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NHS
Frimley Health
NHS Foundation Trust

Trust Policy

Referral to Treatment 18 Weeks Patient Access Policy

Key Points

- This policy applies to all members of staff employed by Frimley Health NHS Foundation Trust and in particular, those staff involved in delivering or supporting direct clinical care. All CCGs have similar standing instructions and these must be referred to, and adhered to, in all instances.

- Referrers have a pivotal role to play in ensuring that patients who are referred are ready, willing and able to have treatment within the referral to treatment and cancer standards timeframes.

- Patients will have access to a summarised version of this policy and they will be made aware of their role in ensuring that the trust is able to deliver the standards set out in this Policy. Patients are expected to attend their scheduled appointments and to notify the trust in advance of any unavailability or changes to their personal circumstances.

- It is the responsibility of Directorate Chiefs of Service, Associate Directors, Directorate Clinical Leads, Directorate and all Departmental Managers and ultimately, the Director of Operations within Frimley Health NHS Foundation Trust to ensure that all clinical, managerial and administrative members of staff adhere to this policy.

- Please note Frimley Health NHS Foundation Trust currently operates under 2 separate contractual arrangements;

    - Frimley South
    - Frimley North

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Version Control Sheet

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0.1	June 2016	Beverly Lindsay, Marion Attfield, 18 Week Team	Draft	Adapted from HWPH policy; updated with changes to the 18 Week Rules as set out by NHS England in October 2015
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1.0	January 2017	Policy Officer	Final	Approved at PRG Minor amendments to layout
1.1	October 2018	Beverly Lindsay, Marion Attfield, 18 Week Team	Draft	Review of policy by 18 week team. Full list of changes available as Appendix 3
2.0	November 2018	Policy Manager	Final	Policy Ratified at ED Meeting

Document Location

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Electronic	Trust Intranet and Trust Internet (for patients)
Paper	18 Week Performance Team

Related Documents

Document Type	Document Name
Policy	Safeguarding Children Policy
Policy	Providing Interpretation Services to Support Effective Clinical Outcomes
Policy	Cancer Access Policy

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1. INTRODUCTION

1.1 Frimley Health NHS trust (hereafter referred to as 'the trust') is committed to providing an exemplary standard of care to patients and an important part of this is patient access to services. The trust is committed to offering reliable access to services, providing patient choice and delivering a positive patient experience.

1.2 In England, under the NHS Constitution, patients have the right to access certain services commissioned by NHS bodies within maximum waiting times or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible. This is also in line with the NHS Choice Framework where patients are empowered to shape and manage their own health and care.

1.3 This policy outlines required systems and processes which must be followed explicitly for:

- Referring patients to the trust
- The pathway management of all patients referred to the trust
- Adhering to national standards and data definitions.

1.4 All clinical and non-clinical staff involved in patient pathway management must ensure that their practices are consistent and in line with this policy.

1.5 The trust is committed to the provision of a service that is fair, accessible and meets the needs of all known vulnerable patients.

1.6 The delivery of patient care will be patient focused, clinically led and consistent with the values of the trust.

1.7 Clear communication and transparency between all stakeholders, including referrers, hospital staff and patients, will underpin the delivery of services in the elective pathway

2. SCOPE OF THE POLICY

2.1 This policy and accompanying processes apply to all members of staff employed by the trust. In particular, it applies to those staff involved in delivering or supporting direct clinical care.

2.2 This policy will be equally applied to all patients treated at the trust.

2.3 This policy will be used by staff employed by Frimley Health NHS Foundation trust as guidance on how to implement, monitor and achieve the targets set within it.

3. DEFINITIONS

3.1 **Active Monitoring:** In many RTT pathways there will be times when the most clinically appropriate option is for the patient to start a period of active monitoring, sometimes without clinical intervention or diagnostic procedures at that stage. This decision must be clearly communicated with the patient and documented in the patient's notes, and the patient's waiting time clock is stopped. Active monitoring can only be initiated for cancer pathways once the patient is diagnosed.

3.2 **Admitted Pathway:** A pathway that ends in a clock stop on admission for treatment, either as an inpatient or day case.

3.3 **Booked Admission:** A patient admitted having been given a date at the time the decision to admit was made, determined mainly on the grounds of resource availability.

3.4 **Booking Teams:** Departments within FHFT that process referrals and book appointments or inpatient to come in dates.

3.5 **Chronological Order:** A general principal that applies to patients categorised as requiring routine treatment. These patients should be seen or treated in order; longest waiting time first. This must only be from the start of their 18 Week RTT clock start date.

3.6 **Clinical Assessment Service:** These services are provided by the trust for patients whose referrals need to be clinically triaged and a decision made to either send the patient for a diagnostic test or to book an outpatient appointment at triage the outcome of the clinical assessment will be recorded in the Patient Administration System (PAS).

3.7 **Consultant Led:** A Consultant retains overall 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 responsibly for patient care.

3.8 **Consultant to Consultant Referral:** A referral from one hospital Consultant directly to another in the same hospital without involvement of the patient's GP.

3.9 **Date Given:** A style of booking whereby the patient is sent a date and time for their appointment in writing without the opportunity to discuss or agree it. This occurs in the main following receipt of paper referrals

3.10 **E-Referral:** A national electronic referral service that gives patients a choice of place, date and time for their first Consultant appointment in a hospital or clinic. E-Referrals will also allow clinical triage before an appointment is booked to ensure the appropriate appointment for the patients.

3.11 **Elective Waiting List Admission:** A patient added to a waiting list having been given no dates of admission at the time a decision to admit was made.

3.12 **Interface Service: GRACe (General Referral Assessment Centre):** An administration and triage facility for GP referrals within Primary Care. An 18 Week RTT clock is started upon receipt at GRACe for a referral appropriate for a consultant led service. The pathway is continuous until first definitive treatment is given.

3.13 **Non-Admitted Pathway:** A pathway that ends in a clock stop where the patient does not require admission to hospital for treatment and usually occurs in an outpatient setting.

3.14 **PLCV:** Procedures of low clinical value where prior funding is required before proceeding to treat.

3.15 **Patient Pathway:** The patient's journey from the point of contact with the trust to when the patient is discharged from our care.

3.16 **Patient Tracking List (PTL):** A list of **all** patients on an active 18 Week RTT pathway waiting for an appointment or elective admission, detailing length of wait for required stage of treatment, and overall waiting time.

3.17 **Pathway Horizons** are ideal clinical pathways with set time frames for each stage of the treatment journey to ensure 18 weeks is achieved.

3.18 **Planned Waiting List Admission:** A patient on an admitted pathway having been given a date or approximate date at the time that the decision to admit was made. If treatment requires a set delay for a clinical reason before initiation, then it could be considered as planned.

3.19 **Primary Care:** The first point of contact for patients requiring care usually based in settings within the local community and includes GPs, Dentists and Opticians.

3.20 **Quarterly Monitoring of Cancer Waits (QMCW):** This is used to identify patients on cancer or suspected cancer pathways and monitor their progress.

3.21 **Suspected Angina Clinic**: A fast track service for patients with chest pain for referral to a cardiologist. These patients must be seen within 2 weeks from the date of the GP referral as they are subject to their own waiting time targets.

3.22 **Referral To Treatment (RTT):** 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 non-treatment clock stop.

3.23 **Rules of Reasonableness:** A reasonable offer is a minimum number of dates that must be offered to the patient with notice, when arranging appointments or elective admission dates. This is referred to as rules of reasonableness.

3.24 **Secondary Care:** Care provided by specialised doctors usually based in hospital settings, usually accessed either in an emergency or via a referral from Primary Care.

3.25 **Tertiary Care:** Care provided by specialised medical staff, usually accessed via referral from Secondary Care.

3.26 **UBRN:** A unique booking reference number which is automatically applied to all referrals processed through the E-Referral system.

3.27 **Waiting Time Clock:** The measure of time taken to proceed along a pathway from the point of referral until the patient is treated or a non-treatment clock stop occurs. Where new decisions to treat occur, patients may have more than one waiting time clock per referral.

4. PURPOSE OF THE POLICY

4.1 The purpose of this policy is to outline the trust and Commissioner requirements and standards for managing patient access to secondary care services from referral to treatment and discharge to primary care. The policy is intended to support a maximum wait of 18 weeks from receipt of referral to first definitive treatment. This includes all stages that lead up to treatment, including outpatient consultations, diagnostic tests and procedures.

4.2 The trust will ensure that the management of patient access to services is transparent, fair and equitable; that the best interests of the patients are foremost and patients are managed according to clinical priority and in line with waiting time standards and the NHS Constitution (April 2010).

4.3 This policy is to ensure that all key individuals, namely FHFT staff, local Clinical Commissioning Groups (CCGs), and General Practitioners (GPs) have a clear, shared and agreed understanding of their mutual roles and responsibilities in the successful clinical management of patient pathways

5. THE POLICY

5.1 Patients must only be referred to FHFT when they are ready, willing and available to attend appointments and start their treatment within the nationally specified timeframes.

5.2 Referrals to FHFT reflect patient choice of provider; however it will not always be possible to accommodate requests for a specific site where services are provided at multiple locations.

5.3 Routine patients will be treated chronologically in order of their referral to treatment target date at all stages of their pathway, unless more specific national targets are in place.

5.4 Consultant to Consultant referrals will only be undertaken where the condition is considered urgent, or relates to the condition for which the patient was originally referred.

6. GENERAL ACCESS RULES

6.1 Patients' Entitlement to NHS Treatment

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

- The choice of hospital and consultant
- A referral from their GP for treatment into a consultant-led service, with a maximum waiting time of 18 weeks from referral for elective conditions
- To be seen by a cancer specialist within a maximum of two weeks from a GP referral where cancer is suspected

If this is not possible, the trust has to take all reasonable steps to offer a range of alternatives.

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

- If the patient chooses to wait longer
- If it is clinically appropriate for the patient's condition to be actively monitored in secondary care with or without clinical intervention or diagnostic procedures at that stage
- If the patient fails to attend appointments that they had chosen from a set of reasonable options.
- If the treatment is no longer necessary
- If the patients decline treatment

The following services are not covered by this Policy:

- Maternity services
- Obstetric services
  - If patients have medical or surgical complications as a result of their pregnancy then there will be an onward referral to a consultant led clinic and an 18 Week RTT clock will start.

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

Patients must be treated within the national waiting time standards. Failure to achieve these targets and thresholds will put the trust at risk of breaching its terms of authorisation as a Foundation trust and may lead to financial penalties within the NHS standard acute trust contract.

6.2 Patients not eligible to NHS treatment

The trust has a legal obligation to identify patients who are not eligible for free NHS treatment. The NHS provides health care for people who live in the United Kingdom. People who do not normally live in this country are not automatically entitled to use the NHS free of charge – regardless of their nationality or whether they hold a British passport or have lived in and paid National Insurance contributions and taxes in this country in the past.

This does not include those patients requiring immediate and necessary treatment for example those patients attending A&E.

All NHS trusts have a ***legal obligation*** to:

- Ensure patients who are not ordinarily resident in the UK are identified
- Assess liability for charges in accordance with Department of Health Overseas Visitors Regulations
- Charge those liable to pay in accordance with Department of Health Overseas Visitors Regulations

The Human Rights Act 1998 prohibits discrimination against a person on any ground such as race, colour, language, gender or religion. The way to avoid discrimination is to ensure everybody is treated equitably.

The trust needs to check every patient's eligibility for treatment. An NHS number does not give automatic entitlement to free NHS treatment. Therefore, at first point of entry, patients may be asked questions which will assist the trust in assessing 'ordinarily resident status'.

6.3 Patients transferring from the Private sector to the NHS

Patients, who are eligible for NHS treatment, can choose to convert between an NHS and Private status at any point during their treatment without prejudice. All patients wishing to transfer from the private service to the NHS must be offered choice and onwards referral to an NHS provider and their GP should be notified.

Patients who are referred from a Private Service can be added direct to the NHS waiting list on the referral received date. They do not need an NHS appointment prior to the addition.

6.4 Patients transferring from the NHS to Private

Patients already on an NHS pathway opting to move to private care must have the relevant episodes cancelled from the NHS system. If the patient is on an active elective pathway this will be removed and the clock stopped.

6.5 NHS Provider Commissioning Private Sector Service

There may be circumstances where the trust chooses to commission services provided by the private sector to enable waiting time standards to be met. In this situation the RTT Pathway waiting time would continue with the trust remaining accountable for the delivery of the RTT pathway standards.

These patients would be identified by the clinicians as being suitable to be treated in the Private Sector. The Private Sector set guidelines of patients they are happy to treat, this is conveyed to the clinicians and at the patients clinic appointments these patients will be identified on either the electronic e-To Come In card or by the paper TCI request.

6.6 **Patients requiring commissioner approval PLCV**

No referral for an excluded procedure should be accepted without prior approval from the relevant CCG. If the referral does not have the relevant approval, the referral should be returned to the GP for them to request treatment funding approval via the relevant CCG panel.

In some instances it will not be apparent until the outpatient consultation that the patient requires an excluded procedure. In these instances it will be more appropriate for the hospital clinician to seek commissioner approval.

6.7 **Access for Armed Forces**

In line with the Armed Forces Covenant:
https://www.gov.uk/government/collections/armed-forces-covenant-supporting-information
the trust will ensure those Armed Forces personnel and their families who have to move home more frequently than the general population are not disadvantaged. Every effort will be made to ensure these patients are seen and treated appropriately.

6.8 **Access to Health Services for Military Veterans**

It is the referring Healthcare Professional's responsibility to inform the trust that the patient being referred is a Military veteran and that the condition they are being referred for is service related. Military veterans should be prioritised over other patients with the same level of clinical need if their condition is service related. An alert must be added to PAS and the patient case notes to identify the patient's status.

6.9 **Interpreter Requirements**

Where a patient requires an interpreter for an appointment or admission, this must be highlighted on the referral or request, and also must clearly state the type of interpreter required. Booking of an Interpreter must comply with the Providing Interpretation Services to Support Effective Clinical Outcomes policy.

6.10 Disabilities or Special Needs

The trust is committed to providing, wherever possible, a booking system to support the requirements of individuals with disabilities; this may involve, for example, booking an appointment time that is more suitable to the patient's needs.

We will continually work towards ensuring that individuals with disabilities are not disadvantaged by this policy. The trust will, through the impact assessment process and involvement with local disability groups, identify areas of concern and work to eliminate these issues wherever possible

6.11 Patient Transport

For initial appointments, patients will be required to contact their referring Healthcare Professional to arrange transport.

Transport required for follow-up outpatients appointments. When a patient attends for their outpatient appointment and needs to book transport for their next visit they are given the relevant telephone numbers for the ambulance service and asked to arrange their transport direct.

The Admissions Booking Team will complete the necessary transport request forms for inpatients and send to the transport department electronically.

Checks will be made with the patient to ensure medical eligibility for patients who are requesting transport to the hospital as the patient's medical condition may change as they progress through their pathway.

The trust is committed to the provision of a service that is fair, accessible and meets the needs of all known vulnerable patients.

6.12 Religion and Ethnicity

The trust is committed to providing, wherever possible, a flexible booking system to support ethnic or religious requirements.

We will continually work towards ensuring that individuals due to their ethnic or religious requirements are not disadvantaged by this policy. The trust will, through the equality assessment process, identify areas of concern and work to eliminate these issues wherever possible.

6.13 Vulnerable Adults

Safeguarding adults is a fundamental part of patient safety and wellbeing and the outcomes expected of the NHS. Safeguarding adults is also integral to complying with legislation, regulations and delivering cost effective care. At any time during a patient's pathway it is important that we understand the needs of the patient and take into account any known safeguarding processes in place when making clinical decisions on the patients care.

7. DUTIES / ORGANISATIONAL STRUCTURE

7.1 Referrer Responsibilities

7.1.1 Ensure that the patient is clinically suitable for their RTT or cancer wait referral and intended pathway of care.

7.1.2 Ensure that the patient is adequately informed if being referred on a suspected cancer pathway and is prepared to be seen within the 14 day target.

7.1.3 Ensure that the patient is prepared to be treated within the maximum referral to treatment times.

7.1.4 Where possible initiate the referral through the use of E-Referral attaching the appropriate referral letter/pro-forma.

7.1.5 Provide the national minimum core data set when transferring care to another provider using the inter-provider form.

7.2 Patient Responsibilities

7.2.1 Attend agreed appointments and give sufficient notice in the event of the need to change agreed date or time.

7.2.2 Make every effort to accept an available appointment within the trust's appointment timeframes.

7.2.3 Respond to hospital communications in a timely manner.

7.2.4 Communicate immediately to the hospital and GP if treatment and/or appointments are no longer required.

7.2.5 Communicate immediately to the hospital and GP any changes in personal contact details.

7.3 Trust Responsibilities

7.3.1 **The Chief Executive** is ultimately accountable to the trust Board for ensuring that effective processes are in place to manage patient care and treatment and to meet and achieve national, local and NHS constitution targets and standards.

7.3.2 **The Director of Operations** is the individual responsible for the operational management and delivery of this policy: overseeing executive responsibility for the application of the policy and overall delivery of access standards.

7.3.3 **The Associate Directors and Operational Managers** are responsible for ensuring that there is sufficient capacity to meet and deliver the activity plan.

To deliver all activities within the national maximum treatment time milestones and targets where clinically appropriate.

To deliver all activities in accordance with the agreed pathways of care and honour agreed dates and times with patients.

Investigate breaches of referral to treatment, cancer pathways and national maximum treatment time milestones when requested by the Clinical Commissioning Group.

To ensure that all staff fully understand the principles and requirements of the policy and for ensuring that Standard Operating Procedures are in place and that staff comply with them.

7.3.4 **Associate Directors, Operational Managers, Service Managers** and Departmental Managers will ensure that all staff who are responsible for adding to and maintaining waiting lists, understand access standards and offer appointments within nationally agreed timescales and ensure there are local Standard Operating Processes in place to guide staff.

7.3.5 **All Clinical Leads / Managers / Team Leaders** are responsible for ensuring that their individual teams are fully trained and understand the processes and procedures that must be followed explicitly to ensure that the requirements of the policy are met.

7.3.6 **All clinical staff** undertaking outpatient consultations are responsible for completing the clinic outcome form personally for each patient they see.

7.3.7 **All staff** are responsible for adhering to National DHSC and NHS England guidelines and the principles outlined in this policy when organising and scheduling clinical care for patients.

7.4 **Clinical Commissioning Group Responsibilities**

7.4.1 Engage with their population and commission services to meet the needs of the population within available funding.

7.4.2 Develop and manage the local healthcare market to provide patient choice.

7.4.3 Ensure that all patients needing elective care are offered clinically appropriate choices of provider.

7.4.4 Ensure that patients are treated within clinically appropriate, commissioned pathways and maximum treatment times.

7.4.5 Ensure GPs communicate the need for patients to be willing and available to attend their appointments in line with either the Cancer Targets or the RTT targets.

8. RAISING AWARENESS / IMPLEMENTATION / TRAINING

8.1 The launch of this policy will be accompanied by distribution to all Chiefs of Service, Associate Directors, Clinical Leads, Operational Managers and relevant Department Managers and is to be included for discussion on all Directorate Business Meetings.

8.2 The policy will be provided to all clerical staff involved in administering the patient pathway and all Consultant medical staff as part of their local

induction. All new substantively employed medical staff will be required to spend time with the booking teams who will be responsible for explaining departmental processes.

8.3 All staff within FHFT will be fully supported by the 18 Week Performance Team. Where required, training will be provided on understanding the Patient Access Policy and how to implement processes either verbally, written or electronically.

8.4 The Policy will be made available to all GPs and other relevant referrers via the trust's website. A summarised version will be made available to aid referrers in understanding their responsibilities and what is expected of the patient.

8.5 Patients will have access to a summarised Access Policy on the trust's public website, and will be made aware of their role and responsibility in ensuring that the trust is able to deliver the standards set out in this Policy.

8.6 SOPs will be developed in line with the Access Policy for each individual area that has responsibility for pathway management.

9. MONITORING COMPLIANCE OF POLICY

9.1 Compliance with access standards is monitored weekly at the trust's Performance meeting; this meeting is chaired by the Chief Executive and attended by all Directorate Associate Directors and Directors of Operations. Metrics considered include A&E wait times, RTT performance by speciality, diagnostic waiting times, cancer wait times and on the day theatre cancellations. Formal actions are recorded and appropriate management teams assigned to resolve where required.

9.2 Compliance with 18 Week and Cancer Targets are monitored fortnightly at the 18 Week and Cancer Board Meetings. This meeting is chaired by the Director of Operations and is attended by all Associate Directors, Operation Managers and Service Managers. Metrics considered include: Incomplete pathway performance, cancer wait times, outpatient waiting list and patients over 30 weeks. Minutes and actions are taken and the appropriate management teams will be tasked to resolve where required.

9.3 Daily/weekly performance reports and a detailed PTL are available on the trust's Individual Shared systems for all patients listed on a RTT or cancer pathway. This resource will be utilised and reviewed by Operational Managers, Team Leaders, 18 Week Performance Team and MDT co-ordinators.

9.4 The RTT process is subject to external audits. This process examines all stages of the administrative patient pathway.

10. REFERENCES

- NHS England Recording and Reporting Referral to Treatment RTT Waiting Times for Consultant Led Elective Care Guidance October 2015
- NHS England – Everyone Counts: Planning for Patients 2013/2014.
- NHS England – Everyone Counts: Planning for Patients 2013/14 Technical Definitions. 4th April 2013
- Department of Health - Referral to Treatment Consultant-Led Waiting Times Rules Suite. October 2015
- Department of Health – The NHS Constitution for England. 26th March 2013.
- Royal British Legion, Honour the Covenant; Policy Briefing Healthcare for Veterans.
- Armed Forces Covenant https://www.gov.uk/government/collections/armed-forces-covenant-supporting-information

EQUALITY ANALYSIS

This policy has been analysed for impact on equality and does not have an adverse impact on any protected characteristic.

APPENDICES

Appendix 1	**…………………………**	**Clinical Assurance Process (18 week RTT Rules)**
Appendix 2	**…………………………**	**Process for Cancelling Clinics (less than 6 weeks' notice)**
Appendix 3	**…………………………**	**Changes noted following review of V1. of policy**

THE PROCEDURE

11. Purpose of the Procedure

11.1 To provide Clinical Commissioning Groups and Frimley Health NHS Foundation Trust clear guidance for managing patient access to secondary care services.

12. Summary of Referral to Treatment Waiting Time Rules

12.1 Clock Start

A waiting time clock starts when any English NHS commissioner approved care professional refers a patient to:

12.1.1 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 care professional or GP.

12.1.2 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.

12.1.3 A self-referral by the patient to a Consultant led service where it is agreed locally to be applicable and ratified by a healthcare professional.

12.2 Clock Stop

12.2.1 A clock stops when a patient receives the first definitive treatment for which they were referred.

12.2.2 First definitive treatment is defined as being an intervention intended to manage a patient's disease, condition or injury and avoid further intervention. This may occur following a consultation or following admission to hospital.

12.2.3 Often, first definitive treatment will be a medical or surgical intervention. However, it may also be judged to be other elements of the patient's 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 patient, then the determining factors should be:

- What do the care professionals in charge of the patient's care consider start of treatment to be?
- When does the patient perceive their treatment as being started?

12.2.4 For cardiac pathways that may include medical management before a procedure, this constitutes first definitive treatment and will stop the waiting time clock.

12.2.5 A clock stops when a clinical decision is made that no treatment is required or the patient refuses recommended treatment and is discharged back to the referring care professional.

12.2.6 A clock stops when a patient refuses treatment but chooses to remain under the care of the Consultant. This is referred to as patient initiated active monitoring.

12.2.7 A clock stops when a clinical decision is made to commence a period of active monitoring / watchful wait.

12.2.8 A clock stops when a Patient Does Not Attend (DNA) their **first outpatient** appointment following the initial referral that started their waiting time clock. The pathway is nullified and not submitted as 18 Week RTT activity. If, following clinical review, another appointment is requested a new start will be entered in the pathway and a new appointment will be booked.

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12.2.9 If the patient DNAs a subsequent appointment, then the clock will only stop following further clinical reviews (including diagnostic test or imaging, pre-assessment appointments or TCI for elective admission) and the patient is discharged back to the 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.

12.2.10 Unlike failure to attend a first appointment, it is not the act of failing to attend a further appointment that stops a waiting time clock, but the act of discharging the patient back to primary care where it is appropriate to do so. This decision is made only by the clinician responsible for that patient's pathway. Should it be decided to offer a further appointment then the patient's clock will continue to tick and the original clock start date is retained.

12.2.11 Any clinical decision to stop the clock and re referrer back to GP must be documented in patient notes.

12.3 **New Clock Start**

12.3.1 Where a patient fails to attend their **first appointment**, following a new referral, and is offered another appointment, then a new clock would start on the date that the patient agrees the new appointment date.

12.3.2 When a patient becomes fit and ready for the second of a bilateral procedure.

- Where patients are undergoing a bilateral procedure; a procedure that is performed on both sides of the body at matching anatomical sites. 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.

12.3.3 Upon the decision to start a substantively new or different treatment that does not already form part of the agreed care plan.

- A new clock would start from the date the new decision to treat was 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 a diagnostics or specialist opinion is made – i.e., when it is decided to refer a patient onto a new 'treatment pathway'.

12.3.4 Upon a patient being re-referred to a Consultant-led service as a new referral.

12.3.5 When a decision to treat is made following a period of active monitoring.

12.4 **Patient initiated delays**

12.4.1 Many patients will choose to be seen at the earliest opportunity. However, patients are entitled to wait longer for their treatment if they wish. Patients must be allowed to plan their treatment around their personal circumstances. Delays as a result of patient choice are taken account of in the incomplete pathways target of 92% giving an 8% tolerance in the operational waiting time standards.

12.4.2 In line with the national RTT rule changes (October 2015), clock pauses will no longer be applied to the RTT pathways for reporting purposes. The trust will continue to record patient choice to delay their pathways to ensure patients are treated fairly, and to effectively manage patient waiting times and for auditing purposes.

- A patient initiated delay may be recorded when a patient has turned down two or more reasonable offers of admission dates. The RTT clock continues to tick.

- A reasonable offer is a date at least 3 weeks in the future. Good practice is at least 2 offers 3 weeks in the future and 2 weeks apart.

- If the patient declines these offers and decides to wait longer for their treatment, then a record of the patient's unavailability will be recorded on PAS from the first reasonably offered TCI date until the patient declares themselves available. The RTT clock will continue to tick.

- To ensure the patient is not at risk clinically, a process is in place to monitor all patient initiated delays (see Appendix 1).

- Clinicians will give guidance on what is a 'safe delay' for their patients and if the patient still chooses to go beyond that period of time the clinician will review the patient's notes and either contact the patient or agree to see the patient in their outpatient clinic. The patient's RTT clock will not stop during this period of time. The outcome of the clinical review will be recorded in the patient's notes for audit purposes.

- If the clinician and the patient agree at any time that the procedure is no longer required they will be removed from the waiting list and their RTT clock will be stopped. The outcome of the clinical review will be recorded in the patient's notes for audit purposes.

- If at any time it is agreed that the delay will not cause any clinical harm to the patient then the patient will remain on the Waiting List and their period of delay will be extended. The outcome of the clinical review will be recorded in the patient's notes for audit purposes.

- The above information must be entered into the patient comments on PAS for auditing purposes

- Regular internal audits will take place to review the patients choosing to delay their treatment to ensure they are not at any clinical risk.

13. Performance Frameworks and Timescales within FHFT

13.1 Performance Frameworks

13.1.1 From June 2015 NHS England announced that only patients on an incomplete pathway are to be monitored.

- 92% of incomplete pathways will be within 18 weeks (126 days) of the referral.

- 99% of patients will not wait longer than 6 weeks for a diagnostic test or image. (Where applicable, the 6 week diagnostic standard occurs within the 18 week pathway.)

- It is not expected that all patients will be seen and treated within these timeframes. Some patients will chose to wait longer and others will not be clinically able to be seen and treated within these timeframes. Operational standards have been set accordingly, with appropriate tolerances.

The RTT pathway does not replace other waiting time targets or standards where these are shorter than 18 weeks. This includes waiting times for patients with suspected cancer or waiting times for Rapid Access Chest Pain Clinics.

Patients may have more than one RTT waiting time running simultaneously if they have been referred to and are under the care of more than one clinician at any one time. Each RTT pathway has to be measured and monitored separately and will have a unique patient pathway identifier in PAS.

It should be noted that referral of any of the following patients is not applicable to the RTT waiting time, unless a new decision to treat or significant new plan of care is commenced.

- An obstetric or midwifery service
  - If patients have medical or surgical complications as a result of their pregnancy then there will be an onward referral to a consultant led clinic and an 18 Week RTT clock will start.
- The fracture clinic following an Emergency Admission or Emergency Department attendance.
- All patients seen in the Outpatient Department who received their definitive treatment following an emergency admission for the same condition.

13.2 Patient Pathway Timescales (Routine 18 Week Patients)

13.2.1 FHFT has set out clear pathway horizons to ensure that patients receive treatment within the referral to treatment standards.

Horizon for Surgical Pathway:
Wait to 1st appointment – 6 weeks
Diagnostic and follow up booked at 8/10 weeks
Patient added to waiting list at week 10
Definitive Surgery week 18

Horizon for Medical pathway:
Wait to 1st appointment – 8 weeks
Diagnostic and follow up booked at 12/14 weeks treatment given

13.2.2 Diagnostic imaging and subsequent medical reports should be available within the pathway horizons.

13.2.3 The pathways are monitored through the patient tracking list that is reviewed by the OPS managers and the 18 Week Validation team on a weekly basis.

14. Non-Admitted Pathways and Outpatient Processes

14.1 Patient Readiness for Referral

14.1.1 As a general principle, the trust expects that before a referral is made for treatment, the patient is both clinically fit for assessment and possible treatment of their condition and ready to start their pathway. The requirement for E-Referral diagnostics will be service specific and set at a local level. The trust will work with the local health care community to ensure patients understand this before starting an elective pathway.

14.1.2 Referrals should only be made for patients who are ready, willing and able to start and proceed with their pathway within the referral to treatment (RTT) or cancer standards timeframe, whichever is applicable first. This is defined as:

- Ready: The patient has no significant pre-existing commitments that would prevent attendance of appointments within required timeframes.

- Willing: The patient wants to be referred for specialist advice / management.

- Able: No pre-existing conditions are going to prevent likely required treatment.

14.1.3 Referring healthcare professionals must ensure patients are aware of the likely timeframes for treatment and their obligation to attend appointments within these timeframes.

14.1.4 Processes must exist within practices of referring GPs and GDPs to ensure that address and contact details of all patients are confirmed before referral onward to secondary care.

14.1.5 Where appropriate, any non E-Referral referrals received by FHFT that do not detail all relevant information and accurate patient contact details including ethnicity and NHS number will be rejected and returned to the referrer.

14.2 Special Requirements

14.2.1 It is the responsibility of the referrer to indicate any special requirements a patient may have in terms of speech and sign language interpretation, religious or cultural needs, vulnerable patients and disabilities.

14.2.2 It is expected that all referrals into FHFT from General Practitioners will be via the E-Referral system. These processes are outlined in section 17, below.

14.2.3 FHFT will have systems to support paper referrals from GDPs, other referrers and tertiary referrals should they be received.

14.2.4 Paper referrals should be sent to:

- Booking Teams at HWPH
  The Booking Centre,
  Heatherwood Hospital,
  London Rd, Ascot, Berkshire SL5 8AA

  Patient Registration Department
  Frimley Park Hospital
  Portsmouth Road
  Frimley
  GU16 7UJ

14.2.5 Referrals can be faxed to:

- 01753 849210 HWPH
- 01276 604696 Frimley Park

14.2.6 Referrals can be made electronically by email to:

- hwp-tr.Referrals@nhs.net – HWPH
- fph-tr.parkCB@nhs.net – Frimley Park

15. Referrals Requesting Advice Only

15.1 Referrals can be made from primary care to FHFT for advice only. These are encouraged through the E-Referral system providing the service offers Advice and Guidance on e-RS. A response is sent back to the GP either via ERS or via a letter.

15.2 The trust aims to respond to routine requests for advice within 7 days, and urgent requests within 4 days.

16. Referral to Treatment Minimum Dataset

16.1 From October 2007 Inter Provider Transfer Minimum Data Set (IPT MDS) forms were mandated as a statutory requirement for all patients on an RTT or cancer pathway who are transferred between providers. This form contains details of the patient's waiting time clock status and start date.

16.2 Where these forms are received, the patient's existing waiting time clock details will be entered onto the trust's PAS system by the Booking Teams. Where a form is not received, the patient's waiting time clock will be assumed to be zero and a new clock will be started for their care pathway with FHFT.

17. Referrals Received Via E-Referral System

17.1 Directory of Services (DOS)

17.1.1 The Directory of Services (DOS) for FHFT is available on E-Referral, and can be accessed nationally. It is the responsibility of each speciality to ensure that the details in the DOS are up to date at all times. Any changes to the DOS need to be made by the Clinicians and Operations Managers within the specialty and then sent to the E-Referral team. The DOS should be reviewed annually to ensure it is up to date.

17.1.2 A rolling annual check is made by the E-Referral team of all the services on the DOS.

17.2 **Patient Choice**

17.2.1 When a referral is made via E-Referral and the choice of FHFT is selected, the choice of provider has been made by the patient. In line with the NHS Patient Constitution, FHFT will honour the choice of provider and where possible will book the patient to their chosen site. Patients will need to be aware that the wait time at their chosen site may be longer than other sites on offer.

17.2.2 The GP must ensure all sites for FHFT are selected from the E-Referral system and all appointments are offered to the patient. FHFT reserves the right to direct patients to an earlier appointment within the speciality to facilitate the delivery of the referral to treatment waiting times in consultation with the patient.

17.2.3 The RTT clock may be reset if:

- If a patient delays their booking via the E-Referral process by 3 weeks or more, the RTT clock will be reset following a validation process showing that two reminder letters were sent to the patient. The date will be reset to the date the patient has chosen to book their appointment.

17.3 **Clinical Triage of Referrals**

All E-Referral referrals will be triaged within 3 working days online by the responsible Consultant or appropriately nominated deputy, for example a Registrar. Clinical triage is expected to include accept/reject and redirection to a more clinically appropriate service.

17.4 **Clinically Inappropriate or Misdirected Referrals**

17.4.1 It is the GP's responsibility to ensure that the patient is referred into the correct outpatient clinic. The clinical responsibility for the patient lies with the referring organisation, i.e., the GP Practice.

17.4.2 If a referral has been made to the wrong speciality, it will be rejected back to the referring GP Practice with advice on the correct referral route. If a referral has been made to the correct specialty and wrong clinic type, FHFT will re-direct the referral, and the GP will be informed accordingly. The clinician will do this, noting the appropriate clinic/service on the E-Referral system, the Booking Teams will action and send a new appointment confirmation to the patient.

17.5 **Patient Cancellations and Delays**

Patients will not be discharged under the direct booking process through ERS. However, pathways will be monitored and reviewed should multiple patient cancellations take the pathways over their 18 week timeframes.

17.5.1 If the patient cancels an appointment and attempts to rebook and there are no appointment slots available on the day, they have the option to 'defer to provider'. The Booking Teams will be alerted via the Appointment Slot Issues (ASI) work list and will take responsibility to book the patient's appointment.

17.5.2 If an appointment has been booked beyond the booking horizon, an investigation needs to take place by the bookings team and the OPS managers. If the delay is patient initiated, this needs to be recorded on PAS. If the patient continues to delay their appointments, a clinical review needs to take place to ensure the safety of the patient is maintained (see Appendix 1).

17.5.3 Following clinical review of the patient initiated delay, the decision may be to discharge the patient back to the care of the GP; a letter will be written to both the GP and the patient informing them of the actions taken.

17.5.4 Patients can cancel their appointment any time up until their appointment date, including on the same day as their appointment. The RTT clock will continue to tick.

17.5.6 Should a patient wish to cancel an agreed follow up appointment, they will be able to re-arrange a more suitable appointment. We should inform the patient that this may put the decision to treat them within 18 weeks at risk. The booking teams must also arrange another appointment with the patient at the time of the cancellation. The RTT clock will continue to tick.

17.5.7 If the patient cannot agree a new appointment time with the booking teams, their RTT clock will continue to tick. These patients will be monitored on the PTL, which is produced daily.

17.6 Appointment Slot Issues / Lack of Visible Capacity

17.6.1 Where there are no appointments available when the patient / GP tries to book via the E-Referral system, they are presented with the option of ‘defer to provider’, where the responsibility falls to the trust to arrange an appointment. An Appointment Slot Issues (ASI) report is generated by the Health Informatics team. The booking teams will take responsibility to book the patients’ appointment in chronological order. The 18 Week RTT clock starts when the UBRN is deferred to the provider.

17.6.2 Where a patient’s referral has been on the ASI list for 4 days or more, the Booking Teams will inform the patient by letter that the trust has received their referral and an appointment will be booked as soon as possible.

17.6.3 Where the Booking Teams are unable to book these appointments due to capacity, this will be escalated to the appropriate Operational Manager. Outstanding capacity issues are to be raised at the 18 Week and Cancer Programme Board meeting and escalated as required. Once escalated, the Operational Managers will have to approve either overbooking onto existing clinics or to arrange extra ad-hoc clinic sessions to enable the patients to be seen.

17.7 Clinical Assessment Service

The Clinical Assessment Service (CAS) within E-Referral is available to patients referred into specific specialities. Patients are booked into virtual slots where clinical triage takes place to assess the patients need for either

being directed for a diagnostic procedure (straight to test) or for an outpatient appointment. Where appropriate, advice only will be given to the GP.

18. Referrals Received Outside of E-Referral / Paper Based Referrals Consultant Triage of Referrals

18.1 It is the trust's policy only to accept referrals from GPs via ERS.

18.2 There are still occasions when paper referrals still need to be raised. The main instances for these are:

- Tertiary referrals from other hospitals
- Internal referrals from wards, A&E, clinics
- Services not currently published on ERS

18.3 **Urgent GP Referrals**

Some patients will present at their GP and will require an urgent referral (walk in / on the day patients referred by GPs) into a consultant led clinic. This referral is subject to consultant triage, and once approved will be booked into the relevant slot on PAS. This referral will not be classed as an emergency attendance and therefore will generate an RTT start on the date of the GP requesting the appointment. A referral letter must be presented by the patient on arrival at the agreed appointment date and time.

Emergency Outpatient Appointment Referrals

The trust accepts emergency referrals from Healthcare Professionals for patients needing to be seen the same day in the following services:

- Eye Treatment Centre
- Ear Nose and Throat
- Paediatrics

These appointments will be made by telephone and will be supported by a paper referral accompanying the patient when they attend clinic.

19. Rapid Access Referrals

19.1 Suspected Angina Clinic/Rapid Access Chest Pain Clinic

19.1.1 All patients referred into the Suspected Angina/Rapid Access Chest Pain Clinic must be seen by a specialist within 14 days of referral.

19.1.2 HWP - Referrals are sent through the ICE system directly from the GPs.

19.1.3 HWP - For any GPs not currently using the ICE system, the referral should be faxed to the centre fax server WPH: 01753 849202 using the locally agreed proforma. These referrals are triaged and booked by the Stroke Nurses.

FPH All referrals are via ERS

19.2 **Rapid Access Transient Ischemic Attack (TIA) Referrals**

19.2.1 The referrer must complete the locally agree TIA risk assessment and referral form indicating the ABCD2 risk score. For patients with an ABCD2 risk score of 4 and above (with the event occurring within the last week), more than one event in the last week, known Atrial Fibrillation or known carotid stenosis, the Stroke Nurse on Duty (SNOD) at Wycombe Hospital must be contacted to discuss the referral. The SNOD will allocate an appointment and the patient will be seen within 24 hours. The SNOD will give the referrer a fax number to which the referral form and any other supporting documents must be sent.

19.2.2 For all patients with an ABCD2 risk score of 3 and below and any patients who score above 4 where the event occurred over a week ago, the Acute Stroke Co-ordinator (ASC) at Wexham Park Hospital must be contacted to discuss the referral. The ASC will give the referrer the TIA central fax server number (01753 849203) to which the referral form and any other supporting documents must be sent. The referrals will be triaged by a consultant/and or a Clinical Nurse Specialist in Stroke Care before an appointment is allocated within 7 days of referral. Appointments will be booked by the Clinical Nurse Specialist in Stroke Care by telephone and by letter where they are unable to contact the patient by telephone.

19.3 **Paediatric Rapid Access**

FPH - Sent through via ERS as Urgent triaged to the appropriate service.

HWP – GPs can contact the paediatric clinic and arrange for an URGENT same day attendance to the paediatric clinics.

20. Administrative Processes in the Outpatient Clinic

20.1 **Confirmation of Appointments**

FHFT will confirm all appointments in writing once the appointment has been booked. If consent has been given a text message will be sent to the patient at the time of booking and a reminder will be sent to the patient close to their scheduled appointment date.

20.2 **Patients Who Do Not Attend (DNA) - First Outpatient Consultation**

20.2.1 A clock stops when a patient Does Not Attend (DNA) their first outpatient appointment following the initial referral that started their waiting time clock. The pathway is nullified and not submitted as 18 Week RTT activity. If, following clinical review, another appointment is requested, a new start will be entered in the pathway and a new appointment will be booked.

20.2.2 If the patient DNAs a subsequent appointment, then the clock will only stop following further clinical reviews (including diagnostic test or imaging, pre-assessment appointments or TCI for elective admission) and the patient is discharged back to the 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.

20.2.3 At the end of the clinic, the DNA notes will be passed to the clinician for review. If it is agreed that the patient is discharged back to the referring healthcare professional/GP, the referral to treatment clock will be stopped and will be reported in the 18 Week RTT returns. A letter will be sent to the GP and patient.

20.2.4 Unlike failure to attend a first appointment, it is not the act of failing to attend a further appointment that stops a waiting time clock, but the act of discharging the patient back to primary care where it is appropriate to do so. This decision is made only by the clinician responsible for that patient's pathway. Should it be decided to offer a further appointment, then the patient's clock will continue to tick and the original clock start date is retained.

Any clinical decision to stop the clock and re referrer back to GP must be documented in patient notes.

20.2.5 At the end of each clinic, the Medical Records Department will notify the relevant booking department by email of the need for a further appointment.

20.2.6 It is the responsibility of the individual departments within FHFT to ensure that the patient's pathway is updated correctly.

20.2.7 Should the patient DNA further appointments and the clinical decision is made to offer another appointment, the RTT clock will continue to tick. If the decision is made to discharge the patient then the RTT clock will be stopped.

20.3 Follow-up Patients

20.3.1 Follow-up patients who DNA their appointment may be discharged back to the referring healthcare professional/GP. This decision will be made by the responsible clinician following a notes review at the end of the clinic. If the decision is made to discharge the patient, a letter should be sent to the referring healthcare professional/GP notifying them of this. The RTT clock will be stopped.

20.3.2 The Consultant responsible can, in exceptional circumstances, request a further appointment, based on clinical concern, e.g., patients with cancer or suspected cancer, paediatric patients, patients on long term treatments requiring specialist monitoring, patients with chronic conditions and vulnerable adults.

20.4 Checking of Demographic and Contact Details

20.4.1 Clinic receptionists and clinical staff who register patient arrivals to clinic on the PAS system must check that demographic and contact details held on the system are accurate. Delivery of care to our patients depends on our ability to contact them; their pathways may be affected if up to date contact details are not held.

20.4.2 There are also kiosks at some of the Frimley Park Hospital reception areas where self-check-in is available – these kiosks will run through a demographics check.

20.5 Clinic Outcome Forms/Bookmarks and Flagging Cancer Pathways

20.5.1 All clinical staff employed by or providing services for FHFT will complete a clinic outcome form/bookmark for each patient they see in the outpatient clinic; this is used to record details of any procedures undertaken and to record clinical pathway management information.

20.5.2 Recording referral to treatment and / or Cancer pathways status is pivotal to ensuring patients receive their definitive treatment within required timeframes. This cannot be delegated to other staff facilitating the clinic. This must be completed by the reception staff at clinic.

20.5.3 Blank/incorrectly outcomed forms will be returned at the end of the clinic for the responsible clinician to complete.

20.6 Entering Data on PAS Relating to the Clinic Outcome Form

It is the responsibility of the Clinic Receptionist to ensure that all relevant information completed by the clinician on the COF/Bookmark, relating to procedures carried out and pathway management information is entered onto PAS accurately. The coding of procedures on the COF/Bookmark form at FPH is entered by the coding department.

20.7 Booking Follow-up Appointments

Where possible, follow-up appointments required will be booked for the patient in the clinic setting immediately following their initial outpatient consultation. Where this is not possible patients will be added to the outpatient waiting list (OWL). The OWL will be monitored and appointments will be booked appropriately from this list.

20.8 Timing of Follow-up Appointments for Patients on RTT Pathways

20.8.1 Following first consultation, many patients may leave clinic with requests for diagnostic imaging and other tests that are required before a management decision can be made and treatment given where appropriate. For these patients, the follow-up appointment should be booked within six weeks.

20.8.2 Staff making follow up appointments (or rescheduling previously booked follow up appointments), need to be mindful of the current treatment status of patients and ensure that the follow up appointments are scheduled at a time appropriate for each patient’s overall 18 week pathway.

21. Hospital Cancellations

21.1 All requests for clinic cancellations or reductions must be submitted in accordance with medical and dental staff leave policy, giving a minimum of 6 weeks' notice and including the relevant authorisation. Clinic cancellations with fewer than 6 weeks' notice must be approved in writing by the appropriate Directorate Associate Director or Chief of Service (see Appendix 2 - Escalation Process).

21.2 Wherever possible, patients must not be cancelled more than once. No appointment will be cancelled more than twice.

21.3 HWP an escalation process (see Appendix 2) has been designed for the booking team to follow if clinics are cancelled at short notice.

21.4 A clinical review process has been introduced to ensure patients are not put at risk following either patient or hospital cancellations (see Appendix 1).

22. Consultant to Consultant Referrals

22.1 Referrals that are directly associated with the condition that was the subject of the original referral may be referred directly from one Consultant to another where required. Examples of this include:

- referrals where the treatment of the primary condition requires the input of another discipline, e.g., pre-operative anaesthetic assessment;
- referrals for cancer or suspected cancer;
- referrals where the treatment of the primary condition requires surgery under a different specialty.

22.2 Referrals for conditions that are not related to the condition, for which the patient was initially referred, will be referred back to the GP. Exceptions to this rule include:

- referrals for cancer or suspected cancer.
- referrals where in the opinion of the Consultant a delay in the referral would risk serious patient harm. In addition to life-threatening conditions this also includes any situation where delay in referral would risk either long term morbidity or acutely distressing symptoms.
- referrals to Suspected Angina Clinic
- referrals to Rapid Access Transient Ischemic Attack (TIA) Clinic
- referrals to the Rapid Access Chest Pain Clinic

23. Diagnostic Appointments

23.1 Direct Access

Where a GP refers a patient for diagnostic test with a view to making a decision to refer or not based on the results, the patient will not have an 18 week clock started. These tests are subject to the six week diagnostic standard.

23.2 Appointments for Diagnostics on an 18 Week Pathway

The rules of booking and administering patient appointments as outlined in section 18 equally apply for diagnostic appointments; however patients will be encouraged to accept dates within two weeks of referral due to the total patient journey timeframes required. Patient cancellations and failure to contact will follow the same process as outlined for outpatient appointments.

24. Pre-operative Assessment Appointments

24.1 The rules of booking and administering patient appointments as outlined in section 18 equally apply to pre-operative assessment appointments. Patient cancellations and failure to contact will follow the same process as outlined for outpatient appointments.

24.2 Where a patient fails to attend an agreed date for their pre-operative assessment appointment, the patient will be contacted by the pre-assessment team to ascertain the reason for the non-attendance. Where there is genuine reasons and the patient wishes to proceed, and where the agreed admission date will not be affected, the patient will be offered a further date for pre-operative assessment. It will be explained to the patient that a further failure to attend may result in them being removed from the elective list following an agreement with the clinician.

24.3 All decisions to remove a patient from the waiting list must be agreed / made by the responsible clinician, who must inform the GP in writing with a copy to the patient. The Admissions Booking Clerk is responsible for removing the patient from the waiting list and appropriately stopping the waiting time clock.

25. Elective Admission and Admitted Pathway Processes

25.1.1 Local commissioners have identified a range of procedures and treatments which are classified as Low Priority Procedures or as Procedures of Limited Clinical Value (PLCV).

25.1.2 The patient’s waiting time clock will not be adjusted until funding approval is rejected, at which point the responsible Admissions Booking Clerk will remove the patient from the waiting list as ‘no funding/approval’. The waiting time clock will be stopped and a letter will be sent to the GP and patient.

25.2 Patient Order for Elective Waiting List Admissions

25.2.1 Patients will be selected for admission chronologically by their Referral to Treatment (RTT) breach date. Priority will only be given to patients highlighted as clinically urgent by the responsible clinician or highlighted as war pensioners and service personnel injured in conflict (DH 2007).

25.2.2 Admissions/Booking Clerks upon receipt of an e-TCI card or referral will validate the patient's pathway to ensure referral to treatment information is accurate; before calculating the patient's breach date. Admissions Booking Clerks will also monitor the Admitted PTL to ensure that patients are treated chronologically. If there are any queries on pathways, the clerks should contact the 18 week team for assistance.

25.2.3 Where patients are on a separate waiting list for unrelated procedures in different specialties, the clinician in charge should discuss the clinical priority of each procedure and then set dates accordingly. The RTT clocks will continue as long as the first definitive treatment has not been completed for either procedure. The clinical decision must be on a case by case scenario.

It is the responsibility of the treating clinician to establish whether a patient is already on a waiting list for another procedure and then to discuss with the clinician responsible for the patient's other condition.

25.3 Patient Delay in Treatment Decision

25.3.1 Where patients require more time to consider going ahead with surgery, the responsible Clinician will raise an electronic e-TCI card/paper TCI card with the period of thinking time agreed. This will give the patient the opportunity to consider their procedure. If the patient decides not to proceed, they should contact the admissions booking teams who will remove the patient from the waiting list and inform the clinician. Their RTT clock will be stopped. The admissions booking team will monitor their waiting lists and check with the patient for their decision to proceed or to be removed from the waiting list.

25.3.2 If the patient subsequently decides to proceed to surgery following a decision to be removed, the booking team can raise a "self" referral and add the patient back onto the waiting list. The time from removal to addition back onto the waiting list should not exceed a 6 month period.

25.3.3 Active monitoring of a patient's condition whilst on the waiting list

Active Monitoring will not automatically be applied when a patient chooses to wait over 3 months for their TCI date. Their RTT clock will continue to tick.

It is advisable that, should the clinician be aware of the patient's unavailability at the time of the outpatient clinic, they should not add the patient to the waiting list but initiate Active Monitoring of the patient's condition suggesting they come back to clinic when they are ready to proceed. A letter should be sent to the GP to inform them of the decision made in clinic.

When a patient is added to the waiting list and then decides they are not ready to proceed, we have to allow for patient choice. If the patient has had multiple TCI dates offered and refused those dates, then the OPS managers may want to review these patients with their clinicians. At that time a decision could be made to put the patient on active monitoring. We must ensure that a letter is sent to the GP with a copy to the patient detailing what we are monitoring and when we expect that monitoring to end. A clinic appointment should also be made for the patient at the end of the monitoring period to ensure nothing has changed and that they patient is now ready to proceed to surgery.

If a patient has not had any dates offered but has informed us of their unavailability, these need to be escalated to the OPS managers to follow the above process with a clinical review.

The patient should be made aware that if at any stage their circumstances change and they then want to proceed to surgery they can contact the hospital and attend as necessary.

25.4 **Medically Unfit for Treatment**

25.4.1 A patient will not be added to the waiting list if there are concerns about the patient's fitness to undergo the procedure. Examples may include;

- the need for treatment for an unrelated medical condition.
- the patient is required to stop smoking.
- the patient is required to lose weight.

25.4.2 The patient will be discharged to the care of their GP and the RTT clock will be stopped in clinic. In some cases, it is not clinically appropriate to discharge the patient and the responsible Clinician will choose to keep the patient under surveillance; in which case the RTT clock will be stopped in clinic until such time that the patient can proceed with surgery.

25.4.3 Where the responsible Consultant requires an opinion from another healthcare professional prior to addition to the elective waiting list; the RTT clock will continue to tick until the patient's fitness is ascertained. Then 25.3.1 or 25.3.2 will apply.

25.5 **Patient Initiated Medical Unfitness**

25.5.1 If a patient, whilst waiting to be admitted, becomes medically unfit for surgery, the following process will take place:

- If the condition is resolvable, we will allow a period of 4 weeks. The bookings team will discuss this with the patient at the time to see if they are intending going to their GP.
- After 4 weeks, where we have not had any contact with the patient about their fitness, the booking team will call the patient to discuss this. If they are still unwell, then we should be asking the patient to attend their GP surgery for advice and help. We need to then raise this to the relevant clinician.

- Bookings team to show the clinician the TCI card and provide the information about the patient's health.
- The clinician will need to guide the bookings team on what action to take. If the clinician feels the patient is not well enough to proceed to surgery, they will make the decision to remove the patient from the waiting list by either discharging to the GP or placing the patient on active monitoring. Each of these decisions needs to be clearly outlined to the GP and the patient. If the decision is to discharge the patient to the GP, then a new referral will need to be raised by the GP via ERS when the patient is deemed fit to proceed.

- Unresolvable > 4 weeks is usually decided at pre-assessment. Onward referral to Cardiology or other specialities does not always result in the patient being removed from the waiting list unless a decision is made that the patient is unfit to proceed.

25.6 **Medically Unfit at Pre-Operative Assessment Clinic**

Where medical unfitness is identified at a Pre-Operative Assessment Clinic the responsible Consultant will be informed and:

- Where the condition identified is transitory (lasting <14 days); the clock will continue to tick and the patient will remain on the waiting list.

- Where the patient requires Cardiology or Anaesthetic review before proceeding with surgery; the clock will continue to tick and the patient will remain on the waiting list until they are declared fit to proceed by the Cardiology Team / Anaesthetist.

- If they are declared unfit by Cardiology because their condition will suffer if they proceed to surgery, they will be removed from the waiting list, following agreement from the responsible clinician, and their 18 Week RTT clock will be stopped.

- Where the patient requires diagnostic intervention before proceeding with surgery; the clock will continue to tick and the patient will remain on the waiting list.

- Where the Consultant deems that surgery cannot proceed; the patient will be removed from the elective waiting list as medically unfit and discharged to GP or for more intervention by another clinician and the patient's waiting time clock will stop.

Where the condition identified is prolonged (lasting >14 days); the patient where clinically appropriate will be removed from the elective waiting list as medically unfit, following consultation between the booking teams and the clinician, and discharged to GP or to the appropriate clinical team and the patient's waiting time clock will stop.

Re-referral following a period of medical unfitness

25.7 It is the responsibility of the patient or GP to inform FHFT that the medical unfitness has been resolved. The patient can be re-referred for surgery by either;

- The patient; direct onto waiting list where the time since medical unfitness is less than 6 weeks
- The GP; direct onto waiting list where the time since medical unfitness is less than 12 weeks
- The GP; outpatient appointment request via E-Referral where the time since medical unfitness exceeds 12 weeks
- By other consultant, in writing, who had the responsibility to assess and ensure the patient is now fit to proceed.

25.8 **Elective Planned Waiting Lists**

Patients should only be placed on a planned list when they are due to have a planned procedure or operation that is to take place at a specific time, such as repeat colonoscopy, or where they are receiving repeated therapeutic procedures such as radiotherapy.

25.8.1 An elective planned waiting list will be used only where the procedure(s) required must be carried out at a specific time or repeated at a specific frequency. Planned activity is also sometimes known as 'surveillance', i.e., repeat check cystoscopy or colonoscopy.

25.8.2 Examples of planned admissions in addition to a check cystoscopy would be follow-up chemotherapy sessions which are necessary at regular intervals; and admissions arising from other treatment, e.g., the planned removal of an internal fixation after three months.

25.8.3 Where the patient requires a sequence of procedures, the first admission should be listed as elective waiting list or booked. All subsequent procedures should be listed as elective planned.

25.8.4 Patients on an elective planned waiting list will not have an active waiting time clock.

25.8.5 When the admit by date for the planned procedure expires, the patient should be transferred back onto an 18 Week elective pathway, unless it is the patient's choice to delay their planned procedure date. This is to ensure the patients on a planned pathway are not put at risk if the trust has a capacity issue.

25.9 **Bilateral Procedures**

25.9.1 An elective planned waiting list must not be used for bilateral procedures. Where bilateral procedures are to be undertaken, the patient should be added to an elective waiting list for the second procedure at the point they are deemed clinically fit and ready to proceed. When the patient declares

themselves fit, the patient will be added to the elective waiting list for the second procedure and a new waiting time clock would start.

25.9.2 Where the decision to add a patient to an elective waiting list for a second procedure occurs outside of a clinic setting; it is the responsibility of the Booking Teams to add an ad-hoc start to the patient's pathway.

25.10 **Paediatric Patients Awaiting Procedure Dependant on Age**

Paediatric patients who have to wait until they reach a certain age before having a procedure can be added to a planned waiting list, their 18 week clock can be stopped at decision to treat.

25.11 **Arranging Elective Waiting List Admission & Patient No Response to Contact Attempts**

25.11.1 The trust operates a 6 week booking process (with the exception of T&O who operate a 12 week booking process). Patients will be contacted 6 weeks before their TCI date to finalise and agree the date.

25.11.2 Staff will attempt to call the patient twice at different times of the day for 3 consecutive days. If the patient is not contactable via telephone they will be sent a letter asking them to call the admissions teams.

25.11.3 HWP will attempt to call the patient once. They will then send a letter, after 7 working days a reminder letter will be sent. After a further 7 working days a final letter will be sent to the patient informing them that if there is no contact in the next 5 days they will be removed from the waiting list. If there is still no contact from the patient, they will be removed from the waiting list on receipt of an email from the referring clinician, and their clock will be stopped.

25.12 **Patient Requested Review of Treatment Decision**

25.12.1 Where a patient already on an elective list for surgery subsequently decides they wish to review or further discuss the treatment, they will be offered the opportunity to discuss with the clinician or member of their team over the telephone, or in clinic with pre-operative assessment staff, or encouraged to discuss matters with their GP.

25.12.2 If the patient still wishes to discuss matters with the responsible clinician in an outpatient clinic setting, then an urgent appointment should be provided; overbooking a clinic where necessary. The patient should remain on the elective list and the waiting time clock will continue to tick. All efforts should be made to ensure the agreed admission date is kept.

25.13 **Removals from the Waiting List for Reasons Other Than Treatment**

25.13.1 There are a number of scenarios where a patient may need to be removed from an elective waiting list without treatment taking place. This may include: the procedure no longer being required, patient no longer wanting the procedure or the patient has chosen to seek treatment privately. In the event of a patient being removed from the elective waiting list, they must only be removed from the waiting list on Patient Administration System (PAS) and not deleted. This is to ensure a robust audit trail exists.

25.13.2 It is the responsibility of the Admissions Booking Clerk to ensure that the reason for removal is accurate. The patient's RTT clock will stop.

25.14 Patients Failing to Attend/Cancelling Elective Admission Date

25.14.1 Should the patient not attend on the agreed date for surgery, the facility (ward or theatre admission lounge) will notify the appropriate Admissions Booking Clerk, who will contact the patient to ascertain the reason for the failure to attend, and will then inform the clinician. The responsible Consultant will discharge the patient and send a letter to the GP copied to the patient informing them of this. The Admissions Booking Clerk will remove the patient from the waiting list and the waiting time clock will be stopped.

25.14.2 The responsible Consultant can request a further date for elective admission; this is offered only in exceptional circumstances based on clinical concern, for example paediatric patients, vulnerable adults and patients with suspected cancer. The 18 Week RTT clock continues.

25.14.3 Should the request to cancel the TCI dates exceed 3 months, then the Clinical Assurance Process should be implemented (see Appendix 1).

25.15 Hospital Initiated cancellations

On-The-Day Surgical Cancellations (Hospital Initiated)

25.15.1 All patients who have operations cancelled on or after the day of admission (including the day of surgery) for non-clinical reasons, are to be offered another binding date within 28 days, or the patient's treatment is to be funded at the time and hospital of the patient's choice (NHS Constitution, contract Schedule 4: EBS2).

25.15.2 Two dates should be offered to the patient within 28 days. If the patient declines these dates the 28 day target no longer applies. The Admissions Booking Teams must ensure this information is recorded accurately within the patient's data on PAS in determining compliance with EBS2.

25.15.3 Hospital cancellations prior to TCI date do not follow the 28 day rule but must be rebooked in a timely fashion following chronological guidelines. The RTT lock will continue.

26. Patients transferring to NHS Treatment Following Private Consultation

26.1.1 Patients seen privately who elect to have NHS treatment after an initial private consultation must be referred by their GP to FHFT. A waiting time clock will start when this referral is received. If the referral is for surgical management, the GP can be advised to refer directly to the Consultant's elective waiting list providing they are referring to the same consultant the patient saw in the private sector.

26.1.2 Consultants cannot under any circumstances refer a patient directly to FHFT from Private Practice; a referral letter from the patient's GP must be obtained and be processed by the Booking Teams or relevant Admissions Booking Clerk.

27. Tertiary Referrals

27.1 In order to support the delivery of referral to treatment pathways across organisations, all NHS trusts are required to provide an Inter-Provider Transfer Minimum Data Set (IPT MDS). Onward referrals should contain reference to key RTT data items clearly stated within the referral letter. These details should be added by the appropriate medical secretary, and will include:

- Patient pathway identifier
- FHFT referrer code (XXXX):
- Referral to Treatment period status
- Decision to refer date
- Referral to Treatment start date

27.2 Where a tertiary referral is received by FHFT, the Booking Teams will ensure that the correct information has been received via the IPT MDS proforma. The patient's pathway information will then be added to PAS.

27.3 Tertiary referrals will not be unduly delayed by requesting missing information. Where possible, FHFT will request information from the referring trust and update PAS upon receiving the missing information.

27.4 Where the referring organisation has not used the appropriate IPT MDS proforma, FHFT will apply a new clock start as the date the referral is received.

27.5 FHFT can be contacted for information regarding tertiary referrals on:

- fph-tr.Interprovider@nhs.net for Heatherwood and Wexham Park Hospitals
- Frimley.hospital@nhs.net for Frimley Park Hospital

28. Referral of Armed Forces

In line with the Armed Forces Covenant:
https://www.gov.uk/government/collections/armed-forces-covenant-supporting-information

The trust will ensure those Armed Forces personnel and their families who have to move home more frequently than the general population are not disadvantaged. Every effort will be made to ensure these patients are seen and treated appropriately.

28.1 Referrals to other trusts for Armed Forces Personnel

Following the Tertiary Referrals process (section 27) above, a flag has been added to the IPTMDS form to identify if the patient is a member of the armed forces. Staff should be aware of this flag to ensure the patient is not disadvantaged when transferring military patients to another hospital.

If a member of the military DNAs their appointment, the clinician should take this into account when deciding to offer another appointment. These patients may have been called to service at short notice.

It is imperative that the correct information is provided to the receiving trust on where the patient is in their current pathway, at what stage of treatment they are at and what is expected of the receiving trust going forward.

28.2 Referrals from other trusts for Armed Forces Personnel

Booking staff need to be aware of any patients belonging to the Armed forces who are referred to us for their continued treatment. It is important that these patients have their referral to treatment dates recorded correctly to ensure they are not disadvantaged and that they receive their treatment in a timely fashion.

If the information is not received correctly, the Booking Teams must contact the referring trust to clarify the referral to treatment start dates and clarify where the patients are on their pathway.

29. Internal Management Information and Reporting

29.1 Referral to Treatment Patient Tracking List (RTT PTL)

29.1.1 The RTT PTL and cancer PTL will be produced daily and is available for all necessary staff on the trust management site.

29.1.2 All staff must use the RTT PTL in order to monitor RTT breach dates. Routine patients requiring appointments and elective admissions must be selected in strict chronological order by referral to treatment breach date. Cancer and Urgent patients will still have priority bookings over all other patients.

29.1.3 All RTT events need to be recorded on PAS.

29.1.4 The data entered on the PAS system is uploaded into a central data warehouse.

29.1.5 All operational managers are responsible for working with the booking teams to ensure sound booking management.

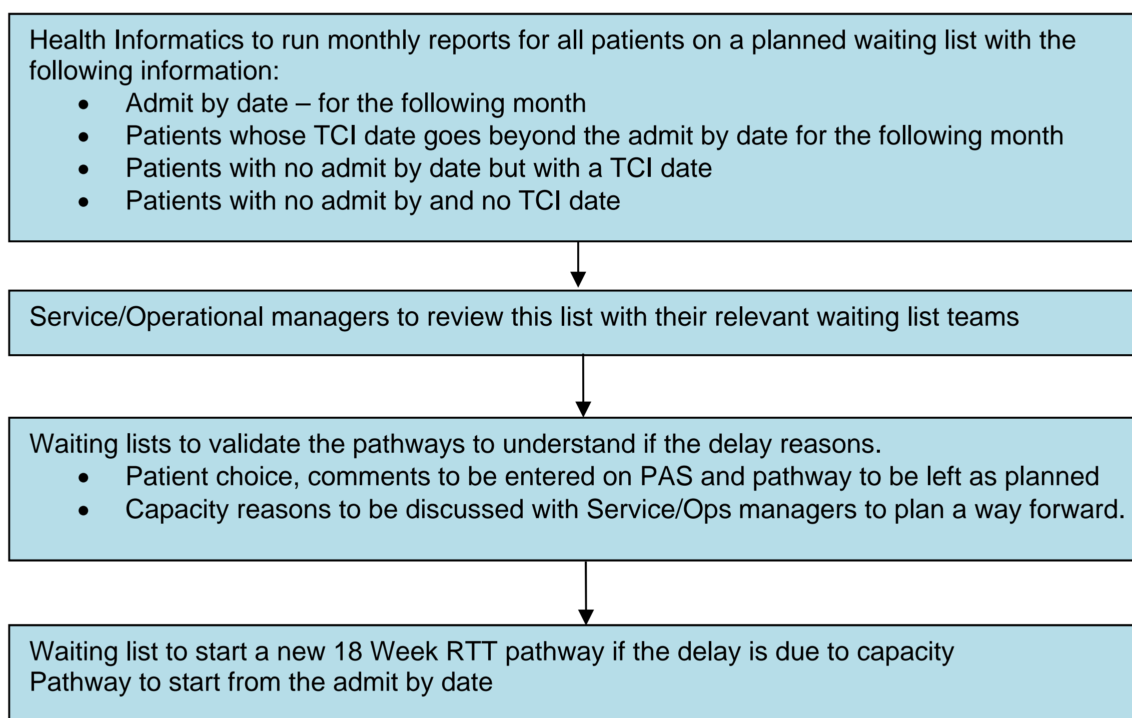
29.1.6 Admissions staff and booking staff will escalate any actual or potential problems relating to RTT management to their line manager when these cannot be resolved. Where further assistance is required, the Associate Director will be informed.

APPENDIX 1
Clinical Assurance Process in line with 18 Week RTT Rules

- In October 2015 NHS England and the Department of Health launched rules for trusts to follow.
- There should be no stops in the pathway unless they are initiated by a clinician.
- Therefore this means that a patient can delay and cancel their appointments/TCI dates and their 18 Week RTT clock will continue to tick.
- To prevent this causing us patient initiated breaches, the trust has to implement a process that involves a clinical review and a clinical decision on the patient's pathway.
- They also required each trust to ensure the patients on a planned pathway are monitored and are not put at risk if there are any capacity issues. (do not move planned patients out further than their planned procedure date due to the lack of capacity)

For Planned procedures on an elective waiting list:

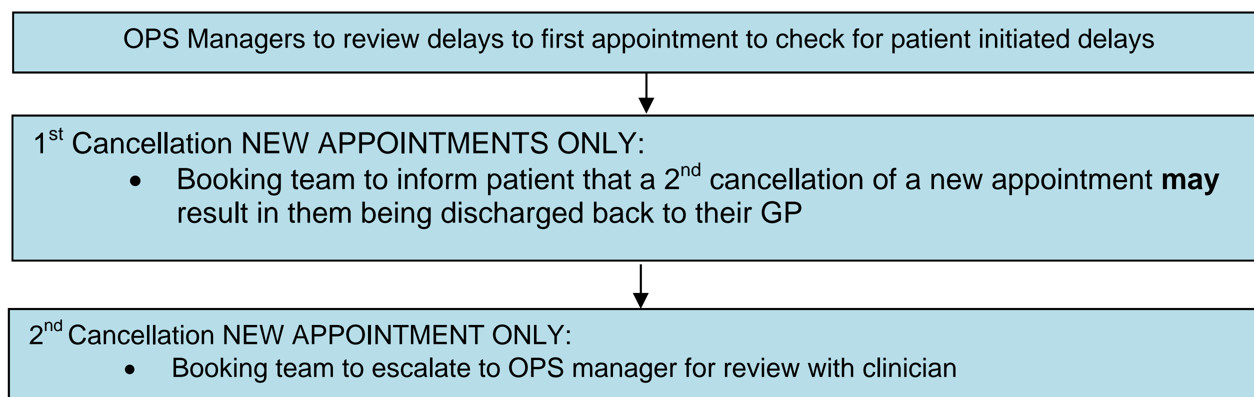
Each speciality needs to review their current planned waiting lists each month for the following month, patients on that list that do not have an admit by date or who have passed their admit by date need to be validated and if still required will need to have a TCI booked.
If the patient chooses to go over their admit by date, leave as planned and monitor for safety dependant on the delay period.



Non Admitted Patient initiated cancellations

New patient cancellations
Patient will not be discharged under direct booking process through ERS. Pathways will be monitored and reviewed which **may** result in a discharge back to the GP.This process is excluded for Paediatric Patients and known vulnerable adults.

SOPs for bookings teams to be updated, KPIs set and monitored by operational managers.

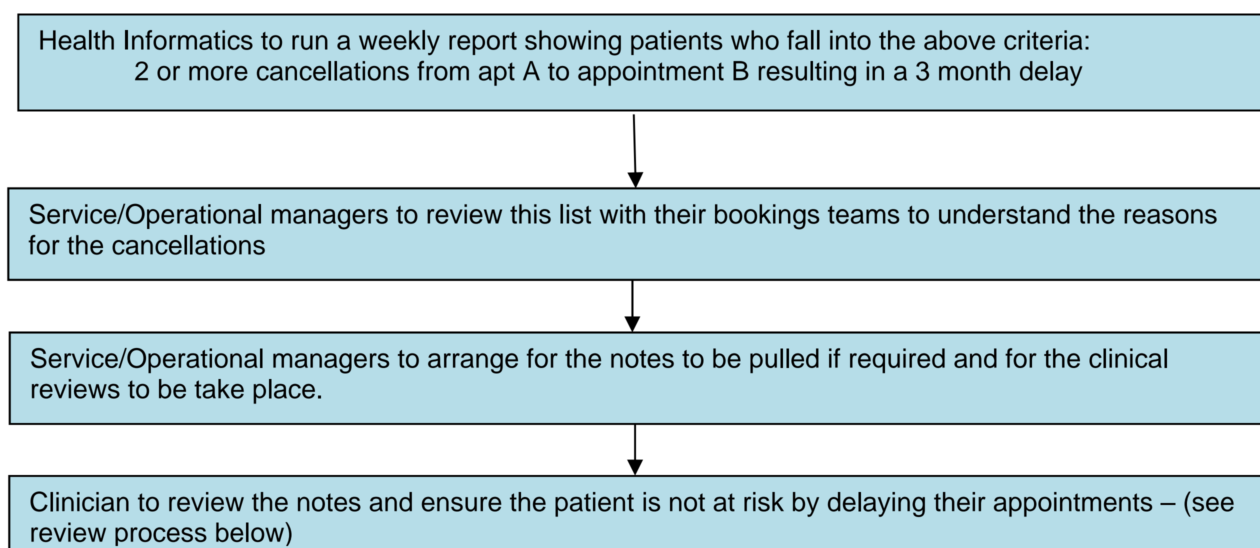


Follow up patients:

To ensure our patients are not being put at risk by cancelling their appointments, we need to put in place a safeguarding process that is clinically driven.

Guidance from NHS England would be 2 patient cancellations. Agreed process for the trust to follow is:

2 or more cancellations causing a delay of over 3 months from appointment A to appointment B. A report from Health informatics could be available with this information on request.



APPENDIX 2

Process for Cancelling Clinics with Less than 6 Weeks' Notice

For FPH
Any cancellations requested <6 weeks can only be actioned on receipt of approval by the OPS managers

HWP Process: Who
Informed person contact Manpower Co-ordinator to make aware that the clinic has been cancelled

Manpower checks rotas to see if there is cover if not escalates as below:

HWP Process: Actions- Escalate for advice/Authorisation to cancel:
Escalate to Operations Manager
or
If the Ops Manager is unavailable **Escalate to Associate Director** or Deputy Director of Operations

If none of the above are available
Escalate to
Director of Operations

WHP Process: Actions
Manpower Co-ordinator to contact booking centre to cancel clinic verbally
(to be followed up with written authorisation)
Manpower Co-ordinator to contact Outpatient nursing staff and patient records to cancel clinic verbally (to be followed up with written authorisation)

Appendix 3 Changes to Access Policy October 2018

Reviewed by T. Southby – ERS Manager
M. Attfield – Performance Manager
B. Lindsay – 18 Week Service Manager

Reference	Action
6.6	removed PLCV process for HWPH – process aligned across trust
6.11	Patient Transport – aligned process across trust
9.4	amended wording about audit process
12.2.8	amended wording around DNA first appt
15.1&15.2	amended wording about advice and guidance process
17.5	amended wording for Patient Cancellations and delays
18.	added wording on remaining paper referrals
25.3.3	added additional wording regarding active monitoring (agreed by DM, EH, MA and BL)
25.5.1	amended wording regarding medically unfit patients (agreed by DM, EH, MA and BL)
25.7.1	amended wording in line with EReferrals
25.7.2	removed wording
25.12/12.1/12.2	removed duplicated previously
Appendix 1	Added Appendix 1
Appendix 1	Removed information about patient cancellations
Appendix 1	Added wording about patient cancellation for SOP's
Appendix 1	Amended wording for follow up cancellations
Appendix 1	Removed information about patient cancellations – duplicated
Appendix 2	Amended wording
Appendix 3	Removed appendix 3 PLCV process no longer required.