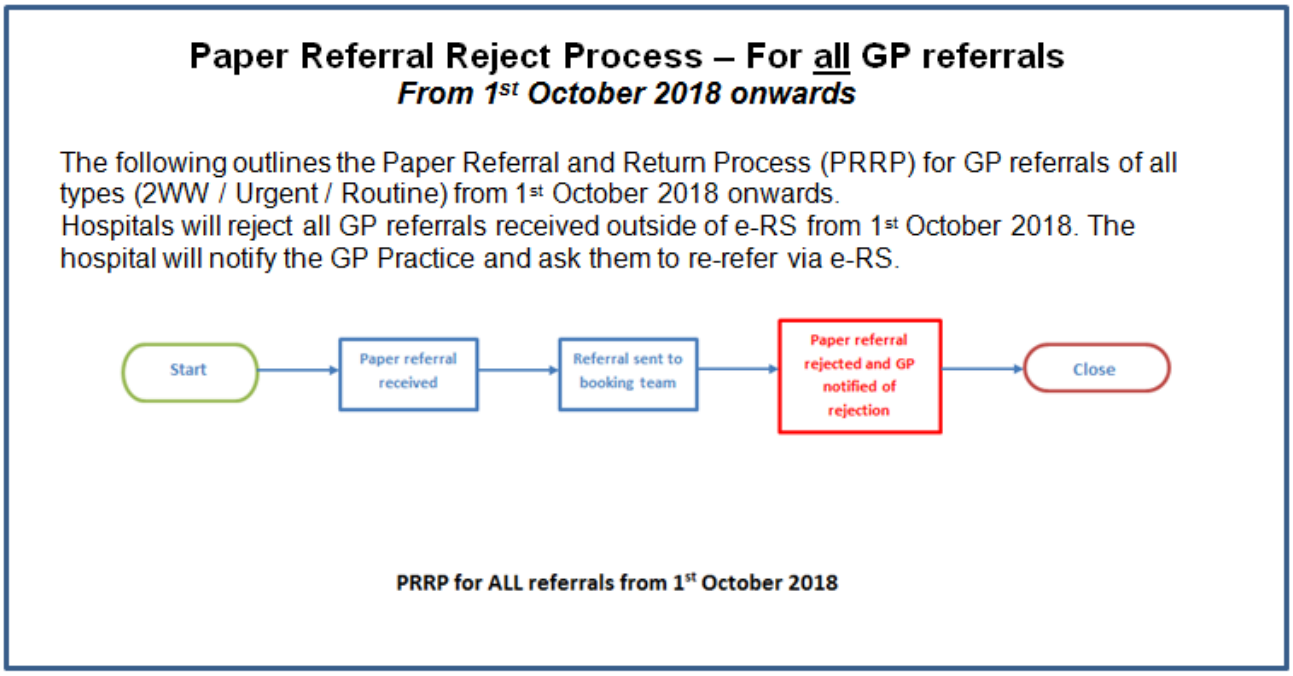
7.1. ICHT accept referrals for elective treatment or diagnostic investigations from:

- GPs or referral management centres (RMCs).
- Consultant to consultant within ICHT; where the care of the patient is being redirected for routine activity such as diagnostics or to a consultant colleague.
- Inter-provider; where the care of the patient is being transferred from other secondary care Trust and community providers to ICHT.
- Self-referrals such as maternity services.
- The private sector; where the care of the patient is being transferred to or from ICHT.

NHS e-Referral Service

7.2. The NHS e-Referral Service (e-RS) is ICHTs method of receiving referrals from GPs and RMCs. In line with the national policy, as of 1 October 2018 referrals received by the Trust and which have been made by GPs and RMCs outside of the e-RS will not be accepted. This does not apply to the excluded services listed in appendix 3.

[3] See NHS Standard Contract Technical Guidance (Updated January 2018)



The minimum dataset for referrals to ICHT

7.3. The following information must be provided on all referrals to the Trust. This is known as the referral minimum data set (MDS):

- Clinical priority of the referral (whether routine or urgent); [4]
- The specialty the patient is being referred into and the sub-specialty if known. Note: patients should be referred to a specialty rather than an individual consultant; [5]
- Patient details (full name, date of birth, gender, NHS number, address and contact telephone number - home and mobile preferably);
- Relevant clinical details of the patient, e.g. pre-existing conditions, any medication;
- Referrers must record any special requirements, e.g. physical disability, mental health issues or spoken language interpreter etc. Referrers must also record any specific information or communication needs relating to disability, impairment or sensory loss as per the Accessible Information Standard.
- Expected action or response (advice, diagnosis, treatment);
- Date of decision to refer;
- Contact details for the referrer (name, telephone number and email address); &
- Where relevant, the current RTT status, including the original clock start date.

7.4. Minimum data sets are a legal requirement for NHS Trusts and must be included on any referral to, or from, the Trust. If a referral is missing any of the minimum data set, the receiving department will contact the referrer within 1 working day of receipt to request the missing information. Patients must not be disadvantaged because it has not been provided and this does not constitute a reason to refer the patient back to their GP or other referrer.

Registration of referrals

[4] Urgent includes 2ww and breast symptomatic.

[5] Under the NHS constitution, a patient has the right to choose which hospital or clinic to go to for their outpatient appointments, as well as which consultant-led team will be in charge of their treatment (as long as that team provides the required treatment). If a patient has exercised their right to choose, this should be included on the referral.

7.5. All referrals for an e-RS directly bookable service will be automatically uploaded from eRS to CDL within 1 working day of the appointment being made. Failed uploads will be managed by the Patient Service Centre (PSC) via an exception queue within the e-vetting system (CDL3).

- The referrals in the 'Appointment Slot Issue' (ASI) worklist in e-RS where the patient has not previously been booked an appointment in Imperial under the same UBRN will not automatically upload to CDL until the referral is booked into an appointment in Cerner.
- Referrals for a 'Referral Assessment Service' (RAS) will not automatically upload to CDL until the referral is booked into an appointment in Cerner.

7.6. The process of recording a referral must include recording the RTT clock start date. An RTT clock start date is the date that the original provider receives the referral. For referrals made via:

- The NHS e-Referral service; this is the date the Unique Booking Reference Number (UBRN) is received as an ASI, RAS or directly booked into the Trust.
- Another Trust or community provider; the RTT clock start date recorded by the other Trust or community provider.
- Consultant to consultant.
- Via email or letter (non-GP letters) direct to ICHT; this is the date the referral is received by ICHT.

7.7. ICHT requires all new referrals to be saved on to the clinical document library (CDL) prior to the patient attending clinic. For e-RS, this is at the point the appointment is made. For non e-RS, this is at the point the referral is received in the Trust.

7.8. ICHT also receives requests for clinical advice and guidance from GPs and other referrers on potential referrals. To provide a robust audit trail, these are encouraged through the e-Referral Service Advice and Guidance functionality once full implemented.

Prioritisation and clinical review of referrals (vetting)

7.9. Once referrals have been recorded on Cerner or other Trust approved PAS the referral is either managed by the cancer 2 week wait team for immediate booking (for suspected cancer or breast symptomatic referrals via e-RS) or directed for to the appropriate consultant or clinical team for vetting. Referrals received via e-RS without the letter will be managed through the MRL (Missing Referral Letter) worklist and the PSC will contact the GP to inform them that the referral cannot be accessed without the letter.

7.10. Where a referral needs vetting, ICHT requires this to be done within:

- 1 working day of registration for urgent referrals (other than suspected cancer or breast symptomatic)
- 2 working days of registration for routine referrals

Changing the status of referrals

7.11. The recommended timeframe for changing the status of referrals is within 2 working days of registration.

Upgrading or downgrading a referral

7.12. Where a consultant or clinical team suspect the possibility of cancer, the referral should be upgraded from routine to urgent. The GP or other referrer must be informed at this time by the person vetting the referral that the clinical priority of their patient has changed. The change will be adapted and managed within the Cerner tracking system.

7.13. Referrals cannot be downgraded without discussion and agreement by the receiving consultant with the original referrer.

Redirecting referrals

7.14. Where the referral has been made to the incorrect clinical team or consultant, the receiver should redirect the referral to the correct clinical service. This does not affect the patient's RTT pathway and the clock should continue to tick from the referral received date.

Rejecting referrals

7.15. At the point of clinical vetting, referrals deemed as inappropriate will be returned to the GP or other referrer with an explanation as to why it has been rejected. It is then the referrer's responsibility to notify the patient that the referral was rejected to ensure the patient does not attend a previously arranged appointment. The duty of care rests with the referrer until such time as the referral is accepted by ICHT.

Consultant to consultant referrals

7.16. Consultant to consultant referrals must follow the guidelines agreed locally by Commissioners. Refer to the Internally Generated Demand (IGD) policy on the Trust Intranet for full detail.

7.17. A clinician must not refer a patient to another clinician where the presenting conditions are unrelated to the original referral from primary care, except in the circumstances listed in the IGD Policy. The exceptions include referrals classed as clinically urgent by a referring consultant (i.e. those which must be seen within 2 weeks).

7.18. As such, patients will be returned to primary care where a presenting condition is not classed as clinically urgent or related to the original referral.

7.19. In cases where the patient is identified as having suspected cancer, the patient must be transferred to the care of the appropriate service within 48 hours. It is the responsibility of the referring clinician to inform the patient's GP or other referrer that the patient has been referred to another team.

Inter-provider transfers (including community services)

7.20. ICHT accepts referrals from other secondary care Trusts for both urgent (including suspected cancer) and routine tertiary care and community providers.

7.21. Both the patient and receiving Trust Consultant must consent to the inter-provider transfer (IPT), whether for diagnostics, treatment or a clinical opinion.

7.22. ICHT may also refer patients to other tertiary services. The same principles apply to referrals going out as they do coming in.

7.23. As part of the referral minimum data set, the patient's RTT pathway status (current 18-week position) and RTT clock start date must be provided as the Trust will inherit any RTT wait already incurred if they have not yet been treated.

7.24. Where it is clear that the patient is yet to receive assessment and/or treatment the RTT clock starts at the date on which the original referral was received by the originating referrer. In practice this means that the receiving 'organisation' (most commonly the ICHT acute setting) should back-date the 'referral received date' in line with the original referral start date.

7.25. If the patient is referred to ICHT for a clinical opinion or diagnostic test only, the clinical responsibility for the patient remains with the originating referrer and ICHT does not record this as an RTT 18-week or urgent suspected cancer pathway.

7.26. If the patient is referred to ICHT from a secondary care provider after receiving the first definitive treatment with a request for a new or substantively different treatment, a new RTT 18-week clock starts when the referral is received.

Managing community pathways

7.27. Staff should refer to the Community pathways SOP for full details of how to facilitate and record referral pathways that cross between our community and secondary care settings.

8. Outpatient booking processes

General principles and standards for outpatient booking

8.1. Appointments are booked in order of clinical priority (urgent over routine) and then in chronological order.

8.2. War pensioners and service personnel must receive priority access for any conditions which are related to their service (over other patients with the same level of clinical need).

8.3. The NHS e-Referral Service is ICHTs only method of receiving referrals from GPs and RMCs. If there are insufficient slots available for the selected service at the time of attempting to book, the patient will appear on the Trust's appointment slot issue (ASI) work list. A member of the booking team will contact the patient directly to arrange an appointment.

8.4. Where a non-GP referral is received a member of the booking team should telephone the patient directly to arrange an appointment in accordance with the Trust outpatient waiting list SOP.

Reasonable offer of appointment

8.5. Patients should be offered reasonable notice of appointment. For an offer of appointment to be deemed reasonable for routine appointments, this is an appointment date with at least 3 weeks' notice and a choice of 2 dates. Appointments with shorter notice may also be offered although are only deemed reasonable if they are accepted by the patient.

8.6. Patients referred as suspected cancer or breast symptomatic must be offered appointments (to be seen) within 14 days and as such will not be routinely offered a choice of appointment date. However, patients that choose an appointment outside of two weeks do not exempt themselves from the standards.

Contacting patients

8.7. The timeframes for contacting patients must be done in accordance with the outpatient waiting list SOP. Where individuals have specific communication needs, services will provide help and information in formats that the patient can understand in line with the NHS guidance on Accessible Information Standards.

Reminding patients

8.8. In an effort to reduce the number of patients not attending their appointment, ICHT encourages all services to remind patients of their upcoming appointments. This could be telephoning the patient in person, or by sending a text or voice reminder.

8.9. Patients will be sent a confirmation letter of their booked appointment with details of who to contact about any queries. Patients can also opt to receive appointment details by e-mail. The letter will explain the Trust policy for not attending or cancelling appointments.

Clinic templates

8.10. Clinic templates should be reviewed annually. This will take into account capacity and demand planning, clinicians' planned leave and additional commitments, such as on-call and MDT meetings. This review should include a review of the e-Referral Service Directory of Services to ensure capacity is accurately represented.

8.11. The start and finish time of the clinic should reflect the actual time the clinician is expected to be in the clinic - face to face with the patient.

8.12. The clinician is expected to arrive in clinic on time, allowing for any preparation required for the first appointment and administration time within the four hour session.

8.13. The lead clinician should be involved in any discussions around changing clinic templates. Other departments, such as the outpatient nursing team, phlebotomy, radiology and other diagnostic teams should be consulted in relation to resource and room availability, to support any changes to clinic templates.

Clinical outcome forms

8.14. Every patient, new and follow-up, whether attended or not, will have an attendance status and outcome recorded on Cerner or other ICHT approved PAS at the end of the clinic. Clinics will be fully outcomed or 'cashed up' within one working day of the clinic taking place.

8.15. Clinical outcome forms are essential to capturing the decisions that determine a patient's progress along their RTT pathway.

8.16. Every attendance must have a defined clinical outcome and RTT status recorded by clinicians on the clinic outcome form directly after the patient's attendance. The RTT status must relate to the outcome of the current activity not next activity. The form must be completed on the day of the clinic and provided to reception staff. This should be recorded on Cerner or other ICHT approved PAS as part of the check in and check out process. These actions should take place on day of clinic and it is the responsibility of the clinic manager to assure this is kept up to date. Outcome forms can be used to outcome telephone clinics.

Cancellations and appointment changes

Hospital initiated cancellations

8.17. ICHT will avoid cancelling outpatient appointments wherever possible.

8.18. Where an outpatient appointment is cancelled, the patient should be rebooked within a maximum of four weeks of the original date or sooner to enable treatment to still take place in under 18 weeks. The reason for cancellation should be recorded on the Cerner patient management system.

8.19. Clinicians are actively encouraged to book annual and study leave requests as early as possible and ideally the year ahead.

8.20. Eight weeks' notice of any planned leave for clinic staff should be given for a clinic cancellation or reduction in order to minimise inconvenience to patients. Six weeks' notice is the minimum notice required.

8.21. Requests made at less than six weeks' notice will only be accepted for reasons of sickness or a family emergency; and can only be authorised by the appropriate Divisional Director or nominated deputy, and by exception.

8.22. Best practice suggests that 'fire break' clinics at six to eight week intervals be built into the annual plan to manage unforeseen circumstances. The patients of the cancelled clinic can then be moved to the fire break clinic thus minimising the amount of administrative work required and inconvenience to patients.

Patient initiated cancellations

8.23. Patients can cancel their appointment once. If they cancel and ask to rearrange a second time, they should be discussed with the clinical team and considered for referral back to the care of the GP.

8.24. Unless it is clinically inappropriate (and the appointment was reasonable and clearly communicated) the patient will be discharged. There must be specific protection for the clinical interests of suspected cancer patients, children and young people under 18 years and vulnerable adults. We will endeavour to gain an understanding of the circumstances when reviewing patient cancellations.

8.25. If a decision to discharge is made, a letter must be sent to the referrer and the patient. All cancellation reasons should be recorded on Cerner.

Additional advice

8.26. Where the patient has experienced delays and inconvenience through hospital cancellations or reschedules, this should be taken into consideration when deciding

8.27. Patients who cancel and then contact the Trust and declare an extended period of unavailability due to social/personal reasons will follow that part of the policy (see sections 10.13 – 10.16).

Did not Attends (DNAs)

8.28. A DNA is defined as a patient failing to give prior notice that they will not be attending their appointment. Patients who give prior notice (irrespective of how short the period of notice they give) are not classed as DNAs and this will be treated as a patient cancellation and as such follow that part of the policy.

8.29. All patients who do not attend for their appointment must be reviewed by the clinician. The clinician will review the patient's notes or referral information in order for a clinical decision to be made regarding next steps, taking into account the individual circumstances. This would ordinarily happen directly after clinic.

8.30. A further appointment would not be routinely offered and the patient will be discharged back to the GP / original referrer, where the following criteria is met:

i. Discharging the patient would not be contrary to the patient's best clinical interests.
ii. The appointment was reasonable and was clearly communicated, including sent to the correct patient address.
iii. There is specific protection for the clinical interests of suspected cancer patients, children and young people under 18 years and vulnerable adults. See sections below.

8.31. The Trust will endeavour to be as flexible as possible where reasons for the DNA were beyond the patient's control; administrative staff should try to contact the patient to ascertain their reason for the DNA and the reason should be recorded on the Cerner patient management system.

First outpatient appointment DNAs

8.32. If the patient DNAs their first appointment, their RTT clock can be stopped and nullified on the date of the DNA'd appointment provided the criteria described above.

8.33. If the clinician decides another first appointment should be offered, a new RTT clock will be started (at zero) on the day the new appointment is agreed with the patient.

8.34. Patient DNAs at any other point on the RTT pathway will not stop the RTT clock, unless the patient is being discharged (following clinical review) back to the care of their GP.

Subsequent (follow-up) appointment DNAs

8.35. If a patient DNAs a follow-up appointment the RTT clock continues if the clinician indicates that a further appointment should be offered.

8.36. If the clinician indicates another appointment should not be offered, the RTT clock stops on the date that the patient is discharged back to the care of their GP or other referrer.

Adult patients who are vulnerable

8.37. The patient/carer must be contacted in person and offered another appointment and the GP or other referrer should be informed of the date and time. If the patient does not attend the second consecutive appointment, consider for discharge back to the care of their GP or other referrer.

8.38. A decision must not be made without first making contact with the patient or their carer to gain an understanding of the circumstances. The clinician is responsible for liaising with the GP other referrer to assess the risk and consider further actions as appropriate.

8.39. Staff should always refer to related policies and resources relating to vulnerable or at risk patients available on the Trust safeguarding pages.

Suspected cancer patients

8.40. Suspected cancer patients will be offered one further appointment. If they fail to attend a second consecutive appointment, the referral will be assessed by the clinical team and they too may be discharged back to the care of their GP. Patients should only be referred back to their GP after multiple (two or more) DNAs.

8.41. Staff should refer to the ICHT Cancer Referral Centre SOP for Management of 2 Week Wait Suspected Cancer and Symptomatic Breast Referrals.

Children and young people who are not brought in

8.42. The Trust Policy for the Management of Children Who Are Not Brought to Outpatient Appointments gives guidance on the process that must be followed if a child fails to attend their outpatient appointment.

8.43. A child is defined as anyone who has not reached their 18th birthday by the date of their appointment. It is important that this policy is used for young people aged 16 – 17 who have been transitioned to adult services and are seen within the adult outpatient environment.

Patients who arrive late for their appointment

8.44. ICHT asks all patients to keep their appointments and arrive in good time.

8.45. If a patient arrives after their appointment time, every effort will be made to see them for their consultation, for example, if delayed arrival is the responsibility of the Patient Transport Service. Patients who arrive late may have to be seen last or it may need another member of the team seeing the patient, if clinically appropriate.

8.46. If the patient arrives too late to be seen and cannot be accommodated within the scheduled time of the clinic, their appointment should be cancelled and another appointment should be made. This will be treated as a patient cancellation and as such follow that part of the policy (it is important that the appointment is cancelled and not rescheduled). Details of this action and reason for delay should be recorded on the Cerner patient management system.

Pre-operative assessment

8.47. The same rules apply for Pre-operative assessment for patient cancellations and DNAs as for any other clinical appointment where the patient has been given reasonable notice.

9. Diagnostic booking processes

Referrals for diagnostic tests / procedures

9.1. Referrals for diagnostic tests/procedures are accepted from the following sources:

- GPs, referral management centres or direct access
- Consultant referral (internal to ICHT)
- Consultant referral (tertiary)

9.2. Patients should only be referred to a diagnostic department if they are ready and available to attend their appointment in the next 6 weeks, unless the diagnostic test is planned for a specific time. It is the responsibility of the referrer to ensure the patient is made aware of this.

9.3. The policy is that all referrals are recorded within 1 working day of receipt. The administration teams are responsible for ensuring that the internal request lists are reviewed and cleared on a daily basis to avoid delays in booking.

9.4. Once diagnostic test requests have been recorded the referral is directed to the clinical team for vetting and clinical prioritisation. ICHT requires this to be done within:

- 1 working day of registration for urgent
- 2 working days of registration for routine

Upgrading or downgrading requests for tests and rejecting requests (See section 7 for reference)

9.5. Patients should wait no longer than **6 weeks**[6] for any routine diagnostic test and no longer than **2 weeks** for urgent cases.

9.6. For all urgent suspected cancer referrals, the diagnostic request must be clearly marked as ‘suspected cancer’.

National diagnostic clock rules

- Diagnostic clock start: The diagnostic clock starts when the request for a diagnostic test or procedure is made (often at a first outpatient appointment).
- Diagnostic clock stop: The diagnostic clock stops when the patient receives the diagnostic test/procedure.

[6] The national standard is that no more than 1% of patients should wait more than 6 weeks for a diagnostic test.

9.7. A large proportion of patients referred for a diagnostic test will also be on an open RTT pathway. *The 6-week diagnostic clock is not the same as an RTT 18 week waiting list clock which will continue to tick.* In these circumstances, the patient will have both types of clock running concurrently:

9.8. If a patient undergoes a diagnostic procedure, during which treatment is also carried out, then the 6-week waiting time target still applies in accordance with the National Diagnostic Waiting Times Guidance. The completion of the procedure during this appointment will stop the patients 18 week RTT clock.

9.9. Where a patient's RTT pathway is closed (treatment already completed), and it is decided during a follow-up appointment that a new diagnostic is required, then a new diagnostic clock would start at the point of request. It is the outcome of the clinic appointment that will determine whether a new RTT clock needs to be started as well.

Diagnostic booking standards

9.10. General principles and standards for diagnostic booking.

- Tests are booked in order of clinical priority (urgent over routine) and then in chronological order.
- Clinicians or administrators inform patients of the likely waiting time for diagnostic appointments.
- The decision to add patients to the diagnostic waiting list must be made by the consultant or designated clinical member of the team. It is the responsibility of the clinician (or designated clinical team member) to place the order for the patient to enable them to be added to the waiting list.
- Every effort is made to contact the patient directly to agree the diagnostic test or procedure date.
- If the patient cannot be contacted (following unsuccessful telephone contact and checking with the GP or other referrer that ICHT have the correct contact details) the patient will be given the next available appointment and sent an appointment confirmation letter.
- Where individuals have specific communication needs, services will provide help and information in formats that they can understand.
- ICHT requires that diagnostic tests/procedures are booked within 5 days of receipt of referral/request.
- ICHT requires patients to be offered a choice of 2 appointment dates with at least 3 weeks' notice of the appointment (reasonableness criteria). This does not preclude offering patients the choice of an earlier date if they agree.
- The appointment must be booked before the 6-week target. The cancer and 18 week RTT status should always be checked.
- If a patient turns down reasonable appointments, i.e. 2 separate dates with 3 weeks' notice, the diagnostic waiting time for that test/procedure can be set to zero from the first date offered.

Diagnostic cancellations and DNAs

Hospital initiated

9.11. Every attempt should be made not to cancel diagnostic tests/procedures, however if the Trust cancels a diagnostic appointment, the patient's appointment should be re-booked as close as possible to their original appointment and within the 6-week target date, with consideration to RTT and cancer target dates where applicable. The diagnostic clock continues and is not restarted.

Patient initiated cancellations and DNAs

9.12. **The same rules apply for diagnostics for patient cancellations and DNAs as for any other clinical appointment where the patient has been given reasonable notice.**

9.13. The new diagnostic appointment should be a reasonable offer and ideally as close to their cancelled or DNA'd appointment as possible, and within the new/recalculated 6-week target date, with consideration to RTT and cancer target dates where applicable.

9.14. If the patient was not given reasonable notice the diagnostic clock would continue to tick and a new appointment should be offered if clinically appropriate

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9.15. Where a diagnostic test is rebooked following a patient cancellation or DNA [as long as the appointment was reasonable], a new diagnostic clock is started on the date of the cancelled/DNA'd appointment.

9.16. If a clinical decision is taken that the patient no longer requires the diagnostic test, the patient will be removed from the diagnostic waiting list and a letter will be sent to the original referrer (for the diagnostic). Where there is an RTT clock this will continue.

10. Inpatient booking processes

Adding a patient to an inpatient waiting list

10.1. The decision to add patients to the waiting list must be made by the consultant or designated clinical member of the team.

10.2. The patient must have accepted the clinician's advice on elective treatment prior to be added to the waiting list.

10.3. The clinician places an order for treatment in clinic, at which point a scheduler has 2 working days to add the patient to the inpatient waiting list. It is the responsibility of the clinician (or designated clinical team member) to action the request (place the order) for the patient to enable them to be added to the waiting list.

10.4. Patients must not be added to the inpatient waiting list if:

- They are unfit for the procedure
- Further investigations are required first to confirm suitability for surgical procedure
- Not ready for the surgical phase of treatment
- They need to lose weight /stop smoking/change lifestyle
- Clinically the operation cannot or should not be done sooner due to clinical reasons (see planned waiting list)

Inpatient booking standards

10.5. Clinically urgent patients will be prioritised and booked according to need, with 2 week waits first, then other urgent patients.

10.6. All routine elective patients must be booked chronologically, meaning patients on the waiting list the longest are booked first.

10.7. War pensioners and service personnel must receive priority access for any conditions which are related to their service (over other patients with the same level of clinical need).

10.8. For an offer of appointment to be deemed reasonable, the Trust has to agree an admission date with the patient giving them at least 3 weeks' notice and a choice of 2 dates. Admission dates with shorter notice may also be offered although are only deemed reasonable if they are accepted by the patient.

10.9. Patients will be contacted by telephone to arrange their admission date and this date confirmed in writing. Two attempts must be made on separate days. Where contact cannot be made after the second attempt, follow the policy for validation letters.

10.10. Where individuals have specific communication needs, services will provide help and information in formats that they can understand.

Outsourcing

10.11. Where there are capacity limitations the Trust may decide to outsource the treatment of patients for certain procedures to another qualified provider. Appropriate patients will be identified by the service and contacted by the outsourcing team. The patient must agree to the outsourcing of their treatment. Staff should refer to the outsourcing process which is contained within the Inpatient waiting list SOP.

Patient unavailability for personal or social reasons

10.12. Some patients will turn down admission dates because they wish to plan their treatment around personal or social circumstances. Patients who declare an extended period of unavailability must be brought to the attention of the clinical team to be reviewed.

10.13. If the patient is not available for admission of up to 8 weeks of first being contacted to arrange a TCI, the patient will be brought to the attention of the clinical team to be reviewed. The patient will be discharged back to their GP and the RTT clock will stop, unless it is agreed by the consultant that this is contrary to their best clinical interest.

10.14. Ultimately, patients will be considered on a case-by-case basis however it is generally not in a patient's best interest to be left on a waiting list for extended periods of time (i.e. several months). There must be specific protection for the clinical interests of suspected cancer patients, children and young people under 18 years and vulnerable adults.

10.15. If a decision to discharge is made the reason should be made clear in the letter to the GP or original referrer and to the patient.

Admission patient initiated cancellations

10.16. Patients can cancel their admission date once. If they cancel and ask to rearrange a second time, they should be discussed with the clinical team and considered for referral back to the care of the GP. Unless it is clinically inappropriate (and the admission was reasonable and clearly communicated) the patient will be discharged. There must be specific protection for the clinical interests of suspected cancer patients, children and young people under 18 years and vulnerable adults.

10.17. When discharging a patient, a letter must be sent to the referrer and the patient. All cancellation reasons should be recorded on Cerner.

Admission Did Not Attends

10.18. All patients who do not attend their admission must be reviewed by the clinician.

10.19. A further admission would not be routinely offered, and the patient will be discharged back to the GP / original referrer, where the following criteria is met:

i. Discharging the patient would not be contrary to the patient's best clinical interests;
ii. The appointment was reasonable and was clearly communicated, including sent to the correct patient address;
iii. There must be specific protection for the clinical interests of suspected cancer patients, children and young people under 18 years and vulnerable adults.

Cancellations on the day of surgery

10.20. Should it be necessary to cancel operations on the day for non-clinical reasons, priority will be based on clinical need with consideration of high priority patients.

10.21. High priority patients includes clinically urgent cases, cancer, patients previously cancelled on the same pathway (28 day rebooks), and long waiters.

10.22. If it is not possible to perform the operation then a verbal explanation together with an apology must be given to the patient by the consultant, surgeon or anaesthetist (or senior member of the clinical team). The discussion with the patient (and their family) should include information about what to expect next and who to contact about any concerns, providing a copy of the Trust's short notice cancellation leaflet. This applies to patients cancelled for clinical reasons as well as patients cancelled for non-clinical reasons.

10.23. In the case of elective operations cancelled by the Trust for non-clinical reasons on the day of admission, after admission or on the day of surgery the patient must be offered an admission date that is within 28 days of the cancellation in order to meet the NHS Constitution guarantee on cancelled operations. This should be noted on the waiting list record to ensure that the patient is not cancelled again. Follow the workflow in the ICHT Cerner guide.

10.24. Where a patient cannot be re-booked within 28 days, the specialty manager must escalate this to the General Manager for intervention.

Planned procedures waiting list

10.25. Planned care means an appointment/procedure or series of appointments/procedures as part of an agreed programme of care which is required, for clinical reasons, to be carried out at a specific time or repeated at a specific frequency.

10.26. Planned activity can include inpatient or day case surgical procedures, diagnostic tests and outpatient consultations. Examples include dialysis, or a 6-month repeat colonoscopy following removal of a malignancy or tumour, or a flexible cystoscopy carried as an outpatient appointment as part of a non-RTT follow-up.

10.27. There are strong clinical governance and safety reasons for the correct inclusion of patients onto the planned waiting list, and why planned activity should not be deferred beyond the clinically determined dates.

Inclusion criteria for planned procedures and diagnostic tests

10.28. 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.

10.29. When patients on planned lists are clinically ready for their care to begin and reach their target treatment date for their planned procedure, they will either be admitted for the procedure or be transferred to the relevant active waiting list and appropriate clock will start i.e. RTT or DM01 6-week wait.

11. Further information

Implementation and dissemination

11.1. Staff involved in the implementation of this policy and procedures, both clinical and administrative, must undertake training provided by the Trust both at induction and by way of regular annual updates. It is the responsibility of all members of staff to

understand the principles and definitions which underpin delivery of all elective access performance measures; cancer, referral to treatment (18 weeks), diagnostics and audiology.

11.2. Key performance indicators (KPIs) have been identified to monitor compliance with the policy, and where performance is below the expected thresholds corrective action must be taken e.g. further training and support.

11.3. The new policy will be uploaded onto the Trust's intranet under Policies and Procedures and the Trust external website, with supporting communications.

11.4. It will be incorporated into elective care training and for all appropriate staff it will be a requirement to read this policy.

References and further guidance

- Department of Health, Code of Conduct for Private Practice: January 2004
- Department of Health, False or Misleading Information (FOMI) offence: February 2015
- Department of Health, Guidance on implementing overseas charging regulations: March 2016
- Department of Health, Meeting the healthcare needs of Armed Forces personnel, their families and veterans, December 2008
- Department of Health, NHS Constitution for England: October 2015
- Department of Health, Referral to treatment waiting times rules suite: October 2015.
- Equality and Human Rights Commission, Equality Act 2010: January 2011
- Equality and Human Rights Commission, Human Rights Act: September 2015
- Hammersmith and Fulham CCG: Individual funding requests and planned procedure with a threshold

For further national guidance

- NHS England provides guidance on monitoring and reporting of referral to treatment waiting times
- See also Department of Health, National Cancer Waiting Times Monitoring Dataset Guidance V9.0: October 2015

For related Trust policies and standard operating procedures

- ICHT and NW London Collaboration of CCGs: Internally Generated Demand (IGD) policy
- ICHT: Diagnostics (DM01) validation SOP
- ICHT: Inpatient waiting list SOP
- ICHT: Outpatient waiting list SOP
- ICHT: Planned waiting list SOP
- ICHT: Community pathways SOP
- ICHT: RTT Validation SOP
- ICHT: RTT Clinical harm review for patients who have waited over 52 weeks for treatment SOP
- ICHT: Policy for the Management of Children Who Are Not Brought to Outpatient Appointments (Do Not Attend / Disengage).
- ICHT: Overseas Visitors Policy and Procedure.

Monitoring arrangements

All aspects of elective care are reported through the Trust Elective Access Programme structures. These include operational reporting to the Trust Board, Executive Committee, Divisional and Directorate performance reviews, Weekly

planned care group and the speciality elective access review meetings. Cancer performance is reported through this same structure above, including also Trust Cancer Board and through structures which report into the London Cancer Alliance.

Definitions

2WW	Two-week wait: the maximum waiting time for a patient's first outpatient appointment or 'straight to test' appointment if they are referred as a 62-day pathway patient.
18 Weeks	The maximum waiting time for a patient to begin their treatment for routine conditions following a referral into a consultant-led service.
Active monitoring	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention.
Active waiting list	The list of elective patients who are fit (for treatment), ready and able to be seen or treated at that point in time. Applicable to any stage of the RTT pathway where patients are waiting for hospital resource reasons.
Bilateral procedures	Where a procedure is required on both the right and left sides of the body.
Chronological booking	Refers to the process of booking patients for appointments, diagnostic procedures and admission in date order of their clock start date.
Consultant-led service	A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse-led clinics.
Elective care	Any pre-scheduled care which doesn't come under the scope of emergency care.
Fire-break clinics	These are clinics which are left empty in case a fully booked clinic needs to be cancelled and rearranged due to unforeseen reasons. Patient appointments are moved to the fire break clinic, minimising the amount of rebooking/administrative work required.
Incomplete pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage.
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night.
Interface or assessment service	Any arrangement that incorporates an intermediary level of clinical triage, assessment and treatment in or between traditional primary and secondary care. In the context of RTT, if the service in question accepts referrals that would otherwise have traditionally been provided by a consultant or consultant-led team; and the referrals may go on to be onward referred to a consultant-led service, then then this should be classed as an 'interface service', and a consultant-led waiting time clock should start on receipt of referral.
Minimum dataset	Minimum mandated information required to be able to process a referral either into the cancer pathway or for referral out to other trusts.
Nullified	Where the RTT clock is not included in any reporting of RTT performance.
Patient-initiated delay	Where the patient cancels, declines offers, does not attend appointments or admission or requests to defer their admission for social or personal reasons. This in itself does not the stop the RTT clock.
Planned inpatient waiting list (for diagnostic or surgical procedures)	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18-week RTT pathway.
Reasonable offers	A choice of two appointment or admission dates with three weeks' notice.

Cerner	Cerner referred to as the Trust health information system that allows staff to electronically store, capture and access patient health information.

Abbreviations

Term	Definition
ASI	Appointment Slot Issue: During the appointment booking process the NHS e-Referral Service will allow the referral to enter the ASI process if there are no slots available for booking at the time of the appointment search. Each time this happens the referral will appear on the Trust 'Appointment Slot Issues' list.
CCGs	Clinical commissioning groups: commission local services and acute care.
DNA	Did not attend: patients who give no prior notice of their non-attendance.
e-RS	(National) E-Referral Service. The NHS e-Referral Service combines electronic booking with a choice of place, date and time for first hospital or clinic appointments. Patients can choose their initial hospital or clinic appointment, and book it in the GP surgery at the point of referral.
IPT	Inter-provider transfer.
MDS	Minimum dataset: minimum information required to be able to process a referral including IPT.
MDT	Multidisciplinary team: here describing a group of doctors and other health professionals with expertise in a specific cancer, who together discuss and manage an individual patient's care.
PAS	Patient administration system: records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient.
SOP	Standard operating procedure: Step by step instructions to help Trust staff to carry out routine tasks, for example RTT and waiting list management in accordance with elective access policy.
UBRN	Unique booking reference number: The unique booking reference number assigned by the e-Referral system when a patient accepts an appointment date offered - via the e-Referral system.
RTT	Referral to treatment.
RMC	Referral management centre: A referral management centre or assessment service is a specific type of interface service that does not provide treatment, but accepts GP (or other) referrals and provides advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient.
CDL	Clinical document library: Trust electronic repository to store correspondence with patients and referrers.
IGD	Internally Generated Demand: Sets out locally agreed rules governing non-GP referrals for treatment.
ICHT	Imperial College Healthcare NHS Trust.

Further information for patients

If you wish to get advice and information about our services please visit our website. Alternatively, you can contact the Patient Advice and Liaison Service (PALS)

Contact details:
Email: pals@imperial.nhs.uk

Charing Cross, Hammersmith and Queen Charlotte's & Chelsea hospitals

Telephone: 020 3313 0088

St Mary's Hospital and the Western Eye Hospital
Telephone: 020 3312 7777

The guide to NHS waiting times for patients aims to provide patients with a guide to NHS waiting times including rights and choice in relation to waiting times.

For GPs and other referrers

GPs, other referrers and primary care professionals should visit the GP and referrers section of our website.

Alternatively GPs can contact the GP liaison office.
Phone: 020 3312 5621. Email: GPliaison.imperial@nhs.net

12. Version control

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Contributing Authors	
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Committees / Groups	

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Committee / Groups:	ICHT Elective Care Delivery Group (represented through nominated individuals for each division at check and challenge meetings); ICHT Elective Care Steering Group; Clinical Quality Group	06.03.2019

Version Control History			
Version	Date	Policy Lead	Changes
	06.03.2019	Terence Lacey	• Active monitoring • Patient initiated cancellations • Diagnostic clock rules and booking standards • Patient extended unavailability for social reasons
	25.03.2019	Terence Lacey	Accessible information (updates)
17.0	26.03.2019	Corporate Governance	Final ratified.

Appendix 1

RTT codes and descriptions in Cerner at ICHT

On 31 July 2017 the Trust introduced changes to RTT codes and descriptions in Cerner to make choosing the right codes for patients easier. The full lookup table is available on The Intranet. If you are unsure about the right code, ask your supervisor for advice.

New RTT description in Cerner
10 New RTT Period
11 New decision to treat after monitoring
12 Consultant referral - new condition
20 Add to Waiting list
20 Pathway continues no change
20 DNA - Rebook (Not First Activity)
20 Diagnostics, add to waiting list
20 Refer to other specialty same condition
21 Referred other provider-same condition
30 Received first treatment today
30 Added to a transplant waiting list
31 Active Monitoring Patient Initiated
32 Clinician/Hospital initiated active monitoring
32 Add to planned WL – surveillance/procedure
33 DNA first contact
34 No treatment patient discharged
34 DNA Discharge
35 Patient declined Rx-patient discharged
36 Patient Died before Treatment
90 Treatment given previously - discharge
90 Treatment given previously - follow up
90 Planned Admission
91 Follow up/Discharge - active monitoring
92 Direct Access to Diagnostics
98 Activity not Applicable to Treat Period
98 Continuation of A&E /emergency pathway
98 Opinion Only
99 Not Known/Admin Error

Appendix 2

Initiating clinical reviews

There are many reasons of why a patient will require a clinical review during their treatment pathway. For example, if a patient repeatedly cancels their appointments and this results in extended delay to their treatment. The reviewing clinician will require relevant information to facilitate appropriate decision making about individual patient circumstances, in line with the Trust elective access policy.

When requesting a clinical review the initiating manager should provide the clinician with as much relevant information as possible; the following gives a suggested format.

Part A Patient Details *(for initiating managers)*	• Name; • Hospital ID • NHS Number
Part B Clinical Review Pathway History *(for initiating managers)*	• Date of referral • RTT start date • Date of decision to admit • Agreed admission date • Appointment history, including dates of any cancellations / DNAs / rearranged appointments or admissions. Include details of who initiated the cancellation and why i.e. patient choice or hospital cancellation. For example, this could be bereavement in the family.

Part C Reason For Clinical Review
 	
(for initiating managers)
	• Provide details of why a clinical review is necessary. For example:
	  ○ Patient-initiated delays where the patient has repeatedly rearranged appointments and / or failed to attend; or
	  ○ The patient has declared an extended period of unavailability for personal or social reasons and has chosen to postpone treatment (and for how long is the requested delay); or
	  ○ The patient has contacted service and asked for an earlier appointment due to a perceived deterioration of their condition.

Key Principles for reviews	• When performing a clinical review the consultant must have access to all relevant information, apply national guidance as contained with the Trust elective access policy and consider the best outcome for the patient.
	• The review may involve the clinical team contacting the patient to discuss individual clinical options or have direct liaison with the GP or other referrer as appropriate.
	• Once the clinical review is concluded, clinicians will determine the next stage in the patient's treatment journey.
	  ○ For example, if the requested delay is clinically acceptable a further appointment /admission date can be arranged.
	  ○ If the decision is that the patient would be best cared for by their GP or other referrer, this must be clearly documented and stored before the patient is discharged or removed from a waiting list.
	• Ultimately patients will be considered on a case by case basis and decisions will be based on the principle of acting in the patient's best clinical interests.

Appendix 3

NHS e-Referral Service – excluded services at ICHT
Excluded Services at Imperial College Healthcare (at Mar-19)

TFC	Service/Sub Service	Reason for exclusion
190	Anaesthetics	Not directly GP accessible service
327	Cardiac Rehabilitation	Not directly GP accessible service
170	Cardiothoracic Surgery	Not directly GP accessible service
822	Chemical Pathology	Not directly GP accessible service
316	Clinical Immunology	Not directly GP accessible service- patients to be referred in to main Allergy clinic first
313	Clinical Immunology and Allergy	Not directly GP accessible service-patients to be referred in to main Allergy clinic first
401	Clinical Neurophysiology	Not directly GP accessible service
800	Clinical Oncology (Previously Radiotherapy)	On specialist commissioning contract-not a GP accesible service
654	Dietetics	Not directly GP accessible service
302	Endocrinology-Traumatic Brain Injury Clinic	Not directly GP accessible service-patients require two appointments. Currently unable to set up in eRS
502	Gynaecology-Termination of Pregnancy	Strict timelines for patients, risk if delay – most are self referrals
370	Medical Oncology	On specialist commissioning contract-not a GP accesible service
422	Neonatalogy	Not directly GP accessible service
651	Occupational Therapy	Not directly GP accessible service
655	Orthoptics	Not directly GP accessible service
658	Orthotics	Not directly GP accessible service
263	Paediatric Diabetic Medicine	Not directly GP accessible service
251	Paediatric Gastroenterology	Not directly GP accessible service
421	Paediatric Neurology	Not directly GP accessible service
657	Prosthetics	Not directly GP accessible service
314	Rehabilitation	Not directly GP accessible service
652	Speech and Language Therapy	Not directly GP accessible service
328	Stroke Medicine	Stroke patients are not direct referral to Trust. They are follow up patients who have previously been admitted to the stroke ware.
329	Transient Ischamemic Attack	Rapid Access same day referral clinic – is not supported by eRS
424	Well Babies	Not directly GP accessible service