

Information and Performance

Patient Access Policy

SWH – 00865

South Warwickshire
NHS Foundation Trust



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1. Introduction

The South Warwickshire NHS Foundation Trust aims to see and treat patients as quickly as possible.

This policy applies to the way in which South Warwickshire NHS Foundation Trust will manage patients who are waiting for treatment / care on an admitted, non-admitted, diagnostic pathway or community care episode. The focus of the policy is on fair, equal and timely access to treatment for patients, as well as compliance with 18 weeks referral to treatment rules, national cancer waiting targets and Department of Health policies.

2. Purpose

This access policy incorporates all aspects of the patients' journey and all clinical departments. The policy is based on the following principles:

- Every process in management of patients who are waiting for treatment must be clear and transparent to patients and to partner organisations and must be open to inspection, monitoring and audit.
- The Trust will give priority to clinically urgent patients and treat everyone else in turn with consideration to case mix and patient pathway complexity.
- The Trust will work to meet and better the maximum waiting times set by the Department of Health for all groups of patients.
- The Trust will at all times negotiate appointment and admission dates and times with patients. The Trust will work to ensure fair and equal access to services for all patients.
- Although referred to as the GP throughout the document, the referring clinician may be any health care professional with referring rights, for example Nurse Specialists / Consultant and Allied Health Professionals.
- Prior to referral onto an 18 week pathway GPs must establish that patients are ready and available to receive treatment within this timeframe.
- As a general principle, other than specific vulnerable groups (e.g. children), where patients are not ready or available they should be returned to the care of the GP unless contrary to their best clinical interest.
- The Trust will ensure that all policies, procedures and performance information will be made widely available, including to the general public (unless there is a specific reason for restricted availability).
- The Trust will pay due attention to the needs of vulnerable and at-risk patients.

3. Audience

- Staff with clinical contact with patients
- Executive and Management Team
- Inpatient and outpatient booking clerks
- Medical Secretaries
- Clinical Commissioning Groups
- General Practitioners and other referrers
- Patients, Carers and Patient Representatives

4. Associated Documents

This policy must be read in conjunction with the following:

- RTT Rules & Definitions Department Health
- SWFT Leave Policy
- SWFT Paediatric DNA Policy
- South Warwickshire Clinical Commissioning Group Low Priority Procedures Policy (LLP)
- SWFT Children's Services and Home Visiting Policy

5. Responsibilities / Duties

5.1 Executive and Management Team

Is Responsible for:

- Ensuring that this policy is applied in all cases and that the appropriate infrastructure is in place to enable delivery.
- Establishing clear lines of responsibility to ensure effective waiting list management.

5.2 Director of Operations

Is Responsible for:

- Implementation of this policy
- Transparent delivery of access targets
- Monitoring waiting list management and compliance with this policy

5.3 Assistant Director of Performance and Information

Is Responsible for:

- Reporting information to the Director of Operations
- Regular data quality audits of standards of data collection
- Recording submission of central returns through the Information Services Department
- Monitoring performance against locally or nationally agreed targets

5.4 Clinical Staff

Are Responsible for:

- Ensuring that the principles of this policy are followed
- Reviewing referrals to ensure the patient is directed to the most appropriate clinical service
- Responding to enquiries from clerical staff regarding applying the policy
- Ensuring compliance with the Trusts leave policy.

5.5 General Managers

Are Responsible for:

- Managing waiting lists to ensure waiting times are minimised and patients are prioritised in accordance with this policy;
- Communicating to clinical staff regularly to update on waiting list position and RTT performance
- Achievement of access targets

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- Providing support to staff managing waiting lists
 - Ensuring sufficient capacity is provided to meet demand
 - Reviewing clinical staff job plans on a regular basis to ensure that capacity and demand flows are in balance to achieve waiting times

5.6 Clerical staff with contact with patients and those who manage patients' access to services

Are Responsible for:

- Ensuring that the principles of this policy are followed and implemented rigorously, including:
- Making all reasonable effort to contact patients and confirm appointment and admission dates and arrangements;
- Giving patients choice and reasonable notice of appointment and admission dates;
- Identifying and communicating the needs of vulnerable patients.
- Following PAS standard operating procedures

5.7 Clinical Commissioning Group

- Ensure robust communication pathways are in place to feedback information to GPs.
- Make commissioning decisions about high cost and low priority treatments
- The CCG plays a pivotal role in ensuring that during their GP consultation patients are made aware of their responsibility to comply with booking procedures.

5.8 GPs and Other Referrers

Ensure that patients:

- Are fit, ready and available for treatment within the 18 week pathway;
- Are encouraged to use the Choose and Book system for outpatient appointments; and understand their responsibility in the booking process and implications of missing or repeatedly rescheduling confirmed appointments.
- Identify and communicate the needs of vulnerable patients to the Trust on referral.

5.9 Patients, Carers and the Public

Patients are responsible for:

- Responding promptly to communication from the Trust;
- Using the Choose and Book system or other method to confirm appointments and dates for admission with the Trust;
- Attending all confirmed appointments and admission dates.
- Updating their contact details with the Trust.
- Notifying the Trust as soon as possible/immediately if they are unable to attend appointments or admission dates.

6. Referrals

6.1 Referrals to Outpatients

Referrals should be made where possible to clinical teams rather than individual Clinicians. This ensures there is an equalisation of waiting lists and that the waiting time for all patients is reduced.

There are 5 recognised referral routes for RTT pathways:

- Via the Choose and Book electronic booking system (preferred method)
- Via written referral by letter or fax
- Internal Consultant-to-Consultant Referrals
- Inter-Provider Transfers
- 2 week referrals

Only one of these routes should be used for an individual referral.

6.2 Internal Referrals relating to 18 week pathways

- Internal referrals may only be made for urgent, complex and 2 week wait (cancer) patients, or for those routine patients who are on an agreed pathway of care.
- Routine patients who need to be referred for an unrelated problem must be referred back to the GP for management.

6.3 2 Week Referrals

- The process for 2 week referrals for Cancer patients is well established using fax referral processes from GP surgeries to achieve the 2wks, 31 day and 62 day targets.
- Choose and Book is also used for the booking of 2 week referrals and will become the main referral route.

Further Cancer specific information can be found on the Cancer Services section of the SWFT intranet.

6.4 Low Priority Treatments or Approval per Case Treatments

- Some conditions such as cosmetic surgery are classed as low priority treatments and will not be funded by commissioners.
- Other patients may be identified as potentially benefiting from high cost treatments which require Clinical Commissioning Group (CCG) approval. These patients must not be added to the waiting list nor seen in outpatients unless explicit approval has been received on a named patient basis from the commissioning CCG or the patient meets the CCG criteria for treatment. Once approval has been obtained, their referral can be processed in the normal way.

7. Communication with Patients

The Trust aims to give patients reasonable notice of 3 weeks or more before appointments and admission dates where appropriate. In the case of admission to hospital, patients will be given an offer of 2 dates verbally or 1 date in writing.

- Patients can schedule the 1st outpatient appointment via the Choose and Book system.
- Alternatively patients will be contacted by telephone and/or letter inviting them to schedule their appointment or admission to hospital.
- All outpatients will be sent a letter confirming the time, date and location of their appointment or admission to hospital.
- Patients who are being admitted for treatment will also receive details of their procedure and pre-operative assessment clinic date. An inpatient information

booklet and leaflet detailing the patient's rights and responsibilities will be included with the letter.

- Patients/ clients in receipt of community services in a home setting will be notified on discharge, via a letter or telephone call, with a time span, when to expect a visit. Subsequent visits will be negotiated with a mutually convenient date, time and location.

7.1 Patients who cannot be contacted

- If patients cannot be contacted after two attempts either by telephone on two different days, or via a letter that they have not responded to, or by two failed home visits, the patient will be discharged back to their referrer and/or the GP notified.

8. Did Not Attend (DNA)

- Patients, where it is safe to do so and with the exception of paediatrics, vulnerable adults and urgent cases, will be referred back to their GP.
- If a patient's appointment was not agreed directly or there were problems with the delivery of the original appointment letter, patients who contact the trust within 2 weeks will be given a further appointment if required.

9. Patient Unavailability, cancellations and re-scheduling

9.1 Declined Appointments and Patient Unavailability

- Where a patient declines 2 reasonable offers of a date (3 weeks' notice) for an outpatient appointment or outpatient diagnostic test they must agree a 3rd offered appointment date.
- The patient must be made aware that the Trust aims to treat patients within 18 weeks, patients that fail to agree an appointment within 4 weeks of the 1st reasonable appointment offer date will be discharged back to the care of their GP. This must be clearly communicated to the patient and GP requiring re-referral when the patient is available.
- Referral back to the GP in this scenario would stop the RTT clock and a new RTT clock would start at the point when/ if the patient and GP agreed to re-refer for treatment

9.2 Reschedule / cancel previously agreed appointment for OPD

- Patients will be offered another appointment but advised that if they reschedule the next agreed appointment they will be returned to the care of their GP.

9.3 Patient Admission Cancellations

- Patients, who cancel their admission for a valid reason, must be informed of the likely arrangements for their admission. Wherever possible, they must be given a re-arranged date at the time of the cancellation that is within the RTT waiting time standard.
- If a patient cancels an accepted admission offer twice, they will be removed from the waiting list and returned to their GP, where it is clinically safe to do so.
- A letter will be sent to the patient and their GP explaining the decision.
- Patients may be sent a patient unavailability letter enabling self referral back into the

Trust and onto the waiting list if they wish.

10. Outpatients

The Trust is committed to ensuring patients are seen and treated within the national maximum waiting time. The purpose of the outpatient booking service is to book the patients into the right clinic efficiently.

- Patients should expect to be given reasonable notice of appointments (3 weeks).
- Patients are requested to keep agreed appointments.
- Patients must contact the Trust at the earliest opportunity if they become unavailable for an appointment.
- Where there is a specific request for the patient to be seen at a specific time/date or where there is an agreed clinical pathway which stipulates when the patient is to be seen, the patients RTT status should be updated to ensure the patient does not breach their RTT pathway.
- No patients are to be booked for their 1st appointment beyond the 18th week without authorisation of the General Manager.
- Home visit appointments should follow the Community Home Visiting guidance.

11. Diagnostics

11.1 Diagnostics and RTT

- Outpatient based diagnostics should follow outpatient access principles and inpatient diagnostics should follow inpatients access principles.
- Diagnostic pathways cannot be 'paused' if the patient is unavailable
- Admissions for diagnostic test must have admission dates within 6 weeks of the DTA (decision to admit) date, or earlier if requested by clinicians.
- There are occasions when a patients RTT pathway has already been stopped that further diagnostic tests are required. If the outcome of the diagnostics is that further treatment is required then that will start a new RTT pathway.
- Occasionally a decision will be made during a diagnostic test that treatment is required and performed during the diagnostic procedure. In this instance this will stop the patients RTT pathway.

11.2 Non RTT Pathway Diagnostic services

The following situations do not constitute part of RTT pathways:

- Patients who have been admitted as an emergency and undergo diagnostic tests
- Patients who have been referred directly for tests by their GP and will return to their GP to have their tests reviewed

12. Inpatients and Day Cases (Admitted Pathways)

The process of selecting patients for admission and subsequent treatment is a complex activity. It entails balancing the needs and priorities of the patient against the available resources of theatre time and staffed beds.

- All patients will be chronologically managed with the exception of clinical priorities and pathway complexities.

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- Decisions to treat patients and add them to the waiting list will be made by clinicians.
 - Patients must be medically fit and be clinically and socially ready for admission.
 - All outpatient consultations and investigations should be complete by the day they are added to the waiting list.
 - Patients who are unavailable for treatment and cannot commit to an admission date greater than four weeks in the future will be asked to contact the Trust once they are available and ready to be admitted for treatment.
 - Patients who are not available for treatment and have been issued with an unavailable for treatment letter, must return this letter within 6 months or be referred by their GP.
 - Patients who decline two or more reasonable offers of admission dates will be asked to contact the Trust once they are available and ready to be admitted for surgery. A pause will be recorded against their RTT pathway.
 - A pathway pause should not extend beyond 60 days in most circumstances.

12.1 Pre-operative Assessment

- Pre-operative assessments will be carried out within 6 weeks of admission date.
- No patients are added to a treatment list unless a preoperative assessment to ascertain fitness for treatment has been carried out.

If a patient becomes unfit after they have been listed.

- An assessment must be made on the likely duration of the period of unavailability.
- If unavailability is over two weeks then the patient must be discharged back to the care of their GP for re-referral into the preoperative assessment clinic.

12.2 2nd Side Procedures

- Bilateral procedures are often agreed with the patient before the first procedure is performed.
- Once patients have recovered from the 1st side procedure and are deemed ready for 2nd side procedures following contact or clinical assessment, the patient can be listed for the 2nd side procedure. This will begin a new RTT pathway for the 2nd side procedure.

13. Trust Initiated Cancellations of Admissions / Waiting List Removals

The Trust acknowledges it is not good practice to cancel a patient where at all possible. However there are some circumstances when this becomes necessary.

When this occurs the patient will be;

- Contacted and an alternative admission date agreed.
- This must be recorded as a Trust cancellation and the patient's length of wait will not be affected.
- Patients cancelled on or after admission must be treated within 28 days of the cancellation or prior to the end of the RTT pathway, whichever is the earliest.
- Patients whose elective inpatient admission has previously been cancelled on more than one occasion are a priority because of the repeated disruption to their lives and the psychological impact of repeated cancellation.

14. Discharges to GP for Re-referral

Routine patients awaiting outpatient appointments will be discharged to GPs if they:

- decline 3 reasonable offers of dates for appointment;
- are unable to agree an appointment within 18 weeks of referral;
- reschedule/cancel confirmed appointments more than once;
- cancel their appointment altogether

Urgent patients and children awaiting outpatient appointment will be discharged to GPs for the following reasons when clinically safe to do so:

- Patient is unable to agree an appointment within 18 weeks of referral;
- Patient reschedules/cancels confirmed appointments more than twice.
- In the case of children the Health Visitor or school nurse will also be notified.

Routine patients awaiting admission to hospital will be discharged to GPs if they:

- are deemed “not fit for surgery”;
- become medically unfit and are therefore unavailable for treatment for periods of 2 weeks or more;
- are identified as being MRSA positive;
- Do not return a Patient unavailability letter within 6 months of issue.
- Cancel two accepted dates for admission (subject to clinical risk assessment by Consultant).

Reasons for discharging patients and clear guidance as to criteria for re-referral will be clearly communicated to the GP and Patient by letter.

15. Transfers between providers

15.1 Transfers between NHS Providers or Private Providers (providing NHS care)

- Transfers out to alternative providers for treatment must always be managed with the consent of the patient.
- If a patient does not wish to be transferred, the original provider must ensure the patient is admitted for treatment in compliance with the waiting time guarantee.
- A completed RTT minimum Data Set (MDS) proforma must sent with all inter-provider transfers.
- Waiting times will continue uninterrupted and the patient must not experience an extended waiting time in their RTT pathway due to the transfer.

15.2 Patients who transfer from NHS to Private care or vice versa

- Some patients transfer to NHS care post treatment, for these patients their pathway status will be assessed at the point of transfer.
- Patients who decide to transfer to private care for treatment will have their RTT pathway stopped on the date they leave NHS care.
- For patients who transfer from the private sector to NHS care will have their RTT clock start on the date the referral was received and NHS care started.

16. Special Patient Groups

16.1 Vulnerable Patients

- It is essential that all staff within their roles ensure that patients who are vulnerable for whatever reason are identified as early as possible in the referral pathway
- Are provided with whatever additional help and support is required
- Are provided with communications in the appropriate format to access services.
- The referrer should make clear what needs have been identified, and this should be recorded on Trust systems, reviewing and updating on subsequent visits.
- When safeguarding issues are identified, trust procedures should be followed in the normal way.

16.2 Treatment Requests for Staff Members

- Occupational Health or Managers, with a member of staff on a waiting list for outpatients, diagnostics or treatment should contact the relevant General Manager who will then arrange to expedite the pathway for the member of staff in liaison with the clinicians.
- Clinical priority will need to be taken into consideration.

16.3 Treatment for Veterans

- If the referral or other correspondence letter states the patient is a veteran then the General Manager should be notified to expedite their pathway.
- Clinical priority will need to be taken into consideration.

17. Monitoring Compliance

- Patient pathways will be monitored and tracked by using the PAS functionality
- Patient Tracking Lists (PTL) are utilised in monitoring and tracking elective services through weekly Workload Planning Meetings, chaired by the Director of Operations.
- Finance and Performance Committee will monitor Divisional performance and compliance against the policy.
- An audit undertaken by the Outpatients Department of patients who cancel on the day of the appointment will be undertaken to understand the reason for the same day cancellation.

Refer also to Appendix 3.

18. Author(s)

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19. Contributors

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20. Equality Impact Assessment Tool

Has an Equality Impact Assessment been carried out?

YES

Preliminary Stage 1 Equality Impact Assessment (must be completed if required*)

What date was Stage 1 completed and published?

June 2013

Has a Full Assessment Stage 2 Equality Impact Assessment Tool been undertaken*?

NO-NA

If yes, what was the date of assessment and publication of Stage 2 and action plan?

N/A

21. References

Referral to Treatment Consultant-Led Waiting Times – Rule Suite, DH(2012)

A 'how to' guide to measuring Referral to Treatment consultant led waiting times, DH (2012)

22. Appendices

Appendix 1 – Glossary

Appendix 2 – RTT Overview

Appendix 3 – Monitoring Compliance Form

Appendix 1 - Glossary

For the purposes of this policy, the following terms have the meanings given below:

18 week referral to treatment (RTT) period	The part of a patients care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other 18 week clock stop point.
Active Monitoring	An 18 week 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 this stage. A new 18 week clock would start when a decision to treat is made following a period of watchful waiting / active monitoring. 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 on-going management, then this constitutes a decision not to treat and should be recorded as such and also stops an 18 week clock. If a patient is subsequently referred back to a consultant-led service, then this referral starts a new RTT clock.
Active Waiting List WL types: Elective Waiting Elective Booked	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.
Breach	Patient episode which would over-run the maximum wait time of 18 weeks from referral to first treatment, excludes cancer and rapid chest pain as these have shorter targets.
Choose and Book (CaB)	Choose and Book electronic 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 Trust or clinic.
Cancelled Ops/procedures	If the Trust cancels a patient's admission on the day of the admission / procedure for a non-clinical reason (i.e. lack of theatre time) – the Trust is required to re-arrange a new operation date within 28 days of the cancelled procedure date, or within target wait time, whichever is the soonest
Care Professional	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 Professions Act 2002.
Carer	Adult with „parental responsibility“ for the child e.g. parent, local authority nominated person
CHD	Coronary Heart Disease

Children and Young People and young people	The policy defines Children and Young People in accordance with the Children Act (1989 & 2004) All Children and Young People aged under 18 or additionally young people under 20 years of age who have: (a) been looked after by a local authority at any time after attaining the age of 16 (b) Have a learning disability defined as a state of arrested or incomplete development of mind, which induces significant impairment of intelligence and social functioning (Children Act 2004) must have their needs assessed in line with this policy. This policy takes account of national and local Safeguarding statutory guidance and child protection processes
Chronological Order / „in-turns“	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.
Clock pause	A temporary stop in the RTT clock for inpatients who declare themselves unavailable for treatment for up to 4 weeks
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. 18 weeks excludes 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 UBRN	When an appointment has been booked via Choose and Book, the UBRN is converted. (Please see definition of UBRN).
Day case	Patient who requires admission for treatment but who is not intended to stay overnight.
Day case Diagnostic	Patients who require admission to the Trust for a diagnostic procedure / test / image and will need the use of a bed but who are not intended to stay in Trust overnight.
DBS or EBS	Directly Bookable Services Electronic Booking Service (both refer to Choose and Book)
Decision to Admit (DTA)	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.
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 must be returned to the waiting list and a new TCI date arranged. For non-clinical deferred treatments, the Trust is required to offer a new operation date within 28 days of the cancelled procedure (NB: 5 days in

	respect of cancelled procedures for Children and Young People).
DNA - Did not attend	When a patient fails to attend an appointment / admission without prior notice.
Elective admission / elective patients	Inpatients 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 patient 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 admitting the patient earlier.
Elective Waiting	Patients awaiting elective admission who have yet to be given an admission date.
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. Symptom specific suggestions for first definitive treatments can be found in the RTT commissioning pathways available from http://www.18weeks.nhs.uk
Fit (and ready)	A new 18 week clock should start once the patient is fit and ready for a 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.
Generic referral	A referral to a speciality rather than a named clinician, usually addressed to „Dear Doctor or „Dear Colleague
IBS	Indirectly Bookable Services (Choose and Book)
Inpatient	Patient who requires admission to the Trust for treatment and will remain for at least one night
Inpatient Diagnostic	Patients who require admission to the Trust for a diagnostic procedure / test / image and are intended to remain in Trust for at least one night.
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. The 18 week target relates to Trust / consultant-led care. Therefore the definition of the term „interface service" within the context of 18 weeks 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: <ul style="list-style-type: none"> • Non consultant-led mental health services run by Mental Health Trusts.

	<ul style="list-style-type: none"> 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.
MDT	Multi-Disciplinary Team
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.
Nullify clock	The 18 week clock is “nullified” when a patient DNA’s their first appointment and is discharged back to the care of their GP
Outpatients	Patients referred by a General Practitioner (medical or dental) or another Consultant / health professional for clinical advice or treatment.
PACS	Picture Archiving and Communication System (for computer distribution of x-rays)
Partial Booking	Sending a patient a letter requesting a call back to make or confirm an appointment
Partial booking database	This database contains details of the future appointment enabling the appointment to be booked between 5 and 3 weeks before the appointment is due. This database is designed to reduce the number of rescheduled appointments if patients and staff are not available far in the future.
Partial booking follow up waiting list	Is this the same as partial booking database?
PAS	Patient Administration (or Admission) System
Patient Cancellation	Patient who has previously accepted an outpatient appointment time or date for operation and then subsequently notified the Trust that they wish to cancel or change their appointment
Patient Choice	From 1st April 2004 patients waiting more than 6 months without being offered a TCI date, will be offered the choice of moving to an alternative Trust for faster treatment.
Patient Pathway ID (PPID)	The unique reference number assigned to a patient’s RTT pathway. Where a patient is referred from another organisation and the pathway has already started, then the PPID will begin with their unique identifier or Choose and Book identifier.
Pause/clock pause	The act of pausing a patient’s 18 week clock. Clocks may only be paused for non clinical reasons and only where a patient chooses to wait longer for admission than 2 reasonable offers made by the provider.
Primary Targeting List (PTL)	The PTL is a required undertaking to monitor and report weekly on the waiting lists against agreed targets.

Reasonable offer	<p>Where a decision to admit, as either a day case or inpatient has been made, many patients will choose to be admitted at the earliest opportunity. However not all will and it would not be appropriate to <i>pause</i> a clock for patients who cannot commit to come in at short notice.</p> <p>A clock may only be paused therefore when a patient has turned down two or more „reasonable offers“ of admission dates.</p> <p>A <i>reasonable offer</i> is an offer of a time and date three or more weeks from the time that the offer was made.</p> <p>If patients decline these offers and decide to wait longer for their treatment, their clock may be paused from the date of the first reasonable offer and should re-start from the date that patients say they are available to come in.</p>
Referral Management or assessment Service	<p>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.</p> <p>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 having clinical discussions with GP practices about good referral practice.</p> <p>In the context of 18 weeks, a 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.</p>
Regular Day Patient	<p>Patients who require admission to the Trust for treatment on a regular planned basis.</p>
Schedules (Waiting list)	<p>Patients awaiting elective admission, diagnostic or outpatient appointment and who are currently fit and available to be called for admission or appointment</p>
Self-deferrals	<p>Patients who, on receipt of offer(s) of admission (TCIs), notify the Trust that they are unable to attend, the TCI date is therefore cancelled by the patient.</p>
Straight to test	<p>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.</p>
Substantively new or different treatment	<p>On completion of an 18 week referral to treatment period, a new 18 week clock starts on the decision to start a substantively new or different treatment that does not already form part of that patient’s agreed care plan.</p> <p>It is recognised that a patient’s” care often extends beyond the 18 week referral to treatment period and that there may be a number of planned treatments beyond first definitive treatment.</p> <p>However, where further treatment is required that was not already planned, a new 18 week clock should start at the point the decision to treat is made.</p> <p>Scenarios where this might apply include:</p> <ul style="list-style-type: none"> • 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);

	<ul style="list-style-type: none"> 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. <p>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 Consultant in discussion with the patient.</p>
TAL	Telephone Appointment Line for Choose and Book managed by NHS Direct for Directly Bookable appointments
TCI	To come in (patient appointment date and time)
UBRN	Unique Booking Reference Number (Choose & Book) The reference number that a patient receives on their appointment request letter when generated by the referrer through Choose and Book. The UBRN is used in conjunction with the patient password to make or change an appointment.
Vulnerable children	<p>All children are vulnerable by virtue of their age and inexperience but some are more vulnerable than others. Safeguarding children is the responsibility of all adults. All children are also vulnerable to failures by adults. Those that are particularly vulnerable as defined by Working together to Safeguard Children, 2006:</p> <ul style="list-style-type: none"> Children in the care of the Local Authority Children on the Child Protection Register or with a Child Protection Plan Child with a Child Safety Order or Parenting Order Children with chronic health needs Children in Trust Disabled children Children in custody or within the Youth Justice system Children from black and minority ethnic groups Migrant children Children of families living in temporary accommodation / travelling families Children from households where there has been domestic violence Children of substance and alcohol misusing parents Children of parents with mental health problems
Watchful waiting	See Active Monitoring

Appendix 2 – Referral to Treatment Overview

From March 2008 the concept of waiting times for the different stages of treatment (outpatient, diagnostic, and inpatient) has been replaced by Referral to Treatment pathway (RTT). RTT covers the patient's journey from referral to first definitive treatment.

The 18 week standard applies to elective pathways that do or might involve medical or surgical consultant-led care and Allied Health Professional care. The decision as to whether or not an RTT clock commences is dependent on who makes the referral and into what type of service.

The Trust has a responsibility to treat 90% of inpatients and 95% of outpatient within 18 weeks of referral. The tolerance levels allow for cases in which clinical complexity delays pathway clock stops, or where the patient exercises choice to defer treatment.

The RTT 18 week Rules & Definitions Policy available via the Department of Health website provides further definition of the 18 week target and includes information on referrals that commence a RTT clock and those that do not.

Types of Pathway

Non –Admitted Pathway: A pathway that ends in a clock stop for treatment that does not require an admission or for 'non-treatment' e.g. an outpatient setting.

Admitted Pathway - A pathway that ends in a clock stop for admission for treatment (day case or inpatient).

All aspects of the patient pathway must be concluded within 18 weeks including investigations and diagnostics.

Sources of referral that commence a RTT 18 week clock

An RTT 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, 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.

Decisions that stop an 18 week clock

An RTT clock is stopped when the patient receives first definitive treatment. This is defined as: "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".

Examples of first definitive treatment include treatment, therapy or procedures in outpatients.

Clock stops also occur for non treatment. For example:

- Clinical decision that treatment is not required and the patient is returned to primary care for care
- Clinical decision to start a period of active monitoring.
- Patient declines treatment
- Patient added to transplant list

Active Monitoring / Watchful Waiting

Active Monitoring may be applied where it is clinically appropriate to start a period of monitoring without clinical interventions during that period. A patient can be placed on Active Monitoring for a minimum period

of 2 weeks. Any period less than 2 weeks will be included in pathway length measurement as part of the 18 week performance tolerances. 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.

Patients may initiate active monitoring themselves, for example by choosing to decline treatment to see how they cope with their symptoms. However, stopping the clock for active monitoring is not appropriate when patients want to delay an appointment, diagnostic test or treatment. Patient initiated delays of this kind may result in a referral to treatment time of more than 18 weeks which should be clearly communicated to the patient and documented within their notes.

Active Monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made. If a decision to treat has been made but subsequently there is a clinical reason to delay treatment/admission then an 18 week clock would usually continue and may result in a referral to treatment time of more than 18 weeks.

Patient initiated and clinical delays of this kind are allowed for in the 18 week tolerance which permits 5% of outpatients and 10% of inpatients to be treated more than 18 weeks after referral.

Clock Pauses (inpatients only)

A clock may be paused only where a decision to admit has been made, and the patient has declined at least 2 reasonable offers for admission. Reasonable offers for admission are when a patient is offered 2 dates with at least 3 weeks' notice. An offer for admission which is less than 3 weeks is deemed reasonable if it is accepted by the patient.

The clock is paused between the date of the earliest reasonable offer and the date on which the patient makes themselves available for admission. In practical terms due to PAS functionality constraints the date the patient is identified as being available is the date for admission. The length of pauses will be monitored and any pauses longer than 8 weeks will be monitored by the Patient Access Team.

If a patient's pathway is paused and a subsequent agreed admission date is cancelled by the Trust the patient's pause will end on the date the Trust cancelled the admission. Patient pauses are calculated from admission offers recorded on PAS. All admission offers made to the patient must therefore be recorded on PAS.

To prevent extended patient waiting on a pause the maximum period of pausing is 60 days. Further admission offers must be made during this period. In the event of the period of unavailability exceeding this then the patient must be removed from the waiting list and returned to the care of their GP.

Appendix 3 – Monitoring Compliance Form

Title of Document	<i>Patient Access Policy</i>
Date	<i>June 2013</i>

CQC regulations relating to this document (if any)			
NHSLA Standard related to this document (if any)	Health and Social Care Act 2008 Regulations: Regulation 17		
Does the document fulfil the criterion of NHSLA? <i>(please circle as appropriate)</i>	YES	No	N/A
	<u>If not, why not:</u>		

Process / minimum requirement to be monitored	Lead	Tool	Written Reporting Frequency	Written Reporting Arrangements
Patient pathways tracked and monitored	General Managers	PAS PTL's Validation	Weekly	Workload Planning
Divisional Compliance	General Managers	PTL's	Monthly	Finance and Performance Committee

Following an audit required changes to practice will be identified and actioned within a specific time frame with a responsible person identified to lead the implementation of the actions. Lessons and action plans will be shared with all the relevant stakeholders.