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### Policy Statement

This policy outlines the way in which The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust will manage patients who are waiting for appointments, investigations and or treatment on a referral-to- treatment pathway.

### Equality Impact

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) strives to ensure quality of opportunity for all service users, local people and the workforce. As an employer and provider of healthcare, RJAH aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed by the Executive Team to ensure fairness and consistency for all those covered by it regardless of their individuality. The assessment form is included in Appendix 3.

### Local Health Community Agreement

The policy has been reviewed and agreed by Shropshire Clinical Commissioning Group’s Clinical Assurance Panel and shared with Welsh Local Health Boards and NHS England.

### VERSION CONTROL

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| --- | --- | --- | --- |
| **Version Number** | **Issue Date** | **Revision Date** | **Amendments** |
| 2.2 | 19/11/13 | 28/11/15 | Superseded by V3 |
| 3.0 | Nov 2015 | May 2016 | Rewrite/Restructure to account for the refreshed guidance produced by NHS England on 1st October 2015. |
| 4.0 | Feb 2016 |  | Further enhancements to fully account for Welsh RTT rules |
| 5.0 | Feb 2016 | Aug 2016 | To incorporate feedback from external stakeholders on version 4 |
| 6.0 | Jul 2017 |  | Update for Welsh RTT rules 2017 and additional Paediatric clarification |

**Document Control**

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| **Control Arrangements** | | This document should be reviewed at least annually in line with changes to relevant national standards.  This is a controlled document and printed copies may not be up to date. Please check the hospital intranet for the latest version and destroy all previous versions. | | |
| **Associated Polices** | | Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care (1st October 2015)  Welsh Assembly Rules for Managing Referral to Treatment Waiting Times (2011) NHS Constitution (27th July 2015)  Choice Framework (March 2015)  Everyone Counts: Planning for Patients 2014/15 to 2018/19 (20th December 2013) NHS Cancer Plan (2000)/NHS Cancer Reform Strategy (2007)  English Cancer Waiting Times Guide Version 8.1  Consultant to Consultant Policy (endorsed by Shropshire CCG 2015) Procedures of Limited Clinical Value (Shropshire CCG)  NHSE - The BlueTeq Prior Approval System, and the IFR policy April 2013  Protocol for cross border healthcare services 2013 | | |
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**Section A Operational Overview**

**INTRODUCTION**

**Policy aims and rationale**

1. The length of time that a patient needs to wait for hospital treatment is an important quality issue and is monitored nationally. RJAH is committed to ensuring that patients receive their treatment in accordance with the national objectives, the contracts agreed with both English and Welsh Commissioners and in line with the eligibility of a patient’s right to treatment by the NHS. In Commissioning terms, for border counties English patients are those registered with an English GP, (regardless of where they live) and Welsh patients are those registered with a Welsh GP (regardless of where they live). For more information please see ‘Protocol for Cross-Border Healthcare Services.
2. This policy outlines the Trust’s approach to managing patient’s access in line with relevant English and Welsh guidance. In this policy Welsh rules have been highlighted in blue. This policy is intended to support delivery of the maximum commissioned waiting times from referral to first definitive treatment, and is designed to ensure fair and equitable access to hospital services in line with the NHS Constitution.
3. The policy’s overall aim is to ensure patients are treated in a timely and effective manner, specifically to:
   1. Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order;
   2. Reduce waiting times for treatment and ensure patients are treated in accordance with agreed standards (*note:* these are different for English and Welsh commissioners);
   3. Provide an operational guide to managing patients in line with the national and local standards;
   4. Define roles and responsibilities for key stakeholders;
   5. Establish a consistent approach to managing patient access across the Trust, supported by training and standard operating procedures; and
   6. Ensure accuracy of all related data to support monitoring of performance and adherence to the policy

### Patient Choice for English Patients

1. Patients have a legal right to choose where they go for their first outpatient appointment, to change hospital if they have had to wait longer than the maximum waiting times (18 weeks or 2 weeks to see a specialist for suspected cancer) and to carry out a specialist test suggested by their GP. (See Choice Framework 2015/16).

### Principles

1. Entitlement to use the National Health Service free of charge is based on where a person normally lives regardless of their nationality or whether they hold a British passport or have lived and paid National Insurance contributions and taxes in this country in the past. Anyone who has lived lawfully in the UK for at least 12 months immediately preceding treatment is exempt from charges.
2. The Trust relies on GPs and other referrers to ensure patients understand their responsibilities (including provision of accurate demographics) and potential pathway steps and timescales when being referred. This will ensure that patients understand the likely speed at which they will be treated, are able to accept timely appointments when offered and are referred under the appropriate clinical guideline with pre- referral diagnostics and reviews, for example completion of Oxford Hip/Knee Score questionnaire, completed in advance. (Reference should be made to Shropshire CCG guidelines).
3. Nothing should be done to limit treatment for patients who have a clinical need for it. The Trust also has a responsibility to ensure no patient is added to waiting lists inappropriately.
4. Everyone involved with implementing the access policy should have a clear understanding of their roles and responsibilities and seek additional training when they are unclear about this; core training is mandatory. Failure to adhere to this policy will be managed in line with relevant Trust policies, e.g. Disciplinary Policy.
5. The policy should be applied consistently across all services.
6. Communications with patients should be timely, informative, clear and concise. The process of waiting list management should be clear to patients.

### KEY OPERATIONAL STANDARDS

**National Standards**

1. The following operational standards are mandatory in the NHS Contract and the performance thresholds are detailed and reported monthly.

|  |  |
| --- | --- |
| **English Operational Standard** | **Threshold** |
| *Referral to Treatment* | |
| Percentage of service users on incomplete RTT pathways active waiters waiting less than 18 weeks from referral | 92% at Specialty Level |
| *Cancer* | |
| Percentage of Service Users referred urgently with suspected cancer by a GP waiting less than two weeks for first outpatient appointment | Operating standard 93% |
| Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers | Operating standard 96% |
| Percentage of Service Users waiting no more than one month (31 days) for subsequent treatment where that treatment is surgery | Operating standard 94% |
| Percentage of Service Users waiting no more than one month (31 days) for subsequent treatment where that treatment is an anti-cancer drug regimen | Operating standard 98% |
| Percentage of Service Users waiting no more than one month (31 days) for subsequent treatment where that treatment is a course of radiotherapy | Operating standard 94% |
| Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer | Operating standard 85% |
| Percentage of Service Users waiting no more than two months (62 days) for first definitive treatment for cancer following a consultant’s decision to upgrade the priority of service user | Local standard 85% |
| *Cancelled operations* | |
| All service users who have their operations cancelled on the day of admission (including day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the service user’s treatment to be funded at the  time and hospital of their choice | All patients |

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| **English Operational Standard** | **Threshold** |
| *Diagnostic test waiting times* | |
| Percentage of service users waiting less than 6 weeks from referral for a  diagnostic test | >99% |

|  |  |
| --- | --- |
| **Welsh Operational Standard** | **Threshold** |
| *Referral to Treatment* | |
| *Welsh Assembly Standard:* Percentage of service users on incomplete RTT  pathways (yet to start treatment) waiting less than 26 weeks from referral | 95% |
| *Welsh Assembly Standard:* Percentage of service users on incomplete RTT  pathways (yet to start treatment) waiting less than 36 weeks from referral | 100% |
| *Local Variation for Betsi Cadwaladr Local Health Board Standard:* Percentage  of service users on incomplete RTT pathways (yet to start treatment) waiting less than 52 weeks from referral | 100% |
| *Local Variations for Powys Local Health Board Standard:* |  |
| Spinal Disorders, Upper Limb & Foot/Ankle: Percentage of service users on | 100% |
| incomplete RTT pathways (yet to start treatment) waiting less than 40 weeks |  |
| from referral |  |
| Other specialties: Percentage of service users on incomplete RTT pathways | 95% |
| (yet to start treatment) waiting less than 26 weeks from referral |  |
| *Cancer* | |
| Service Users referred urgently with suspected cancer by a GP waiting more than two weeks for first outpatient appointment | No standard in place – manage in line with English standards |
| Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers | Operating standard 98% |
| Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer | Operating standard 95% |
| *Diagnostic test waiting times* | |
| Percentage of service users waiting less than 8 weeks from referral for a  diagnostic test | 100% |
| Percentage of service users waiting less than 14 weeks from referral for  specified therapy services | 100% |

### Internal Operational Standards

1. To support effective performance across the operational pathways, the Trust has the following standards for internal compliance.

|  |  |
| --- | --- |
| **Internal Standard** | **Threshold** |
| *Referral to Treatment Pathways* | |
| Receipt of referral to registration of referral on trust systems | 1 working day |
| Receipt of referral to appointment booked | 5 working days |
| Receipt of Appointment Slot Issue (ASI) report to capacity identified by  relevant sub-specialty | 3 working days |

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| **Internal Standard** | **Threshold** |
| Receipt or Production of Referral either internally or from another organisation  to Registration | 3 working days |
| Review of Referral Letters by Clinician to ensure appropriate classification or service | 5 working days from the date appointment made |
| Outpatient Attendance Status to be completed | In real-time during the clinic session |
| Patient Clinic Outcome and Coding Status to be completed | 2 working days |
| Notification of Clinic Template Changes | 7 days minimum notice |
| Hospital-initiated cancellations | No more than 2 in succession |
| Clinic Session Alterations (e.g. a clinic session cancellation or reduction) | No more than 10% of cancelled sessions provided with <6 weeks’ notice |
| Decision to Treat date to the date patient added to the inpatient waiting list | 2 working days |
| Slot Utilisation – percentage of planned appointment slots used in a clinic  session | 95% |
| Session Utilisation – percentage of planned (in job plan) clinic sessions taking  place | 85% |
| Session Utilisation – percentage of planned (in job plan) theatre sessions taking place | 80% (with adjustment for Trauma commitments) |
| DNA Rate – percentage of patients failing to attend an agreed outpatient  appointment | 6.5% |
| Clinic Session Closure (no routine patient additions to the clinic) | 72 hours prior to clinic session |
| Theatre session planning, notification of cancellation of an in job plan session | 6 weeks |
| Theatre session planning, lists closed down | 2 weeks |
| Theatre session planning, individual list lock down | 7 days in advance |

### Internal Pathway Waiting Times Standards

1. The length of time a patient needs to wait for hospital treatment is an important quality issue and is a visible and public indicator of the efficiency of the hospital services. At RJAH the target maximum waits should be:

|  |  |
| --- | --- |
| **Pathway** | **Internal Standard** |
| *England* | |
| Maximum wait from referral to first outpatient attendance | 6 weeks |
| Maximum wait from referral to completion of diagnostics | 11 weeks |
| Maximum wait from referral to treatment | 18 weeks |

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|  |  |
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| *Welsh Patients* | |
| Maximum wait from referral to first outpatient attendance | 8 weeks |
| Maximum wait from referral to completion of diagnostics | 16 weeks |
| Maximum wait from referral to treatment | 26 weeks |

### DUTIES AND RESPONSIBILITIES

**Chief Executive**

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 that meet national and local targets and standards as set out in the Trust’s Service Level Agreement with commissioners, and for achieving these targets.

### Director of Operations

1. The Director of Operations is the Executive Lead for clinical operations and is therefore responsible:
2. Through the Clinical Directors, Divisional Managers and Deputy Director of Operations for ensuring that effective processes are in place to manage patient care and treatment that meet national and local targets and standards as set out in the contracts with Commissioners.
3. With Clinical Directors, Divisional Managers and Deputy Director of Operations for achieving access targets, including Referral to Treatment Times, NHS eReferral Service (patient appointment systems) and cancelled operations.
4. For implementing effective Trust-wide monitoring systems to ensure compliance with this policy and avoid any breaches in targets.
5. With Clinical Directors, Divisional Managers and Deputy Director of Operations for monitoring progress against achievements of the targets and taking action to avoid any potential breaches.
6. With Clinical Directors, Divisional Managers and Deputy Director of Operations for managing any actual breaches in achieving targets.
7. For keeping the Trust Board and Trust Executive informed of progress in meeting access targets and any remedial action taken.

### Clinical Directors, Divisional Managers and Deputy Director of Operations

1. Clinical Directors and Divisional Managers are responsible for complying with the Policy and performance thresholds by effectively managing waiting times and, therefore, proactively managing inpatient, outpatient and diagnostic waiting lists is essential. In particular, they must ensure compliance with notice periods defined for cancellation of direct clinical activity and ensure processes are in place to manage this effectively.
2. In addition the Deputy Director of Operations will lead the weekly Patient Treatment List review meeting.

### Performance Managers and Validation Team Lead

1. Performance Managers in conjunction with Validation will:
2. Ensure that correct rules are applied and that staff throughout the organisation are both aware of these rules and supported with necessary training;
3. Monitor waiting list positions across the Divisions and work proactively to ensure that robust plans are developed to ensure delivery and address any underlying issues such as lack of capacity versus demand.
4. Have line management responsibility for the booking teams.

### Consultants and their teams

1. Consultants and their clinical teams are responsible for providing sufficient notice of direct patient care activity to minimise the impact on the patient experience and working within the guidelines outlined, complying with the operational performance thresholds and Standard Operating Procedures appended to the Policy. In particular, they are responsible for explaining the patients’ responsibilities in terms of being available within 18 weeks/26 weeks for any potential treatment. A patient should only be placed on an active waiting list for surgery if:
2. The patient is clinically ready, fit and available to undergo surgery
3. There is a sound clinical indication for surgery
4. Consultants as senior clinicians must be aware of the various routes that patients enter their referral pathways; including the NHS e-referral system, telephoned urgent referral, personal GP letter, transfer from the private sector, services provided at other NHS providers (in both planned and unplanned care settings), consultant to consultant referrals (please note that not all consultant to consultant referrals start a new clock, see para 76-82). In addition, consultants need to be aware of the differences in pathways where a new referral will be required; for example, a subsequent procedure agreed as part of the original care plan does not need a new RTT clock however where a new condition is being treated a new referral and associated RTT clock start is required.
5. Providing patient information leaflets related to the relevant clinical condition to support the patient and careers with treatment options and decision making at the time of the appointment.

### Information Lead

1. The Information lead is responsible for the provision of regular management reports to support on a daily, weekly, monthly and ad hoc basis for use by Trust managers and clinical/booking teams and reporting to external sources. The Information Lead will provide support to the month end validation process and produce the monthly submission for authorisation by the relevant Executive Director, prior to submissions to Secondary Users Service (SUS) and Clinical Commissioning Groups.
2. The Information lead will provide data quality reports to assist the tracking on RTT pathways and to provide appropriate assurance to the Trust’s Board through a robust regular audit process
3. Have responsibility for the validation team and monthly validation of the waiting list and feedback of the “lessons learnt” through this process back up through to divisional and booking teams.

### Central Appointments Team

1. The inpatient and outpatient booking teams will ensure that on a daily basis individual patient pathways are proactively managed in line with the principles outlined in this policy. They will ensure that training needs analysis occurs with necessary training being provided and that Standard Operating Policies are identified, written, regularly reviewed and adhered to. They will be responsible for ensuring that waiting lists are proactively managed and that patients are booked for their treatment within the English and

Welsh guidelines. Liaison between the booking staff and individual Consultants will ensure that patients are listed according to the time they have been on the waiting lists, unless deemed medically urgent.

### Medical Secretaries

1. Medical Secretaries are responsible for ensuring that their practices are consistent with the Policy and that they are working within the Standard Operating Procedures at all times. They must ensure that systems are in place to support effective waiting list management from referral to discharge, in particular timely triage of referrals and review of diagnostic reports by clinicians.

### Commissioners

1. Commissioners are responsible for ensuring that the contract with the Trust has sufficient capacity to ensure that the access targets within this Policy can be adhered to and to ensure that referrers are familiar with the contractual arrangements.

### GPs and Other Referrers

1. GPs and Other Referrers are responsible for ensuring that patients are ready and available to receive treatment within the operational standards outlined in this Policy and are aware of their responsibilities in terms of attending agreed appointments or admission dates. Referrals will be managed in line with agreed guidelines as set out in this policy, which means on an 18 weeks pathway unless a different Commissioner agreement is in place. A patient should only be referred if:
2. The patient is clinically ready, fit and available to undergo surgery
3. There is a sound clinical indication for surgery
4. There is a real expectation by the patient that they will be treated within a reasonable time in relation to the patient’s clinical priority and within 18 weeks/26 weeks
5. Shropshire CCG’s Procedures of Limited Clinical Value policy provides a list of interventions ‘not routinely funded’ by the CCG and the specified criteria required for the funding of other certain interventions. Patients should not be referred for a low priority procedure unless commissioner approval has been sought in advance.

### Outpatients Department

1. All outpatient staff are responsible for working within the guidelines outlined in this Policy and in line with the Standard Operating Procedures. In particular, they are responsible for complying with the Internal Standards to support this Policy and for escalating issues with capacity as appropriate.
2. Ensuring relevant clinical condition patient information is available in the clinic areas for the medical teams to offer to patients.

### Patients

1. Patients are responsible for being available for treatment within the timescales available to them within this Policy. They must ensure that RJAH has been notified of any change to their demographic details and should make every effort to attend all appointments provided for them. Patients must inform their GP of any changes in their medical condition that may affect their attendance or clinical priority. Where a parent/guardian/carer is supporting the patient, they should undertake to ensure that the patient fulfils

their responsibilities. Patients who no longer wish to have surgery/treatment, for whatever reason, must advise both their GP/referrer and the hospital consultant.

1. Welsh patient responsibilities: patients will be expected to make themselves available for treatment within reasonable timescales. Their inability to do so may result in a longer waiting time.

# Section B Consultant Led Referral-to-Treatment Guidance

### REFERRAL GUIDANCE

1. The Trust will work with Clinical Commissioning Groups and Local Health Boards in developing booking and choice systems. Where appropriate, explicit referral guidelines will be agreed between services and those who make referrals. If a consultant/service deems that a referral is not suitable, it will be returned/rejected to the referrer with an explanation or changed to a more appropriate service for the needs of the patient.
2. Referrers should be encouraged to use generic referrals which can be allocated to an appropriate Consultant with the shortest waiting time through the e-Referral booking system where applicable. Referrers should ensure that the patient’s demographic details are up to date and all relevant information is included in the referral letter (e.g. past medical history, current medications). The referral letter should also identify:
   1. The commissioner approval reference if the patient is being referred for a low priority procedure or details of why outpatient consultation is being requested to determine if they meet the exception criteria;
   2. If the patient requires transport and what their mobility is;
   3. If the patient requires an interpreter service, what language for and how we should make contact with them;
   4. If the patient has a disability that requires RJAH to make contact with them in a particular way, e.g. partially sighted person requiring an appointment letter with larger font;
   5. If the patient is considered to be a vulnerable adult;
   6. If the patient is a military veteran; and the referral is linked to their military service
   7. If the patient is an overseas visitor who is not entitled to free NHS care (so that the appropriate charges can be made). This should be discussed with the patient prior to the referral being made.
3. Referrals should be made to a service rather than a named clinician; however patients have the legal right to choose the consultant-led team for their first outpatient appointment. Patients may be offered the choice of an earlier appointment with another consultant-led team but, if a patient turns down this offer, their waiting time clock should continue to tick.
4. As a general principle, before a referral for treatment is made, the Trust expects the patient to be both clinically fit for assessment and possible treatment of their condition, and ready to start their pathway within 2 weeks of the initial referral.

### Process for Referrals Received that Require Commissioner Approval

1. Patients should not be referred for treatment that is not routinely funded as determined by the Commissioner’s current guidelines. Commissioner approval should be sought prior to referral and, therefore, an approval reference should be detailed on the referral. Where this approval reference is not detailed, and the referral letter does not detail the reasons for consultation in terms of meeting exception criteria, contact will be made with the GP in the first instance to clarify.
2. Patients who do not meet the referral criteria will have the referral rejected as an inappropriate referral and the GP informed. The GP is responsible for informing the patient in this instance.
3. All policies relating to ‘Procedures of Low Clinical Value’ or ‘Limited Clinical Effectiveness’ implemented by our English and Welsh Commissioners must be adhered to. Shropshire CCG’s Procedures of Limited Clinical Value policy provides a list of interventions ‘not routinely funded’ by the CCG and the specified

criteria required for the funding of other certain interventions. Patients should not be referred for a low priority procedure unless commissioner approval has been sought in advance. Patients should not be added to the waiting list unless the approval reference has been provided in the referral letter. If there are exceptional clinical circumstances that the clinician believed a patient requires a procedure of limited clinical value, where specified criteria are not met, applications may be considered on an individual basis through an Individual Funding Request (IFR) process. This process should be explained to the patient and the appropriate approval received before the decision to treat is made and patient added to the waiting list. The 18 week clock will continue during this process.

### New Referral Waiting Times

1. RJAH will endeavour to provide a first new outpatient appointment within the timeframe as set out in Section A Operational Standards.
2. RJAH does not recognise a ‘soon’ category for outpatient referrals.

### Outpatient Capacity (New Patients)

1. Under direct booking, in circumstances where a patient calls the national Appointments Line and an appointment slot is not available within the Trust, the national e-Referral Telephone Appointments Line (TAL) will forward the referral request details (UBRN) by email to the Trust. The patient pathway starts from the date the TAL sends the electronic request to the Trust on the Appointment Slot Issues Report (ASI).
2. It is RJAH’s responsibility to ensure capacity is available to meet demand in line with the forecast annual activity and, therefore, contracted levels of activity. Therefore, RJAH’s appointment service must be notified of the lack of appointment availability for patients on the ASI Report within 2 working days of receipt to ensure sufficient time is given to contact the patient and to comply with the internal target of appointing within 5 working days. RJAH will liaise directly with the patient to mutually agree a date for their appointment.

### Patient Choice of Consultant

1. Under the English NHS Constitution and 2015/16 Choice Framework patients have the right to express a preference as to which consultant they wish to be referred to and to have that preference met where practical. RJAH may be able to offer patients an earlier date with another consultant and should advise the patient of this. Patients may only be transferred to another clinician if they have explicitly agreed to this. If the patient declines the offer to transfer then this must not affect their waiting time.
2. Some patients may state that they prefer to be seen/treated by a doctor of a particular gender. RJAH will comply with the patient’s wish if this is possible. Referrers are asked to ensure that this request is included in the referral letter. If the service does not employ a doctor of the required gender within the requested specialty, RJAH reserves the right to return the referral letter to the GP.
3. For Welsh patients, if a transfer of care is offered and declined their clock can be reset. This must be appropriately documented.

### Misdirected Referrals

1. If a referral has been made and the speciality of the Consultant does not match the needs of the patient, the Consultant should cross-refer the patient to an appropriate colleague where such a service is provided by the Trust. In this instance the 18 week clock is still running.
2. If the referral is for a service not provided by the Trust then the referral letter will be returned to the referrer with a note advising that the patient needs to be referred elsewhere. In this instance the 18 week clock will stop. With the eRS system, where a referral is rejected by the clinician, the referrer is responsible for seeking alternative care provision and communicating this to the patient.

### Tertiary Referrals

1. For English patients, a tertiary referral received by the Trust will be expected to include the 18 week national mandatory Inter Provider Transfer Administrative Minimum Data Set (IPT MDS), which includes the date the original Trust received the referral. Consultants referring patients to other providers are required to use the mandatory national 18 week IPT MDS template for each referral. If the IPT MDS form is not received, contact should be made with the referrer to request this information. If any of the above information is missing, the referral should be recorded on PAS and the information actively chased by the central booking office.
2. For Welsh patients, the date of receipt is recorded as the clock start; referrals will be routed per the Local Health Board processes.

### Internal Referrals (Consultant to Consultant Referrals)

1. Every effort will be made to ensure that patients are seen in the correct clinic at the outset of the RTT pathway; however if, following the initial consultation, a decision is made that the patient should be seen by another specialist the RTT clock will continue to tick from the original referral date.
2. Referrals for a different, unrelated condition to the original referral (excluding urgent referrals, suspected cancer referrals and other agreed exclusions) must be discharged and referred back to the GP to support patient choice. Please note that

*Service Condition 8.4, NHS Standard Contract 2014, states with regards to Consultant to Consultant referrals:*

*"Except as permitted under an applicable Prior Approval Scheme, the Provider shall not carry out, nor refer to another provider to carry out, any non-immediate or routine treatment or care that is unrelated to a Service User's original Referral or presentation without the agreement of the Service User's GP."*

1. Consultant to consultant referrals should only be made, in line with Shropshire CCG’s ‘Consultant to consultant referrals policy’, for the following reasons:
   1. Suspected cancer referrals
   2. Clinically urgent referrals e.g. patients requiring an urgent cardiology assessment pre- operatively
   3. Cross specialty referrals related to the original condition
   4. Referrals to a service only accepting Consultant referrals e.g. specialist children’s services
   5. Where it is deemed appropriate for a Consultant to Consultant referral as part of the 18 week pathway for a new condition. Under these circumstances the 18 week clock may be stopped and a new 18 week pathway will commence.

The full policy document is attached at Appendix 6.

1. When a consultant provides a peripheral clinic but has no operating rights at that Trust, e.g. community or Shrewsbury and Telford Hospitals, and need to refer the patient to RJAH for surgery a referral to themselves is permissible, the full minimum dataset (see 5.7.5 below) must be completed, however the ongoing nature of care means any subsequent outpatient appointment will be classed as a follow up. *Note: patients should not be referred to RJAH for ongoing outpatient care or to access diagnostic services, these should be delivered in line with the provider Trust’s contractual arrangements.*
2. The 18 week IPT MDS template will be used for consultant to consultant internal referrals so as to ensure good data quality. The preferred routes for internal referrals to be sent to the Appointments Office are electronic or hand-delivery. These referral systems offer the least opportunity for loss or delay between referring and the referral being received. If a clinician decides to send a referral through the internal post the burden will be upon him/her to ensure the Appointments Office has received the referral within 3 working days.

### Transfer of Care Following a Consultant Leaving RJAH

1. Where patients are transferred from one consultant to another because Consultant A leaves the Trust and patients are transferred to Consultant B the RTT clock will continue.

### Military Veterans

1. All military veterans are entitled to priority access to NHS hospital care for any condition, as long as it's related to their service, whether or not they receive a military pension and length of service is not taken into consideration. They should be seen in an outpatient setting within 4 weeks where their condition is classified as routine and should be treated in accordance with their clinical priority for treatment so as not to disadvantage clinically urgent patients who are not military veterans.

### Referral of Private Patients to NHS Care

1. In line with the ‘Code of Conduct for Private Practice: Recommended Standards of Practice for NHS Consultant’, patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient. The following principles should be applied
2. 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.
3. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients and; in addition
4. Should a patient be 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.

### Referral of NHS Patients to Private Care

1. Where a patient chooses to be treated privately rather than receiving NHS care, the consultant must refer the patient back to the care of their GP detailing all relevant clinical information to ensure there is no delay in the patient’s ongoing care.
2. NB: This does not apply to patients who are being treated in the private sector as a result of capacity shortfalls.
3. Welsh patients wishing to change from private to NHS status must be referred back to their GP or the GP/referral management service for Welsh patients, so that choice can be offered for their onward referral to the NHS.

### REFERRAL PROCESSES

**Registering and Allocating Referrals**

1. E-Referrals for directly bookable services will already be registered onto PAS automatically and appointment dates will already be given except where capacity is not readily available.
2. For indirectly bookable services, the date of contact by the patient is classed as the date of referral. All referrals made outside of e-Referral will be entered on to PAS within one working day of receipt at the Appointments Office. The referral with appointment booking details will then be passed on to the specialty for acceptance or rejection by the clinician.
3. If the referral is rejected by the clinician, the Appointments Office will reallocate the referral to the correct specialty or refer back to the referrer. Accepted referral letters will be stored in a centrally accessible folder to ensure Health Records can access these for health records to be prepped for clinic.
4. If the GP has identified particular requirements for the patient as detailed in section B, para 2, these must be detailed on PAS. This will ensure that any rearranged appointments or requests for admission are made in a format or method that is suitable for the patient.

### Logging of New Referrals When a Referral Already Exists

1. If a patient is already under the care of RJAH and another referral is received for a different condition this will be classed as a new referral. If a referral is received for the same condition (e.g. request for another appointment or an appointment to be brought forward) and the patient has previously been discharged from the service the referral will be classed as new. If the patient is still under the care of the service and has been seen recently or has an appointment in the future then the letter will not be registered as a new referral and instead will be passed on to the relevant Consultant for action.

### Clinical Prioritisation of Referrals

All referrals received through the e-referral service must be reviewed by an appropriate clinical team within one working day of receipt for urgent referrals, and five working days of receipt for routine referrals.

1. The consultant must accept the referral if appropriate to do so, reject the referral or change the service as necessary. Failure to do this will result in patients being turned away from the outpatients department as they have unknowingly been referred incorrectly.
2. For paediatric referrals, consultants must vet all referrals and mark them for the appropriate clinics, time scale and person.

### Closing Referrals Opened in Error

1. If a referral is opened in error, the user closing the referral must always enter ‘Clerical Error’ as Reason for Closure and should ensure that the corresponding RTT Pathway is removed.

### SUMMARY OF CLOCK START AND CLOCK STOP RULES

**(See appendix 7)**

1. Consultant-led services are subject to the 18 week referral to treatment target for English patients, see paragraphs 11 and 13 for Welsh standards. The pathway commences with a ‘clock start’ date and closes with a ‘clock stop’ date at the point of first definitive treatment. A patient’s first definitive treatment is an intervention intended to manage a patient’s disease, condition or injury and avoid further intervention. All patients must be managed according to their clinical urgency and within the operating standard.
2. The Rules Suite Summary below provides an overview of these factors but further information should be obtained from the Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care guidance (NHS England, 2015; Welsh Assembly, April 2017).

### Clock DOES NOT start

1. There is a range of activity that is not subject to the referral to treatment 18 week target. Referrals for these services do not start an RTT clock:
   1. Outpatient services not led by a Consultant
   2. Direct Access Diagnostic Services
   3. Any subsequent activity AFTER a clock stop has been initiated for treatment (unless subsequent treatment is required).
2. Relevant National RTT Status Codes – Clocks Not Applicable. All relevant steps in the patient pathway must be recorded using nationally recognised RTT Status Codes. This includes a range of codes to identify that a clock is not applicable. These must be added accurately and in a timely manner and are:

|  |  |  |
| --- | --- | --- |
| Code 90 | After treatment (i.e. any activity after first definitive treatment has occurred) | It is unlikely this code would be used for a new outpatient appointment |
| Code 91 | Active monitoring during activity not part of 18 week RTT period | Should never be used for a new outpatient appointment |
| Code 92 | Patient not yet referred for treatment,  undergoing direct access diagnostic | To be used by diagnostic services only |
| Code 98 | Activity not applicable to 18 weeks |  |

### Clock Starts

1. A waiting time clock starts when any care professional or service permitted by an English NHS Commissioner or Welsh Local Health Board to make such referrals, refers to:
   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 health professional or general practitioner (GP);
      1. The date of receipt by RJAH is the clock start date for these categories of referral. In the case of an E-referral system referral, the clock start is recorded as the date that the patient converts their Unique Booking Reference Number (UBRN).
      2. If a patient is booked into a Clinical Assessment or Advice and Guidance Service the clock starts on the date the GP referred the patient, not the date of the appointment.
   2. An interface, referral management or access 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 (GP);
      1. In general, if this service has only assessed the patient then the clock start will commence on the date that the referring service received the referral from the patient’s GP.
      2. If the interface service provided a first definitive treatment that was subsequently determined to be unsuccessful, or if the patient is referred on following active monitoring, then the clock start date will be when RJAH receives that referral.
      3. The interface, referral management or access service must provide details of the clock start date when referring the patients to the Trust using the appropriate form. The Shropshire Orthopaedic Outreach Service (SOOS) should also ensure this information is provided for any patients referred on to RJAH.
      4. For referrals from Welsh Interface services (e.g.CMATS) the clock will start from the date that RJAH receives the referral

### Self-Referrals

1. A waiting time clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers.
2. Welsh patients are allowed to self-refer back in for up to 6 months when removed from waiting list for reasons other than treatment e.g. patient choice, this starts a new RTT clock.
3. The clock start date will be the date of contact by the patient.

### Consultant to Consultant Referrals

1. The following should be read in conjunction with the Consultant-to-consultant referrals policy (September 2015) <http://edms/doc/Pollib/Consultant%20to%20Consultant%20(C2C)%20referrals%20Shropshire%20Clinical>

%20Commissioning%20Group%20Patients%20Policy.docx

### Consultant to Consultant Referrals (same condition)

1. If the referral is from one consultant-led service to another for the same condition (e.g. clinician refers to a colleague who may sub specialise in the management of a specific condition) the clock start is the date

the initial referral was received by RJAH. Consultant-to-consultant referrals for the same condition do not start new RTT clocks.

### Consultant-to-Consultant Referrals (different condition)

1. These types of referrals are not permitted by Commissioners (except Powys Local Health Board) unless this would cause unnecessary delay in care that would affect the patient’s wellbeing and should be referred back to the GP or GP/referral management centre (The exceptions are as described in the Consultant to Consultant policy, which includes concept of referred pain see link above.

### Consultant-to-Consultant Referrals (from an emergency setting to an elective setting)

1. When a clinician in an emergency setting (including at other hospitals, e.g. Wrexham, Shrewsbury, etc) makes an outpatient referral requesting that the patient is reviewed on an elective basis, the clock starts on the date that the consultant decides to refer and not the date when the referral is received (except for Welsh patients, where the date received is recorded). These referrals should only be made where referral back to the GP would cause unnecessary delays in care that would affect the patient’s wellbeing.
2. In cases where a patient has been initially admitted on a non-elective pathway (an emergency setting) and it is identified that they require further treatment as an elective patient, the start of the RTT clock is the date that a decision to list was made. It is imperative that the date of decision to list is clearly noted in the medical records.
3. Where a decision to list cannot be made during the non-elective episode (e.g. the team caring for the patient need to refer to another specialty for further advice or to carry out the procedure), the RTT clock will start on the date of referral to the other consultant-led team. Again, this must be clearly noted in the medical records.
4. If referrals to RJAH are required from other hospitals an Inter Provider Transfer Administrative Minimum Data Set (IPT MDS) should be completed to ensure all appropriate data is recorded.

### Relevant National RTT Status Codes – Clock Start

1. All relevant steps in the patient pathway must be recorded using nationally recognised RTT Status Codes. These must be added accurately and in a timely manner and are:

|  |  |
| --- | --- |
| Code 10 | First activity in referral to treatment period OR subsequent different period |
| Code 11 | End of active monitoring – first activity at the start of a new RTT period |
| Code 12 | Consultant review – new RTT for a separate condition |

### Other Reasons for a Clock Start

1. Upon completion of a consultant-led referral to treatment period, a new waiting time clock only starts:
   1. When a patient becomes fit and ready for the second of a consultant-led bilateral procedure. It is imperative that the date the patient becomes fit and ready is clearly noted in the patient’s medical record and confirmation that the procedure meets commissioning standards, e.g. relevant Oxford score.
   2. Upon the decision to start a substantively new or different treatment that does not already form part of that patient’s agreed care plan. The clock should start at the point the decision to treat is made and this must be clearly noted in the patient’s medical record. The decision about whether treatment is substantively new or different from the patient’s agreed care plan is a clinical one that must be made locally by a care professional in consultation with the patient.
   3. Upon the patient being re-referred to a consultant-led, interface, or referral management/assessment service as a new referral by a clinician. When a patient has been discharged back to the care of the referring healthcare professional, any new referral, even if this is for the same condition that has worsened or an original treatment plan hasn’t worked, must start a new clock in line with the guidelines previously mentioned.
   4. When a decision to treat is made following a period of active monitoring. The clock should start from the date the decision to treat is made and this should be clearly noted in the patient’s medical records.
   5. When a patient rebooks their appointment following a first appointment DNA that nullified their earlier clock. The section on patients who do not attend their appointment provides further detail on this aspect.

### Clock Continues

1. When the patient is continuing on a pathway and does not meet the criteria for a clock stop (see next section), their RTT position must be recorded accurately and in a timely manner. For example, they may require further investigations to be carried out or they are added to a waiting list. Their continuing care prior to a treatment decision being made may possibly be carried out at a different hospital and this should also be recorded accurately and in a timely manner.
2. Where a patient requires 'thinking time' of less than 2 weeks, their clock continues see paragraph 89 below. If a patient requires more thinking time this should be with the support of the clinician and it may be appropriate to initiate a period of active monitoring.

### Relevant National RTT Status Codes – Clock Continues

1. All relevant steps in the patient pathway must be recorded using nationally recognised RTT Status Codes. These must be added accurately and in a timely manner and are:

|  |  |
| --- | --- |
| Code 20 | Subsequent activity prior to treatment (e.g. diagnostic investigation required, further outpatient appointment required, patient added to the inpatient waiting list) |
| Code 21 | Transfer to another healthcare provider (e.g. to another hospital) |

### Clock Stops for Treatment

1. A clock stops for treatment when a first definitive treatment (clinical judgement) has started such as:
   1. Treatment provided by an interface service.
   2. Treatment provided by a consultant-led service.
   3. Treatment provided by a therapy or healthcare science intervention provided in secondary care where this is determined as the best way to manage the patient’s disease, condition or injury and avoid further interventions.

### Clock Stops for Non-treatment reasons

1. A waiting time clock stops when it is communicated to the patient, and subsequently to their GP and/or other referring practitioner without undue delay that:
2. It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care. The clock stops as the wait for the hospital consultant-led service and pathway ends.
3. A clinical decision is made to start a period of active monitoring. Active monitoring (watchful waiting) caters for periods of care without (new) clinical intervention, e.g. 3 monthly routine check-ups. This 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, e.g. if they wish to see how they cope with their symptoms without treatment. Active monitoring should not be applied for short periods of time (2 weeks), or where a patient wants to have a particular diagnostic test/appointment or other intervention but wants to delay this appointment.
4. A patient declines treatment having been offered it*.*
5. A clinical decision is made not to treat.
6. A patient DNA’s their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient with sufficient notice in line with English and Welsh rules (see later guidance on DNA’s). For English patients this means minimum of three weeks’ notice or verbal confirmation at shorter notice. For Welsh patients this means a mutually agreed appointment.
7. Patients who do not attend further appointments or admission will have their pathway reviewed by the consultant Should the consultant decide it is in their best clinical interest to be discharged back to the care of their GP, the RTT clock is stopped.
8. Consultant to Consultant referrals – When a patient is transferred between consultants for reasons of clinical necessity that prevents the current pathway being completed, the clock will stop and will start a new pathway and this will start on the receipt date of the referral to the second consultant. This is for Powys patients only (See appendix 7)

### Relevant National RTT Status Codes – Clock Stops

1. All relevant steps in the patient pathway must be recorded using nationally recognised RTT Status Codes. This includes a range of codes to identify that a clock is not applicable. These must be added accurately and in a timely manner and are:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Code 30 | Start of first definitive treatment | | To be used regardless of whether a patient is discharged or not, e.g. a patient may have received treatment but is still under the care of the consultant | | |
|  | Code 31 | Start of active monitoring – initiated by  patient | | For patients on a non-admitted pathway only | | |
|  | Code 32 | Start of active monitoring – initiated by care | | For patients on a non-admitted pathway only | | |
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|  |  |  |
| --- | --- | --- |
|  | professional |  |
| Code 33 | Patient did not attend very first appointment (e.g. first OP appointment/diagnostic  appointment) | For patients on a non-admitted pathway only |
| Code 34 | Decision not to treat by clinician or used for any subsequent DNA’s after the first  appointment (e.g. follow-up appointments) |  |
| Code 35 | Patient declined offered treatment |  |
| Code 36 | Patient died before treatment |  |

**DELAYS TO TREATMENT**

### Clock Pauses – ENGLISH PATIENTS

1. Clock Pauses can no longer be applied to patients on active pathways.

**Clock Restarts for Patients who ‘Could not Attend’ – WELSH PATIENTS**

1. The following can only be applied once to each stage of a Welsh patient’s pathway and a reasonable offer must have been made/agreed with the patient.
2. Patients who notify the hospital that they can no longer attend a previously agreed appointment for any stage along the pathway should be treated as a ‘Could Not Attend’ (CNA). A patient may have multiple CNAs within their RTT period, but only one CNA within each stage of the pathway.
3. On the first CNA within a stage of the pathway, the clock should be reset to the date on which the patient notifies the organisation of their inability to attend the appointment. A new appointment should be made as soon as the patient is available.
4. On the second CNA within the same stage of the pathway, the patient should be removed from the waiting list, and responsibility for ongoing care returns to the referrer. Appropriate notification of removal must be given to the patient and the referrer.
5. If the consultant responsible for the patient considers that they should not, for clinical reasons, be removed from the pathway following a second CNA, the clock will continue and no further adjustment or reset can be applied.

### Patients who wish to delay their treatment for longer periods of time – ENGLISH PATIENTS

1. It is generally not in a patient’s best interest to be left on a waiting list for an extended period, and so where delays (i.e of many months) are requested by patients a clinical review should be carried out. There is no set maximum length to a patient initiated delay, however clinicians should provide booking staff with guidelines as to how long (in general) patients should be allowed to defer their treatment without further clinical review. Patients requesting a delay longer than this should have a clinical review to decide if this delay is appropriate. Clinicians are responsible for explaining the patients’ responsibilities in terms of being available within 18 weeks/26 weeks for any potential treatment. A patient should only be placed on an active waiting list for surgery if:
   1. The patient is clinically ready, fit and available to undergo surgery
   2. There is a sound clinical indication for surgery
   3. If the clinician is satisfied that the proposed delay is appropriate then the Trust should allow the delay, regardless of the length of wait reported. (Please refer to SOP on patient initiated delays)
2. If the clinician is not satisfied that the proposed delay is appropriate then the clinical risks should be clearly communicated to the patient and a clinically appropriate procedure date agreed; if the patient refuses to accept the advice of the clinician then the clinician must act in the best interest of the patient.
3. It is not acceptable to refer a patient back to their GP simply because they wish to delay their appointment or treatment.
4. If the clinician feels it would be in the best clinical interest of the patient to discharge the patient back to the care of their GP and inform them that treatment is not progressing then this must be made clear to

the patient. This must be a clinical decision, taking the healthcare needs of each individual patient into account.

1. If the clinician feels the requested delay is clinically acceptable but the clinician believes the delay will have a consequential impact (where treatment may fundamentally change during the period of delay) on the patient’s treatment plan, the patient will be placed on active monitoring (clock stops).

**Patients who wish to delay their treatment for longer periods of time – WELSH PATIENTS**

1. When a patient is unavailable due to social reasons, an adjustment to the RTT period may be applied. When the period of unavailability is:
   1. Less than two weeks, no adjustment may be made;
   2. Between two and eight weeks, an adjustment may be made for the full period of time that the patient is unavailable;
   3. More than eight weeks, the patient should be returned to the referrer and the RTT period will end.

### Patients who are medically unavailable – ENGLISH PATIENTS

1. If a patient is not fit for surgery the Trust will ascertain the likely nature and duration.
   1. **Long term medically unfit patients** - If the clinical issue is more serious than the patient requires optimisation and/treatment for it, clinicians should indicate to the waiting list office:

* If the patient should be optimised/treated within secondary care (active monitoring clock stop) or if they should be discharged back to the care of their GP (clock stop).
  1. **Short term illnesses** - if the clinical issue is short term and has no impact on the original clinical decision such as a cold, then patients should contact the waiting list office and agree a new TCI date, normally within 3 weeks of the original date. This will allow patients with minor acute clinical reasons for delay such as a chest infection time to recover. The 18 week clock will continue to tick during this time. If the patient is not fit after that period they will be discharged and returned to their GP where this is clinically appropriate for the management of their on-going chronic clinical condition. This will stop the 18 week clock. Re-referrals should then be made by the GP when the patient is fit which will result in a new pathway and clock start.

**Patients who are medically unavailable – WELSH PATIENTS**

1. When a patient is unavailable due to a short-term medical condition, an adjustment to the RTT period may be made.
   1. If, in the opinion of a suitably qualified healthcare professional, the patient has a condition which will be resolved within 21 days, the patient should remain on the active waiting list and an adjustment may be applied. The adjustment should start from the date of the decision that the patient is medically unfit to the date that the patient is declared fit for the procedure. This period must not exceed 21 days in each stage of the pathway.
   2. If a patient is reviewed after the expected recovery period and recovery has not been effective, or a further condition has developed, the patient should be returned to the referring clinician, or another clinician who will treat the condition, and the RTT period will end.
   3. A second 21 day period cannot be applied within the same stage of the pathway.

## APPOINTMENT CANCELLATIONS (CNA) OR FAILURE TO ATTEND (DNA)

1. The inpatient and outpatient booking teams will ensure that for the booking of routine appointments and admissions, all patients should be provided with reasonable notice (i.e. a choice of 2 dates with at least 3 weeks’ notice). Where clinical urgency dictates the notice period is shorter, choices should be offered and agreed with the patient in person and confirmed with a letter.

### ENGLISH PATIENTS

**Patient Cancellation/Alteration of NEW Outpatient Appointment**

1. If a patient no longer requires their new appointment, the outpatient waiting list entry is removed and the 18 week clock stopped. The referrer must be informed of the patient’s decision to cancel their referral.
2. The clock continues if a patient chooses to alter their appointment to a later date unless they do this on 2 consecutive occasions. RJAH should endeavour to ensure that the cancellation does not result in an extended waiting time beyond 10 weeks. Where a patient cancels a second appointment a clinical review will be undertaken. The RTT clock stops if the clinician indicates that it is in the patient’s best interests to be discharged back to their GP/referrer.

### Patients Who Do Not Attend (DNA) an Outpatient Appointment

1. The act of a patient failing to attend their first appointment following the referral that started their waiting time clock stops and nullifies a patients’ waiting time clock (provided that the provider can demonstrate that the appointment was clearly communicated to the patient).
2. For these patients it is necessary to nullify the record, therefore removing from numerator and denominator in the RTT data returns.
3. Children and vulnerable patients should be offered a further appointment, then a new clock will start on the date that the patient agrees the new appointment date (not the date of the rescheduled appointment itself)..

See separate SOP on Management of Children who Fail to Attend Appointments/Admissions (DNA) Guidelines

1. For all other patients, the patient’s health records should be reviewed in accordance with our DNA SOP and a decision made regarding offering a further appointment. If a further appointment is not offered then the referrer and patient will be informed. If it is appropriate to offer the patient a new appointment, then a new clock will start on the date that the patient agrees the new appointment date (not the date of the rescheduled appointment itself).
2. If patient contacts RJAH within 21 working days of the DNAd appointment date with genuine reasons for failing to attend, e.g. on holiday when an appointment letter was sent to them or admitted in hospital elsewhere, their referral will be re-opened and a new appointment agreed with them providing reasonable notice. The RTT clock will start from the date that contact was made by the patient.
3. An inability to contact Welsh patients when they have not responded to the booking process within 4 weeks from the date of the DNA letter sent, should be removed from the waiting list and the referrer and patient notified. This does not apply to Children and Vulnerable Adults. **Patients who DNA subsequent appointments**
4. The act of a patient failing to attend their first appointment following the referral that started their waiting time clock stops and nullifies a patients’ waiting time clock (provided that the provider can demonstrate that the appointment was clearly communicated to the patient).
5. Patient DNAs at any other point on the RTT pathway will not automatically stop the RTT clock, if the patient is being discharged back to the care of their GP as per the national rules. The action of discharging the patient will stop the clock provided that:
   1. It can be clearly demonstrated that the appointment was clearly communicated to the patient with reasonable notice;
   2. Discharging the patient is in the best clinical interests of the patient which may only be determined by a clinician;
   3. Discharging the patient is carried out according to local, publicly available, policies on DNAs
   4. These policies are clearly defined and specifically protect the clinical interests of vulnerable patients and are agreed with clinicians, commissioners, patients and other relevant stakeholders.
6. If the above criteria are fulfilled the RTT clock stops on the date that the patient is discharged back to the care of their GP.

### Patients who Cancel Two or More Consecutive Appointments

1. Patients who cancel two or more consecutive outpatient appointments (including pre-operative assessment appointments) will not automatically be offered a further appointment. The patient’s case will be referred to the owning consultant for review and a decision made as to whether the patient should be discharged back to the care of the GP based on. the patient’s best clinical interests. The consultant must write to the patient and the GP notifying them of this decision. The RTT pathway should be closed by the consultant’s secretary in this instance unless the decision was made in an outpatient setting. If a decision is made to offer another appointment, the clock continues. For children, the separate SOP on management of children who fail to attend appointments/admissions DNA guidelines.

### Discharge and Cancelling of Outpatient Referrals Following a DNA/Cancellation

1. When a patient DNA’s or cancels their appointment and the clinical decision is made to discharge the patient, the receptionist or member of staff responsible must discharge the patient on PAS. The receptionist or member of staff responsible must ensure the patients referral is always closed and updated the reason for discharge as Patient DNA or multiple CNA’s. A letter to the GP and patient must be produced and sent following every case of discharge.

**WELSH PATIENTS**

1. Patients who have not kept a reasonable appointment at any stage along the pathway and have failed to tell the hospital in advance that they will not be attending are identified as a ‘Did Not Attend (DNA)’. If the patient does not attend, the clock stops and the patient should be returned to the referrer.
2. If the patient is re-referred, or if the referrer seeks to reinstate the patient within a given timescale, a reinstatement should take place at the clinically most appropriate place on the pathway and a new clock would start at the receipt of the referral.
3. If a Consultant overrides the DNA protocol for clinical reasons then the clock would continue whilst the Provider actively seeks to make contact with the patient.
4. The DNA guidance above does not apply to children, if a child DNAs an appointment at any stage of the pathway their 26 week clock should continue.
5. Two CNA’s in the same stage of the pathway for adult patients, if reasonable offers have been made, will stop the clock, and the patient should be discharged and returned to their GP. There should be a clinical decision to discharge in the case of children’s appointments.
6. The DNA reset may be applied on a maximum of 2 occasions in any one RTT pathway. Confirmation of any reset must be communicated verbally or by letter to the patient.

## HOSPITAL INITIATED CANCELLATIONS

1. Hospital-initiated cancellations are to be avoided wherever possible. Compliance with partial booking rules, waiting times for new patients, leave notice periods and appropriate planning for services should minimise the requirement for RJAH to cancel patients booked into clinics.
2. Where this is unavoidable (e.g. sickness), previous cancellations should be taken into consideration and RJAH will ensure that patients are not cancelled more than twice in succession. Patients should not be moved to an appointment that is more than 4 weeks ahead of their current appointment without clinical involvement in this action. Clinicians must review each affected patient’s case within 5 working days of request.
3. If a clinician takes a decision to cancel a patient (e.g. a slot needed for an urgent patient); they must liaise with the Divisional Manager regarding their RTT status. If the patient to be cancelled is identified as a breach (or will become one within 6 weeks) the clinician must work with the relevant Divisional Manager to solve the potential breach.

## CLINIC OUTCOME AND ATTENDANCE STATUS

1. All patients must have their clinic attendance recorded on PAS (Lorenzo) to ensure the activity is recognised. This should be recorded in real-time (on the day of clinic) and all staff in an outpatient setting are responsible for ensuring this is complied with.
2. Clinic outcome forms capture important details to ensure that RJAH correctly reports RTT performance and that any outpatient procedures are recorded and coded so that RJAH receives the appropriate income for these (Appendix 4). It is the responsibility of all staff in a clinic setting to ensure that an outcome form is completed for all patients. The RTT status must be accurately captured in line with the 18 week Rules Suite Guidance (see link in the Introduction).
3. The outcome and procedure for coding recorded on this form must be entered in PAS (Lorenzo) by the person responsible for this duty, e.g. a receptionist, at the end of the clinic session but no more than **2 working days** of the clinic closure.

### Discharge When Treatment Complete

1. When a patient is discharged from a clinic, the receptionist or member of staff responsible (i.e. nurse) must discharge the patient on PAS. The receptionist must ensure the patient’s referral is always closed. A letter to the GP and patient, if requested, must be produced and sent following every case of discharge by the responsible person.

## THE MANAGEMENT OF FOLLOW-UP APPOINTMENTS

1. Follow up appointments must only be arranged where it is deemed clinically necessary and in line with discharge protocols where these are available. (see the SOP relating to Hip and Knee replacement follow

ups in Appendix 5). Where patients require a follow up appointment a waiting list entry should be created. The appointment should be agreed and arranged prior to leaving clinic for urgent review (i.e. within the following 3 months). Where the appointment has not been agreed in clinic a waiting list entry should ensure the appropriate ‘appointment due by’ date is entered as indicated by the clinician and any tests or investigations required on arrival at the appointment are detailed on PAS. The patient’s GP must be informed of the timeframe for subsequent follow-up.

1. Each Divisional Manager is responsible for managing the Follow-up Outpatient Waiting List in conjunction with the clinicians, ensuring that all patients are booked an appropriate follow-up in the agreed timescale and with reasonable notice.

### Where Demand Exceeds Capacity

1. At times demand may exceed capacity and this should be proactively managed by the responsible Divisional Manager and Consultant. Where it is not possible to see patients within 4 weeks of the agreed timescale for their follow-up appointment the Divisional Manager will agree appropriate action with individual clinicians to address the problem. The responsible clinician should review each patient’s case within **5 working days** of the request.
2. Where there are clinical concerns within specialties that have major shortfalls in capacity that cannot be resolved internally this needs to be escalated through the risk management system and appropriate action agreed with commissioners.

## CLINIC CODES AND TEMPLATES

1. Clinic codes and standard templates within subspecialties must be set up and reviewed on an annual basis to support the annual activity planning process and to ensure that performance measures are valid. This should include:
2. Validation that the clinic code is still in use; and
3. Review of the clinic template compared to demand and new-to-follow-up ratio performance.
4. Where changes are required to a clinic template, these must be authorised by the Divisional Manager for that service. Divisional Managers are responsible for quantifying the effect of clinic template changes on their capacity to treat patients and where necessary ensuring that capacity is put in place to treat patients by their waiting time target.

### Change Required to an Existing Clinic Template

1. Where template changes are approved, an E-referral administrator must be informed. If adequate notice, **at least 7 working days**, is not provided, it is possible that changes may not be made by the required date.

### Introduction of a New Clinic Session/Template

1. It is the responsibility of the Divisional Manager to agree arrangements at the business planning stage with supporting departments (e.g. imaging, pharmacy, facilities, medical engineering) to ensure that adequate resources are provided to enable all aspects of the new clinic to run effectively. It is essential that this process includes the room requirements and this should be agreed with Outpatients. Where clinic room capacity is not available in hours, consideration may need to be given to evening or weekend sessions, therefore, having an effect on the proposed job plan.
2. Once a full evaluation of the new clinic session has been undertaken, the Divisional Manager will ensure that authorisation is gained from the Director of Operations at least 7 weeks in advance. This does not include replacement clinic sessions or changes to existing clinic templates.

## CLINIC CLOSURE

1. To minimise the impact on patient experience, inefficiencies for resources and costs associated with last minute ‘routine’ patient additions to outpatient clinics, the clinic session will be closed 72 hours prior to the appointment date. Where there is a clinical requirement for this operational standard to be over-ruled, the consultant will contact the Appointments Office to provide authorisation.

## HEALTH RECORDS AVAILABILITY

1. A patient’s health records must be available for all outpatient appointments. If they are not available, this may result in the patient being cancelled and RTT waiting times delayed as a result. The Trust has implemented a ‘paperlite’ process and increasingly clinics will be run with legacy case notes scanned into EPR.

## CLINICAL DECISIONS MADE OUTSIDE OF OUTPATIENT AREAS

1. There may be instances where a clinician reviews test results outside the Outpatient setting with the intention of informing the patient and their General Practitioner of the outcome e.g. results normal and discharged; requires follow up to discuss results. In this instance the clinician is required to document the outcome in a clinical letter to the patient and/or GP.
2. Following this each medical secretary will be required to complete the outcome of attendance screen in PAS (Lorenzo) with the appropriate RTT status code AND if appropriate add a waiting list entry and/or create an appointment as per the Standard Operating Procedures supporting this Policy. Any decisions outside of clinic should be recorded with the correct date to reflect the date the decision was made and communicated to the patient.

## CLINIC SESSION CANCELLATIONS, REDUCTIONS OR REINSTATEMENTS

### Clinic Session Cancellations or Reductions

1. All clinic session changes must be made with appropriate notice so as not to affect the patient experience, i.e. with more than 6 weeks’ notice. Clinical Teams must provide appropriate notice of their leave requirements and it is the responsibility of Divisional Managers to ensure that the processes supporting authorisation of such leave result in at least 6 weeks’ notice being provided to the Outpatient Team. RJAH requires that no more than 10% of clinic cancellations or reductions are made with less than
2. weeks’ notice and in order to comply with this, and allow for administrative processes following submission, a minimum of a further 2 weeks’ notice prior to leave request submission should be allowed,

i.e. a total of 8 weeks’ notice where clinical activity is going to be affected.

### Short-Notice Clinic Sessions Cancellations or Reductions (e.g. <6 weeks’ notice)

1. If a short notice cancellation is necessary, e.g. due to sickness, where appropriate the clinician/Divisional Manager should arrange cover of the list with colleagues within the speciality, ensuring that all relevant staff are informed of any change. Where appropriate, patients will be pooled within specialities unless

clinical or governance issues dictate this is inappropriate. It is not appropriate for clinic sessions to be reduced or cancelled at short notice to attend meetings if patients are affected and where this cannot be avoided clinical review of the patients will be undertaken within 2 working days of the cancellation/reduction being requested or preferably beforehand.

1. Corporate departments should consider appropriate notice when requiring clinical attendance at meetings/events

### Clinic Reinstatements

1. Clinic Sessions cannot be reinstated without 4 weeks’ notice.

### Additional Clinic Sessions (OJP)

1. Where additional clinic sessions are required, 4 weeks’ notice must be provided in order to ensure the appropriate staffing levels are planned in advance. The only exception is additional clinic sessions for 2ww referrals.
2. During an RTT pathway, it may be identified that a patient requires admission for treatment requiring addition to an inpatient waiting list. These patients are classed as being on the ‘admitted pathway’ for RTT performance monitoring purposes. Admitted patient pathways cover patients on the elective or booked admission waiting list. Planned admissions are excluded from active RTT monitoring.
3. When a patient is admitted to the waiting list, validation of a patients’ RTT status should be undertaken to ensure the appropriate clock start and breach date is recorded.

### Adding Patients to a Waiting List

1. A patient should only be placed on an active waiting list for surgery if:
   1. The patient is clinically ready, fit and available to undergo surgery
   2. There is a sound clinical indication for surgery.
2. The consultant in charge has overall responsibility for defining the patient’s operation and associated resources/stock requirements. This should be recorded on the trusts theatre system, Bluespier, in line with the Theatres Scheduling and Booking Procedure.
3. Clinicians must not place a patient on a waiting list to reserve a place against the possibility that treatment may be necessary in the future. If the clinician requests an opinion, e.g.for a patient with angina, a consultant-to-consultant referral can be made for an opinion after the patient is added to the waiting list where it is believed that the patient is clinically ready and fit for the procedure. In this instance the RTT clock continues.
4. Patients should be added to the waiting list on PAS (Lorenzo) within **2 working days** of the decision being made to treat. Patients for elective surgery under general anaesthetic will undergo pre-operative assessment. Patients admitted for elective surgery will undergo MRSA screening prior to admission.

### Patients Requiring Admission Under Two Separate Sub-specialties

1. Where patients are under the care of two separate specialties for two separate conditions and both conditions require admission for treatment, the patient should remain on both lists. If at the time a TCI is offered for one of the procedures, the patient is not fit, ready and available due to the other procedure, a period of active monitoring should be initiated as per the medically unfit principles. Where a procedure is a minor procedure that does not require general anaesthetic it may be appropriate to proceed. This should be confirmed with the consultant.

### Children Under the Age of Two Requiring Admission

1. Prior to listing a child under the age of two for elective surgery, all requirements of the Paediatric admission policy must be met and documented accordingly.

### Admission Dates

1. All patients must be admitted on the day of their operation, unless the Pre-Operative Assessment Team or Clinician clearly identifies a clinical need to dictate otherwise; this must clearly be recorded on PAS (Lorenzo). Patients should be provided with reasonable notice of an offer of admission (i.e. a choice of 2 dates with at least 3 weeks’ notice).
2. Patients should be prioritised in order of clinical need first and foremost and then in RTT breach date order. In order to comply with clinical need.
3. Patients will be provided with reasonable notice of an offer of admission (2 dates with 3 weeks’ notice). If they decline these dates and a third offer with reasonable notice is provided which they subsequently decline, the consultant will be informed. and a clinical review will be undertaken in accordance with para 67-72.

### Planned Waiting Lists

1. Patients on a planned waiting list are waiting to be admitted as part of planned sequence of treatment or investigation. Patients on the planned waiting list are not routinely on an RTT pathway. The planned list may include:
2. Patients who require periodic review as an inpatient/day-case in order for an ongoing condition to be monitored (e.g. surveillance cystoscopy);
3. Patients for whom the clinical team may request that a period of time elapses following initial treatment before any subsequent treatment is undertaken (e.g. a Trauma & Orthopaedic surgeon may request that metalwork inserted to support healing of a fracture is only to be removed after a certain period of time);
4. Patients undergoing a series of treatments (e.g. a patient may attend for a course of pain- relieving injections on a 6 monthly basis);
5. The procedure has to be performed at a set point linked to a clinical criteria, e.g. where a child needs to be 4 years old before a procedure can be performed OR where the date of admission is determined by the needs of the treatment, e.g. a child needs to be a certain size.
6. The planned waiting list must not be used to hold patients who wish to defer surgery or are unable to have surgery due to underlying medical conditions.
7. All patients on the planned list must have an ‘expected date of admission’ which should not be exceeded. When a patient on a planned list does not have the procedure by their ‘due date’ they will be managed in accordance with RTT rules and an RTT clock will start.
8. In planning capacity, Divisional Managers must take into account patients waiting for planned procedures and take into consideration that they may require a series of treatments throughout the year. Where a series of treatments/investigations are required only the next treatment/investigation due will be added to the waiting list. Therefore, when planning capacity requirements these must be taken into account.

### Bilateral Procedures

1. Bilateral procedures are defined as surgical operations performed on both the right and left side of a patient’s body. Where this procedure is necessary in two operative sessions, the 18 week clock will be

stopped following the first operation/treatment. At the point the patient becomes fit and ready for the second stage of the treatment, a new 18 week clock will start and this must be clearly recorded in the clinic note.

### CANCELLATIONS, ALTERATIONS OR FAILURE TO ATTEND FOR ADMISSION

1. Cancellations or alterations of an admission date can occur prior to, or following, the acceptance of an admission date.

### Patient Cancellation BEFORE Admission Date Agreed

1. If a patient is uncertain about going ahead with treatment, the relevant clinician will be notified and asked to provide an update for the waiting list status in writing. It may be appropriate to discharge the patient and refer them back to their GP, where their ongoing care will continue to be managed within primary care. If and when the patient feels ready for treatment they can ask their GP to re-refer them. Referral back to the GP in this scenario would stop the RTT clock and a new RTT clock would start when the Trust receives a new referral.
2. Welsh patients are allowed to self-refer back in for up to 6 months when removed from waiting list for reasons other than treatment or patient choice, this starts a new RTT clock.

### Patient Cancellation AFTER Admission Date Agreed

1. If a patient no longer requires their operation and wishes to cancel their appointment date and hence their 18 week pathway, the waiting list entry is updated and closed on PAS (Lorenzo) and the RTT week clock stopped. This request should be discussed with the relevant clinician and the GP informed of the decision made.

### Patient Alteration AFTER Admission Date Agreed

1. If a patient wishes to alter their admission date the clock continues, please see para 67-72 on lengthy delays. (For Welsh patients see Could Not Attend guidelines)

### Hospital Initiated Cancelled Operations on the Day of Admission

1. If a patient’s first definitive treatment is cancelled on the day of admission for non-clinical reasons the 18 week clock continues, e.g. due to lack of theatre availability. Patients must be readmitted within 28 days of the original admission date. This should be escalated to the Divisional Manager if this will result in an unexpected breach of the 18/26 week target OR a waiting time that now exceeds 35 weeks.
2. If a patient’s first definitive treatment is cancelled on the day of admission for clinical reasons and the patient no longer requires treatment, the clock stops, e.g. after admission, it is discovered that the patient is not clinically suitable for the operation, the situation is discussed with the patient and it is agreed the surgery will not be performed. The patient is discharged and the RTT clock will stop. If the patient is deemed temporarily unfit for surgery, e.g. for a chest infection, then the RTT clock should continue to tick and another date agreed when they are fit.
3. Patients who do not attend for a planned procedure will have their pathway reviewed by their consultant, with the exception of vulnerable patients, e.g. cancer patients and children. If the patient falls into these categories or had been prioritised as urgent the patient’s health records must be reviewed by the Consultant and a decision made regarding offering a further admission date. If the patient’s consultant decides that they should be offered a further admission date, the RTT clock continues to tick. Should the patient’s consultant decide that it is in their best clinical interest to be discharged back to the GP, the RTT clock is stopped.

### MAINTAINING WAITING LISTS – OUTPATIENT AND INPATIENT

1. All waiting list entries will be made using the Standard Operating Procedures governing this process. Waiting lists should be kept up to date by staff with waiting list management responsibility using data received from various sources. To ensure consistency and the standardisation of reporting all waiting lists are to be maintained using the Trust’s Information system. All waiting list entries must be made within the Patient Administration System, manual card based/diary systems are not acceptable. Entries in the Bluespier theatre system will not automatically populate the Patient Administration system and therefore entry in both is necessary.

### Procedures Requiring Commissioner Approval

1. Commissioner policies on ‘Value Based Commissioning’ and ‘Limited Clinical Effectiveness’ provide a list of interventions ‘not routinely funded’ and the specified criteria required for the funding of other certain interventions should be followed. Patients should not be referred for a low priority procedure unless commissioner approval has been sought in advance. Patients should not be added to the waiting list unless the approval reference has been provided by the Commissioner. If there are exceptional clinical circumstances that the clinician believed a patient requires a procedure should be undertaken, where specified criteria are not met, applications may be considered on an individual basis through an Individual Funding Request (IFR) process from the appropriate Commissioner (Shropshire NHS England or Wales). This process should be explained to the patient and the appropriate approval received before the decision to treat is made and patient added to the waiting list. The 18 week clock will continue during this process.
2. ALL staff responsible for managing waiting lists must ensure they validate the waiting lists on a weekly basis to include the review of:
   1. Long waiting patients without dates for outpatient or inpatient care including planned procedures
   2. Long waiting patients with a date outside of their 18 week breach date (open pathways)
   3. Long waiting patients with an outpatient appointment date outside of their expected review date (closed pathways)
   4. Duplicate Referrals
   5. Outstanding ‘Logs’
   6. eRs Outpatients for Booking List (TAL/ASI report)
3. Waiting list data will be published on working days via the information distribution system. Summary data will be made available to the weekly Patient Tracking List and Activity meetings.

### Escalation Process where Demand Exceeds Capacity

1. Where demand exceeds capacity and patients cannot be admitted within their 18 week breach date, this must be escalated to the Divisional Manager for that specialty.
2. A clinical harm review must be completed for patient’s that have been waiting in excess of 52 weeks.

### Transfers to the Private Sector for NHS Treatment

1. A Divisional Manager may request authorisation from the Directors of Operations and Finance to transfer patients for NHS treatment to the private sector to ensure they are treated within 18 weeks. The following process should be followed:
2. Provisional list of patients identified to be reviewed by the Clinical Lead for appropriateness.
3. Contact made with private provider to negotiate terms of contract to include:
   1. Tariff for procedure
   2. Who will provide pre-operative assessment
   3. Who will provide outpatient follow-up
   4. Whether medical devices/prostheses are required and who will provide them
   5. Whether repatriation to RJAH will occur at a set period of time following surgery
4. Final list of appropriate patients for transfer contacted by RJAH to enquire if they accept transfer for treatment.
5. Confirmed patients details provided to private provider and RJAH advised of admission date.
6. Admission date added to PAS and health records provided.
7. Health records returned following admission with appropriate documentation from private episode of care copied and retained in RJAH records.
8. PAS updated with accurate RTT outcome of admission.

# Section C Cancer Access Targets

- Please see separate Cancer Access Policy

# Section D - Diagnostics

### DIAGNOSTIC ACCESS TARGETS (6 weeks for England, 8 weeks for Wales)

1. The Diagnostic Imaging Dataset (DID) is a monthly data collection covering data on diagnostic imaging tests on NHS patients in England. It includes estimates of GP usage of direct access to key diagnostics tests for cancer, for example chest imaging and non-obstetric ultrasound. A target of 6 weeks was introduced from the point of referral to the point the test is carried out and, to support this, the DID reports on imaging activity, referral source and timeliness.

### REFERRAL GUIDANCE – DIAGNOSTIC INVESTIGATIONS

1. The 6 week rule applies to all referral routes (i.e. whether the patient was referred by a GP or by a hospital-based clinician or other route) and also all settings (i.e. outpatient clinic, inpatient ward, x-ray department, primary care one-stop centres etc.). -. Ensuring patients receive their diagnostic test within 6 weeks is also vital to ensuring the delivery of the Referral to treatment waiting time if they are referred to diagnostics as part of their RTT pathway.

### Making a referral

1. When it is identified that a patient requires a diagnostic investigation, the clinician should fully complete the request at the time of the decision to request. Missing information on the request card will delay the process. Consideration should be given to Imaging Protocols and appropriateness of requests in relation to IRMER regulations or clinical requirements, e.g. no metal foreign bodies present if requesting a MRI scan.
2. Requests made in respect of cancer patients should be marked as such on the waiting list entry to ensure appropriate appointments are allocated. Failure to do this will result in a longer wait.

### Clock Starts

1. The clock starts on the date the referral is made – NOT the date it is received.

### Clock Pause

1. The clock cannot be paused for diagnostic 6 week waits.
2. The clock cannot be paused for the diagnostic phase of the English RTT pathway.
3. Please see Section B, para 61-74 on Welsh clock pauses that may be applicable to the diagnostic phase of the Welsh RTT pathway.

### Clock Stop

1. The diagnostic clock stops at the point the diagnostic investigation has taken place. Only the referring consultant can make clinical decisions to stop the RTT clock, if this is deemed to be in the patient’s best clinical interests, by discharging the patient or agreeing a period of active monitoring.

### Delays in Receipt of Referral

1. Where a request has been received via the internal mail and a significant delay has occurred the referrer will be contacted to discuss whether the referral is still required. If it is not required, then the patient should be contacted and informed at the same time as the test is cancelled. If it is still required, the original date of request is used and, therefore, the wait time will be consistent with the 6 week rule.

### Imaging Prioritisation of Referrals

1. All paper request cards will be logged on to the Radiology Information System upon receipt within **one working day**. The referral will then be protocolled according to the Department’s Standard Operating Procedures. An appointment will be agreed with the patient within **48 hours** of protocolling.

### Reasonable Notice

1. A choice of dates should be offered to the patient; the drive to reduce referral to scan time means this will often be below three weeks. A patient is able to choose to wait for their scan, this does not stop the clock.
   * If a patient declines, cancels or does not attend a diagnostic appointment, the diagnostic clock start can be reset to the date the patient provides notification of this. However, the ????? must be able to demonstrate that the patient’s original diagnostic appointment fulfilled the reasonableness criteria for the clock start to be reset.
   * Resetting the diagnostic clock start has no effect on the patient’s RTT clock. This continues to tick from the original patient initiated cancellations, declined appointments, DNA’s.

### Patient Cancellation/Alteration of a Diagnostic Appointment

1. If a patient chooses to alter a diagnostic appointment, the patient will be offered another appointment within three weeks of the original appointment. If a patient chooses to cancel a diagnostic appointment, the appointment will be cancelled on the Radiology Information System and the referrer informed.

### Patients Who DNA a Diagnostic Appointment

1. If a patient fails to attend a diagnostic appointment the referrer will be informed and a decision made as to whether re-referral is required, e.g. the patient may be a vulnerable adult. This needs to be in line with DNA policy described in section B, para 78-91.

### Patients Who are Waiting for More Than One Diagnostic Test

1. Patients waiting for two separate diagnostic tests/procedures concurrently should have two independent waiting times clocks – one for each test/procedure.
2. Alternatively if a patient needs test X initially and once this test has been carried out, a further test (test

Y) is required – in this scenario the patient would have one waiting times clock running for test X. Once test X is complete, a new clock is started to measure the waiting time for test Y.

# Section E- Supporting delivery of policy

### ESCALATION PROCESSES WHERE DEMAND EXCEEDS CAPACITY

1. All people responsible for managing an outpatient, inpatient or diagnostic waiting list are required to proactively escalate shortfalls in capacity to the relevant Divisional Manager immediately. The Divisional Manager and Clinical Lead for the specialty, or modality, concerned will work together with clinical colleagues to plan for additional capacity to meet demand and, therefore, the Patient Access Policy requirements. Shortfalls in capacity will be reported at the Patient Access Board where actions to resolve this will be requested.
2. Additional capacity requirements should not, wherever possible, incur additional costs to the organisation. Where these costs cannot be avoided, the Divisional Manager should ensure that all costs and potential impact on supporting services is taken into consideration and approved.
3. Where demand exceeds capacity on a consistent and regular basis and is outside of the annual activity plan, the Director of Operations will notify the relevant commissioners.

### MANAGEMENT/PERFORMANCE INFORMATION

**Information for Managing 18 Weeks**

1. A RTT patient tracking list (PTL) for admitted patients is made available via the intranet to Divisions. It is imperative that the PAS (Lorenzo) system is accurate at all times to ensure the weekly 18 week return and Waiting List situation report is correct.

### Information for Managing Cancer Access Targets

1. The cancer PTL is available on a spreadsheet and is reconciled to PAS and Open Exeter tracking.

### Information to Monitor

1. Data returns will be submitted to Monitor to meet the statutory requirements as published in the Data Manual.

### Other Reports

1. Divisions will also be provided with access to the following reports (this list is not exhaustive):
   1. Number of outstanding logged referrals
   2. Patients added to the an inpatient waiting list, including conversion rates by GP, specialty and consultant (distributed to GPs)
   3. Patients on planned lists
   4. Cancer waiting times report
   5. Outpatient Dashboard including slot utilisation, session utilisation, DNA rates and clinic cancellation performance
   6. Diagnostic waiting lists

### AUDIT

1. Regular audits of compliance with the policy will be in place; these will be agreed with and reported to the Audit Committee.

### POLICY REVIEW

1. The Patient Access Policy will be reviewed in six months and then on an annual basis to take account of any changes in national guidance/ new directives.
2. Necessary changes throughout the year will be issued as amendments to the Policy. Such amendments will clearly reference the section to which they refer and indicate the date on which they were issued.

### Appendix 1

**Definitions**

The following is a list of the definitions issued by the Department of Health that are used in this policy.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 18 week Referral To Treatment (RTT) period | | | | | | |  | The part of the patient’s care following initial referral which initiates a clock start, leading up to the start of the first definitive treatment or other 18 week clock  stop point. | |  |
| Active monitoring | | | | | | |  | Where it is clinically decided to start a period of monitoring in secondary care without clinical  intervention or diagnostic procedure at that stage. | |  |
| Active waiting elective planned) | | list | (elective | | waiting | and |  | The list of elective patients who are fit and able to be treated at that point in time. The active waiting list is also used to report national waiting time statistics. | |  |
| Admitted pathway | | | | | | |  | An admitted pathway means the patient requires admission to hospital, as either a day-case or an  inpatient to receive their first definitive treatment. | |  |
| Cancelled operations/procedures | | | | | | |  | If the Trust cancels a patient’s operation or procedure on the day of, or after admission for non-clinical reasons – the Trust is required to rearrange treatment within 28 days of the cancelled date or within standard wait time whichever is soonest. | |  |
| e-Referral | | | | | | |  | e-Referral (was Choose and Book) is a national electronic referral service that gives patients a choice of place, date and time for their first Consultant  outpatient appointment. | |  |
| Chronological order (in turn) | | | | | | |  | The general principle that applies to patients categorised as requiring routine treatment. All routine patients should be seen or treated in the order they  were initially referred for treatment. | |  |
| Clock Pause | | | | | | |  | Applies to WELSH PATHWAYS ONLY.  A period during which the patient has stated they are socially unavailable, their RTT clock is ‘paused’ for this specified period.  A patient requested clock pause applies when a patient is unable to accept TCI date given with  reasonable notice, resumes ticking on date patient is available again, or accepts an alternative TCI. | |  |
| Clock Start | | | | | | |  | Any referral to a Consultant-led service starts an 18 week clock. Any referral to an interface service (all arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment) start an  18 week clock. May include self-referrals to these services where agreed by Commissioners and providers. Clock starts on the date that the provider receives notice of the referral or UBRN conversion  date if through choose and book. | |  |
| Clock Stop | | | | | | |  | **Clock Stop – First definitive treatment**  Defined as an intervention intended to manage a patient’s disease, condition or injury and avoid further intervention (what constitutes first definitive treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient).  **Clock Stop – Non-treatment**  Patient returned to primary care for treatment, including therapy based.  Clinical decision to start a period of active monitoring. Patient declines treatment. | |  |
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|  |  |  |
| --- | --- | --- |
|  |  | Clinical decision not to treat. |
| Converts their UBRN |  | When an appointment has been booked through choose and book, the UBRN (unique booking  reference number) is converted. |
| Decision to admit |  | Where a clinical decision is made to admit the patient  for either day case or inpatient treatment. |
| Decision to treat |  | Where a clinical decision is taken to treat a patient as  an inpatient, day case or outpatient setting. |
| Did Not Attend (DNA) |  | Patients who have agreed or been given reasonable  notice of their appointment/treatment and who without notifying the Trust fail to attend. |
| Elective admission/elective patients |  | Inpatients are classified in 2 groups, emergency and elective. Elective patients are so called because the  Trust can ‘elect’ when to treat them. |
| Elective Planned |  | Patients admitted having been given a date or approximate date at the time that the decision to admit  was made. This is usually part of a planned sequence of clinical care determined mainly on clinical criteria. |
| Elective waiting |  | Patients waiting elective admission. |
| First definitive treatment |  | An intervention intended to manage a patient’s disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgment in consultation with  other as appropriate, including the patient. |
| Incomplete or Open pathways |  | Patients either on an admitted, non-admitted or  diagnostic pathway still waiting for treatment. |
| Non-admitted pathway |  | A non-admitted pathway means the patient does not require admission to hospital to receive their first definitive treatment e.g. treatment is given or prescribed  in outpatients. |
| Outpatients |  | Patients referred by a general practitioner (medical or  dental) or another Consultant/health professional for clinical advice or treatment. |
| Patient Tracking List (PTL) |  | Patient Tracking List, a report used to ensure the maximum waiting time standards are achieved by identifying all patients that will breach current wait time  standards. |
| Reasonable offer |  | Any date mutually agreed between the patient and the organisation, given with at least 3 weeks’ notice, with a choice of at least two dates offered.  If a patient verbally accepts a short notice date, for waiting time purposes thereafter, this is treated as  reasonable notice. |
| RTT |  | Referral to Treatment, from December 2008 the  maximum waiting time for NHS patients is 18 weeks from referral to treatment. |
| TCI (to come in) |  | A proposed future date for elective admission. |
| UBRN |  | Unique Booking Reference Numbers used for choose and book. The patient is notified of this on their appointment request letter when generated by the referrer through choose and book. The UBRN is used in conjunction with the patient password to make or  change an appointment. |

### Appendix 2

**Policy Risk/Impact Assessment Title of Policy: Patient Access Policy**

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| --- |
| 1. What clinical/corporate safety and effectiveness issues does this policy address? What Trust-wide assurance issues does this policy address (include a reference to the appropriate NHSLA and/or Healthcare Commission Standard)? |
| This policy details the main principles that apply when patients are referred to the hospital for treatment, providing assurance that the process is transparent, timely, comprehensive and consistent. The policy ensures that the Trust is compliant with National guidelines and standards, particularly with respect to the  18 week Referral To Treatment standard. |
| 2. What are the risks if this policy is not endorsed? |
| Breach of Commissioner and/or national waiting time standards. Breach of Information Governance requirements. Delays to patient’s care. |
| 3. What are the operational requirements for this policy to be implemented? |
| Changes to existing working practices supported by detailed operating procedures. Changes to reporting arrangements to support the management and monitoring of National standards. |
| 4. What are the financial requirements (if any) to support implementation? |
| To support potential changes to functionality of healthcare records team. |
| 5. What are the training requirements to support the implementation and is this training programme currently in place? |
| Role-based training programme on the new policy and associated processes/procedures to be set-up and implemented. Ongoing training will be provided for new starters. |
| 6. Has the equality impact assessment form been completed and considered? |
| Yes |
| 7. What are the systems/processes that are required to implement this policy (action plan to be attached)? |
| Training plan and SOPs in place to support operational delivery of the policy. Structured and recorded team meetings at department level and the weekly waiting list meeting support effective communication. |
| 8. Has an audit proposal been agreed to monitor the implementation of the policy (audit proposal to be attached)? |
| Following the Deloitte LLP review of waiting list management processes a new audit programme is being  developed to independently assess compliance with the policy. |
| 9. What are the Governance monitoring measures/data that provide corporate/clinical feedback/assurance relating to the effectiveness/outcomes expected? |
| Daily monitoring reports, summarised reporting to the Board of Directors and through the performance framework of the Trust at monthly Divisional performance reviews. The complaints process is also utilised to  identify trends relating to potential non-compliance with the policy. Additionally performance is reviewed via contract meetings. |

**Committee approval:**

Comments:

Signature:

Chair of the Committee

### Version number and date: V6.0 Review required by:

**Equality Impact Assessment Appendix 3**

**RJAH EQUALITY IMPACT REVIEW FORM**

|  |  |
| --- | --- |
| Title of Document/function | Patient Access Policy |
| Type of document/function:  *i.e. is it a strategy / business case / proposal (e.g. for a new build, change to working practices or changes to*  *service and delivery) or a main policy document?* | Main Policy document |
| Status of document/work practice:  *i.e. is it proposed; draft; existing; other?* | Draft |
| Name of Person completing the Equality Impact Review Form  *(Please print)* | Gemma Brett/Mark Lowe |
| Please give details of the goals or purpose of this document/work practice i.e. *Why we need to have this document/work practice?* | This policy outlines the way in which the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust will manage patients who are waiting for appointments, investigations and or treatment on a referral-to-treatment pathway. |

**Impact review**

*For support in completing this review, please refer to the Equality Impact Review Guidance Document*

In reviewing this strategy, business case / proposal / policy document / work practice have you identified either a potential positive or negative impact on any of the protective characteristics\* or other disadvantaged groups?

### Yes/No

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. | Have you acquired support or information in understanding the impact/or ways of mitigating the impact? Please provide details of support / information sought. | | N/A | |  |
| 2. | If you felt there to be no requirement to seek additional support please explain reasons for this | | N/A | |
| 3. | If an impact has been identified please provide the detail | | N/A | |
| **If an impact has not been identified there is no requirement to complete questions 4, 5, 6 & 7 below.**  **You should now complete the review date and signature section at the end of this form and attach to your document.** | | | | |
| 4. | How do you intend to consult in relation to the identified impacts  *i.e. consider consultation with the Patients panel, Senior Management, Nursing Staff, Estates, staff, representatives of the disadvantaged group* | |  | |
| 5. | Following consultation, what actions are you taking to mitigate or remove the impact?  *(Refer to examples on guidance sheet)* | |  | |
| 6. | How do you intend to communicate the proposed actions for improvement, risk or changes to the policy/function?  i.e. consider communication with the Patients panel staff, representatives of the disadvantaged group | |  | |
|  | Version 6.0 Approved  28/01/2019 | **Patient Access Policy Current version held on the Intranet**  Check with Intranet that this printed copy is the latest issue | | Page **43** of **52** | |

|  |  |  |
| --- | --- | --- |
| 7. | How will you monitor the outcomes of your actions so as to ensure success?  i.e. how will you measure the outcomes of your actions? Will you *gather specific data, staff satisfaction reports, patient responses etc.* |  |

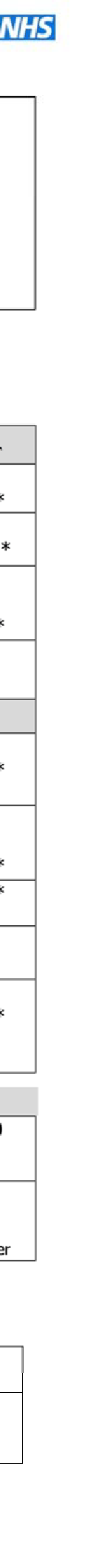
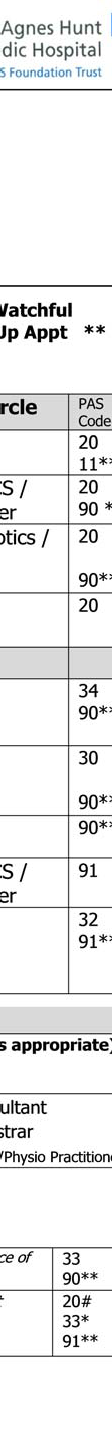
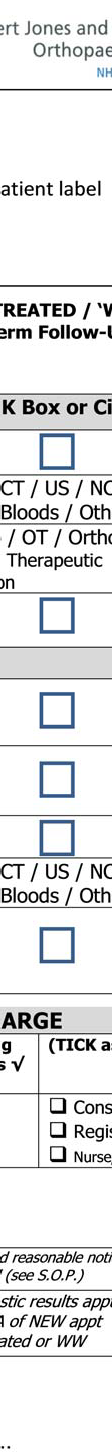
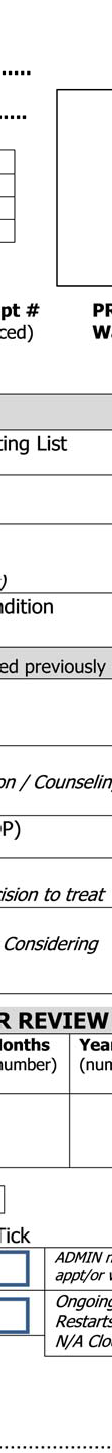
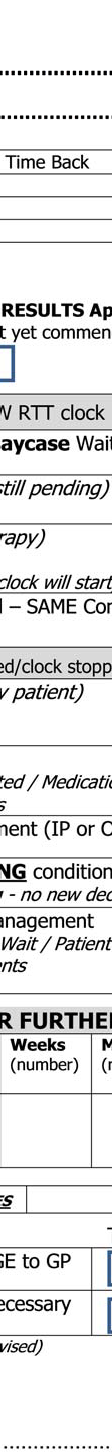
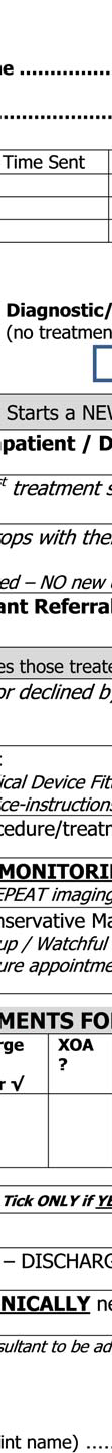
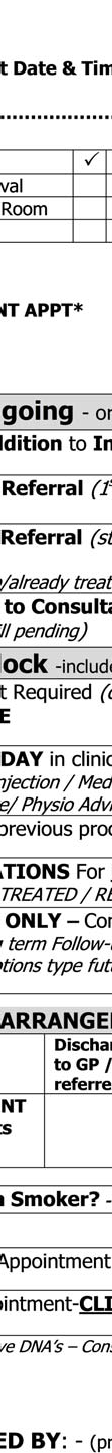
Equality Impact Review date: January 2018

Signature of person completing the form: G Brett/J M Lowe Date completed: TBC

A copy of the impact Assessment should be attached to the back of the strategy/ business case / proposal / policy document / work practice documentation and an electronic copy forwarded to the Trust Office Assistant for logging on the EIA spread sheet

### Appendix 4

**Clinical Outcome Form**



**Appendix 5**

**List of Supporting Standard Operating Procedures**

1. Processing of Referrals
2. Registering a Patient
3. Adding Patients to Waiting Lists
4. Dating Patients
5. Booking Appointments
6. Patient Unavailability
7. DNA’s
8. Cancellations
9. Medically Unfit Patients
10. Clinic Outcomes
11. Secretarial support for post diagnostic reviews
12. Hip and Knee Replacement Follow up

### Appendix 6

**Shropshire Consultant to Consultant Referral Policy**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | | | |
| **Title:** | Consultant to Consultant (C2C) referrals  Shropshire Clinical Commissioning Group Patients Policy | | | |
| **Unique Identifier:** | POL099 | **Document Type:** | Policy | |
| **Version Number:** | 1.0 | **Status:** | Approved | |
| **Responsible Director:** | Medical Director | | | |
| **Author:** | Stephen White – Medical Director | | | |
| **Scope:** | Trust wide | | | |
| **Replaces:** |  | | | |
| **To be Read in** | PLCV SCCG C2C V1 18/12/14 | | | |
| **Conjunction with the** | Patient Access Policy | | | |
| **Following Documents:** |  | | | |
| **(list related policies)** |  | | | |
| **Keywords:** | Consultants, Referrals, SCCG, Rheumatology, Referred Pain | | | |
| **Considered By Executive Owner:** | John Grinnell, Director of Finance | **Date Considered:** | | 03/09/2015 |
| **Endorsed By:** | Shropshire Clinical Commissioning  Group (SCCG) | **Date Endorsed:** | | 12/08/2015 |
| **Approved By:** | Executive Team | **Date Approved:** | | 03/09/2015 |
| **Issue Date:** | 03/09/2015 | **Review Date:** | | 03/09/2017 |
| **Security Level:** | **Open Access**   | **Restricted** |  | **Confidential** |
|  | | | | |

**Overview for Consultant to Consultant Referrals (C2C) applicable to this Trust**

In order to avoid confusion about referrals by one consultant to another, this policy has been produced as a joint commissioning statement by Shropshire Clinical Care Group (SCCG) and this Trust. There are some particular points that are related to the orthopaedic and rheumatology case referrals which are as follows:

* For orthopaedic surgeons patients may be referred with symptoms in one area of the body which actually arise from another source hence the notion of referred pain. These patients can be referred directly on to the appropriate specialist. This for example, would apply to knee referrals when the discovery is arthritis of the hip producing referred pain to the knee.
* For rheumatology referrals the Rheumatologist should refer patients on to specialist orthopaedic surgeons at their discretion if they feel it is appropriate for the patient to receive joint specific treatment when this treatment is needed to manage symptoms that they are currently managing.

The rest of this policy is a direct transcript from the Shropshire CCG for completeness.

**Commissioning Policy for Shropshire Patients: Consultant to Consultant Referrals - April 2014**

**Background**

This policy has been revised from the existing SCCG Policy for Consultant to Consultant Referrals - January 2012, in accordance with the change in the Service Condition of the Standard Contract for 2014 as laid out below. The purpose of this policy is to ensure that patients are referred to appropriate services within secondary care. The 18 week rule suite should be appropriately applied to referrals.

**Introduction**

Service Condition 8.4, NHS Standard Contract 2014, states with regards to Consultant to Consultant referrals:

"Except as permitted under an applicable Prior Approval Scheme, the Provider shall not carry out, nor refer to another provider to carry out, any non-immediate or routine treatment or care that is unrelated to a Service User's original Referral or presentation without the agreement of the Service User's GP."

The following guidelines form the prior approval scheme that TWCCG and SCCG stipulate providers shall work to.

1. **General Principles**

The vast majority of referrals should be made from Primary to Secondary Care (“GP to Consultant”) for the following reasons:

* + To offer patient choice for each different episode of care. Patients should be offered the opportunity for ‘Choice’ in relation to referral for and opinion or management of a condition.
  + To provide care closer to home wherever possible by ensuring management of patients within primary care where appropriate.
  + To contribute to the management of secondary care capacity by ensuring only those genuinely needing secondary care receive it, and in a more timely way as part of 18 weeks pathway.

For these reasons, when a Consultant decides that the opinion of another Consultant/service should be sought, in the majority of cases he/she will write back to the referring GP detailing this opinion so that the patient and their GP can agree on further management.

There are however circumstances in which a “Consultant to Consultant” referral is clinically appropriate. This policy describes these.

No matter how well defined these circumstances are, there will always be occasional exceptions where Consultants and Commissioners will have to take a view based on individual patients and clinical circumstances.

1. **A Consultant may refer directly to another Consultant when:**
   * In the opinion of the Consultant at the time of the first appointment, the patient’s condition is clinically urgent and is most appropriately dealt with by direct urgent or “2 week” referral to a Secondary Care colleague/service
   * If the original referral is for 2 conditions, e.g. glaucoma and cataract and one need treating prior to the other
   * Where the referral is for the investigation or further treatment either medical or surgical, of the condition for which the original referral was made
   * Where diagnostics and investigations e.g. an endoscopy is required as part of the patient pathway for the original presenting condition.
   * When a patient specifically asks that the diagnosis is not shared with their GP (e.g. some sexual health cases)
   * Where sub-acute tertiary referral is needed, i.e. an inpatient waiting to go to a specialist unit Examples to consider when applying this policy:

* A chest physician concludes that the patient requires an endoscopy as part of the investigation into their breathlessness and cough. If the consultant plans to review the patient after the endoscopy and intends to continue the management of that patient, then consultant to consultant referral is appropriate. If the consultant intends to hand over the management of the patient to the gastroenterologist, and the problem is not urgent, then referral back to the GP is likely to be most appropriate.
* A Gastroenterologist sees a patient with abdominal pain, and is subsequently found to have gallstones (in line with Value Base Commissioning Policy), a referral to the upper GI surgical team would be appropriate.
* An Orthopaedic surgeon concludes that a patient’s back pain is due to osteoarthritis, that surgical intervention is not appropriate and suggests referral to the local pain clinic. Pain clinics have a working relationship with local consultant colleagues so direct onward referral is likely to form part of a robust pathway of care. However, local pain management prescribing guidelines begin in Primary Care so the consultant needs to ensure that the primary care element of the guidelines is already in place before making a direct referral to the pain clinic.
* A dermatologist concludes that skin lesions are vascular and should be assessed by a vascular surgeon. If longstanding and non**-**urgent, then referral back to the GP may be the most appropriate course of action. If the condition is more acute or urgent, then consultant to consultant referral may be appropriate.

1. **Circumstances in which Consultant to Consultant referrals are NOT appropriate:**

Consultant to Consultant referrals are not appropriate when:

* + The GP referral does not contain enough information to ensure that the patient will see the right consultant at their first appointment
  + The referral triage process has not been adequately applied (Where this is the case, commissioners reserve the right to refuse payment for a consultation with ‘the wrong’ consultant)
  + An incidental finding is made during the course of assessment or investigation that is unrelated to the reason for referral
  + A patient discloses symptoms to the consultant that indicate a diagnosis unrelated to the reason for referral
  + The consultant is considering a designated ‘procedure of low clinical value’ as the next management option for the patient

In all these circumstances, the patient (with a letter from the consultant or the original GP referral letter) should be directed back to their GP with adequate information and guidance to allow the patient and GP to agree an appropriate course of action. Primarily it is considered that some consultant to consultant referrals may be requests for clinical management that could be carried out in a primary care setting.

1. **Monitoring compliance with the policy**

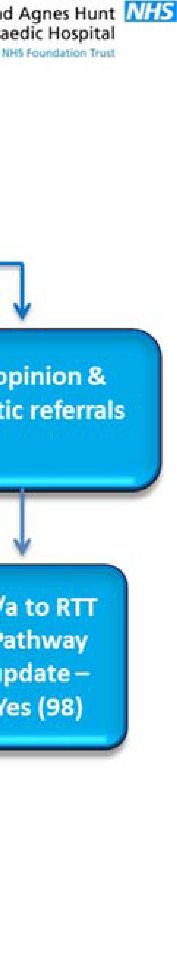
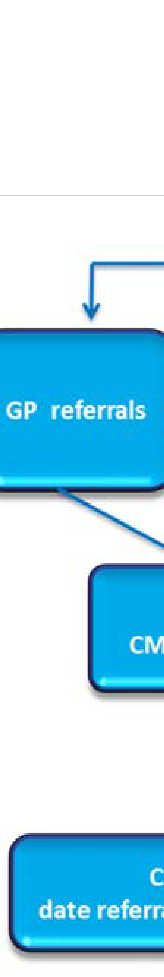
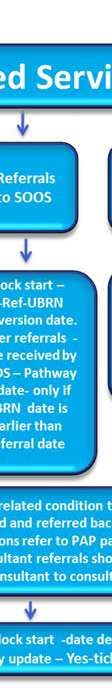
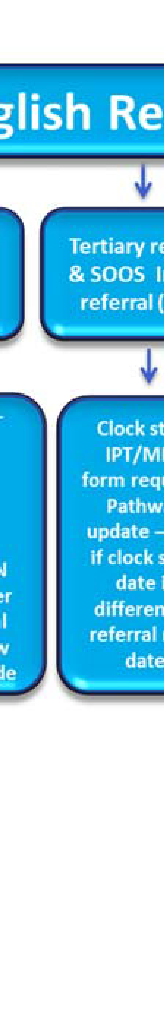
This policy is expected to see a reduction in the amount of Consultant to Consultant referrals at the Trust and monitoring will take place to ensure that this policy is adhered to. Providers should provide regular reporting of Consultant to Consultant referral activity including evidence that the CCG policies are being adhered to. Audits will be agreed with CCG and Provider trusts to ensure policies are being followed.

If the CCG identifies non-adherence to the policy, it will abate payment where it is clear that this protocol has not been followed by the Trust.

The wording of this document has been approved by the Medical Director – Stephen White and Dr Julian Povey - Clinical Director of Contracting and Performance. References emailed to Steve White from Julian Povey on 12th August 2015 at 17:19 hrs.

**Appendix 7**

**English & Welsh Referral Flow Charts**



**Appendix 8**

**Record of Minor Amendments**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Record of Amendments to:** Patient Access Policy 6.0 | | | | |
| **Amendments approved by:** Chairman / Trust Board | | | | **Date** |
| **Section number** | **Amendment** | **Deletion** | **Addition** | **Reason** |
| N/A |  |  |  |  |
| Section A |  |  |  |  |
| Section A |  |  |  |  |
| Section B |  |  |  |  |
| Section B |  |  |  |  |
| Section E |  |  |  |  |
| Section E |  |  |  |  |
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