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1. Introduction

This Access Policy is intended to ensure that all patients who are referred and treated by Manchester Surgical Services Limited receive high-quality care, fair and equitable access, and services in line with 18-week Referral to Treatment (RTT) and the NHS Constitution.

This policy will provide Manchester Surgical Services with a coherent approach to managing waiting lists, scheduling, and booking across the organisation. It will ensure that patients are treated in line with local and National Policies regarding Vulnerable Adults, Patients with Learning Disabilities, and War Veteran Guidance.

It is essential that all staff involved in managing patients waiting for elective treatment have a clear understanding of their roles and responsibilities in this process. This includes clinical, managerial, and administrative staff. Every process in the management of patients waiting for treatment must be clear and transparent to patients and partner organisations, and be open to inspection, monitoring, and audit. We will give priority to clinically urgent patients and treat everyone else in turn, and we will share correspondence that is sent between clinicians and patients regarding their care.

The policy reflects the key access targets for Outpatient, Inpatient, Diagnostic and Planned Waiting List Management, 18 Week Referral to Treatment, and Cancer Waiting Time Standards, in line with the NHS Constitution. Although we do not offer cancer services at times we do have to refer onwards for suspected cancers.

The NHS Constitution brings together, for the first time in the history of the NHS, what staff, patients and the public can expect from the NHS. As well as capturing the purpose, principles and values of the NHS, the Constitution brings together several rights, pledges and responsibilities for staff and patients alike. These rights and responsibilities are the result of extensive discussions and consultations with staff, patients and the public, and they reflect what matters to them.

This policy will be continuously reviewed, reflecting any changes considering patient feedback, the commissioning intentions of the local Commissioners and NHS Constitutional rights and pledges.

It provides a framework for operational procedures to ensure access to services for outpatients and day cases under the 18-week referral to treatment (RTT) standard. The policy combines an interpretation of national guidance with local standards of productivity and equity, thereby minimising waiting and maximising activity.

Compliance with this policy will ensure:

- A streamlined patient pathway with minimum waits
- Adherence to mandated milestones and standards of measurement relating to elective patient pathways
- Consistent and equitable treatment of patients on elective pathways
- Effective use of resources

Clinical Staff, Managers, and Secretarial and Clerical Staff all play an important role in effectively managing the referral-to-treatment process. The core responsibilities of the company and wider health community include:

- Treating patients in a timely manner
- Keeping hospital visits to the minimum required
- Delivering high-quality, efficient and responsive services
- Prompt and informative communications with patients

This policy details how elective patients will be managed administratively at all points of contact with Manchester Surgical Services (MSS). It is the responsibility of all associated members of staff to understand the RTT principles and definitions.

2. Key Principles

The principle underlying the maximum 18-week referral-to-treatment standard is that patients should receive excellent care without unnecessary delay. We aim to reduce the maximum waiting times set by the Department of Health for all patient groups. This policy is intended to cover all non-emergency services provided by the Company.

Every process in the management of patients waiting for treatment must be clear and transparent to staff, patients, and partner organisations, and must be open to inspection, monitoring, and audit as required.

Patients should not be referred for acute services unless they are fit, ready, and willing to access services within 18 weeks.

The Company, whenever possible, will negotiate appointment and admission dates and times with patients.

We aim to ensure fair and equal access to services for all patients.

All patients must be seen primarily in the order of wait time, except for war pensioners and service personnel injured in conflict, who must receive priority treatment if their condition is directly attributable to injuries sustained in conflict. Clinically Urgent patients are defined as those who, for clinical reasons, cannot wait for the current maximum waiting times and require priority access to the Consultant. Those patients prioritised as clinically urgent by the Consultant will be seen within shorter timescales rather than the standard maximum 18-week pathway in place for patients clinically prioritised as routine.

All referrals, additions and removals from all waiting lists will be made in accordance with this policy.
All waiting lists for outpatient appointments and hospital admissions should be held and managed through the Patient Administration System (PAS).

The accuracy and reliability of the waiting list and diagnostic information are the responsibility of all staff who are involved in the processing and management of outpatient referrals, diagnostics, and admissions to the hospital.

A clinician will only refer directly to another clinician in urgent cases (e.g., cancer) or where there is an agreed pathway. In all other instances, if a patient requires a referral to another consultant within the service or another service provider, they should be referred to their GP, and the GP should be advised that a further referral is required. In accordance with the Consultant-to-Consultant (C2C) Referral Protocol (Appendix 1).

3. Waiting Time Guarantees

The current national waiting time guarantees fall into three areas:

- Referral to treatment time (maximum18 weeks)
- Waiting times for Cancer treatment
- In addition, the Company has local standards for the waiting time for the stages of treatment.

3.1 18 Week Referral to Treatment

All patients should receive their first definitive treatment within 18 weeks of referral to secondary care.

The performance against this standard is required to be:

- A minimum of 90% of admitted patients complete their pathway within 18 weeks
- A minimum of 95% of non-admitted patients complete their pathway within 18 weeks
- A minimum of 92% of patients who are still waiting for treatment in any period (incomplete pathways) should have waited less than 18 weeks

The targets are not 100% because the nature of the clinical condition of some patients will mean that treatment within 18 weeks is not appropriate or possible. Also, some patients will request a delay in their treatment so that treatment within 18 weeks is not possible. These two groups of patients are the only patients who may wait longer than 18 weeks.

3.2 Cancer Waiting Times

The target waiting times for patients where cancer is suspected, diagnosed, or being treated are as per national guidelines. Although the Company does not treat patients with a cancer diagnosis, there are times when a patient has a suspected cancer and needs to be referred to the most appropriate clinical service.

3.3 Straight to test diagnostics

Where a GP refers a patient for a diagnostic prior to an Outpatient appointment with a consultant as part of an agreed pathway, i.e. it is known that the patient will require a consultant appointment, then the patient is on an 18-week RTT pathway, and the clock starts on receipt of the referral to the Consultant. The national standard is that a patient must wait no longer than six weeks for their diagnostic procedure. As a rule, the Company is not commissioned for services that include straight-to-test diagnostics.

3.4 Patients requiring commissioner approval

Clock stops can only be made to a patient's RTT pathway when treatment occurs or a decision not to treat is made. No adjustments or clock stops can be made to a pathway whilst a panel or approval board assesses commissioner approval requests. Patients who require treatment which must have commissioner approval prior to commencement must not be disadvantaged by having their referral returned to primary care. Therefore, the referrer to the Company must seek prior approval before referring the patient. The approval must accompany the referral.

In some instances, it will not be apparent until the outpatient consultation or on completion of diagnostic testing, that the patient requires an excluded procedure. Commissioners should hold approval panels in line with the 18-week timeframes for any patient referred for assessment who has already commenced an RTT pathway.

4. 18-week referral to treatment (RTT)

It is the responsibility of all members of staff to understand the 18-week principles and definitions. They must be applied to all aspects of the patient's pathway. More detailed guidance on the 18-week referral-to-treatment time measurement is contained in Appendix 2.

4.1 Start of the 18 Week Pathway

4.1.1 **An 18-week clock starts when any healthcare professional refers to:**

(i) A consultant-led service, regardless of location, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring healthcare professional (usually GP).

(ii) A referral management or assessment service, that may result in an onward referral to a consultant-led service before responsibility is transferred back to the referring healthcare professional (usually GP).

4.1.2 **An 18-week clock also starts when:**

(i) A new decision to treat is made for a patient currently receiving ongoing care at the hospital. For example, a patient has been prescribed medication that is intended to treat their condition and is followed up in an outpatient setting. When the patient attends for a routine review, the condition has changed, and an intervention is required. A new 18-week pathway period starts when the decision to admit (DTA) is made.

(ii) A referral is made by a consultant either within the hospital or from another provider to a consultant-led service for a new course of treatment. For example, a patient has been managed conservatively in a medical speciality, but their condition deteriorates, and surgical intervention is required. A new 18-week pathway starts when the referral to the surgical speciality is made.

(iii) When a patient becomes fit and ready for the second stage of a bilateral procedure, for example, a cataract operation on the second eye. A new 18-week pathway starts when the patient is fit to be treated and returned to the 'active' waiting list.

4.2 End of the 18 Week Pathway

The 18 week pathway ends when:

(i) The patient receives their first definitive treatment that is intended to manage their disease, condition, or injury. The clock stops if the treatment given is intended to avoid further intervention. Treatment will often continue beyond the first definitive treatment and after the clock has stopped.

(ii) The patient declines treatment.

(iii) When a diagnosis has been reached but either the patient or the clinician decides that rather than treatment a period where the condition is monitored on a regular basis in secondary care is appropriate. This is termed 'active monitoring'. The patient remains under the care of the hospital during this period and must be actively followed up. A patient on active monitoring should either, be on a 'planned' waiting list, be on the outpatient review list with a scheduled review date or have a future outpatient appointment booked. If a decision is made that treatment is now appropriate, then a new period on the 18-week pathway is created and a new 18-week clock is started.

(iv) A patient is added to a transplant waiting list.

(v) A decision is made that no treatment is required, or the patient is not ready for treatment, and the patient is discharged back to primary care (usually GP).

(vi) Patient has treatment as an emergency which was previously intended to be done electively.

5. Referrals

The primary route for the receipt of referrals will be electronically through the Electronic Referral System (eRS). However, in the short-term referrals will also be received:

(ii) Electronically through NHS mail for tertiary referrals (inter-provider transfers)
(iii) On paper for tertiary referrals (inter-provider transfers)

All inter-provider transfers (IPTs) should contain or be accompanied by the minimum data set for IPTs. This applies to both those received from another provider and those sent by the Company. Details of the minimum data set are in Appendix 2. If the information is not provided, then the referrer should be contacted asking them to provide the required information as soon as possible. If the start date is not available, then a date 8 weeks before the date the referral is received should be used.

5.1 Referrals received through Electronic Referral System

A detailed procedure document is available that sets out the processes to be used for Electronic Referral System referrals and appointments. This includes the procedures for dealing with Appointment Slot Issues (ASI). Appointment Slot Issues arise when the referrer or patient cannot find an available appointment slot on ERS. These appointment requests are then 'deferred to provider'. Then, in line with the national requirement, the Company should contact the patient within 4 working days to agree an appointment date and time with them.

5.2 Inter-Provider Transfers received through NHS mail

The appropriate NHS mailbox should be accessed at least once a day and the referrals processed in the same way as paper referrals.

5.3 Paper Referrals

All referral letters from GPs should be stamped with the date of receipt and entered onto PAS within 24 hours (1 working day) of receipt. To ensure that this is the case, all mail regardless of the addressee or any 'medical in confidence' status should be opened and processed within 1 working day of receipt. Only mail addressed 'Personal – addressee only' is exempt from this requirement.

All patients should be given at least 7 days' notice of their appointment, unless, in discussion, they agree to attend at shorter notice, should there be an appointment available. It should be made clear to the patient that they can change the appointment any time up to 24 hours before the date and time they have been allocated, but that if they fail to attend for the appointment, they will be referred to their GP and a new referral will be required.

5.4 Misdirected Referrals

If a referral has been made to a named consultant and the special interest of the consultant does not match the needs of the patient, the consultant should not see the patient but pass the referral on to an appropriate colleague. A new referral should not be created on the PAS, but the consultant changed to the appropriate one. If the referral is for a service not provided by the Company, then the referral letter will be returned to the referrer with a note advising that the patient needs to be referred elsewhere. If a patient has booked an appointment using the eRS system but the receiving consultant or service judge that it would be better if the patient was seen in a different clinic/service, then the appointment will be re-scheduled into an appropriate clinic with the minimum possible inconvenience to the patient. The patient will be contacted, and an alternative appointment will be booked for the patient using the eRS system. Only in exceptional circumstances should the appointment be booked outside of eRS. The referrer will be informed of the change via the eRS work lists.

6. Outpatient Appointments

6.1 Referrals for Cancer Services

The Company as an independent provider is not fully equipped to manage cancer referrals and as such would return any such referral to the referrer within 1 working day.

6.2 Referrals other than Cancer

All referrals using the ERS system will be date-stamped with the date the letter is received and entered onto PAS upon receipt. When a clinician determines that an urgent appointment is needed, attempts should be made to agree a date with the patient within 14 days of the referral being received. All other referrals should be seen in chronological order.

An appointment date will then be agreed with the patient. The date of all new appointments must be agreed with the patient and recorded as such on the Company's PAS system. This also applies to appointments rearranged by MSS. All patients must receive at least 7 days' notice of all appointments. If it is necessary to rearrange the appointment, then the patient must be contacted by phone and a new date agreed. Appointments must not be rearranged without agreeing the new date with the patient.

6.3 Patients who do not attend an Outpatient Appointment

6.3.1 Cancer Referrals – New Appointment

Any patients referred under the cancer two-week wait standard will be referred to the referrer within one working day.

6.3.2 Cancer Referrals – Follow up (subsequent) Appointment

If a patient referred to the Company and has been seen as an outpatient and following an investigative result there is a suspicion of cancer then the clinician in charge of the patient will arrange an immediate onward referral to the most appropriate service

6.3.3 Other Referrals – New Appointment

Patients who do not attend (DNA) a new appointment should be removed from the Outpatient Waiting List. The clinician concerned will write to the patient's GP and formally discharge the care back to the GP

Any correspondence or conversations concerning an outpatient appointment must clearly state that if the patient fails to attend, they will be referred back to their GP. If a patient does not attend a new appointment, then the patient's address that is held on PAS should be verified, either by contacting the patient's GP or by accessing their record on the Summary Care Record. If the address on PAS is not the most up to date one, then the patient should be contacted, and a further appointment made.

If the patient's address is correct, then the patient should be informed that they have been discharged and returned to the care of their GP. They should be asked to contact their GP practice if they have any problems or still require the referral. The General Practitioner will be informed that the patient did not attend and will not be offered another appointment. In exceptional circumstances the Consultant may ask for a second outpatient appointment to be arranged without referring to the GP. If a patient does not attend their first outpatient appointment, then the 18-week clock is nullified (i.e., cancelled).

For all patients who do not attend their appointment, an 'Outpatient DNA Review Form' must be completed by the administration and nursing staff. To identify any triggers of concerns regarding safeguarding, those with concern must be highlighted the clinician.

6.3.4 **Other Referrals - Follow up (subsequent) Appointment**

Patients who do not attend (DNA) a follow up (subsequent) appointment should be discharged. The clinician concerned will write to the patient's GP and formally discharge the care back to the GP.

Any correspondence or conversations from the hospital concerning an outpatient appointment must clearly state that if the patient fails to attend, they will be referred to their GP.

If a patient does not attend a follow up appointment, then the patient's address that is held on PAS should be verified, either by contacting the patient's GP or by accessing their record on the Summary Care Record. If the address on PAS is not the most up to date one, then the patient should be contacted, and a further appointment made.

If the patient's address is correct, then the patient should be informed that they have been discharged and returned to the care of their GP. They should be asked to contact their GP practice if they have any problems or still require the referral. The General Practitioner will be informed that the patient did not attend and will not be offered another appointment. In exceptional circumstances the Consultant may ask for a second outpatient appointment to be arranged without referring to the GP.

For all patients who do not attend their appointment, an 'Outpatient DNA Review Form' must be completed by the administration and nursing staff. To identify any triggers of concerns regarding safeguarding, those with concern must be highlighted to the clinician.

When informing the patient's GP of the failure to attend it is important to point out any risks or vulnerabilities that the patient may be subject to, and that the GP may be unaware of that could be exacerbated by the non-attendance. Where necessary this should extend to a request for intervention by the GP which may lead to a further referral. This is a clinical responsibility of the Consultant responsible for their care.

6.4 Patients Who Change an Outpatient Appointment

6.4.1 **Cancer Referrals – Follow up (subsequent) Appointment**

The Company is aware that a referral may be generated incorrectly. The referral will be returned within 1 working day to the referrer and advised of the limitations of the company service.

6.4.2 **Other Referrals**

Patients who contact the hospital to change their outpatient appointment should agree an alternative appointment at the time of cancellation. They should be informed that if they cancel this rearranged appointment, they will be referred to their GP i.e., if they cancel two consecutive appointments.

Patients who contact the Company on the day of their appointment will be advised that the Consultant will review the patient's records and decide regarding further management. A letter will be sent to the patient and GP informing them of the decision.

Patients who book their appointments through ERS can cancel and rebook these at any time, other than by contacting the hospital, in any of three ways:

- Using the internet
- Via their GP
- Via The Appointment Line (TAL)

If they cancel an appointment, they do not have to rebook it immediately. If they do not rebook within 7 days, then they should be contacted and asked if they still require the appointment. If a patient cannot be contacted then a letter should be sent to him / her and their GP informing that the appointment request will be removed from the system and if he /she still requires an appointment, the GP will need to make another appointment request.

If a patient cancels two appointments that he / she has agreed, then he / she should be contacted and informed that if he / she cancels again he / she will be referred to their GP.

6.5 Clinic Cancellation or Reduction

It is hoped that **all staff holding clinics** (including consultants) would provide as much notice as possible of any planned leave. Clinics will now be booked to 6 weeks and patient inconvenience and distress are minimised by staff providing as much notice of leave as possible. Consultants must give a minimum of 6 weeks' notice for planned leave and for any other staff holding clinics, the exigencies of the service will be interpreted as a minimum of 6 weeks' notice. There should not be any clinic cancellations or reductions for this reason without at least 6 weeks' notice. All clinic cancellations that are not the result of an authorised planned absence or are within less than 6 weeks must be reported by the Out-patient Manager.

- Where patients must be cancelled, the case notes should be reviewed by the clinician concerned.
- Patients that have been previously cancelled by the Company should not where possible be cancelled a second time.
- An alternative appointment must be agreed with the patients who would have attended the cancelled or reduced clinic as soon as possible in line with clinical need and 18-week guarantee.

Short notice cancellations must be an exceptional event as they are inconvenient for patients and could possibly lead to deterioration in their health. Clinical Directors and Service Managers will be expected to monitor the cancellation reasons and to intervene if avoidable cancellations are indicated. Where cancellations are a regular feature, actions to reduce the frequency will be agreed for each specialty and progressive reductions over time will need to be demonstrated.

Any other changes to patients' appointments must be agreed with the patient, and where possible, 7 days' notice of the alternative given.
The practice of sending the patient a revised appointment without agreeing it with them or without making it clear that they can rearrange this appointment is not acceptable.

6.6 Follow-up appointments

Many patients will not require a follow-up appointment and will be discharged back to their referrer following their first assessment. When the clinician decides that a follow-up appointment is necessary, the GP should be informed, and the letter should clearly state why the follow-up is necessary.

If patients have not yet started treatments (i.e. they are on an open pathway) and a clinician indicates that a patient requires a follow up appointment, then this date and time should be arranged and agreed with the patient before he / she leaves the outpatient clinic. This appointment must be such that the patient can still commence their treatment within 18 weeks.

If the patient has already started their treatment (i.e. is on a closed pathway) and the appointment is required within 8 weeks then this should be arranged with the patient before he / she leaves the outpatient clinic so that, the date and time can be agreed with the patient. If the appointment is required after 8 weeks, then it can be arranged with the patient before they leave the outpatient clinic or the patient can be placed on a follow up outpatient waiting list with a date by when they should be seen. Patients should then be contacted at least 3 weeks before their due date and an appointment date agreed with them. All patients should be given at least 7 days' notice of their appointment, unless in discussion they agree to attend at shorter notice, should an appointment be available.

If it becomes necessary to rearrange any appointments, then the patient should be contacted, and a new date and time agreed. The practice of sending the patient a revised appointment without agreeing it with them or without making it clear that they can rearrange this appointment is not acceptable.

For vulnerable adults it is important that the arrangements for follow up appointments are agreed with their carer. These patients are identified on the PAS system. Some of these patients may find it difficult to deal with the administrative processes and if it is necessary to rearrange their appointment then it is essential that they and/or their carer's are contacted personally and not communicated with solely by letter.

6.7 Outcome of Outpatient Appointments

The outcome of all outpatient appointments should be recorded on PAS at the time of the clinic and the appropriate action should be taken (e.g. patient added to the inpatient or day case waiting list).
There are patients (such as those with long term conditions) who require annual follow up. These should be placed on outpatient review lists and managed accordingly.

All patients should receive a copy of their consultation and any associated clinical letters (results etc) relating to their episode of care unless they choose to opt out of such correspondence.

7. Diagnostic Test

7.1 Waiting times for diagnostic tests

Patients referred for diagnostic tests should have these within 4 weeks of the date of referral. It is the intention that patients should be sent from outpatient clinics directly to diagnostic imaging for some investigations to be carried out on the day of the outpatient appointment.

7.2 Patients who fail to attend for diagnostic tests

7.2.1 Cancer Patients

Cancer patients will not be referred for diagnostics with the Company. The referral will be returned to the referrer within 1 working day.

7.2.2 Other Patients

For all other patients who DNA an appointment for a diagnostic test, the diagnostics department should inform the requesting clinician that the patient has DNA'd and advise that one further appointment will be offered but that if the patient fails to attend again then they will be discharged back to GP. If the patient DNAs again, the diagnostics should discharge back to GP and this letter must be copied to requesting clinician.

Any correspondence or conversations from the hospital concerning an appointment for a diagnostic test must clearly state that if the patient fails to attend, they will be referred back to their GP. The process outlined in 6.4.4 for validating the patient's address should be followed.

8. Waiting Lists

8.1 Adding Patients to the Waiting List for Admission

The decision to add a patient to a Waiting List must be made by a consultant or a Clinician authorised to do so.

Patients who are added to the waiting list including booked admissions must be, in the opinion of the clinician, clinically ready for admission on the day the decision to admit is made. The clinician must determine that the patient is available and prepared to be admitted at any point within the remaining time to ensure that the 18-week RTT is honoured, and that the patient would be well enough to proceed with the operation/procedure at any point within that time frame. The overriding principle should be if there was a bed available tomorrow for the patient, they would be fit, ready, and able to come in.

8.2 Booked Patients

Whenever possible, a date for admission should be agreed with the patient at the time the decision to admit is made (see also section 7.1). If the patient requires pre-operative assessment, then the appointment for the pre-assessment clinic should be where possible made at the time the decision to admit is made. Patients who have an agreed date for admission will have their details added to the active waiting list with a booked TCI (to come in) date and they will be included in all statistical returns and monitoring. The agreed date should be within the 18 weeks RTT unless the patient chooses otherwise. If the patient chooses to delay their treatment, then a patient pause should be recorded as described in section 9.2.1.

8.3 Information About the Patient

When the patient arrives at the clinic the following information should be obtained:

(i) Confirmation of all the patient's details i.e. patient's address (including postcode), date of birth and registered General Practitioner and ethnic origin (if not already present)

(ii) Patient's telephone numbers (home and work; daytime and mobile telephone) or a number through which they can be contacted for availability to come in at short notice (less than 48 hours) if an unexpected vacancy arises and if the patient has not been given an admission date.

(iii) Any special circumstances requiring longer notice than usual for admission (e.g. caring for elderly relative, transport arrangements etc.)

8.4 Confirmation to the Patient

Every patient should receive a letter confirming that they have been put on a waiting list or have agreed to a booked admission date. This should include details of how the patient can contact the Company if they will not be able to accept an admission date during a particular time.

If a Patient Information leaflet is available for the intended procedure this should be given to the patient in clinic or included with the letter (not both).

9. Structure of waiting lists

To aid both the clinical and administrative management of the waiting list, it is recommended that lists should be sub-divided into a limited number of smaller lists, differentiating between active lists and others.

9.1 Active Waiting Lists

The active waiting list should consist of patients awaiting admission who are available to come in or who have accepted a booked admission date. Clinicians should decide how they wish to subdivide their active waiting lists to assist them with the clinical management of patients, but these subdivisions should be as few as possible.

9.2 Planned Waiting Lists

TPlanned waiting list patients are those who are waiting to be recalled to hospital for a known further stage in their course of treatment or investigation/intervention. These patients are not waiting for a first treatment date - they have commenced their treatment and there is a plan for the subsequent stages of that treatment.

Examples include:

- "Check" endoscopic procedures
- Age/growth-related surgery

Patients should only be on a planned list if there are clinical reasons why the patient cannot have the procedure or treatment until a specified time. Patients on planned waiting lists should not be on open 18-week pathways. There should be no patients on a planned waiting list for social reasons.

10. Maintaining the waiting list

Waiting lists should be kept up to date by the responsible person using data received from various sources. They need to ensure that patients are listed promptly and that the list does not contain patients who no longer need their operations at the hospital.

10.1 Computer Systems (PAS data entry)

To ensure consistency and the standardisation of reporting with Commissioners, all waiting lists are to be maintained and managed using the Patient Administration System (PAS). In no circumstances should duplicate manual waiting list records be held.

Details of listed patients must be entered onto the computer system within 2 working days of the decision to admit. Failure to do this will lead to incorrect assessment of where the patient is on the 18-week RTT and incorrect reporting of the waiting list size. The date of decision to admit must be the same as the clinic attendance date or the date the test results were received.

10.2 Patient Pauses

The process of suspending patients from the waiting list is no longer appropriate. The only pauses in the 18-week RTT periods are those requested by the patient – known as patient pauses.
Some patients are not currently available for admission due to social/personal reasons, e.g. holidays, work commitments and may request that their admission be delayed. For the measurement of the 18-week RTT this is classified as a patient pause, and the waiting time is adjusted to take this into account. Clock pauses cannot be applied within the diagnostic phase of the pathway.

A patient pause can only be recorded if the decision to admit has been made and the patient has declined at least 2 reasonable appointment offers for admission. This is defined as offering the patient two alternative dates with at least three weeks' notice. The pause starts on the date of the first reasonable offer and ends on the date from which the patient makes themselves available again for admission. However, there are some patients who will request that their treatment is carried out in a particular time period e.g. students, schoolteachers, people working abroad. In these cases, it is acceptable to record a patient pause before any offers are made. The pause should start on the date of the first reasonable offer that could have been made by the company. The reason for the patient pause must be entered clearly in the case notes and recorded on the PAS waiting list entry. It is recommended that a provisional TCI date be agreed with the patient and recorded on PAS in the comment field. The clock re-start date is the date the patient says they will be available for treatment, even if the company cannot offer that exact date to the patient.

Clock pauses cannot be applied within the diagnostic phase of the pathway.

If a patient chooses to delay their treatment for a period longer than 6 weeks, the patient should be referred to their GP until they are fit, willing and available to begin their treatment.
All patient pauses must have an end date. If the patient is unable to give a date by which they will be available, then they must be removed from the waiting list and returned to the care of their GP until they become available for treatment. Patient pauses should be no longer than 6 weeks.

Once the patient is available for treatment, the GP should refer them back for reconsideration of the intended treatment. The patient should re-enter the care pathway at the point from which they left it, but a new 18-week clock would begin.

10.3 Patients who are unfit

The overriding principle is that a patient should not be on the waiting list for admission unless they are fit, ready, and able to come in. Where a patient is clinically assessed as unfit for receiving treatment because of an existing condition or a previously undiagnosed or untreated condition, the patient should be referred to their General Practitioner. The GP is responsible for that patient's care until such time as the patient is ready for treatment.

Once the patient is fit for treatment, the GP should refer them back for reconsideration of the intended treatment. The patient should re-enter the care pathway at the point from which they left it, but a new 18-week clock would begin.

The only exception to this is when the unfit status is short-term (less than 2 weeks), for example, if the patient has a cold. In this case, the patient should not be returned to the care of their GP and should still be treated within 18 weeks. The 18-week clock does not stop because the patient is unfit.

A patient who is MRSA+ may continue to be managed, but the 18-week clock continues until the patient either receives their surgery or is referred to their GP.

10.4 Active Monitoring

Active monitoring is where it is clinically appropriate to monitor the patient in secondary care without clinical intervention or further diagnostic procedures. Active monitoring can be initiated by either the patient or the Clinician. The start of a period of active monitoring stops the RTT waiting time, a new clock starts from zero weeks wait at the end of the active monitoring period, and the company has a further 18 weeks to treat the patient.

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

Stopping a patient's clock for a period of active monitoring requires careful consideration on a case-by-case basis and its use needs to be consistent with the patient's perception of their wait. For example, stopping a clock to actively monitor a patient knowing full well that some form of diagnostic or clinical intervention would be required in a couple of days' time, is unlikely to make sense to a patient, as they are likely to perceive their wait as being one continuous period from the time of their

initial referral. Its use may be more appropriate where a longer period of active monitoring is required before any further action is needed.

Patients may initiate the start of a period of active monitoring themselves (for example by choosing to decline treatment to see how they cope with their symptoms). However, it would not be appropriate to use patient initiated active monitoring to stop patients' clocks where a patient does want to have a particular diagnostic test/appointment or other intervention but wants to delay the appointment.

Where such patient-initiated delays prior to admission mean that 18 weeks cannot be delivered for that patient, then the minimum operational standards for 18 weeks allow for patients for whom starting treatment in 18 weeks would not be appropriate.

Examples of where it is and where it is not appropriate to use active monitoring are given in Appendix 4.

11. Arranging Dates for Admission

11.1 Offers of Admission Dates

All dates for admission will be agreed with the patient. This can be either by agreeing the admission date with the patient at the time that the decision to admit him / her is made (full booking) or by asking the patient to contact us to arrange his / her admission (partial booking).

It is expected that:

- Patients will be made a reasonable offer – that is an offer of two alternative dates with at least 3 weeks' notice
- Patients will be selected from the waiting list in accordance with the individuals' 18-week pathway.
- All patients will undergo pre-operative assessment, where required, in advance of admission.
- Wherever possible, an admission date will be negotiated with the patient at the time the decision to admit is made.

11.2 Hospital Cancellations

Patient admissions should not be cancelled for non-clinical reasons at any stage. If, in unavoidable circumstances, a patient admission is cancelled on the day of admission for a non-clinical reason then they must be admitted within 28 days from the date of cancellation.

11.3 Patient Cancellations

Patient admissions should not be cancelled for non-clinical reasons at any stage. If, in unavoidable circumstances, a patient admission is cancelled on the day of admission for a non-clinical reason then they must be admitted.

11.4 Cancer Patients

If a cancer patient cancels and rearranges three admission dates, then they should be returned to the care of their GP.

11.5 Patients Who Do Not Attend

If a patient does not attend for their admission, then the following steps should be taken:

- If the treatment is not urgent then the patient's details, in particular their address should be verified. The consultant should be informed, and the patient should then be removed from the waiting list and a letter sent to the patient and their GP informing them of this.

12. Private patients

The following guidance is taken from 'A Code of Conduct for Private Practice' published by the Department of Health in 2004 and the 'Commissioning Policy: Defining the boundaries between NHS and Private Healthcare' Reference NHSCB/CP/12 published in April 2013.

UK residents and others eligible for NHS treatment who choose to be treated privately are entitled to re-enter NHS services on the same basis of clinical need as any other patient. The maximum waiting time guarantee applies to these patients as they re-enter the NHS service.

Where a patient wishes to change from private to NHS status, consultants should ensure that the following principles apply: -

- Any eligible patient seen privately is entitled to subsequently change their status and seek treatment as an NHS patient.
- Any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients because of having previously held private status.
- Patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients.
- If a patient is admitted to an NHS hospital as a private inpatient but subsequently decide to change to NHS status before having received treatment, there should be an assessment to determine the patient's priority for NHS care.
- A private outpatient consultation should not lead to earlier treatment within the NHS or earlier access to NHS diagnostic services than their clinical priority requires.
- Patients referred for NHS services following a private consultation or private treatment should be treated in the same way as a referral from any other source.
- The 18-week RTT pathway starts at the point at which the patient was referred into the NHS, not at the point they were seen privately.
- NHS patients opting to have private treatment must be removed from the NHS waiting list, their 18-week RTT clock stopped, and the referral and pathway ended.
- Patients who have an acute complication following private surgery or treatment are entitled to access emergency care as an NHS patient and should not be treated on a different basis to other NHS patients because of having previously held private status.

13. Priority treatment for war veterans

When a referral for a war veteran is received, the clinicians involved their care must be made aware of this and their obligation to give the patient priority throughout their treatment. This is in line with the guidance on the treatment of war pensioners and military veterans (HSG(97)31) and 'The Armed Forces Covenant'

The guidance states that 'NHS hospitals should give priority to war pensioners, both as outpatients and inpatients, for examination or treatment that relates to the condition or conditions for which they receive a gratuity, unless there is an emergency case or another case that demands clinical priority'. This covers all military veterans who require treatment for service-related conditions and not just those in receipt of a war pension. Every effort must be made by staff involved in these pathways to ensure that any requirement for these patients is met, such as afternoon appointments or appointments on specific days.

A veteran is someone who has served in the armed forces for at least one day. When service men and women leave the armed forces, their health care is the responsibility of the NHS.

The guidance is that:
'Where a person has a health problem because of their service to their country, it is right that they should get priority access to NHS treatment, based on clinical need. They should not need first to have applied and become eligible for a war pension'.

It is suggested that veterans are most likely to present with service-related conditions requiring:

- Audiology services – because of noise-related hearing loss
- Mental Health services – these conditions may present sometime after the patient has left the service
- Orthopaedic services – because of injuries during a person's time in the armed forces that begin to present problems sometime after discharge from the service.

GPs are asked to identify such patients at referral. Secondary care clinicians are to prioritise these veterans over other patients of the same level of clinical need. Veterans should not be given priority over other patients with more urgent clinical needs.

14. Management Information

14.1 Information for managers

Detailed information on the waiting lists is published every month as part of routine contract monitoring.

14.2 Definitions

MSS seeks to promote equality, diversity and human rights and aim to ensure that our services are accessible, culturally appropriate, and equitably delivered to all parts of the community, by a workforce which is valued and respected.

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

Active Monitoring / Watchful Waiting	A clinical/patient decision is made that no treatment or further intervention is required for the time being whilst development of the patient's condition is assessed over time. The patient remains under the clinical responsibility of the consultant during this period. The clinician has to have agreed this active monitoring with the patient.
Admitted Pathway	A pathway that ends in a clock stop for admission (day case or in-patient).
Active Waiting List	Patients who are awaiting elective admission for treatment and are currently available to be called for admission.
Booked Patients	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. These patients form part of the active waiting list.
Clinical Assessment Service	A service that does not provide treatment but assesses referrals from GP's and others to advise on the most appropriate next steps for the place or treatment of the patient.
Commissioners	A group of Practitioners who have the responsibility of commissioning care for their practice populations.
Clinician/Healthcare Professional	Allied Health Professionals (e.g. physiotherapists, dietitians etc.) Consultant and other hospital-based medical staff General Practitioners General Dental Practitioners Nurse Practitioners
Contracted Activity	The levels of patient treatments to be provided by healthcare providers, purchased by service commissioners, and set in the form of a legal contract.
Day cases	Patients who require admission to the hospital for treatment and will need a period of recovery, but who are not intended to stay in hospital overnight.
Decision to Admit (DTA)	Where a clinical decision is taken to admit the patient for either day case or inpatient treatment
Diagnostic Procedure	A procedure undertaken to help diagnose the patient's condition and inform the future treatment and management of that condition
Did Not Attend (DNA)	Patients who have been informed of their date of admission or pre-assessment (inpatients/day cases) or appointment date (outpatients) and who without notifying the hospital did not attend for admission/pre-assessment or outpatient appointment.
Elective care	A procedure or treatment chosen (elected) by the patient or doctor that is of benefit to the patient but not urgent

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 hospital clinic.
First Definitive Treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention.
Full Booking	Full booking is where the offer of appointment or admission date is agreed with the patient at the time the offer is made.
Incomplete Pathway	A pathway where patients are waiting to start treatment and where the 18-week clock is still running at the end of any reporting period
Inpatients	Patients who require admission to hospital for treatment and are intended to remain in hospital for at least one night.
Inter-Provider Transfers	A referral from another healthcare provider other than BHNFT
Medical Suspension	Patients who have become medically unfit for surgery whilst on the waiting list.
Minimum Data Set	National data sets which define a standard set of individual data items from information generated from patient care records
Non-admitted Pathway	A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment'.
Outpatients	Patients referred for clinical advice or treatment.
Partial Booking	Partial booking is where we ask the patient to contact the hospital to agree an appointment date and time or admission date.
PAS	Patient Administration System
Patient Pause	An allowable pause in the patient pathway in certain circumstances, initiated by the patient.

Planned Admissions	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. These patients do not form part of the active waiting list.
Pre-documentation (Pre-doc)	Entry of patient details onto hospital computer system at the time of receipt of referral in advance of patient appointment offer.
Referral Management Centre	A service that does not provide treatment but assesses referrals from GP's and others to advise on the most appropriate next steps for the place or treatment of the patient.
Referral to Treatment Time (RTT)	The time from referral to first definitive treatment for a single condition.
Service Commissioner	Organisations responsible for purchasing healthcare services for the local or national populations.
Social/Personal Suspension	Patients who have asked for their admission to be delayed for social/personal reasons
Service Provider	Organisations responsible for providing healthcare services for local or national populations.
TCI (To Come In) Date	Date set for patient's admission to hospital
Therapeutic Procedure	A procedure undertaken to help treat the patient's condition

APPENDIX 1

Consultant-to-Consultant (C2C) Referral Protocol

Introduction

There are occasions when consultants decide to refer patients on to other consultants, within the same or different specialties or within the same or between different providers. These referrals are often called consultant-to- consultant (C2C) referrals.

The number of consultant-to-consultant referrals has been increasing in recent years and is the main source of non-GP referrals.

Consultant-to-consultant referrals for a new or different treatment start a new RTT clock. In many providers consultant-to-consultant referrals are poorly tracked, have implications on hospital payments and remove responsibilities from primary care for holistic patient care.

Consultant-to-consultant referrals should only happen when it is in the best clinical interests of the patient or part of the clinical pathway for which the patient is being treated.

Contract Clause
Under contract C2C referrals should only be made in line with Service Condition 8.5 which states;

“Except as permitted under an applicable Prior Approval Scheme, the Provider must not carry out, nor refer to another provider to carry out, any non-immediate or routine treatment or care that is not directly related to the condition or complaint which was the subject of the Service User’s original Referral or presentation without the agreement of the Service User’s GP.”

The following protocol aims to assist clinicians in implementing this clause across the health care system.

The purpose of the C2C outpatient referral protocol is to provide efficient and high-quality care for patients, allowing GP’s to retain oversight of their patients’ care, but not requiring the GPs involvement when C2C referrals are appropriate.

Communication with GPs

a. Details of and any indication for any C2C referrals made must be clearly set out in the clinic letter to the GP relating to the patient’s initial appointment or subsequent clinic attendance.
b. Details of any proposed onward referral resulting from attendance must be clearly set out in the discharge letter to the GP

Communication with Colleagues

a. When initiating a C2C referral clearly indicate on the referral / GP letter from the clinic outcome how the patient meets the above criteria for C2C.
b. Note: These referrals should contain the same level of information as referrals from Primary care.

Communication with Patients

a. Patients not requiring consultant to consultant referral should be advised to make an appointment with their GP to discuss any new presenting conditions, for the GP to manage. Part of this management may be that a referral to secondary care is necessary, but this expectation should not be set by secondary care.
b. Patients who are actioned as a C2C referral should be advised that the referral to a colleague is for advice and may lead to an appointment with the Specialty.

APPENDIX 2

18 Week Pathway
Guide to 18 Week Clock Rules

Purpose

The 18-week pathway standard is that:

No patient should wait more than 18 weeks for treatment to start following referral to a new care pathway.

Patients on the 18-week pathway have a clock start date once they are referred and a clock stop date once treatment has started or the pathway ends for other reasons.
This local guidance explains these definitions and is in three sections:

1. Clock start
2. Clock stop
3. Exceptions

1. Clock start

1.1 What starts the 18-week clock?

1.1.1 Referrals from primary care (usually GPs/GDPs) to services led by a consultant. For example:

- Outpatient clinics
- Satellite or outreach clinics
- One stop services
- Diagnostic services intended to lead on to treatment within a consultant-led service.

1.1.2 Self-referrals by patients to consultant led services start a clock once the referral has been ratified by a consultant or other healthcare professional. This includes long term patients who refer themselves back into the service.

1.1.3 Referrals from primary care to cancer services.

- The two week, 31 day and 62 day cancer standards continue to apply
- An 18 week clock also starts and overrides these targets if the 18 week point comes first
- If cancer is later excluded, 18 weeks continues to apply to any treatment that is required
- Patients who are treated for cancer which then recurs will start a new 18 week clock.

1.1.4 Referrals from primary care to Obstetrics.

- Referrals for healthy pregnant women do not start a clock

- However, a clock starts for pregnant women if there is a separate condition or complication requiring medical or surgical consultant-led attention
- If it is not possible to carry out treatment because the patient is pregnant, the patient should be referred back to primary care until the patient is fit, ready and able to commence treatment for their non-pregnancy related condition

1.1.5 Referrals from other hospital services such as Accident and Emergency to a hospital consultant start a clock unless the patient is being admitted as an emergency.

1.1.6 A decision made by a consultant following emergency admission to start a new elective treatment pathway will start a clock.

1.1.7 Referral by a hospital consultant (within or outside the Trust)
To another hospital consultant, for an unrelated new condition, a second clock starts while the original clock continues to tick. Consultant-to-consultant referrals within the Trust for unrelated conditions will only be for urgent cases, with routine referrals going back to the GP.

1.1.8 Upon completion of an 18-week referral to treatment period a further new clock only starts in the following circumstances.

- A decision made by the consultant at outpatient follow up to initiate a new treatment plan which is not part of the patient's existing care plan will start a clock. This will apply particularly in the case of the management of long-term conditions.
- A decision made by the consultant that a patient on a planned waiting list is clinically ready for a procedure will start a clock when this is a new treatment plan. For example, it is decided that a patient who has had several 'check scopes' requires surgical intervention.
- When a patient becomes fit and ready for the second of a consultant-led bilateral procedure.
- When a decision to treat is made following a period of active monitoring.
- If a patient is allocated another appointment following a first appointment DNA that stopped and nullified their earlier clock.

1.1.9 Referrals from primary care to intermediate services such as.

- Referral Management Centres
- Clinical Assessment Services
- Primary Care practitioners with specialist interests start a clock which continues to tick if the patient is then referred on to the Trust.
- A decision made by the consultant that a patient on a planned waiting list is clinically ready

1.2 What does not start the clock?

1.2.1 Referrals from primary care to intermediate services such as or example to:

- Nurse led clinics not under the responsibility of a medical or surgical consultant
- Allied healthcare professionals (for example Therapy services)
- Midwives
- Healthcare sciences (for example Hearing services)

- Direct access diagnostic services not intended to lead to treatment
- Primary dental services provided by dental students
- Orthodontic services which are not led by a consultant orthodontist
- Community multi-disciplinary teams.

1.2.2 Referral by a hospital consultant (within or outside the Trust) to another hospital consultant for treatment which is related to the original condition does not start a new clock, and the original clock continues to tick.

1.2.3 Referral following an emergency admission to a follow-up clinic for related care

1.2.4 Self-referrals by patient (for example to GUM clinics), which have not been ratified by a consultant or healthcare professional

1.2.5 Routine dialysis appointments are not part of the 18-week pathway.

1.3 Whose referrals start the clock?

1.3.1 **From primary care:**

- General practitioners
- General dental practitioners
- Optometrists' opticians, and Orthoptists
- Walk in Centre
- Specialist nurses or allied health professionals with PCT authorisation to refer (unless the clock has already started within an intermediate service) • National screening services
- Prison health services.

1.3.2 **From hospital services when the patient is not being admitted as an emergency:**

- Accident and Emergency
- Minor Injuries Unit
- Eye casualty
- GUM Clinical staff (not self-referrals by patient)

1.3.3 Hospital consultants or other authorised Allied Health Professionals (AHP) for a separate or unrelated condition or for a new treatment plan.

1.3.4 Self-referrals, once ratified by a consultant.

1.4 What defines the clock start date?

1.4.1 For referral letters received from primary care: the date of receipt of the referral.

1.4.2 For referrals made through Choose and Book: the date on which the appointment request is converted into a booking by the patient. This date continues to apply even if the patient is booked into the wrong clinic initially.

1.4.3 For referrals received from other hospital services or intermediate care services for a new care pathway: the date of receipt of the referral.

1.4.4 For referrals received from intermediate care services, such as the Musculoskeletal Service, the date on which that service received the referral from primary care, where a treatment has not already been given.

1.4.5 For referrals received from consultants (within or outside the service for an unrelated condition), the date of receipt of the referral.

1.4.6 For referrals received from consultants (within or outside the service) for treatment for the original condition: the date that the original referral was received from primary care.

1.4.7 For new treatment decisions made by a consultant: the date of the decision.

1.4.8 For patients being seen privately, if the decision is made to transfer to NHS care, the date the service accepts the referral to the NHS.

1.4.9 For self-referrals, the clock starts on the date that the referral is ratified by a clinician.

2. Clock Stop

2.1 What stops the 18 week clock?

2.1.1 First definitive treatment (see 2.2 below)

2.1.2 A clinical decision that consultant led NHS treatment is not required, at the date that this decision is communicated to the patient and referrer:

- Decision that treatment is not required, or the patient is not ready for treatment, and therefore to discharge the patient to primary care.
- Decision to discharge a patient to primary care for treatment in primary care.
- Decision to discharge a patient to a Referral Management Centre for treatment if the treatment is not to be a consultant led surgical or medical treatment.
- Decision to refer out of the NHS (e.g. for private treatment).

2.1.3 Decision to embark on a period of active monitoring (often known as watchful waiting).

2.1.4 Decision to place a patient on a transplant list.

2.1.5 Patient declines treatment having been offered it.

2.1.6 Patient has treatment as an emergency which was previously intended to be done electively.

2.2 What defines first definitive treatment?

2.2.1 This is the first treatment that is intended to manage a patient's disease, condition, or injury. It may include first line treatment when this is intended to manage a condition and avoid more invasive procedures.

2.2.2 First definitive treatment can include:

- Inpatient or day case treatment: the clock stops on the date of admission.
- Outpatient treatment or consultant-led treatment in other settings: the clock stops on the date of attendance
- Diagnostic tests that turn into therapeutic procedures during the investigation: the clock stops on the date of attendance or admission
- The fitting of a medical device: the clock stops on the date of the definitive fitting (or the date of trial fitting with no undue delay in subsequent fitting sessions).
- Prescribing of medication intended to treat the condition.

2.3 What defines active monitoring (or watchful waiting)?

2.3.1 If a clinical decision is made that no treatment or further intervention is required at this time but the patient's condition needs to be monitored in secondary care. The clock stops on the date that this decision is made and communicated to the patient. The patient remains under the clinical responsibility of the consultant, and it is possible that there will be regular follow up appointments.

2.3.2 When at a future date a decision to treat or otherwise intervene is made, this starts a new 18-week clock on the date that this decision is made and communicated to the patient.

2.4 Planned patients and series of procedures

2.4.1 Patients on planned waiting lists are outside the scope of 18 weeks, but if a patient on a planned list does not have their consultant-led treatment procedure on or around the planned date they should be transferred to an active list and an RTT clock should start i.e. an RTT clock should start if the due date for the planned consultant-led procedure is reached and the patient has not yet received treatment. Thereafter, 'normal' RTT rules should apply.

2.4.2 When a series of procedures is intended from the outset (for example two stage or bilateral procedures) the clock stops at the date of the first definitive procedure. Subsequent stages should be completed without undue delay.

2.4.3 When the decision for subsequent treatment is made at a later date and separately from the first, this starts a new 18-week clock.

2.4.4 What does not stop the clock?

2.4.5 Any steps taken to manage a patient's condition in advance of a definitive treatment, including pain relief prior to a surgical intervention.

2.4.6 Referral by a hospital consultant (within or outside the service) to another hospital consultant for the same or a related condition.

2.4.7 Inpatient or day case admission for a diagnostic procedure only, unless it results in a therapeutic procedure. For example, if during a colonoscopy that was intended to be diagnostic only a resection of a lesion is carried out.

1. Exceptions

1.1 What are exceptions?

1.1.1 There will always be patients for whom the 18-week timescale to the start of treatment is clinically inappropriate or against the patient's wishes.

1.1.2 A nationally agreed percentage tolerance has been set for patients whose pathway end date is later than 18 weeks for these reasons. The tolerances are 5% for non-admitted pathways and 10% for admitted pathways.

1.1.3 There are limited circumstances in which the clock can be "paused" as set out in 3.2 below

1.1.4 The reason for an exception or clock pause must be documented, legitimate and auditable, and must be explicitly communicated to the patient and the referrer.

1.2 Clinical Exceptions

Exceptions may occur where treatment within 18 weeks may not prove possible. For example:

- When a series of tests needs to be carried out in sequence
- When a second condition presents that requires treatment before the first
- Where a patient and consultant have agreed that a second opinion is required and despite best efforts this adds a critical delay
- Where there is genuine clinical uncertainty regarding a diagnosis, but active monitoring is inappropriate.

1.3 Patient initiated delay

Exceptions may occur where patients turn down a reasonable appointment because, for example, they prefer to take an extended holiday or because of work commitments. Should such a delay be over 3 months in duration, the patient should be discharged back to the referring clinician until they are available for treatment, at which point the patient should be rereferred back, joining the pathway at the same point as they left it.

1.4 Do Not Attends (DNA's)

There are limited circumstances in which DNA's nullify the 18-week clock:
Any patient who DNA their first appointment after initial referral their clock will have nullified and their referral returned to the referrer .

- Patients who cancel their first appointment in advance will not have their clock stopped unless their rebooked appointment entails a delay making it unreasonable or impossible for 18 weeks to be achieved.
- Patients who do not rebook their first appointment within a reasonable time will have the first clock nullified and a new clock started at the point of rebooking.
- DNA's and cancellations do not stop the clock at any other point on the 18-week pathway.

APPENDIX 3

18 Week Pathway
Inter-Provider

1. Definition

1.1 Inter-provider transfer.

This is when a patient is referred from another provider.

2. Information required.

The referrer is required to provide as a minimum, in addition to any relevant clinical information the following:

- Pathway Identifier
- Pathway Start Date
- Current Treatment Status
- Pathway End Date – if applicable

3. Provision of the Information

The information is available from the PAS systems and can be incorporated into the referral letter.

4. Obtaining the Information

If the information is not provided on the referral letter, then it is the responsibility of the receiving provider to contact the referrer to obtain this information as soon as possible.

For all such transfers an inter-provider Minimum Data Set (MDS) must accompany the transfer. This pro forma will include all RTT clock information. The purpose of the MDS is to ensure that the administrative RTT data required to enable the receiving provider to report on the patient pathway is transferred from the referring provider to the receiving provider when responsibility for a patient's care has transferred. Referrals from another Trust can only by rejected on clinical grounds if the company cannot provide this clinical service.

Equality Impact Assessment Questions
Title of the policy being Equality Impact Assessed Access and Choice
Date of Assessment 03.20

Who is undertaking this assessment SMT	
Detail anyone else involved in this assessment. no	
Detail the aim and scope of the policy. Equitable and timely access	
Who will benefit from the policy patients and families.	
Have service users/staff been involved in the development of the policy. staff	
Could this policy affect any of the following equality group unfavourably	
	Yes/No
Race	No
Disability	No
Gender	No
Age	No
Sexual Orientation	No
Religion/Belief	No
Transgender	No
Maternity/Pregnancy	No
Marriage/Civil Partnerships	No