Trust-wide Policy

For

Access Policy

A document recommended for use

In: All departments / Divisions

By: All staff

For: Managing patients care pathways & compliance to NHS constitution and Care Quality Commission (CQC) standards

Key Words: Access, 18 weeks, cancer wait, standards

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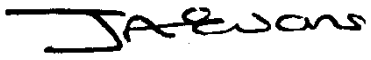
Trust Ratification: 

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Equality Impact Assessment

This document has been reviewed in line with the Trust's Equality Impact Assessment guidance and no detriment was identified. This policy applies to all regardless of protected characteristic - age, sex, disability, gender-re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership and pregnancy and maternity.

Dissemination and Access

This document can only be considered valid when viewed via the East & North Hertfordshire NHS Trust Knowledge Centre. If this document is printed in hard copy, or saved at another location, you must check that it matches the version on the Knowledge Centre.

Associated Documentation

Document Title & Version Number	Location
NHS Constitution Handbook, The NHS belongs to us all (8 March 2010, DOH)	Link to NHS Constitution Handbook The NHS Constitution March 2013
Cancer Waiting Times (October 2011)	Cancer Waiting Times - Version 9
Referral to treatment consultant-led waiting times, Rules Suite October 2015	Referral to treatment consultant-led waiting times Rules Suite 2015

Contents

1.0 Introduction

This policy sets out the Trust's local elective patient access policy. The aim of this policy is to ensure that patients are treated promptly, efficiently and consistently in line with national guidance and good practice. It will provide guidance for staff within the East and North Hertfordshire NHS Trust about the requirements and processes for effective management of elective patient access.

The Referral to Treatment Standard (RTT) is;

- At least 92 per cent of patients on incomplete pathways should have been waiting no more than 18 weeks from referral for definitive treatment

There are additional rules for some other specific pathways which are outlined in section 2.1. Cancer pathway management is detailed in section 5.

This policy reflects the requirement to comply with:

- The NHS Constitution
- The referral to treatment standards (RTT)
- The National Cancer waiting time standards
- Acute Trust Performance Framework
- NHSI Governance Framework

This policy is reviewed every two years or updated as required in line with Department of Health guidelines or changes in Trust systems review includes reference to all national guidance and equality impact assessments.

The Trust and local CCGs are working together to ensure the achievement of all the patient's constitutional rights and to ensure that we deliver against all key standards set out in our contracting agreements. The policy is designed to ensure that access to hospital services is fair and equitable.

This policy sets out the rules and definitions of the 18 week standard to ensure that each patient's 18 week clock starts and stops fairly and consistently. It does not provide detailed guidance on how the rules should apply to every situation, but provides the Trust with an over-arching framework to work within to make clinically sound decisions locally about applying them, in consultation with relevant stakeholders.

This policy aims to continuously improve the experience of our patients by:

- Ensuring patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order.
- Supporting the reduction in waiting times, cancelled appointments and operations, and the achievement of all access standards.
- Making sure that all the information relating to the number of patients waiting, seen and treated is accurate, recorded on PAS and is reported in accordance with national guidance.
- Ensuring compliance with the policy by routine audit by external auditors.

This policy will be applied consistently and fairly across the Trust. The Associate Director of Operations (Performance), the Divisional Director and the Divisional Chair for each Division will be accountable and responsible for the implementation of the access policy within each area.

2.0 Key Principles

2.1 General Key Principles

Patients will be managed based on clinical priority and patients given treatment according to their clinical needs. Patients with the same clinical priority will be treated 'in turn' based on their clock start date, where this reduces overall waiting times, and does not disadvantage patients already dated.

Referrals will be accepted routinely from any registered GP, GDP, nominated referrer or Clinical Assessment Services (CAS) where these are in place. Electronic referrals will be accepted as part of the e-Referral System. Telemedicine referrals will be accepted in those specialties with local agreements in place.

Patients will be managed using the Trust's Patient Administration System (PAS). All transactions on PAS should be completed immediately wherever practical and in any event within three working days.

Patients and Commissioners will receive clear and honest communication about waiting lists and waiting times. The process of waiting list management should be open, visible and accessible to patients, staff and commissioners.

It is a requirement for all staff managing waiting lists to be trained in the Access Policy, and to be aware of all amendments and updates.

Referrers will be informed when patients are added to the waiting list for treatment as part of the clinic letter, when patients are treated as part of the discharge summary and when they are removed from the list. In addition they will be told why the patient has been added to the list and whether they have been added to the planned or active list.

It is the responsibility of the Clinician, at the end of each outpatient appointment to complete a Clinic Outcome Form (Appendix 2) in order to confirm events in a patient's pathway.

Patients who are not part of an 18 week RTT Pathway include:

- Emergency Admissions
- Obstetric Patients
- Elective Planned Patients (in sequence of treatment, who have already had a definitive treatment. See section 3.4).

In addition to compliance with the RTT the trust will provide the following access standards;

- Patients referred to the Rapid Access Chest Pain Clinics (RACPC) will be offered an appointment within 2 weeks from when their referral is received in the Trust.
- High risk TIA referrals (ABCD2 score 4-7) will be seen in the next high risk TIA clinic, which will be either on the same day or the next working day following receipt of the referral and within 24 hours of first being seen by a healthcare professional unless the patient is unable to attend within the timescale. This is a 7 day service.

- Low risk TIA referrals will be seen in a TIA clinic within 7 days of the patient first being seen by a healthcare professional, unless the patient is unable to attend within the timescale. This is a 7 day service.
- Patients referred to Colposcopy should be offered an appointment within the relevant standard from when their referral is received in the Trust. (See Appendix 3).
- All patients requiring a routine diagnostic test/procedure must be offered an appointment within 6 weeks (42 days) of the referral being made. (see section 4.0).

2.2 Referrer Responsibilities

The Trust relies on all referring clinicians to the Trust to ensure that patients understand their responsibilities and potential pathway steps and timescales when being referred. This will help ensure that patients are referred under the appropriate clinical guidelines and are aware of the speed at which their pathway may be progressed and are in the best position to accept timely and appropriate appointments. Therefore the Trust expects that, before a referral is made for treatment on an 18 week Referral to Treatment pathway, the patient is ready, willing and able to attend for an appointment and undergo any treatment that may be required. This will include being both clinically fit for assessment and possible treatment of their condition and available for treatment across that pathway. This is the responsibility of the referring clinician, eg the GP. The provider and commissioners will work together to ensure that patients understand this before starting and that they are ready and able to attend the first outpatient appointment.

- Referrers must provide accurate, timely and complete information within their referral.
- Referrers must comply with national timeframes for referral attachments when referring via e-Referral System.
- Referrals to secondary care should only be made if all other alternatives have been explored (i.e. patient/clinical pathways have been followed) and the patient is ready, willing and available to be seen and commence treatment within the next 18 weeks.
- To minimise waiting times and to enhance patient access to services, Referrers are encouraged to make unnamed referrals (referred to as Dear Doctor referrals) unless there is a specialist requirement for a named consultant or there is a patient history which requires continuity of care.
- When referring children or adults who cannot understand or give consent for their own treatment, the referrer must provide details of who is legally able to act on behalf of the patient.
- Referrers should identify any special communication requirements their patients may have and detail these on the letter. (e.g. literacy problems, need for BSL or other language interpreter).
- At the time of the referral the following information should be supplied

    - Patient demographics & contact address.
    - NHS number (and hospital number identifier if known)
    - Home, work and mobile telephone numbers wherever possible
    - All relevant clinical information together with the referrer's assessment of the level of clinical urgency
    - The patient's availability (as well as their willingness to be seen at short notice). For 'routine' referrals, if it is known that patients will be unavailable to be seen for a period of time, the referrer should delay the referral.
    - Any relevant information regarding the patient's capacity or relevant information related to safeguarding.

- Patients should be referred having already undergone all relevant tests, as outlined in the pathway of the relevant specialty.
- Referrers are required to ensure that all suspected cancer referrals are made through the agreed route – i.e. a 2-week Cancer Proforma sent to the dedicated EMAIL for each tumour site within 24 hours of being seen by a GP. Referrals for patients with breast symptoms must be clearly marked as such. Referrers must ensure that patients are available to attend an appointment within 14 days from the date of referral.

- Wherever possible, referrals should be made electronically through e-Referral System (ERS).
- After a referral has been made, the referrer must inform the hospital if the patient no longer wishes or requires to be seen.
- On making a referral, the referrer must inform the patient that:

    - They need to honor agreed appointments or admission dates, and to expect to be discharged if they do not. Patients should be advised to contact the Trust as soon as possible if there is any likelihood that they will not attend their appointment in order to use this appointment for another patient.
    - Patients will be fast tracked to the most appropriate specialist who may be another Consultant or an appropriate specialist.
    - An appointment may not be available at the patient's local site so an appointment at an alternative trust hospital site may be necessary
    - Patients should be ready and willing to receive treatment within the next 18 weeks from their referral

- The referrer must notify the trust of the patient's ineligibility for NHS care.
- The referrer has a responsibility to follow agreed referral pathways of those directed by commissioning and contractual arrangements. Where referrals do not follow the agreed pathway then the referral should be returned as directed by the commissioners.

2.3 Clinical Assessment System (CAS) / Referral Management Systems (RMS)

CAS has a responsibility:

- For all patients being transferred on to another provider, a minimum data set is required as per National Guidance.
- To ensure that only patients with a condition requiring treatment not available in primary care are referred on to secondary care.
- To ensure that onward referrals to secondary care do not disadvantage patients.
- To ensure that onward referrals to secondary care do not add delay to a comparable pathway with GP direct referral to secondary care by ensuring all onward referrals are made within agreed pathways ensuring patients receive first definitive treatment within 18 weeks.

Direct Access Endoscopy - Referrals that require an endoscopy procedure before it is appropriate for the patient to be seen in an outpatient clinic should be treated as such and added to the appropriate waiting list.

Referrals for 'advice only' -Where a patient is referred for advice, rather than for an appointment and this is clearly marked on the letter, this will be dealt with by the relevant specialty. It will not be logged onto the PAS system unless the consultant concerned decides to see the patient. Where this is the case the patient will be added to the list from the point at which a decision is made that the patient needs to be seen and the referrer will be notified

See Appendix 6 for flow chart of where **RMS/CAS 'triage' arrangements are in place**

2.4 Patient Responsibilities

- Patients must inform the hospital of any changes to their name, address, telephone numbers or GP.
- Patients should keep their appointment, and make every effort to arrive on time.
- Patients who cannot attend, should cancel or rearrange their appointment with as much notice as possible
- Patients must inform their GP if their medical condition improves or deteriorates in a way that may affect their attendance.

- Patients who no longer wish to have their outpatient appointment, diagnostic procedure or admission, for whatever reason, must advise the referrer and the hospital immediately.
- Patients should be aware that their appointment could be within any appropriate healthcare facility within the Trust and with any member of the specialist team.
- Patients who know that they will be unavailable in the future should inform the hospital and their referrer. Patients who already know they will not be available for the next 18 weeks at the time of the GP appointment should inform their GP and the Trust, and they will be discharged back to the original referrer and their referral will be closed.
- Patients who make themselves unavailable for 6 consecutive weeks within their pathway for non-clinical reasons, may be discharged back to their original referrer following discussion with the appropriate consultant.

2.5 Hospital Responsibilities

- All routine referrals will be treated in accordance with any agreed minimum and/or maximum National Standards. All efforts will be made to consider patients availability.
- Unnamed referrals (referred to as 'dear doctor' letters) will be allocated to the consultant with the shortest wait, taking into account a consultant's sub specialty interests or patient needs for continuity of care where relevant.
- Dear Doctor letters received at MVCC (a tertiary service) will be returned to the GP, except those for palliative care or potential recurrence of cancer, with a letter recommending an appropriate referral route.
- If a referral from primary care is made to a named consultant, but he/she believes the patient would get more appropriate care from a colleague, or the colleague has shorter waiting times, the letter will be allocated to the colleague before the outpatient appointment and recorded on PAS as the colleague's patient.
- The Trust reserves the right to re-allocate referrals from one clinician to another, where this is clinically appropriate, in order to ensure equity in waiting times.
- If a referral is made to a consultant for a service or treatment that we do not offer within the Trust then the referral will be returned to the GP or CAS and the patient discharged.
- The trusts reserves the right to transfer a patient's care to an appropriate colleague should the consultant become unavailable for reasons other than annual leave during the patient's pathway, preventing the ability to adhere to the RTT standards.

3.0 Referral to Treatment (RTT) Pathway

3.1 Clock Starts

Referral to treatment consultant-led waiting times only apply to services commissioned by English NHS commissioners and for those patients that English commissioners are responsible.
Many waiting time clocks will start with a referral from a GP. However, a referral from any care professional, provided that it is in line with locally agreed referral practices, to the following types of services should start a waiting time clock. This may include referrals from:

- Nurse Practitioners
- GPs with a special interest
- Allied Health Professionals
- A&E
- Consultants
- Dentists (although not for referrals to primary dental services provided by dental undergraduates in hospital settings)

A waiting time clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to:

- A consultant led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner.
- An interface or referral management or assessment service, which may result in an onward referral to a consultant led service before responsibility is transferred back to the referring health professional or general practitioner.

A consultant is defined as "a person contracted by a healthcare provider who has been appointed by a consultant appointment committee." He or she must be a member of a Royal College or Faculty. The definition of a consultant does not, however, include non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.

A consultant-led service is one where "a consultant retains overall clinical responsibility for the service, team or treatment." The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.

The setting of the consultant-led service is immaterial – i.e. a referral to a consultant or consultant-led service starts a waiting time clock irrespective of setting – i.e. a referral to a hospital based consultant starts a clock in the same way as does a referral to a consultant-led team based outside of a traditional secondary care environment, e.g. in an outreach clinic in a GP practice.

A referral to a consultant includes referrals to diagnostics services, provided the patient will be assessed and might, if appropriate, be treated by a medical or surgical consultant-led service, before responsibility is transferred back to the referring health professional (i.e. 'straight-to-test'). Direct access referrals to diagnostic services are excluded if the referral is not part of a 'straight-to-test' arrangement.

Also included are referrals to obstetrics, although pregnancy referrals should only start a consultant- led waiting time clock when there is a separate condition or complication requiring medical or surgical consultant-led attention.

3.2 What defines the clock start date?

The clock start date is the date on which the provider receives the patient's referral.

For referrals made through e-Referral System, the clock starts on the date of which the patient converts their unique booking reference number (UBRN)

In the case of referrals to CAS or RMS, the RTT clock starts when the referral is received by the CAS or RMS if there is a possibility that they may be referred on to a Consultant led service, irrespective of when they are actually referred onto a Consultant led service.

3.3 What does not start the clock?

Referrals to the following services will not start the clock:

- If another condition is identified at a follow up outpatient appointment, the patient must be returned to the GP to be offered choice of provider. Urgent cases and some specific conditions are exempted from this rule. See Appendix 9.
- Diagnostic services (i.e. direct to x-ray) if the referral is for the GP to make a decision about onwards referral for treatment
- Primary dental services provided by dental students in hospital settings

3.4 New Clock Starts

Upon completion of a consultant-led referral to treatment period, a new waiting time clock only starts:

- When a patient becomes fit and ready for the second of a consultant-led bilateral procedure;

Where patients are undergoing a bilateral procedure - i.e. a procedure that is performed on both sides of the body, at matching anatomical sites (for example, removal of cataracts from both eyes), then the initial waiting time clock will stop at first definitive treatment for the first procedure. Once the patient is fit and ready for the second procedure then a new waiting time clock should start from the date that it is clinically appropriate for the patient to undergo that procedure, and from when the patient says they are available (not from the date that the provider has the capacity to admit/treat them).

- Upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan;

Many patients will require further planned stages of treatment after their waiting time clock has stopped. This treatment should be undertaken without undue delay and in line with when it is clinically appropriate and convenient to the patient to do so.

However, where further (substantively new or different) treatment may be required that was not already planned; a new waiting time clock should start. This new clock will often start at the point the decision to treat is made. However, where a patient is referred for diagnostics or specialist opinion with a view to treatment it may be more appropriate to start the new clock from the point that the decision that diagnostics or specialist opinion is made – i.e. when it is decided to start the patient off on a new 'treatment pathway'.

- Upon a patient being re-referred into a consultant-led; interface; or referral management or assessment service as a new referral:

Where a patient has already been on a consultant-led treatment pathway but is subsequently referred back into the service by their GP or other permitted referrer, then a new waiting time clock should start as long as it can be demonstrated that the patient had been discharged from the previous pathway.

- When a decision to treat is made following a period of active monitoring:

A patient's waiting time clock will stop when commencing a period of monitoring in secondary care or at an interface service without clinical intervention or diagnostic procedures at that stage. If, subsequently, perhaps at a follow up outpatient appointment, a decision to treat is made, then a new waiting time clock should start from the date that that decision is made.

As with new clock starts for substantively new or different treatments, in some cases it may be appropriate to start a new clock before a 'decision to treat' is made, where, for example, there has been a decision to refer a patient for diagnostics/specialist opinion with a view to starting treatment.

- When a patient cannot be treated by their planned due date for non-clinical reasons:

A patient who is on a planned waiting list for a planned procedure must be dated by their due date. If the provider or patient is unable to meet this requirement for non-clinical reasons the patient must be transferred on to an elective waiting list and a new RTT clock commenced.

- When a patient rebooks their appointment following a first appointment DNA that stopped and nullified their earlier clock:

Where a patient DNA's the first appointment after the initial referral that started their waiting time clock, their clock will be nullified (i.e. as if the referral never existed). Where the provider decides that it is appropriate to contact the patient to rebook the appointment (i.e. the patient is not referred back into primary care), then a new waiting time clock should start from the date that a new appointment date is agreed with/communicated to the patient.

A DNA is defined as when a patient fails to attend an appointment/admission without prior notice. Patients who cancel their appointments in advance should not be classed as a DNA and therefore should not have their clocks nullified, providing that the provider can demonstrate that the appointment was clearly communicated to the patient and the Clinician has requested the discharge via the outcome form (See section 3.14, 3.15 & Appendix 10).

3.5 Clock stops for treatment

A clock stops when:

- First definitive treatment starts. This could be:
    - Treatment provided by an interface service;
    - Treatment provided by a consultant-led service;

First definitive treatment is defined as being an intervention intended to manage a patient's disease, condition or injury and avoid further intervention. The date that first definitive treatment starts will stop the clock - this may be either in an interface service or a consultant-led service.

Often, first definitive treatment will be a medical or surgical intervention. However, it may also be judged to be other elements of the patients care, for example, the start of counselling. In all cases, what constitutes First Definitive Treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient. If there is doubt about what first definitive treatment is for any given patient or pathway, then the key determining factors should be: a) what do the care professionals responsible for the patient's care consider start of treatment to be; and b) when does the patient perceive their treatment as being started. An example would be when diagnostic tests turn into therapeutic procedures during the investigation; for example a colonoscopy which reveals a polyp which can be removed there and then, would stop the clock on the date the procedure was undertaken.

It is vitally important that clinical decisions on what is first definitive treatment, mirror patients' perceptions of their care. Doing this will ensure that patient-reported experiences of their care reflect NHS reported referral to treatment times.

- 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;

Where a consultant-led or interface service decide that therapy or a healthcare science intervention should be the first definitive treatment for the patient, then the patient's clock should keep ticking until the start of that treatment. Where, however, a decision is made to refer back to primary or community care for therapy or healthcare science intervention, then the clock does not keep ticking until start of treatment, but stops on the date that the decision to refer back to primary or community care for treatment is made and communicated to the patient.

- 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.

There is often a period of time between the need for a transplant being identified, and a suitable organ for transplantation becoming available. Therefore, where first definitive treatment requires the patient to be added to a transplant list, then the patient's clock should stop on the date that they are added to the list, and when this is communicated to the patient. Where a donor has already been identified (e.g. a family member), then first definitive treatment would usually be the start of treatment itself.

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 to start a period of active monitoring; (see section 3.8 Active Monitoring)
- A patient declines treatment having been offered it;
- A clinical decision is made not to treat;
- A patient DNAs (does not attend) their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient and the Clinician has requested the discharge via the outcome form; (See Appendix 10)
- A patient DNAs any other appointment and is subsequently discharged back to the care of their GP, provided that;

    - The provider can demonstrate that the appointment was clearly communicated to the patient;
    - Discharging the patient is not contrary to their best clinical interests and the Clinician has requested the discharge via the outcome form
    - Discharging the patient is carried out according to local, publicly available/published, policies on DNAs;
    - These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g. children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders (See Appendix 10).

3.7 What does not stop the clock?

The following examples do not stop the clock:

- Administration of pain relief before a surgical procedure takes place, or other steps to manage a patient's condition in advance of definitive treatment
- Consultant to Consultant referrals where the underlying condition remains unchanged
- The act of making a tertiary referral or a referral from one provider to another
- Waiting for IFR or exceptional treatment responses

3.8 Active Monitoring

In many pathways there will be times when the most clinically appropriate option is for the patient to be actively monitored over a period of time, rather than to undergo any further tests, treatments or other clinical interventions at that time. When a decision to commence a period of active monitoring is made and communicated with the patient, then this stops a patient's waiting time clock. Active monitoring may be applied where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage.

Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made. If such a decision has been made but subsequently it becomes apparent that there is a clinical reason to delay treatment/admission then a waiting time clock would usually continue.

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. For example, stopping a clock to actively monitor a patient knowing full well that some form of diagnostic or clinical intervention would be required in a couple of days' time, is unlikely to make sense to a patient, as they are likely to perceive their wait as being one continuous period from the time of their initial referral. Its use may be more appropriate where a longer period of active monitoring is required before any further action is needed.

Patients may initiate the start of a period of active monitoring themselves (for example by choosing to decline treatment to see how they cope with their symptoms). However, it would not be appropriate to use patient initiated active monitoring to stop patients' clocks where a patient does want to have a particular diagnostic test/appointment or other intervention, but wants to delay the appointment. Where such patient initiated delays prior to admission mean that 18 weeks cannot be delivered for that patient, then the minimum operational standards for 18 weeks allow for patients for whom starting treatment in 18 weeks would not be appropriate.

3.9 Open Appointments (SOS)

Where a clinician believes that a full patient discharge would not be suitable but a fixed appointment may also be of no benefit to the patient, they may be offer the patient an open appointment (SOS - Self-referral of symptoms). This option permits the patient to contact the Trust within 6 months from their last outpatient attendance and receive an appointment with the relevant clinician. The SOS system can be very effective in reducing both follow-up appointments and DNA rates in some situations. For the specialties of Breast and Paediatrics, the SOS option is permitted for 12 months.

SOS (open appointment) can only be used for follow-up patients and must be for a period of no longer than six months excluding Breast and Paediatrics. Following this period the old referral must not be opened and any subsequent referral to the same specialty must be via the patients GP and treated as a new referral.

When an open appointment has been requested, the patient's 18 week clock stops at the date of their appointment with an RTT code of 31 – Patient to think about treatment. Where a patient requests an appointment within the 6 months' time limit, a new 18 week clock is started.

Patients will be provided with an SOS card or letter specific to their specialty for reference if the need of a consultation arises. Where the SOS system is used, patients need to be made aware of the events that should trigger the need to see a clinician by the clinician.

Divisions need to ensure that any requests for an appointment are fast tracked and capacity provided accordingly. If a patient does not contact the Trust regarding an appointment within the 6 months they will be automatically discharged back to their GP. The Outpatient Department will action the discharge from monthly data indicating those open appointments that have exceeded the 6 months' time limit and will inform the GP and patient accordingly.

3.10 Patient Cancellations

If a patient cancels an appointment or TCI anywhere in an RTT pathway, another appointment or TCI must be rearranged if required. If the rearranged appointment may result in a risk of the patients not receiving first definitive treatment in 18 weeks then this must be escalated to the relevant Deputy General Manager/General Manager for resolution as the RTT clock is still ticking.

A patient cancellation does not stop or pause the 18 week clock.

If the patient cancels an accepted appointment or TCI date on two consecutive occasions the clinician can decide to return the patient in writing to the care of the GP/referrer and patient. The RTT clock will stop. If they are subsequently re-referred by the GP this will start a new 18 week RTT pathway. Alternative arrangements can be made to this in exceptional circumstances; these decisions will be discussed and agreed through specialty management structures.

However, Consultant discretion may be used to rebook the appointment / TCI date in circumstances like the following:

- The patient is a '2 week wait' cancer patient.
- The patient is categorised as 'clinically urgent'.
- The patient is receiving long-term care from the Trust and failing to offer a new date may be detrimental to the patients' health
- The Trust already has a clinical responsibility towards the patient (for example, if they are on a course of treatment or drugs prescribed by it).

3.11 Hospital Cancellations

If the hospital cancels an appointment or TCI anywhere on an RTT pathway, the clock continues to tick. The patient should be re-dated within the existing RTT standards.

For patients whose operations are cancelled for clinical reasons, due to the patient being unfit for surgery, for less than 2 weeks for example for a minor cough/cold, the clock must continue, and the patient will be offered another date within the RTT standards.

In the event of long-term periods of the patient being medically unfit (over two weeks) the responsible / listing consultant (or anaesthetist, as per local agreement, in the case of preoperative assessment) can decide to refer the patient back to the care of their GP for management of the condition rendering the patient unfit for the required surgical procedure. The letter back to the GP will state the optimisation required and need for re-referral once resolved. It should be copied to the patient and the responsible consultant surgeon. Discharging the patient to their GP / referring clinician stops their RTT clock. A new RTT clock is started if the patient is re-referred back to the consultant for the identified procedure. At the time of removing from the waiting list, the patient's RTT status must be recorded as 'decision not to treat'

If the patient is cancelled on the day for an elective admission then the patient must be rebooked and treated within 28 days. The patient should be re-dated within whichever target is first (RTT target or 28 day target). This is a requirement under the NHS Constitution.

3.12 Reasonable Offer Definition

On an RTT pathway, a reasonable offer of an outpatient or diagnostic appointment date is considered to be the following;

- A written offer, a minimum of 3 weeks' notice before the appointment date(s)
- For an elective procedure or outpatient appointment, a minimum of 2 dates on different days with a minimum 3 weeks' notice.
- A verbal offer, at any point before the date occurs providing the patient has agreed to the date offered

If a patient accepts a short notice offer but then cancels or DNA's the appointment, the appointment will still be treated as a reasonable offer. This must be made clear to the patient at the time of the short notice offer.

3.13 Reinstatement of Patients

Patients cannot be reinstated to an RTT pathway once removed. The GP may re-refer and this will commence a new RTT pathway and 18 week clock start.

NB: If a patient is removed in error from an RTT pathway then the Associate Director of Operations (Performance) /Director of Operations must be contacted to action a reinstatement.

3.14 Did Not Attend (DNA) – Adults

A DNA is defined as where a patient fails to attend an appointment/admission without prior notice. Patients who cancel their appointments in advance should not be classed as a DNA and therefore should not have their clocks nullified.

Where a patient fails to attend the first appointment after the initial referral that started their waiting time clock, the patient will be discharged back to their GP, and the clock nullified.

- Consultant discretion will be used to determine if the patient is to be rebooked or discharged and will be communicated via completion of the outcome form. Only if it can be demonstrated that the patient's failure to attend was not the fault of the Trust (e.g. the patient did not receive notice of the appointment).
- Alternative arrangements can be made to this in exceptional circumstances; these decisions will be discussed and agreed through specialty management structures.
- Patients who are referred under the '2 week wait' cancer rule should be rebooked in line with section 5.4 regarding 2ww DNA guidance)

If the decision is made to rebook the patient's appointment, the 18 week clock will be reset from the point the new appointment date is agreed with the patient.

If a patient DNAs any other appointment they will be discharged back to the care of their GP, provided that:

- The provider can demonstrate that the appointment was clearly communicated to the patient;
- Discharging the patient is not contrary to their best clinical interests;
- The patient is not < 18 years old (see section 3.17 DNA – paediatrics & Young Adults 0-18 years)

Any patient who is discharged after DNA will receive a letter informing them that they have been discharged, and telling them that if they desire to be re-referred they will need to contact their GP. The GP/GDP will also be informed via a letter including details of the appointment/s that they missed, any treatment or diagnostics that have taken place in the pathway and discharging care back to the GP.

Prior to the decision being taken to discharge an adult patient who 'does not attend' DNA consideration should be given to whether there would be any safeguarding concerns by doing so. Some adults may be reliant on others to bring them to appointments; some adults may have impairment to the functioning of their mind or brain and may not have the mental capacity to make the decision about whether or not they attend their appointment. These factors need to be taken into consideration by the clinician when making a decision about discharge. If the clinician or clinical team has safeguarding concerns about the adult these should be followed up either by contact with the adult, their representative or care provider or back to the referrer, or using the 'Safeguarding Adults from Abuse or neglect' procedures as appropriate.

See Appendix 10 for flowchart

3.15 Did Not Attend (DNA) – Paediatrics & Young Adults 0-18 years, & Adults at Risk

Children may miss appointments for a variety of reasons. To ensure that non-attendance is not due to child protection related issues the following is required;

A letter should be sent to the parents, child if appropriate, and G.P, or the referring professional, to inform them of the child's non-attendance. A decision needs to be made by the consultant/clinician/health professional whether to offer another appointment for the child.

Should the child not attend the second time (including DNA, cancellation or deferral of appointment), then the consultant/clinician/health professional should escalate to the Children's Safeguarding Team, and the patient's GP. The provider must also ensure that the appointment was clearly communicated to the patient and the Clinician has requested the discharge via the outcome form; (See Appendix 10)

If clinicians consider that non-attendance at a hospital appointment impacts adversely on a child's health or development a referral must be made to Children's Services. Contact the Children's Safeguarding Team for advice on referral to children's social care.

The Children's Safeguarding Team should be contacted for advice if unclear on the action to be taken when a child or young person misses an appointment.

See Appendix 10 for flowchart

3.16 Consultant to Consultant referrals – Internal & Tertiary (See Appendix 9)

In order to allow GP's to manage care for their patients, clinicians should not refer directly to colleagues if the referral is for a condition that does not relate to the original referral, but should write to GP's and advise on appropriate treatment or referral

If the internal referral is related the original condition onward referral to another professional within the Trust is permitted. There is no need to refer back to the GP.

Tertiary referrals apply to procedures not carried out within the Trust. A completed RTT Minimum Data Set (MDS) pro-forma (Appendix 4) must be sent with all inter-provider transfers indicating key referral information related to the patients 18 week pathway. Tertiary referrals for cancer patients should have a pro-forma completed via Infoflex.

Consultant to consultant referrals must be triaged and action authorised by an appropriate consultant and the GP notified. The patient should not be put at any advantage or disadvantage in relation to the care they receive. Consultant to consultant will be treated in chronological order unless there is a clinical indication that dictates otherwise.

3.17 Consultant to Consultant referrals for urgent conditions (See Appendix 9)

Consultant to consultant referrals directly to colleagues within or outside of the Trust (Tertiary centre) must offer patient choice of clinician/provider. Such referrals are accepted when:

- Circumstances are clinically urgent, i.e. suspected cancer or likely to lead to emergency admission within 28 days. Referrals to Rapid access chest pain clinics, TIA service, Heart Failure clinics are deemed clinically urgent. The referring consultant must use the appropriate pro-forma.This will be communicated to the GP by the discharge summary or the clinic letter.

3.18 Consultant to Consultant referrals – Private to NHS Care (See Appendix 9)

Patients seen as an outpatient at a private hospital, or private clinic or as a private patient at an NHS clinic may not be transferred to an NHS waiting list unless their need for care is clinically urgent (suspected cancer).

Otherwise, onward referral for treatment at the Trust can only be made when the referral is for tertiary treatment due to clinical complexity and only then in accordance with agreed pathways.

For non-urgent care the consultant should inform the GP of the outcome of the private consultation, and refer the patient back to the GP for onwards referral to an NHS provider.

Following receipt of any private accepted referral to the Trust the patient can be added directly to the waiting list, with no requirement to be seen as an outpatient unless this is clinically indicated. The referral must be accompanied by an appropriate MDS form which will indicate the correct RTT clock start (see appendix 4).

As with any other patient who changes between private and NHS care, the patient should not be put at any advantage or disadvantage in relation to the NHS care they receive. They are entitled to NHS services on exactly the same basis of clinical need as any other patient and will be treated in chronological order.

3.19 Transfer to other providers (See Appendix 9)

In order to comply with the NHS Constitution there is a requirement to offer patients the choice to be treated by an alternative provider. Patients that are on the outpatient or elective waiting list but due to capacity and/ or choice, cannot be treated with 18 weeks, should be offered treatment at another hospital, either NHS or private.

3.20 Overseas Visitors

Entitlement to hospital treatment (secondary care) is based on residency, if a patient does not reside in the UK on a lawful permanent basis they may not be entitled to treatment without charge. A person does not become ordinarily resident in the UK simply by: having British nationality; holding a British passport; being registered with a GP; having an NHS number; owning property in the UK, or having paid (or currently paying) National Insurance contributions and taxes in this country. Whether a person is ordinarily resident is a question of fact, for which a number of factors are taken into account.

<u>European Economic Area</u>
In order to receive hospital treatment which is deemed “immediately necessary” and which arose during a visit to the UK, Overseas Visitors who are resident in an EEA country or Switzerland must have a valid European Health Insurance Card (EHIC) or be in possession of a valid Provisional Replacement Certificate (PRC). Failure to provide an EHIC will result in the patient being charged directly for their hospital treatment.

<u>Other Reciprocal Health care Agreements</u>
Several countries and territories outside the EEA also have reciprocal healthcare agreements with the UK covering their nationals, or sometimes all residents regardless of nationality. Patients who can show they are lawfully resident in one of those countries (and a national of that country, if applicable) are exempt from charges providing the need for treatment arose during their visit to the UK.

<u>Urgent and Immediately Necessary Treatment</u>
Urgent or immediately necessary treatment will never be withheld from chargeable overseas visitors

pending payment, although charges will still apply, these charges cannot be waived.

For further information please contact the Overseas Visitors Team or see the Knowledge Centre pages for the Trust's Private Patient and Overseas Visitor policy.

3.21 Military Personnel and Veterans

Military personnel and veterans should receive priority access to NHS secondary care for any conditions which are likely to be related to their service, subject to the clinical needs of all patients. Veterans are ex-service personnel who have served at least one day in the UK armed forces and sustained injuries during that service. Priority should not be given for unrelated conditions.

Serving personnel and their family members should retain their relative position on any NHS waiting list, if moved around the UK due to service person being posted.

GPs are required to state clearly in referrals that the patient is military personnel or a military veteran and requires priority treatment for a condition that in their clinical opinion may be related to their military service. On receipt of such requests, trust administrative staff must highlight the status of the patient to the relevant clinician and to the service manager for appropriate recording, prioritisation and action.

However, it remains the case that military personnel and veterans should not be given priority over other patients with more urgent clinical needs.

4.0 Patients referred for diagnostics

All patients requiring a routine diagnostic test/procedure must be offered an appointment within 6 weeks (42 days) of the referral being made. The diagnostic waiting time clock starts when the referral is made. The diagnostic waiting time clock stops when the patient receives the diagnostic test/procedure

Patients who cancel or DNA following a reasonable offer will have their diagnostic waiting time clock for that test/procedure set to zero. The waiting time clock starts again from the date the patient cancelled or DNA'd their appointment. This does NOT affect any clock running on an 18 week RTT pathway.

4.1 Patients listed for surgery

4.2 Planned Procedures

- Planned patients are patients who need to come into hospital as part of a scheduled sequence of treatment or for an investigation at a specific clinically agreed timescale. When they are put on the waiting list they are given at least an approximate date for their treatment. Examples include: removal of metal work, surveillance or check procedures, investigations or treatments that must be given in sequence.
- A patient who is on a planned waiting list for a planned procedure must be dated by their due date (approximate date for treatment). If the provider or patient is unable to meet this requirement for non-clinical reasons the patient must be transferred on to an elective waiting list and a new RTT clock commenced.
- A patient who is not clinically fit to have their procedure by their planned due date, the clinician must agree a revised due date.
- Where a child needs to be a certain age before a procedure is clinically appropriate they should be discharged back to the GP with the instruction to re-refer when the child reaches the appropriate age. Where this is not clinically appropriate patients should be added to the planned waiting list. Patients should be given a planned date for surgery which meets their appropriate age for surgery.

4.3 Procedures requiring Funding Confirmation

Procedures that require funding agreements from CCGs in advance of treatment:

Prior Approvals and the Individual funding Request team (IFR):

Prior approval means that the provider must seek the agreement of the responsible commissioner to fund a treatment for certain procedures as highlighted in Appendix 5. Each specialty has their own specific prior approval request form which is to be completed by the clinician making the decision to treat at the same time as completing a Health screening questionnaire. The consultant will instruct the patient to go to the pre-assessment hub, and the patient will take both the HSQ and the prior approval request form with them. The IFR team is located within the hub.

The vast majority of Prior Approval requests are approved as they meet the pre-set criteria. However, on occasions patients may fall outside of the threshold criteria and clinicians may appeal by demonstrating how the patient is clinically exceptional. In these cases the request is then considered via the IFR process.

Individual Funding Request (IFR) - Is a request received from a clinician providing care to a patient, for a specific treatment that is not covered by existing policy or for a service which is not commissioned by ENHCCG (an Individual Case). Or where the CCG is responsible for commissioning the service/treatment in question and/or a local policy is in place however the patient does not meet the criteria and is deemed to be clinically exceptional (an exceptional case).

- All patients **must be added** to the elective waiting list.
- The IFR team register and email the funding request to the relevant CCG for approval within a maximum of ten working days of decision to treat.
- The requesting clinician will inform the patient, during their clinic appointment, when prior approval is required and ensure that they are aware of action and possible alternative treatments if available if approval is not received.
- The IFR team will manage the process to ensure that approval is received. If the CCG responds that funding is refused then an appeal on clinical grounds can be made where appropriate. No patient should proceed to treatment without approval being received in advance. If funding is refused the default position will be to refer the patient back to their GP and clinicians should provide any further clinical advice or treatment options to the GP. The clinician will advise the patient in writing that they have been refused treatment and advise them to contact their GP.
- In addition to this process referral for some specialties should be referred into the Trust via the individual CAS system managed by CCGs as this will guarantee approval for treatment at the point of referral. Please refer to Appendix 6 for details on CAS referred specialties.

Exceptional Treatments:

In these cases, the patient is suffering from a presenting medical condition for which ENHCCG has a policy for the medical condition and/or its treatment, but where the patient's particular clinical circumstances fall outside what the CCG has agreed to fund ('an exceptionality request; an exception to the policy').

- A number of treatments are only funded in exceptional circumstances by the CCG. Appendix 5 lists those procedures concerned.
- The patient **must not be added** to a waiting list for an exceptional treatment until funding approval has been received. Until a decision is made this cohort of patients will be monitored by presence on the 'not added to waiting list – outcome report'.

- When a clinician determines the patient requires one of the procedures listed as an Exceptional Treatment they must complete a request form for the Individual Funding (Exceptional) Cases Panel for approval. The IFR team registers the details and forwards the Exceptional Treatment form to Panel for approval within 3 weeks. If the patient is not granted approval then this information is provided to the consultant by the external panel. At this point a clinical decision will be made. The patient will either return to the hospital for a consultation regarding alternative treatment options or they will be discharged back to their GP. The patient will be advised in writing of the outcome.
- If approved the clinician must complete a Booking form/HSQ and send with the copy of the approval letter to waiting list office at which point the patient is added to waiting list. If not approved the patient must be discharged to their GP.
- If the clinician does not agree with the Panel's decision he/she should appeal in writing setting out reasons for the appeal within 30 days of written notification of outcome of the first panel decision. If the appeal is refused the patient must then be discharged back to their GP.

The CCG is responsible for instructing the author of the policy of any changes to this.

4.4 Patients with a Body Mass Index (BMI) of 30 or more

For patients with a BMI of 30 or above there must be a clear clinical reason to proceed for immediate surgery, for example if an urgent operation is clinically needed and a delay to this would cause a significant risk or harm to the patient.

Requests and rationale must be sent to the CCG for consideration on the grounds of individual clinical exceptionality.

If there is no clear clinical reason and the patient has a BMI of 30 or above then the patient will need to lose 10% of their body weight over 9 months (as per the commissioners' instructions http://www.enhertsccg.nhs.uk/sites/default/files/Letter-to-ENHGPs-BMI-December2011-Final.pdf). The patient will be advised that the operation cannot proceed until the required weight loss has been achieved. The consultant will write to the GP to advise him/her of the outcome and the patient is to be discharged from PAS, with a new clock starting if a new referral is received.

4.5 Patients who smoke

This section provides instructions for the management of patients with a decision to admit who require referral to the Hertfordshire Stop Smoking Service, which currently covers All General Anaesthetic Procedures

When presented with a Booking form/HSQ for an identified smoker the following procedure is to be applied:

- Add the patient to the elective waiting list under the appropriate waiting list code.
- List the hospital site code as SS (stop smoking)
- Complete the electronic Hertfordshire stop smoking service referral form and email this to **Hertfordshire.stopsmokingservice@nhs.net** copying the email to indfunding.enh- tr@nhs.net.
- Enter a medical deferment on to the waiting list entry for a period of 8 weeks from the DTT. The comment must read – Patient referred to HSSS. This does not stop or pause the patients RTT clock.

For management of smokers under CCG smoking cessation instruction, please refer to Appendix 8

4.6 Patients needing more than one operation

If a patient needs several linked procedures in a specific order & timescale then he/she is added to the active waiting list for the procedure that needs to be done first. He/she are added to the planned list for the second and subsequent procedures. Patients will only be added to the planned waiting list where their procedure forms part of a planned series of treatment and where clinical requirements dictate when each stage of treatment should be undertaken at specific intervals. The first treatment should take place within the RTT 18 week period. At the time that the patient is fit and ready to receive the second planned procedure they should be transferred from the planned list to the active waiting list where their subsequent procedure should be completed within the RTT 18 week period.

Where a patient needs two procedures that do not necessarily need to be done in a specific order or timescale he/she should be added to the active list for the first procedure and reviewed in outpatients once it is complete. He/she can then be added to the active list for the second procedure. The first treatment should take place within the RTT 18 week period. A new 18 week clock will start for each of the subsequent procedures on the day that the Consultant decides treatment is required and the patient is ready, willing and able to have surgery.

If a patient needs two completely different unlinked operations then they should be placed on both active waiting lists. However, if the patient becomes unavailable for the second procedure whilst undergoing/ recovering from the first procedure then the patient will either continue on the waiting list or be removed. An RTT clock should exist for each condition and each will stop on the date of admission for the respective procedures.

4.7 Pre-Operative Assessment (POA) and decisions made at POA

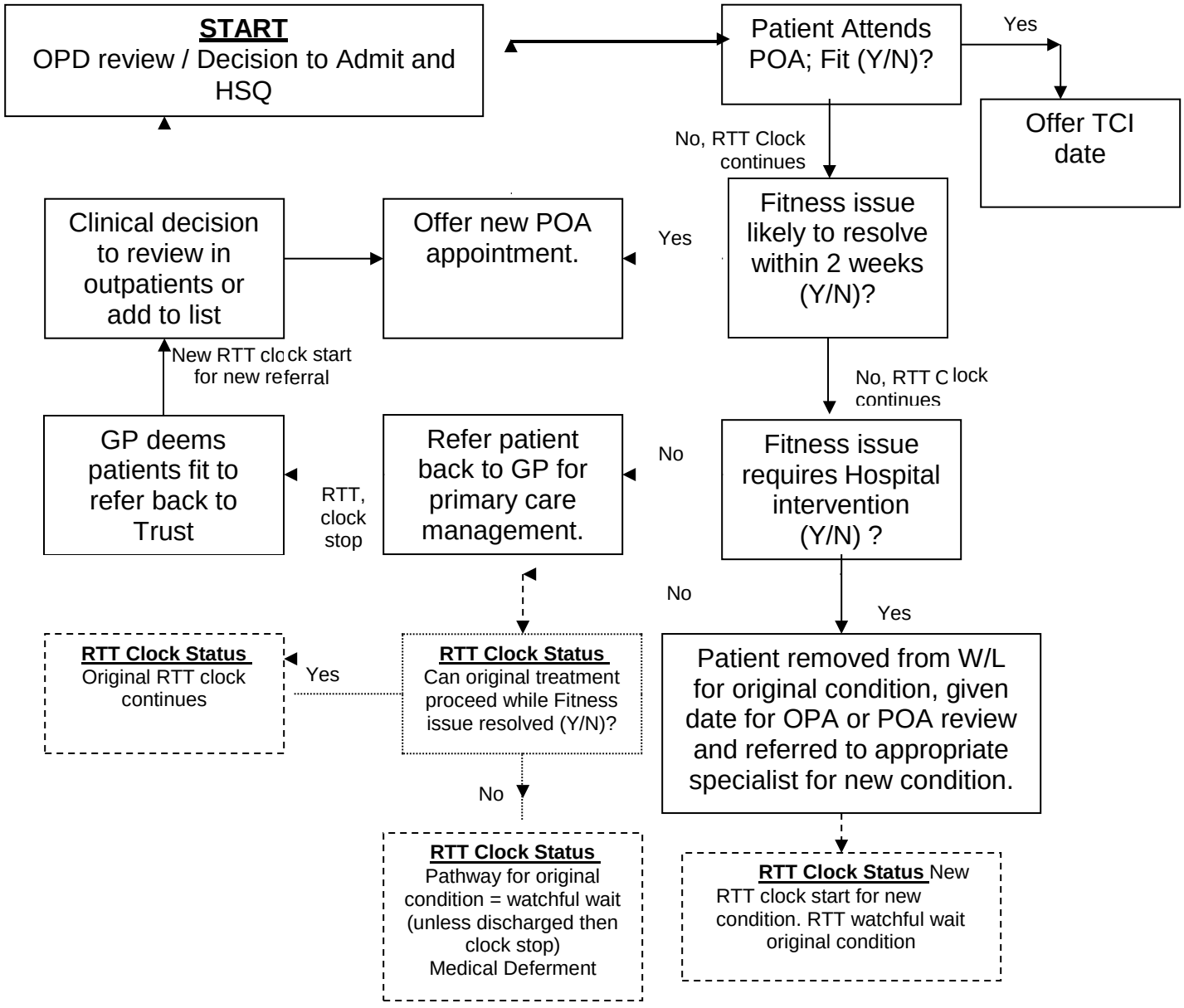
Patients will attend a pre-assessment hub as soon as possible after the decision to treat has been made. Where possible, all patients should attend on the same day as their outpatient appointment. Patients should attend once they have completed the HSQ in the outpatient department.

Becoming medically unfit while waiting for an elective procedure does not stop a patient's RTT clock. Short-term periods of unavailability (two weeks or less) must be absorbed into the overall patient waiting time.

In the event of long-term periods of the patient being medically unfit (over two weeks) the responsible / listing consultant (or anaesthetist, as per local agreement, in the case of preoperative assessment) can decide to refer the patient back to the care of their GP for management of the condition rendering the patient unfit for the required surgical procedure. The letter back to the GP will state the optimisation required and need for re-referral once resolved. It should be copied to the patient and the responsible consultant surgeon. Discharging the patient to their GP / referring clinician stops their RTT clock. A new RTT clock is started if the patient is re-referred back to the consultant for the identified procedure. At the time of removing from the waiting list, the patient's RTT status must be recorded as 'decision not to treat'.

Patients should be managed through pre-operative assessment according to the pathway outlined below.

Admission Pathway from Decision to Admit to Offer of TCI date



4.8 Giving Patients an admission (TCI) date

Patients will be selected according to clinical priority followed by chronological order of addition to the waiting list. There may be times where some patients are operated on out of turn to ensure efficient running of operating lists. This may happen, for example if a list has been booked in chorological order which leaves a gap of 30 minutes. Another case may be further down the waiting list but may be the only case able to be operated on within the available time frame.

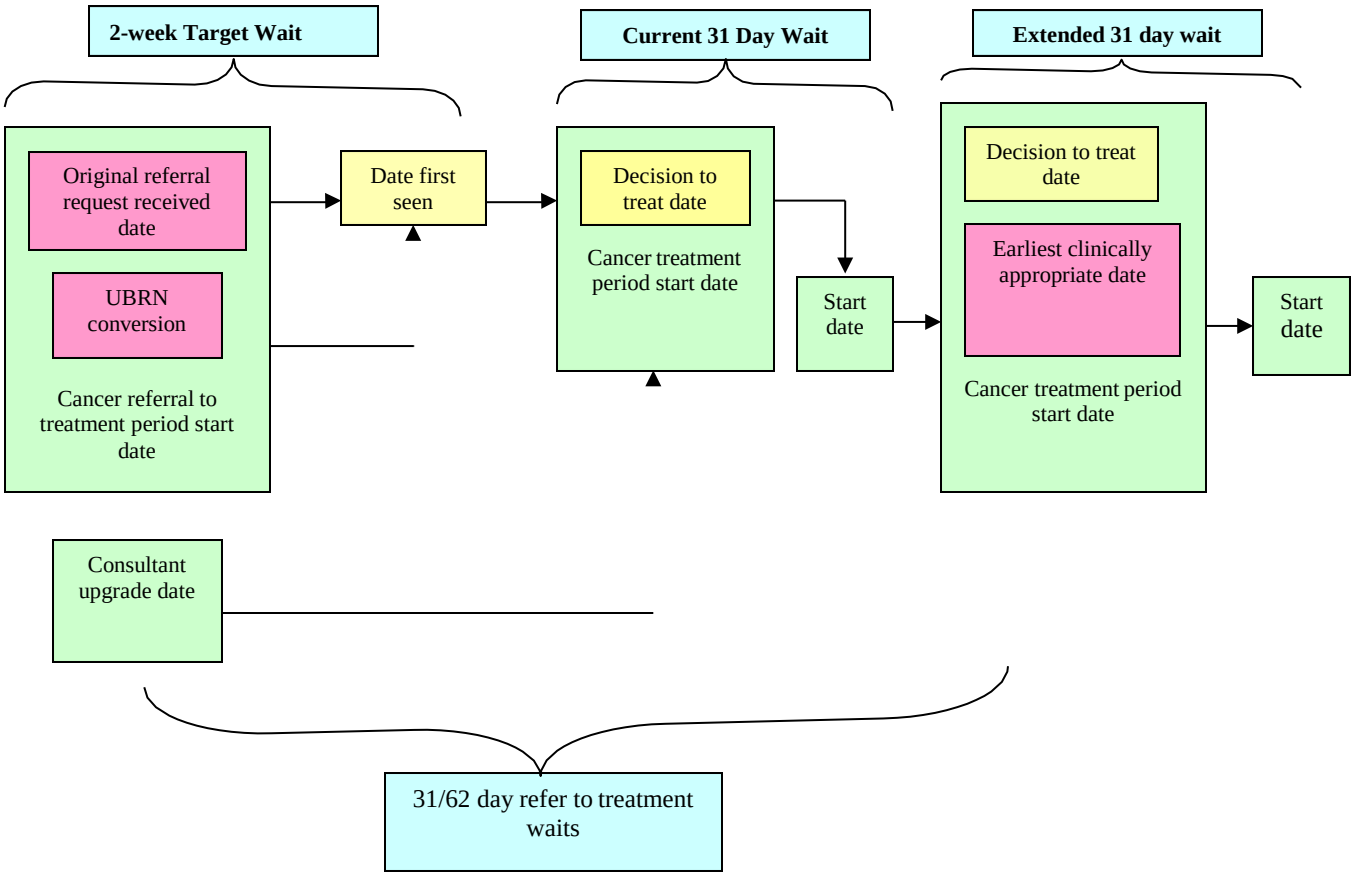
Patients can be admitted 'out of turn' to allow for case mix and junior doctors training needs at the discretion of the consultant. However all patients should be treated within RTT standards.

Where necessary patients may be asked to transfer to another consultant or hospital site where waits are shorter. However, patients have the right to refuse such an offer without their total waiting time being affected. The same Consultant at a different site is considered to be a reasonable offer.

Every effort should be made to agree a date with the patient.

5.0 Cancer Waits

The cancer standards have been extended to incorporate additional entry points for the 2 week wait via the national screening programme, consultant upgrade and 31 day standards for subsequent chemotherapy, radiotherapy and surgical treatments. Breast referrals other than cosmetic treatment or family history patients are also seen within 2 weeks, but not as part of the Cancer Pathway.



5.1 Two week wait for patients suspected of having cancer

The 2 week wait aims to ensure that those patients identified with a strong possibility of having cancer have their first hospital assessment within 2 weeks of the need for referral being identified by their GP. If cancer is still suspected the patient continues on 62 day pathway until diagnosis is confirmed or ruled out. If cancer is excluded the patient continues on the 18 week pathway if treatment is needed.

5.2 Clock Starts for 31 day and 62 day Pathway

The cancer pathway starts at receipt of a two week wait GP/GDP referral OR the date of a consultant upgrade OR the date of a UBRN conversion. Receipt of referral is day zero. This also starts the 62 day clock as does a referral receipt from a national cancer screening programme. A 31 day clock starts the date the patient is considered fit to receive first definitive or subsequent treatment and both the patient and the doctor agree to the plan of treatment.

5.3 Two Week Wait Referrals

The 2-week wait applies to patients suspected of having cancer and referred by their GP under the 2-week wait system. The referral should be submitted on a 2- week wait referral pro-forma and marked as suspected cancer or 2-week wait. The patient will need to have a hospital assessment within 2 weeks (14 days) of the receipt of the referral by the GP. This can be when the patient is seen for the first time by a consultant or in a diagnostic clinic. At the point of making a two week wait referral, the GP should check the patient is available to engage in the full 62 day pathway ensuring that they have supplied the correct patient contact details. Where inadequate information is provided the referral will not be rejected, but more information will be requested from the referring clinician.

2-week wait referrals should be sent within 24 hours of the patient seeing a GP, to a 'Safe Haven' email and should be acted on immediately upon receipt. The patient's details should be entered onto PAS and a confirmation email back to the referrer should be sent indicating the referral has been received and is being acted upon.

Any routine CAS referrals that are triaged as suspected cancer should be immediately referred as a 2 week wait by CAS the same day, and the date to start is from receipt (as the urgent referral is only being made then). The referral should be sent within 24 hours to the Trust using the dedicated email address. The GP should be advised that a 2 week wait referral has been made to the Trust immediately by the CAS team.

The patient should be telephoned within 24 hours of the date of receipt of referral and a reasonable offer made within the 2- week timescale – this will count as a fully booked appointment. The Trust will aim to book all first appointments within 7 days. In many circumstances it may be appropriate for patients to have diagnostic tests before an outpatient appointment. Going straight to test may reduce the number of visits that a patient needs to make to hospital and ensure that each visit adds value, improving the patient's experience. This will count as first appointment.

Each cancer multidisciplinary team should agree in conjunction with primary care colleagues the most appropriate diagnostic test in a particular set of circumstances. This should be in line with national guidance and for suspected cancer pathways should have been agreed through the Cancer Network Tumour Site Specific Groups (NSSG's) and SCN.

Paediatric patients with suspected cancer are not accepted via the e-Referral System or written referral route. Patients should be referred directly to the Paediatric Assessment Unit (PAU) or A&E department by the GP. Where a patient is referred via the '2 week wait' route, the Contact Centre will liaise with the referring GP and instruct that the patient attends PAU or A&E departments for immediate assessment.

No referral to the central email address will be accepted.

5.4 Reasonable Offers

2WW outpatient appointments/diagnostics- The date of an outpatient appointment offered over the phone has to allow for three working days to be considered as a reasonable offer i.e. contacting a patient on a Monday the reasonable offer would be the Thursday. For patients that are un- contactable via phone a letter must be sent and a reasonable offer is defined as four days, this includes working days and is inclusive of a Saturday but not a Sunday.

TCI dates- The offer of 'reasonable' for cancer patients is defined/interpreted as any offered appointment within a cancer referral to treatment period. Due to the nature of the pathway only 1 date needs to be available to be offered to the patient. The referrer (GP's/GDP's/Optometrists) should explain to the patient that urgent care will be offered and that they need to be available for short notice attendances at the hospital. – The Trust defines a reasonable offer for treatment as seven days.

No pauses will be allowed for:

- Medical Suspensions
- Patient or hospital initiated delays during the diagnostic phase of the 62 day pathway
- Patient or hospital initiated delays for non-admitted treatment (outpatient) setting, e.g. majority of Radiotherapy and Hormone therapies
- Religious Events

5.5 Patients Who Did Not Attend Initial Outpatient Appointment/Diagnostic Clinic

A stop in the pathway can be initiated within the 2 week pathway where a patient DNAs their initial outpatient appointment/diagnostic clinic, due to the potential clinical consequences of discharge for the patient. A further appointment should be offered and if so, a clock reset can be applied from the date upon which the patient makes contact to rebook their appointment. The patient should normally be offered a new appointment within seven days but no longer than fourteen days of the new date.

Patients should not be referred back to their GP after a single DNA or cancellation.
If a patient DNA's a second appointment it is good practice for the consultant to contact the referring clinician and discharge the patient requesting they re-refer if appropriate.

5.6 Patients who Cancel Appointments

The patient is not to be discharged to the referring GP if they have made multiple cancellations as they are engaging with the Trust. They should only be discharged if this has been agreed with the patient and the clinician.

5.7 Patients Admitted as Emergencies Prior to 2ww First Appointment

If a patient is admitted as an emergency for the same condition they have been referred under the two week wait standard for but have yet to have their first seen date, this admission would count as the date first seen. The patient would no longer be counted as part of the two week wait cohort. However, such a patient could be upgraded onto the 62 day upgrade pathway if the consultant suspect's cancer is the cause of the admission.

Patients' who are admitted as an emergency for a different condition, continue with the existing 2ww cancer referral pathway. If the patient is seen by the team relevant to the 2ww referral during the admission, then the date they were reviewed is classed as first seen and the 62 day pathway applies if the patient is subsequently diagnosed with a cancer.

If the patient is not reviewed they will stay on the 2ww pathway unless the receiving clinician deems it inappropriate and in consultation with the GP, removed the patient off the 2ww/62 day pathway.

5.8 Downgrading of Patients

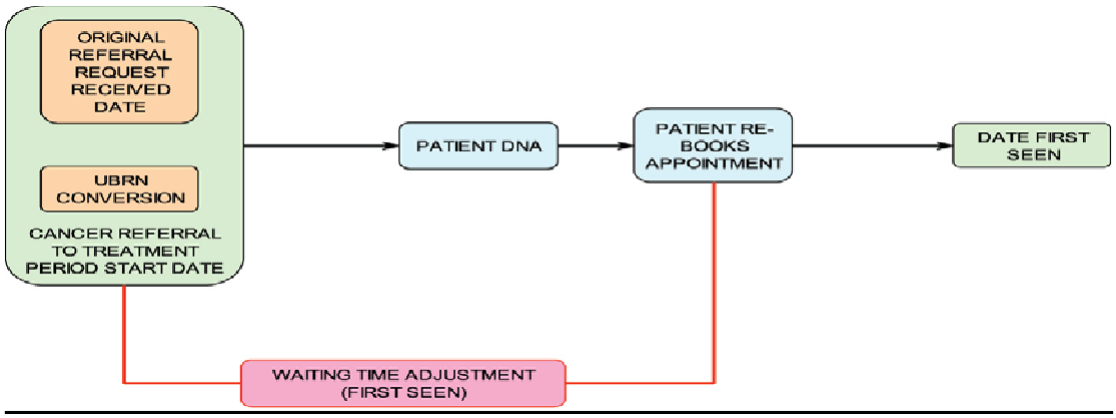
If at any point in the 62 day pathway, a consultant determines that the patient is no longer required to be on the 62 day pathway, the consultant may downgrade the patient to a routine pathway ensuring the patient and GP have been informed. The 18week pathway will then apply.

If the Consultant believes that the referral of a patient under the 2-week rule is inappropriate, the Consultant is responsible for initiating the dialogue with the GP. If the GP agrees, then the referral may be downgraded and PAS should be updated accordingly.

5.9 Two week wait – Symptomatic Breast Standard

This standard applies to all patients (men and women) with breast symptoms not covered by the NICE referral guidelines for suspected cancer but that a healthcare professional believes still need to be seen by a specialist.

The patient will need to be seen by a specialist within 2 weeks of a referral being received from their GP or other relevant health professional. There will be no downgrading of patients referred with breast symptoms.



The following types of breast referral are excluded from this standard.

- For family history clinics (unless a patient is symptomatic);
- For cosmetic breast surgery (such as enlargement or reduction).

The starting point for this standard (i.e. day 0 when the clock starts) is the receipt of the referral for an appointment at an appropriate breast clinic.

The referral can be received direct from:

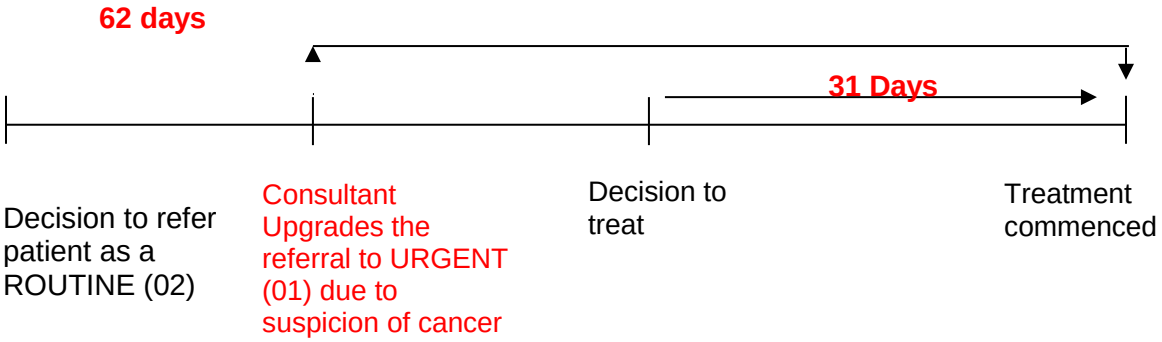
- The GP or other healthcare professionals who may see a patient with breast symptoms
- E-Referral System, in which case the UBRN CONVERSION (the Unique Booking Reference Number conversion date for an appointment) would mark the start of the 2ww period.

The end point for the standard would be when the patient is seen for the first time by a specialist or in a diagnostic clinic following the referral receipt.

If cancer is suspected or confirmed the patient continues on a 62 day pathway for treatment. If cancer is excluded the patient continues on the 18 week pathway.

5.10 Consultant Upgrade

All patients who have their referral upgraded from 'Routine' to 'Urgent' by a Consultant or designated member of the clinical team, are to be treated within 62 days from the date the decision to upgrade was made. On triaging the referral letter if the consultant believes that the patient needs to be upgraded then they will document this on the referral letter stipulating "urgent – 2 weeks" and it will be returned to the contact centre for administering.



5.11 Patient Availability

Patients who are referred on a 2ww suspected cancer pathway must be available for treatment at the point of referral. For the first 2 week wait appointment, in line with good practice, if a patient is unavailable for the offered appointment, all attempts must be made to identify another appointment date within the original 14 days If the patient remains unavailable or an alternative date is not available, for example, a specialist clinic operates fortnightly; this will be classed as a patient choice breach.

For treatment if a patient has agreed to a reasonable offer which they subsequently cancel/DNA, no pause is allowed and the clock continues. As part of the re-booking process the patient should be offered alternative dates for admission. If at the re-booking stage the patient declines a reasonable offer of admitted treatment then an **adjustment can be made**. The clock is paused from the next available date that can be offered for treatment (please refer to exclusions under section 5.4). The date must follow reasonable offer guidelines. The end of the pause will be the new date that the patient states they are available from.

If a patient is unavailable for a set period of time e.g. they are going on holiday then offering a date within this period would be inappropriate. In these circumstances then a pause can be applied from the earliest reasonable date that treatment could have been offered, to when the patient makes themselves available again, i.e. when they are back from their holiday (please see exclusions under section 5.4). For a pause to be applied the patient must be notified of the dates that could have been offered to them.

If a patient declines treatment offered or decides to be treated privately they should be removed from the cancer pathway as ‘cancer confirmed, no NHS treatment planned.’

Appendix 1: Access Policy Familiarisation

The Trust must ensure that all staff members are provided with sufficient training to gain the knowledge and understanding of policies and processes included within the Trust Access Policy. Training will be provided by the Clinical Support Services Division in the first instance with each Division required to cascade the training to staff within their areas.

This will include a presentation providing familiarisation of each aspect of the Trust Access Policy and an assessment of individuals' competencies in relation to their roles. Training and competency information will be required to be held centrally within the remit of the General Manager for Outpatients & Health Records role. Divisions undertaking 'familiarisation' sessions must therefore complete the Attendance and Competencies and forward original copies the Division for Clinical Support Services for monitoring purposes.

New employees to the Trust will have Access Policy on induction and training provided as necessary.

The Access Policy must be reviewed on an annual basis by the author and training for all relevant staff must follow any amendments that are made. This maybe in the format of refresher training sessions or Trust wide communication if amendments are minimal.

An example of the Attendance Recording and Competency Analysis is displayed in Appendix 1.

In addition to access policy familiarisation training, the Trust will ensure that all staff utilising IT systems as part of the booking process, for example e-Referral System, will be provided training programmes to support them in their daily roles. Special regard will be given to newly recruited staff and A&C Bank Staff.

ACCESS POLICY FAMILIARISATION

Attendance Recording and Competency Analysis

				COMPETENCIES MEASURED													
				General Principles		RTT Pathways			Outpatients			Inpatients & Daycases			Cancer Waits	
Date	Staff Member Name	Department	Role	1	2	3	4	5	6	7	8	9	10	11	12	13

Appendix 2: Outcome Form

Outpatient Clinic Outcome Form

«PatientFACILNumber» «PatientForename»«PatientSurname»	«OutpatientAppointments»

Section A & B must be completed by Clinician

Attended □ / DNA □

Section A ***PLEASE TICK ONE ONLY***	√	
Future appointment (AWL OPD): Months:_____ Weeks:_____ Date: _____ Overbook if Necessary: **Y / N** Comment:	**Overbook Approved by:**	
Discharge- Back to GP (DO NOT complete Section B)		**34**
Discharge- Patient having ongoing care elsewhere (PLEASE COMPLETE Section B)		
Open Appt/SOS (open for 6 months only, 12 months for Breast and Paediatrics)		
• **Treatment Given**		**30**
• **Watchful Wait**		**32**
Add to waiting list:		
• **Inpatient/Day Case**		
• **Outpatient Diagnostic** (Patient follow-up to be booked 8 weeks in advance/add to OPD F/U waiting list with 8 weeks OPA by date-awaiting results)		
Admit from clinic		**10**
Section B ***PLEASE TICK ONE ONLY***	√	
Definitive Treatment given: - Advice - Weight loss - Prescription - Physiotherapy - Treatment - Life Style Advice **PLEASE ENSURE ACTION IS SPECIFIED IN CLINIC LETTER**		**30**
Patient declined treatment		**35**
Referred for/to:		
• Diagnostics		**20**
• Same condition elsewhere		**21**
• Same department		**20**
Watchful Wait / Active Monitoring ***(patient will remain under your care but needs no treatment now)***		**32**

When you are adding patient to waiting list:		
• After previous treatment (Previous advice, medication, procedure, physio etc)		**11**
• No previous treatment (First appointment or post diagnostic)		**20**
Please fill in OPCS code if applicable:		

Appendix 3: Colposcopy Referral Guidance

All referrals to Colposcopy should be logged on the Patient Administration System (PAS) by the Colposcopy Administrator as soon as they are received. In order to ensure that the patients are seen within the timeframe set, they are to be logged on PAS under Colposcopy 2 or 6 weeks in accordance with the Colposcopy Operational Manual and the Colposcopy Service Fail safe procedures.

If a patient cancels or does not attend (DNA) their appointment then the original timescale for the appointment will reset. It is the responsibility of the Colposcopy Administrator to ensure that the patient is rebooked within this timescale. Rebooking of appointments are managed through the PTL process detailed above, and needs to be booked as soon as possible.

Where a patient is referred following an abnormal smear result does not want to rebook their appointment, a discussion will take place with the GP and the patient to ensure that they understand the need for the appointment and the consequences that could follow if they do not attend.

Where a patient DNA's with a Low Grade cytology referral and has confirmed the appointment or has had adequate notice as per the Access Policy, then the patient will be discharged back to the care of their GP, both the patient and the GP will be made aware of this via a DNA discharge letter.

Where a patient DNA's with a High Grade cytology referral, another appointment will be made for them, should they DNA the second appointment and have confirmed the appointment or has had adequate notice as per the Access Policy, then the patient will be discharged back to the care of their GP, both the patient and the GP will be made aware of this via a DNA discharge letter.

Appendix 4: Minimum Data Set Form

Referring organisation to complete and send within 48 hours of decision to refer.

FOR REFERRING ORGANISATION	
Referring organisation name: 1	Referring organisation code: 2
Referring clinician: 3	Referring clinician registration code: 4
Contact name: 5	Contact phone: E-mail: 6
Patient details	
Patient's family name: 7	Patient's fore name: 8
Title: 9	Date of Birth: 10
NHS number: 11	Local patient identifier: 12
Correspondence address: Post code: 13	Contact details : Patient: Yes No (delete as appropriate) Name of lead contact if not the patient: Home: Work: Mobile: E-mail: 14

Reason for referral (Please delete as appropriate):
Opinion without transfer of care **Diagnostic without transfer of care** **Transfer of care**

GP details	
GP name: 15	GP practice code: 16

Is the patient eligible under the definition of an 18 Weeks RTT pathway? Yes No (delete as appropriate) (NB if no - do not complete items 18 - 21) If yes - is this referral part of an existing pathway or the start of a new pathway? Existing □ New □ 17	
Unique pathway identifier (where available): Allocated by (organisational code): (Organisation that received the original referral that started the clock) 18	Clock start date: (Date the patient started on the existing pathway, or the date the decision to refer onwards was made if it starts a new pathway) 19
Date of decision to refer to other organisation: (Required for existing pathways only) 20	For existing pathways only: Not yet treated □ Treated □ Active monitoring □ 21
Receiving Organisation details	
Receiving Organisation Name: 22	
Receiving Clinician: 23	Receiving treatment function (speciality/department): 24
Date and time MDS sent: 25	
FOR RECEIVING ORGANISATION	
Date/time received: 26	

Appendix 5: List of Prior Approval Procedures & Exceptional Treatment Procedures Prior Approval is required for the following Low Priority Treatments

Exceptional Treatments include the following:

- Back injections – Epidural, Facet Joint Injections (Herts only) radio
- frequency denervation – Beds & Herts
- Breast surgery (not had cancer within the last 2 years) – Beds only
- Video Capsule Endoscopy & Balloon Enteroscopy – Herts & Beds
- Cataracts (if no approval at referral stage) – Herts & Beds
- Circumcision - Bedfordshire patients only
- Grommets (under 18 only) – Herts and Beds
- Haemorrhoidectomy – Beds patients only
- Hand Surgery – Ganglions (Herts & Beds), Carpal Tunnel , Fasciectomy and Trigger Finger, Herts only
- Hernia procedures (only 16 and over) – Herts & Beds
- Hysterectomy – Herts & Beds
- Knee Arthroscopy – Herts only
- Laparoscopic cholecystectomy - Beds only
- Minor Skin Surgery – Herts and Beds
- Prolaspe (incontinence) – Beds only
- Rhinoplasty – Beds only
- Tonsils & Adenoids (children and adults) – Herts and Beds
- Total Hip Replacement – Herts only
- Total Knee Replacement – Herts only
- Varicose veins – Herts and Beds

Exceptional Treatments include the following

- Abdominoplasty/Apronectomy
- Abnormally Placed Hair
- Bat Ears (Pinnaplasty) (Except children less than 16 years)
- Benign skin lesions S068, S069
- Blepharoplasty
- Botulinum toxin
- Operations on nipple
- Breast reduction/augmentation and reversal of prosthetic implants
- Congenital Vascular Abnormalities
- Dermabrasion
- Face lift
- Labioplasty
- Liposuction
- Osseointegrated Dental Implants
- Penile Prosthesis for Erectile Dysfunction
- Radiofrequency Injections (Hertfordshire only)
- Removal of redundant fat
- Rhinoplasty
- Repair external earlobes
- Tattoo laser removal
- Thread Veins or Telangiectasias

Click the following link to access the full list of prior approval and exceptional

Treatments for Bedfordshire CCG:
Policies - Bedfordshire - Funding Requests – South, Central and West.htm

Click the following link to access the full list of prior approval and exceptional treatments for Hertfordshire CCG:
http://www.enhertsccg.nhs.uk/bedfordshire-and-hertfordshire-priorities-forum

Appendix 6: List of specialties where there is a RMS/CAS 'triage'

Clinical triage - on receipt of referral to Trust
Oral maxilla-facial surgery – Hertfordshire only

Administrative triage - referrals must be received into the Trust via the triage Service
Dermatology – Hertfordshire only
Diabetic medicine – Hertfordshire only
Pain management – Bedfordshire only
Rheumatology – Bedfordshire only
Trauma and Orthopaedics – Bedfordshire only

Appendix 7: Cancer First Definitive Treatment Types

First definitive treatment type	Circumstances where this applies
Surgery	Complete excision of a tumour Partial excision/ debulking of a tumour (This wouldn't include a biopsy for diagnostic purposes) Palliative intervention i.e. insertion of a oesophageal stent Excisional biopsy where the intent is to remove the tumour i.e. in skin cancer
Chemotherapy	This will include cases where this is being given prior to a planned surgery or radiotherapy
Biological Therapy	This will include treatments targeted against a specific molecular abnormality in the cancer cell and treatments which target the immune system
Hormone Therapy	Hormone treatment should be counted as first definitive treatment in two circumstances: Where hormone treatment is being given as the sole treatment modality Where the treatment plan specifies that a second treatment modality should only be given after a planned interval. This may be given to patients with locally advanced breast or prostate cancer where hormone therapy is planned for a period to shrink the tumour before the patient receives chemo or radiotherapy.
Radiotherapy (Teletherapy /Brachytherapy)	Given to the primary cancer site or to treat metastatic disease. This can also include cases where radiotherapy is given prior to planned surgery or chemotherapy
Specialist Palliative Care	Given via hospital SPC teams Given via community SPC teams Hospices
Active monitoring	When none of the other defined treatment types apply and the patient is receiving symptomatic support and is being monitored. The date of commencement of active monitoring should be the consultation date on which the plan of care is agreed with the patient. This treatment type may be used for any tumour site if appropriate For the purposes of waiting times the field active monitoring should also be used to record patients with advanced cancer who require general palliative care.

Appendix 8: Smoking Cessation Flowchart

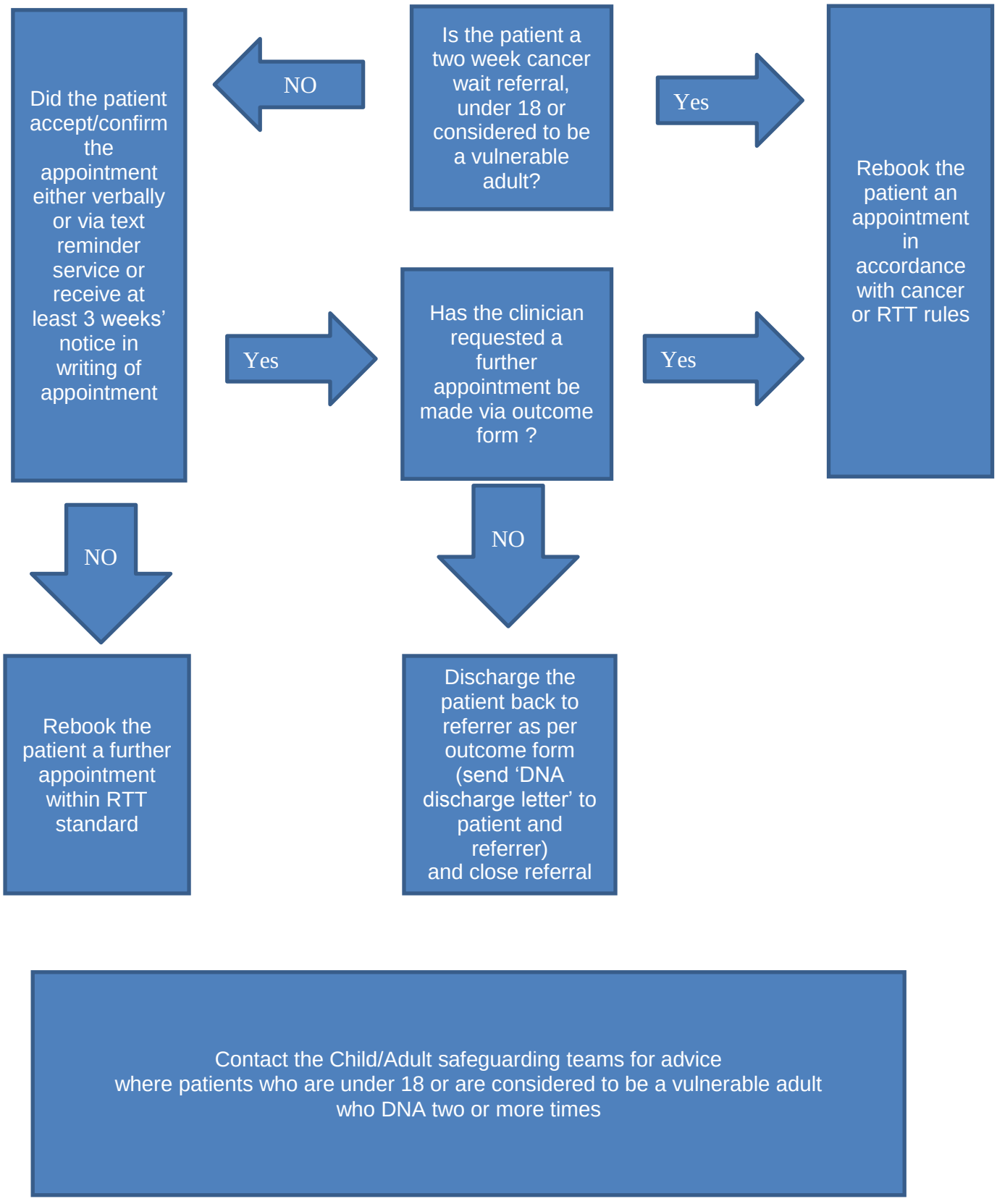
Management of smokers under Hertfordshire smoking cessation instruction				
Description of cohort	Patient seen by HSSS and **do not stop smoking**, but **by exception only**, these patients need their surgery given their medical priority	Patient seen by HSSS and have **attempted** to stop smoking	Patients who **did not attend (DNA)** their HSSS appointment	Patient seen by HSSS and have **refused** to stop smoking
Waiting list action, once notified of attendance or non-attendance at HSSS	Open patient's waiting list entry	Open patient's waiting list entry	Open patient's waiting list entry	Open patient's waiting list entry
PAS hospital site action	Change hospital site from SS to appropriate site	Change hospital site from SS to appropriate site	Remove the patient from the waiting list, by discharging patient back to GP, reason - removed for other reasons	Remove the patient from the waiting list, by discharging patient back to GP, reason - removed for other reasons
Next steps	Enter the medical deferment as the date of the HSSS appointment	Alter the end date of the medical deferment, so that it is 6 weeks after the date of the HSSS appointment. This will allow the patient to receive the full clinical benefit from giving up smoking	Add comment that patient was discharged due to "failure to attend a smoking cessation meeting therefore funding refused".	Add comment that patient was discharged due to "failure to stop smoking therefore funding refused".
	Check funding approval for patient before dating, in accordance with normal procedures.		Patient to be sent a copy of the patient information letter	Patient to be sent a copy of the patient information letter
			Patient to be notified that their surgery cannot proceed until they have attended HSSS and that they have been referred back to their GP	Patient to be notified that their surgery cannot proceed until they have stopped smoking and that they have been referred back to their GP

Appendix 9: Consultant to Consultant Referral Guidance

No	Type of Referral	Source of Referral	Definition	Agreed referral protocol	Action based on RTT Policy
1	Urgent referral	Within Trust (including	Urgent defined as suspected cancer or life threatening condition (includes referrals for TIA, RACP and Heart failure using the appropriate pro-forma)	Accept referral	Continuation of previous wait
		Other provided of NHS care (NHS hospital, NHS treatment centre, private provider)			
		Provider of private care, (NHS hospital, private provider)			For previously private patient, clock start on date of C2C
2	Same condition	Within Trust	Internal referrals for any specialty directly relating to the original reason for referral, i.e. patient has associated symptons.	Accept referral	Continuation of previous wait
			Does not include referrals for secondary condition or where referral is only loosely associated with original problem or referrals to the wrong clinical team.	Back to GP	Clock stop
		Other provided of NHS care (NHS hospital, NHS treatment centre, private provider)	Referrals from other NHS providers only to be accepted when referred on as a tertiary referral for complexity on an agreed pathway.	Accept if part of an agreed pathway	Clock stop
		Provider of private care, (NHS hospital, private provider)	Referrals from private providers should go back to GP for further discussion regarding onward treatment	Back to GP	Clock stop
3	Different condition	Within Trust	Referral for secondary condition, loosely associated problem or where original referral was to the wrong clinical team	Back to GP	Clock stop
		Other provider of NHS care (NHS hospital, NHS treatment centre, private provider)			
		Provider of private care, (NHS hospital, private provider)			
4	Second opinion	All providers		Back to GP	Clock stop

No	Type of Referral	Source of Referral	Definition	Agreed referral protocol	Action based on RTT Policy
5	Referral from ED - referrals only for a symptomatic condition directly related to presentation at ED	All providers of ED care (Trauma only)	Patient reviewed via emergency department and referred on to a specialty as a direct result of their presentation at ED when further intervention or significant specialist dressings are expected	Accept referral	Clock start on date of Consultant to Consultant referral
			If non symptomatic, patient to be referred back to GP. Consultant to Consultant referral will not be accepted within ED	Back to GP	Clock start if new referral from GP
6	Referral from ED - not trauma related	All providers of ED care	Patient reviewed via emergency department and referred on to a specialty as a result of non- trauma related injury	Back to GP	Clock start if new referral from GP
	Referral from ED - not trauma related but urgent	All providers of ED care	Urgent defined as suspected cancer or life threatening condition (includes referrals for TIA, RACP and Heart failure)	Accept referral	Clock start
	Allied Health Professionals	All non GP Health Professionals		Back to GP	Clock start if new referral from GP
7	Self-referral	Patients	Referral should be initiated by a GP	Back to GP	Clock start if new referral from GP
		Patients with an SOS appointment within 6 months	Referral can only be activated if specialty specific triggers for follow up are met	Accept referral	New clock start if activated within 6 month
8	Bilateral procedure		Decision taken following completion of first side that patient is fit and ready for a subsequent bliateral procedure - GP to be informed if second procedure necessary		Clock starts from the date of patient has confirmed they are fit ready and able to undertake a second procedure
9	Military patients	GO referrals from Military Medical Centres	Patient referred via Senior Medical Officer	Accept referral	Clock start
10	Midwife referrals	Antenatal referrals only. (if the referral doesn't relate to pregnancy, send back to GP)		Accept referral	Clock start
11	Dental referrals			Accept referral	Clock start
12	Ophthalmology referrals	Referrals from GP		Accept referral	Clock start
		Referrals from opticians		Not accepted, return	Clock start if new referral from GP

Appendix 10: DNA guidance flow charts



Appendix 11: Glossary

18 Week Referral to treatment period	The part of a patients care following initial referral, which initiates a clock start of first definitive treatment or other 18 week clock stop point.
Active Monitoring	A waiting time clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage.
	A new waiting time clock would start when a decision to treat is made following a period of active monitoring (also known as watchful waiting).
	Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to refer the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such and also stops a waiting time clock.
	If a patient is subsequently referred back to a consultant-led service, then this referral starts a new waiting time clock.
Active Waiting List	The list of elective patients, who are fit and able to be treated at that given point in time. The active waiting list is also the list used to report national waiting times statistics.
Admission	The act of admitting a patient for a day case or inpatient procedure.
Admitted Pathway	A pathway that ends in a clock stop for admission (day case or inpatient)
Bilateral (procedure)	A procedure that is performed on both sides of the body at matching anatomical sites, for example, removal of cataracts from both eyes.
Booked Patients	These patients are on the active waiting list. However, when they were put on the waiting list, they agreed a date to come into hospital with us.
	The patient has been given the opportunity to agree their appointment/admission date within 24 hours of the decision to admit or treat.
Cancelled Operations/procedures (Deferred Treatment)	Occasionally, an admission may be deferred for clinical or non- clinical reasons once the patient has been admitted (e.g. lack of theatre time).
	Patients that are **cancelled for clinical reasons**, for example a patient is unfit for surgery, for **less than 2 weeks**, the clock must continue, and the patient will be offered another date within the RTT standards.
	Patients that are **cancelled for clinical reasons**, for example a patient is unfit for surgery for **more than 2 weeks**, will result in the clock being stopped, and the patient discharged back to their GP.
	If the patient is cancelled on the day for an elective admission then the patient must be rebooked within 28 days. Where a suitable TCI date cannot be offered this should be escalated to the Deputy General Manager/General Manager for resolution. The patient should be re-dated within whichever target is first (RTT target or 28 day target)
Care Profession	A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professionals Act 2002.
CATS	Clinical Assessment, Treatment and Support services

CHD	Coronary Heart Disease
e-Referral System	A national electronic referral service that gives patients a choice of place, date and time for their first Consultant outpatient appointment in a Hospital or clinic. (formally choose and book)
Chronological Order/'in turn'	This is a general principle that applies to patients categorised as requiring routine treatment (as opposed to urgent treatment). All these patients should be seen or treated in the order they were added to the waiting list.
Clinical Decision	A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements.
Consultant	A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. Consultant-led waiting times exclude non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.
Consultant led	A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.
Convert(s) their URBN	When an appointment has been booked via e-Referral System, the UBRN is converted. (Please see definition of UBRN).
Day Cases	Patients who need to come into hospital for treatment or investigations. These patients will need to recover after their treatment/ investigation, but are not expected to stay in hospital overnight.
Did Not Attend (DNA)	DNA (sometimes known as an FTA – Failed to attend). In the context of consultant-led waiting times, this is defined as where a patient fails to attend an appointment/ admission without prior notice, however short the notice period.
Decision to admit	Where a clinical decision is taken to admit the patient for either a day case or inpatient.
Decision to treat	Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatments performed in other settings, e.g. as an outpatient.
Elective admission/elective patients	In patients are classified into two groups, emergency and elective. Elective patients are so called because the Trust can 'elect' when to treat them.
Elective booked	Patients awaiting elective admission who have been given an admission date which was arranged and agreed with the patients at the time of the decision to admit.
Elective Planned Excluded from Active Waiting list.	Patients who are to be admitted as part of a planned sequence of treatment or investigation. The patient has been given a date, or approximate date at the time a decision to admit was made. The date is set for clinical reasons (e.g. check cystoscopy) and there is no clinical advantage in admitted the patient earlier.
Elective Waiting	Patients awaiting elective admission who have yet to be given an admission date.
Firebreak/Reserved clinic	Outpatient clinic time that is left free to accommodate cancelled clinics.

First definitive treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.
Fit (and ready)	A new RTT clock should start once the patient is fit and ready for a subsequent bilateral procedure. In this context, fit and ready means that the clock should start from the date that it is clinically appropriate for the patient to undergo that procedure, and from when the patient says they are available.
Healthcare science intervention	See Therapy or Healthcare science intervention.
Inpatients	Patients who need to come into hospital for treatment or investigations and who are expected to stay in hospital for at least one night.
Intended Management Day Case	Patients who require admission to Hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.
Intended Management in-patient	Patients who require admission to Hospital for treatment and are intended to remain in Hospital for at least one night.
Intended Management Regular Day Patient	Patients who require admission to the Hospital for treatment on a regular planned basis.
Interface service (Non Consultant led interface service)	All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care.
	Consultant-led referral to treatment relates to hospital/consultant-led care. Therefore, the definition of the term 'interface service' for the purpose of consultant-led waiting times does not apply to similar 'interface' arrangements established to deliver traditionally primary care or community provided services, outside of their traditional (practice or community based) setting.
	The definition of the term does not also apply to:
	• Non Consultant led mental health services run by Mental Health Trusts.
	• Referrals to 'practitioners with a special interest' for triage, assessment and possible treatment, except where they are working as part of a wider interface service type arrangements as described above.
Korner	Statistical returns made to the Department of Health are called Korner Returns. These include KH07 – Active Inpatient and Day Case Waiting list and QM08 – Outpatient Waiting list.
NICE	National Institute for Clinical Excellence.
Non admitted pathway	A pathway that results in a clock stop for treatment that does not require an admission or for 'non treatment'
Non Consultant led	Where a Consultant does not take overall clinical responsibility for the patient.
Non Consultant led interface service	See interface service.

Outpatients	Patients referred to the hospital by their GP or another consultant for clinical advice or treatment. In some cases other healthcare professionals, such as nurses, Health Visitors or optometrists, may refer patients to the hospital. In some cases referrals will arrive at the Trust via a Clinical Assessment Service (CAS).
Patient Choice	At the point of referral the GP or CAS will normally offer patients a choice of 4 or 5 providers. A patient then has the right to be treated within the current maximum waiting time at the Trust where he/she agreed to be referred. Where a patient is unusually referred to a named consultant he or she has the right to be treated by that consultant or a member of his/her team.
Planned Patients	Planned patients are patients who need to come into hospital as part of a scheduled sequence of treatment or for an investigation at a specific clinically agreed timescale. When they are put on the waiting list they are given an approximate date for their treatment referred to as a due date. Examples include: removal of metal work, surveillance or check procedures, investigations or treatments that must be given in sequence.
PTL	Primary Target List. A report used to ensure the maximum waiting times standards are achieved by identifying all patients that will breach the current wait time's standards. A PTL requires regular monitoring at patient level, to achieve 2 week access to cancer, breast and rapid access clinics, 6 weeks for diagnostic interventions and 18 weeks from referral to treatment standards.
Reasonable offer	In the context of consultant led waiting times a reasonable offer is 3 weeks' notice in writing or any time prior to the appointment/TCI if agreed by the patient.
Referral Management or assessment service	Referral management or assessment services are those that do not provide treatment, but accept GP (or other) referrals and provide 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.
	Referral Management and Assessment Services should only be in place where they carry clinical support and abide by clear protocols that provide benefits to patients. They must not be devices either to delay treatment or to avoid local clinical discussions about good referral practice.
	A waiting time clock only starts on referral to a referral management and assessment service where that service may onward-refer the patient to a surgical or medical consultant-led service before responsibility is transferred back to the referring health professional.
RTT - Referral to Treatment	The part of a patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other clock stop.
Straight to test	A specific type of direct access diagnostic service whereby a patient will be assessed and might, if appropriate, be treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional.
Substantively new or different treatment	Upon completion of a consultant-led referral to treatment period, a new waiting time clock starts upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.

	It is recognised that a patient's care often extends beyond the consultant-led referral to treatment period, and that there may be a number of planned treatments beyond first definitive treatment. However, where further treatment is required that was not already planned; a new waiting time clock should start at the point the decision to treat is made. Scenarios where this might apply include:
	• Where less 'invasive/intensive' forms of treatment have been unsuccessful and more 'aggressive/intensive' treatment is required (e.g. where Intra Uterine Insemination (IUI) has been unsuccessful and a decision is made to refer for IVF treatment);
	• Patients attending regular follow up outpatient appointments, where a decision is made to try a substantively new or different treatment. In this context, a change to the dosage of existing medication may not count as substantively new or different treatment, whereas a change to medication combined with a decision to refer the patient for therapy might.
	Ultimately, the decision about whether the treatment is substantively new or different from the patients agreed care plan is one that must be made locally by a care professional in consultation with the patient.
Therapy or Healthcare science intervention	Where a Consultant led or interface service decides that Therapy (for example physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science (e.g. hearing aid fitted) is the best way to manage the patient's disease, condition or injury and avoid further interventions.
To Come In (TCI)	Date when patient is due to be admitted to hospital
URBN (Unique Booking Reference Number)	The reference number that a patient receives on their appointment request letter when generated by the referrer through e-Referral System. The UBRN is used in conjunction with the patient password to make or change an appointment.