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Patient Access Policy

NGH-PO-263

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POLICY

CONTENTS

Version Control Summary 4
SUMMARY 5
1. INTRODUCTION 6
2. PURPOSE 6
3. SCOPE 6
4. COMPLIANCE STATEMENTS 7
5. DEFINITIONS 7
6. ROLES & RESPONSIBILITIES 10
7. SUBSTANTIVE CONTENT 11
7.1. Key Points 11
7.2. Key Principles 11
7.2.1. Our Core Vision and Values 11
7.2.2. Maintaining the integrity of Data Quality 11
7.2.3. Policy Principles 12
7.2.4. Our Patient Focus 12
7.3. NATIONAL PERFORMANCE MEASURES 12
7.3.1. Referral to Treatment (RTT) 12
7.3.2. Cancer Waiting Times 12
7.3.3. Diagnostic Waiting Times 13
7.3.4. Inpatient Non-Clinical On the Day Cancellations 13
7.4. Data Quality/Data Protection 14
7.4.1. Data Quality 14
7.4.2. Data Protection 14
7.5. Referrals 14
7.5.1. Management of Referrals 14
7.5.2. Inappropriate Referrals 15
7.5.3. Consultant specific referrals 15
7.5.4. NHS e-Referrals 15
7.5.5. Paper Referrals 16
7.5.6. Cancer 2 week wait referrals (Inc. breast symptomatic) 16
7.5.7. Referrals for low clinical priority procedures (LCP) 16
7.5.8. Military Veterans 17
7.5.9. Overseas visitors 17
7.5.10. Consultant to Consultant Referrals 17
7.5.11. Emergency and Ward Admissions 18
7.6. Patient Contact Outpatients 19
7.6.1. Reasonable offers 19
7.6.2. Outpatient Letters 19
7.6.3. Booking Outpatient Appointments 19

7.6.4. Patients Requesting Time to Consider Treatment Options (Thinking Time).... 20
7.6.5. New appointment DNA 20
7.6.6. Follow Up Appointment DNA 21
7.6.7. 2 Week Wait First Appointment DNA's 21
7.6.8. 2 Week Wait First Appointment Cancellations 22
7.6.9. Patient Cancellations (CNA – Could Not Attend) 22
7.6.10. Hospital Cancellations 22
7.6.11. Outpatient Clinic Cancellations with six weeks' or more notice 22
7.6.12. Outpatient Clinic Cancellations with less than six weeks' notice 23
7.7. Diagnostics and Imaging Appointments 23
7.7.1. Diagnostic Referrals/Requests 23
7.7.2. Diagnostic Prioritisation 23
7.7.3. Diagnostic Reasonable Offers 24
7.7.4. Diagnostic Patient Declines Reasonable Appointment Offers 24
7.7.5. Diagnostic Inappropriate Referrals 24
7.7.6. Diagnostic Cancer Referrals 24
7.7.7. Diagnostic Urgent Referrals 25
7.7.8. Diagnostic Routine Referrals 25
7.7.9. Diagnostic Imaging Appointments 25
7.7.10. Diagnostic Waiting Lists 25
7.7.11. Diagnostic Active Waiting List 25
7.7.12. Diagnostic Planned Waiting List 25
7.7.13. Therapeutic Procedures 25
7.7.14. Diagnostic Patient Discharged - Treatment not Taken Place 26
7.7.15. Diagnostic Did Not Attend 26
7.7.16. Diagnostic Patient Cancellations 26
7.7.17. Diagnostic Session Cancellation 27
7.7.18. Diagnostic Session Cancellation with six weeks' or more notice 27
7.7.19. Session Cancellation with less than six weeks' notice 27
7.8. Patient Contact Inpatients 27
7.8.1. Reasonable offers 27
7.8.2. Pre-operative assessment (POA) 28
7.8.3. Patient Assessed As Fit to Proceed 28
7.8.4. Patients Assessed As Not Fit to Proceed 28
7.8.5. POA Appointment DNA 29
7.8.6. Booking Admissions 29
7.8.7. Admission Letters 30
7.8.8. Patient Request for Review of Treatment Decision/Plan 30

7.8.9. Patients Requesting Time to Consider Treatment Options (Thinking Time).... 31
7.8.10. Principles of Waiting List Management 31
7.8.11. Planned Waiting Lists 32
7.8.12. Endoscopy Pathways 32
7.8.13. Maintaining Waiting Lists 32
7.8.14. Patient-initiated delays and RTT pathways/ Patients Not Available 33
7.8.15. The Active Waiting List (PTL) 33
7.8.16. Patients Requiring Commissioner Funding Approval (LCP) 34
7.8.17. Adding Patients to Active Inpatient / Day Case Waiting Lists 34
7.8.18. Patients Listed For More Than One Procedure 34
7.8.19. Did Not Attend (DNA) 35
7.8.20. Patient Cancellations (CNA – Could not attend) 35
7.8.21. Cancer Admissions 36
7.8.22. Patients Who Become Medically Unfit Prior to Admission 36
7.8.23. On the day cancellations 36
7.8.24. Operation Session Cancellation with six weeks' or more notice 38
7.8.25. Operation Session Cancellation with less than six weeks' notice 38
7.8.26. IP Waiting List Validation and Review 38
8. IMPLEMENTATION & TRAINING 38
9. MONITORING & REVIEW 39
10. REFERENCES & ASSOCIATED DOCUMENTATION 39
APPENDICES 40
Appendix 1 18-Week REFERRAL TO TREATMENT CODES 41
Appendix 2 GLOSSARY OF TERMS 43
Appendix 3 HARM REVIEW FORM 45

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2 NGH-PO-263 V2	March 2010		Superseded	Hospital Management Group Updated in line with national guidance
3 V3-PDG	Dec 2011		Superseded	Procedural Documents Group Updated in line with national guidance
5.1 NGH-PO-263	Oct 2014		Superseded	Head of Information & Data Quality Updated in line with national guidance
6	January 2018	Sean McGarvey	Ratified	PDG Chair Approval

SUMMARY

The purpose of this document is to both outline and define how the Trust and its staff manage access to its key services, ensuring fair treatment for all patients. The successful management of patient waiting lists is fundamental to achieving NHS England's objectives in reducing waiting times and improving patient choice.

This Policy describes the processes that are to be followed to ensure transparent, fair and equitable management of waiting lists. It includes guidelines and procedures to ensure:

- Our waiting lists are managed effectively
- Services provided to our patients are of a high quality.
- Optimum use is made of resources within the Trust.

This document has been created to be used by all staff working at the Trust dealing with all patient activity. It will ensure that patients are treated in order of clinical priority, and that patients of the same clinical priority will be seen in turn. It will also help provide equality of access across sites throughout the Trust.

The Policy is not intended to replace local and departmental operational policies and procedures including defined Patient Administration System processes

1. INTRODUCTION

This Patient Access Policy for Northampton General Hospital NHS Trust has been developed and reviewed following investigation of best practice throughout the local health economy.

Medical staff, managers and administrative staff have an important role in managing waiting times effectively. Treating patients and delivering a high quality, efficient and responsive service, ensuring prompt communications with patients is a core responsibility of the Trust, and all staff. Staff must ensure that all national standards are adhered to and that all notification rules are observed. These are detailed throughout the Policy and summarised below for ease of reference.

2. PURPOSE

This Patient Access Policy for Northampton General Hospital NHS Trust has been developed and reviewed following investigation of best practice throughout the health economy.

The aim of this document is to:

- Establish a consistent approach to patient access across the Trust
- Ensure that national and local standards of care are met through clarity of definition and process
- Provide an operational guide for all areas to work to consistently, in conjunction with local operational procedures which cover the detail of day-to-day administrative processes. This Policy does not replace local operational procedures but seeks to support them.

3. SCOPE

This policy sets out the overall expectations of NGH and its local commissioners on the management of referrals and admissions into and within the organisation, in line with current national policy regarding patient access and waiting times and defines the principles on which the policy is based.

This policy and the Patient Access User Manual are intended to be of interest to and used by all staff within NGH, who are responsible for referring patients, managing referrals, adding to and maintaining waiting lists for the purpose of organising patient access to hospital treatment. The principles of the policy apply to both medical and administrative waiting list management.

4. COMPLIANCE STATEMENTS

Equality & Diversity
This document has been designed to support the Trust's effort to promote Equality, Diversity and Human Rights in the work place in line with the Trust's Equality and Human Rights Strategy. It has also been analysed to ensure that as part of the Public Sector Equality Duty the Trust has demonstrated that it has given 'due regard' to its equality duty and that, as far as is practicable, this document is free from having a potential discriminatory or adverse/negative impact on people or groups of people who have relevant protected characteristics, as defined in the Equality Act of 2010.

NHS Constitution
The contents of this document incorporates the NHS Constitution and sets out the rights, to which, where applicable, patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with the responsibilities which, where applicable, public, patients and staff owe to one another. The foundation of this document is based on the Principles and Values of the NHS along with the Vision and Values of Northampton General Hospital NHS Trust.

5. DEFINITIONS

New Patients	A first attendance by a patient will be the first appointment either of a series of appointments or only appointment which took place for a condition which the patient was originally referred for, irrespective of which clinician or specialty is involved in the treatment.
Follow Up Patients	All subsequent appointments following the first attendance by a patient, which take place for the condition which the patient was originally referred for should be recorded as follow-up.
RTT (Referral to Treatment)	As a general principle, the Trust expects that before a referral is made for treatment, the patient will be clinically fit for assessment and treatment. The patient must be available for assessment and treatment within 18-Weeks of referral. The Trust will work with GPs, CCGs and other primary care services to ensure patients have a full understanding of this before starting an elective care pathway.
Cancer 2 Week Wait (2WW)	Time from GP referral to first outpatient appointment
Cancer 62 day target	Time from Urgent GP referral or consultant upgrade to start of first treatment
Cancer 31 day target	• Time from Decision to treat to treatment • Time from referral to subsequent treatment • Time to specialised treatment via a 2ww referral to start of

	first treatment i.e. testicular cancer
Locally agreed first Appointment wait time, non- two week wait	11 weeks from referral to first appointment (Subject to change)
RTT Clock Starts	An RTT clock starts when any health professional (or service permitted by an English NHS Commissioner to make such referrals) refers to a Consultant-led service. Services that do not start an RTT pathway are: • Emergency pathways, • Diagnostic, • Rehabilitation, • Obstetrics, • Fracture • Learning disability specialties. The RTT clock start date is the date that the Trust receives the referral. For referrals received through NHS e-Referral, the RTT clock starts when the patient converts their unique booking reference number (UBRN). A new RTT clock should also be started when a patient becomes fit and ready for the second of a Consultant-led bilateral procedure or after a period of monitoring (watchful wait).
RTT Clock Stops for Treatment	An 18-week clock stops when a patient receives treatment in an outpatient setting; this could be medication, advice, fitting of a brace or appliance, the initiation of a therapy treatment plan or the patient is admitted for treatment. In circumstance where a series of interventions may be required, and will depend on the clinical response of the patient, the first intervention should be recorded as the clock stop i.e. pain clinic may try a number of procedures or therapies before they identify the one that best suits the induvial patient. Where the treatment requires day case or inpatient admission, the clock stops on the day of admission. It does not stop where the admission is for diagnostic tests only. A diagnostic procedure that turns in to a therapeutic procedure or the fitting of a medical device will also stops the RTT Clock.
RTT Clock Stops for Non-Treatment	An RTT clock stops when the patient and their GP are informed that it is clinically appropriate to return the patient to primary care for non-Consultant-led treatment in primary care, this will include: • A clinical decision is made not to provide treatment. • A patient DNAs (did not attend) and a clinical review of the referral results in the patient being discharged.

	• A patient declines treatment having been offered it. • A decision is made to start the patient on a period of watchful wait / active monitoring. The clock stops when this decision is made and communicated to the patient
Active Monitoring / Watchful Waiting	In many pathways, there will be times when it is clinically appropriate, or clinically acceptable if initiated by the patient and a Harm form is completed (Appendix 3), to start a period of active monitoring without further clinical intervention or diagnostic procedure. The clock stops when this decision is made and communicated to the patient. Some clinical pathways require patients to undergo regular monitoring/review diagnostics as part of an agreed programme of care. These types of events would not themselves indicate a decision to treat or a new clock start. It is not appropriate to stop a clock for a period of active monitoring if some form of diagnostic or clinical intervention is required in the immediate future, but it is appropriate if a longer period of active monitoring is required before further action is needed. If a decision was made to treat after a period of active monitoring / watchful waiting, a new RTT clock would start on the date of decision to treat (DTT) should be recorded.
New Clock Starts	If a decision is made to start a substantively new or different treatment that does not already form part of that patient's agreed care plan this will start a new RTT pathway clock and the patient shall receive their first definitive treatment within a maximum of 18-Weeks from that date. This will include all patients whose pathway has been stopped previously but who are then added to an elective waiting list for surgery or other therapeutic intervention.
Reasonable Offers	A reasonable offer is an offer of a time and date three or more weeks from the time the offer was made. Shorter times can be mutually agreed with the patient; in such circumstances, this will be considered a reasonable offer. Waiting time's guidance on 'reasonableness' states that: • Written offers: In order for a written offer to be deemed reasonable, the patient is to be offered an admission date with a minimum of three weeks' notice. • Verbal offers: For a verbal offer to be deemed reasonable, the patient is to be offered a minimum of two admission dates, with at least three weeks' notice before the first of these offered admission dates.

	However, if dates are offered with less than 3 weeks' notice as well as later dates as per the above, and the patient chooses to accept this date, this will constitute a reasonable offer and must be documented.
Diagnostic waits	Speed of diagnosis is a significant factor in the quality and timeliness of care. Service providers are required to ensure that more than 99% of patients have a maximum wait of 6 weeks for a diagnostic test.
Day case (DC) procedure	The patient is not intended to occupy a hospital bed overnight.
Planned admission	A patient admitted, having been given a 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 social or clinical criteria (e.g. cystoscopy).
Waiting List admission	A patient admitted electively from a waiting list having been given no date of admission at a time a decision was made to admit.
Booked Admission	Patients that are provided with the opportunity to book their admission or treatment date immediately following their clinic appointment or very shortly after.
CRIS	Radiology Requesting system
ICE	Test requesting and results system

6. ROLES & RESPONSIBILITIES

ROLE	RESPONSIBILITY
Chief Executive and the Trust Board	Are responsible for ensuring there is a policy in place.
Chief Operating Officer	Accountable for the delivery of operational standards relating to the provision of elective care, diagnostic and cancer services.
Divisional Managers	Overall responsibility for implementing and ensuring adherence to the Policy within their areas.
All Trust Employees	Have a responsibility to: • Support the Trust to achieve its Vision • Act at all times in accordance with the Trust values • Follow duties and expectations of staff as detailed in the NHS Constitution – Staff Responsibilities

7. SUBSTANTIVE CONTENT

7.1. Key Points

- Patients will be treated within national waiting time standards
- Patients should only be added to a waiting list if there is a real expectation that they will be treated
- Patients should only be added to the waiting list if they are willing, fit and able to be admitted / appointed for their treatment or consultation
- Patients will be treated in order of their clinical need
- Patients with the same clinical need will be treated in chronological order
- All non-urgent patients must be given reasonable notice of their appointment or admission date, this is determined as three weeks.

NHS patients can expect a certain level of service to be maintained at all times. These include the right to be seen by an appropriately qualified health professional, to have a clear explanation of their condition and treatment options, and to be treated fairly in accordance with this Policy.

7.2. Key Principles

This Policy will be applied consistently and without exception across the Trust. This will ensure that all patients (including prisoners) are treated equitably and according to their clinical need.
All staff employed by Northampton General Hospital Trust will adhere to the Patient Access Policy.

7.2.1. Our Core Vision and Values

- Best Possible Care
- We aspire to excellence
- We put patient safety above all else
- We reflect, we learn, we improve
- We respect and support one another

7.2.2. Maintaining the integrity of Data Quality

- Patient computer system must be up-to date
- All records should be accurate and entered in a timely manner
- All staff must be informed and trained.

All stakeholders including, CCG's, Area Teams, patient representatives, patients and others will have access to this Policy.

7.2.3. Policy Principles

This Policy is based on the following over-riding principles:

- Full patient demographics and GP details must be confirmed at each point of contact
- Patients to be added to a waiting list must be fit and available for surgery
- A patient should only be added to a waiting list if there is an expectation of treating them
- All additions, changes, or removals from waiting lists must be made in accordance with this Policy
- The waiting list module on the Patient Administration System (PAS) must be used to administer all waiting lists and booked admissions. It is the responsibility of all those involved in waiting list management to ensure that the information held is accurate and updated in real time Dates offered must be recorded on both the PAS and waiting list cards.

7.2.4. Our Patient Focus

- Patients to have choice and responsibility in organising their care within the 18-week journey
- Patients to have the opportunity to negotiate and choose the date and time of their treatment
- Patients can expect reasonable notice to prepare for their appointment and treatment of no less than three weeks, unless otherwise agreed with the patient
- Equitable access to care via chronological management for patients of the same clinical priority
- A ‘no cancellation/alteration Policy’ aside from exceptional circumstances e.g. staff sickness
- Patients will wait no longer than the National waiting time

7.3. NATIONAL PERFORMANCE MEASURES

7.3.1. Referral to Treatment (RTT)

In June 2015, NHS England announced changes to the tracking of RTT wait times, with a focus on incomplete pathways.

Therefore, the only national reporting of RTT waiting times will be as follows: 92% of patients on an incomplete pathway (waiting for treatment) should be waiting less than 18-Weeks from the date of their referral.

Definitions of RTT codes are detailed in Appendix 1

7.3.2. Cancer Waiting Times

The headline performance measures are against a minimum threshold of:

- 93% of patients referred by a GP (GMP or GDP) for suspected cancer will be seen within 2 weeks from referral
- 93% of patients referred with breast symptoms (where cancer is not suspected) will be seen within 2 weeks from referral
- 96% of patients will receive first definitive treatment within 31 days of the decision to treat (DTT)
- 94% of patients will receive treatment within 31 days of the DTT where that is a second or subsequent treatment(s), including those diagnosed with a recurrence, where the subsequent treatment is surgery.
- 98% of patients will receive treatment within 31 days of the DTT where that is a second or subsequent treatment(s), including those diagnosed with a recurrence, where the subsequent treatment is drug treatment.
- 94% of patients will receive treatment within 31 days of the DTT where that is a second or subsequent treatment(s), including those diagnosed with a recurrence, where the subsequent treatment is radiotherapy.
- 85% of patients will receive first definitive treatment within 62 days of urgent GP (GMP or GDP) referral for suspected cancer.
- 90% of patients will receive first definitive treatment within 62 days of urgent referral from an NHS Cancer Screening Programme (breast, cervical and bowel) for suspected cancer.
- Patients will wait a maximum of 62 days from a Consultant upgrade of urgency of a referral to first treatment – currently no operational performance standard.

Patients will wait a maximum of 31 days from urgent GP referral to first treatment for children's cancer, testicular cancer and acute leukemia (monitored within the 62-day standard but no separate operational standard).

7.3.3. Diagnostic Waiting Times

Speed of diagnosis is a significant factor in the quality and timeliness of care. Service providers are required to ensure that 99% of patients have a maximum wait of 6 weeks for a diagnostic test. Local Policy may provide for shorter wait times, which should be observed

7.3.4. Inpatient Non-Clinical On the Day Cancellations

Where a patient is cancelled on the day of admission or day of surgery, they must be rebooked within 28 days of the original admission date. Two reasonable offers must be made to the patient within 28 days of the date of cancellation.

If the Trust cannot offer the patient a date within 28 days of the cancellation, the Trust must offer to fund the patient's treatment at the time and hospital of the patient's choice where appropriate.

The patient may choose not to accept a date within 28 days; if the offer of a new date was reasonable but the patient prefers to be treated after the 28 day period then this will not be

considered a breach but where possible the Trusts should work with the patient to offer a date that is suitable to them whilst fully documenting the reason for declining the offers made.

7.4. Data Quality/Data Protection

7.4.1. Data Quality

Data quality is the responsibility of ALL clinical and clerical staff, who are engaged with the collection of information to aid our recording of clinical care activity. All information must be recorded accurately and in a timely manner.

- Acceptable data quality is crucial to our operational and transactional processes.
- High quality information leads to improved decision making.
- Management information produced from patient data is essential for the efficient running of the trust.
- Poor data quality puts our organisation at significant risk.

7.4.2. Data Protection

- You must take reasonable steps to ensure the accuracy of any personal data you obtain.
- Ensure that the source of any personal data is clear.
- Carefully consider any challenges to the accuracy of information.
- Consider whether it is necessary to update the information.

To ensure the excellence of our Data Quality and Data Protection regular validation must be undertaken, this also needs to be audited to highlight any issues that need to be addressed by the relevant manager, any breaches and patient initiated delays must be documented on a Harm review form (Appendix 3).

7.5. Referrals

All routine and urgent referral letters should be sent to the relevant outpatient booking office. Referrals are received by the Trust in either paper form or electronically in the form of an NHS e- referral

7.5.1. Management of Referrals

All outpatient waiting lists must be managed using the Patient Administration System (PAS), with appointments made in chronological order and on a first come first served basis to ensure equity of access. This process should take no more than five working days.

7.5.2. Inappropriate Referrals

If a referral has been made to a Consultant whose service/specialist interest does not match the needs of the patient, the Consultant should advise the GP promptly so that appropriate treatment can be sought.

If the opinion of a different specialty is required, this should be made in agreement with the patient's registered GP and an onward referral made. This does not constitute a new referral. The original referral must be changed to reflect the change of Consultant.

If the referral is for a service not provided by the Trust the referral letter will be returned to the referring GP with a note advising that the patient needs to be referred elsewhere. Such patients will not be registered by the Trust.

7.5.3. Consultant specific referrals

Where clinically appropriate, referrals should be made to a service (an open/generic referral) rather than a named clinician. This is in the best interests of patients as it promotes equity of waiting times and allows greater flexibility in terms of booking appointments.

As a general principle, generic referrals will be sent to the Consultant with the shortest waiting time in that specialty. However, it is the patient's right to request a named Consultant.

7.5.4. NHS e-Referrals

All NHS e-referrals must be reviewed and accepted / rejected within 24 hours for an urgent referral and 48 hours for a routine referral by Clinical Teams. Where there is a delay in reviewing these referrals this will be escalated to the relevant clinical team and actions agreed to address this.

Where possible the Trust will endeavour to provide an NHS e-Referral appointment at the hospital site of the patient's choice. If this is not possible, the patient will be offered an appointment at one of the other sites where that service is provided by the Trust.

If a patient's appointment has been incorrectly booked on the NHS e-Referral system into the wrong service by the referrer, the NHS e-Referral team will re-direct the patient to the correct service and a confirmation letter of the appointment change will be sent.

If a NHS e-Referral referral is received for a service not provided by the Trust, it will be rejected back to the referring GP advising that the patient needs to be referred elsewhere.
If there are, no slots available for the selected service the patient will appear on the Appointment Slot Issue **(ASI)** work list.

If the patient cannot be appointed straight away, then they should be added to the Outpatient Waiting List and be appointed in accordance with Trust targets.

When adding the Referral to IPM, please ensure that you use the correct referral date i.e. when referral received, NOT when actioned by the Dept.

Once the Patient has been added to the waiting list from the slot issue list, you must ensure that they are REMOVED from the slot issue list.

If the patient advises that the appointment is no longer required, they should be removed from the waiting list and discharged back to the GP with details recorded on PAS; the 18-Week clock will be nullified.

7.5.5. Paper Referrals

All paper referrals must be date stamped upon receipt at point of entry to the Trust. Details of the referral will be entered onto PAS at this point reflecting recorded date by the Trust; for patients referred by paper this is the point that the Referral to Treatment (RTT) clock starts on waiting time standards and 18-week pathway.

Referrals will be sent to Clinical teams for prioritisation. Prioritisation should be recorded as “Cancer” (where a 2ww pro forma has not been used) 'Urgent' or ‘Routine'.

Patients should be given appointments within the agreed maximum timeframe for each specialty (agreed by clinical specialties and at Executive Level).

7.5.6. Cancer 2 week wait referrals (Inc. breast symptomatic)

Referrals must be faxed by the GP/GDP to the Trust (within 24 hours of the patient being seen) to the 2WW Booking Office, staff will liaise with the Consultant to ensure that all patients will be offered a date within 14 days.

GP’s and GDP’s should ensure their patients are able to attend an appointment within the following 2 weeks. If a patient is unavailable, GP’s and GDP’s should consider whether it is appropriate to defer the referral until such time that their patient can attend an out-patient appointment within 2 weeks of being referred.

Patients should not be referred back to their GP because they are unable to accept an appointment within 2 weeks, i.e. once a referral has been received, it should not be returned due to patient unavailability.

Two-week wait referrals can only be downgraded by the GP - if a Consultant thinks the 2 week wait referral is inappropriate, it should be discussed with the GP and the GP asked to withdraw the two week wait referral status. GPs should not be asked to downgrade a patient (or withdraw the referral) simply because they are unavailable to accept an appointment within two weeks.

7.5.7. Referrals for low clinical priority procedures (LCP)

Patients referred for treatment outside of existing contractual agreements will follow the agreed protocol:

- LCP procedure referrals should not be accepted until evidence of funding approval is provided.
- When patients are assessed and funding approval for treatment is required, this must be obtained before adding the patient to the active waiting list.

Departmental processes will vary but if the GP is requested to seek the required funding the RTT clock will be stopped. A new clock start should be applied once approval has been received.
If the department is requesting the authorisation to treat, the relevant form should be completed immediately and sent to the commissioners by email. A response should be received within 4 working days; the clock is not stopped.

If there is no response within 4 working days it should be taken that authorisation has been given, it is important this evidence is documented and filed appropriately to cover any possible challenges by the commissioner over payment in the future. It is essential that the department have suitable processes in place to monitor patients waiting for funding to ensure no delay to treatment.

7.5.8. Military Veterans

All veterans and war pensioners should receive priority access to NHS care for any conditions which are related to their service subject to the clinical needs of all patients, in line with December 2007 guidance from the Department of Health.

GPs should notify the Trust of the patient's condition and its relation to military service when they refer the patient so that the Trust can ensure that it meets the current guidance for priority service over other patients with the same level of clinical need. In line with clinical Policy, patients with more urgent clinical needs will continue to receive clinical priority.

7.5.9. Overseas visitors

Confirmation must be made for all patients requesting elective care as to their eligibility for NHS care.

Relevant NHS bodies must always provide treatment, which is classed as immediately necessary by the treating clinician irrespective of whether or not the patient has been informed of, or agreed to pay charges, and it must not be delayed or withheld to establish the patient's chargeable status or seek payment. It must be provided even when the patient has indicated that they cannot afford to pay.

7.5.10. Consultant to Consultant Referrals

Consultant-to-Consultant referrals will be kept to a minimum wherever possible and must relate to the original condition.

Consultant-to-Consultant referrals must follow the strict "Referral Protocol" process as agreed with the CCG. At present referrals may be accepted under the following circumstances:

- Consultant to Consultant outpatient referral or Accident & Emergency to Consultant outpatient referral is considered of benefit to the patient when a different specialist Consultant opinion is needed to advance the management of the presenting or associated condition
- When the referral is for investigation, management or treatment of cancer, or a suspected cancer

- Symptoms or signs suggest a life threatening or urgent condition
- Surgical assessment of an established medical condition with a view to surgical treatment
- Medical assessment of an established surgical condition with a view to medical management
- Anaesthetic risk assessment
- A&E referrals to fracture clinic
- Referrals that are part of the continuation of investigation/treatment of the condition for which the patient was referred. These will continue their existing pathway.
- Suspected cancer referral; this will be vetted and dated by the receiving Consultant and upgraded if deemed necessary. Once upgraded the patient will be treated within 62 days of the date the referral was received by Consultant.
- Management of pain where surgical intervention is not yet appropriate

All other referrals must be returned to the referring Consultant for referral back to the patient's GP.

Investigation for, or treatment of any condition other than the condition for which the patient was originally referred, requires the patient to be referred back to the GP for onward referral to a different specialist.

7.5.11. Emergency and Ward Admissions

Patients who require an outpatient appointment with the Consultant Team that was responsible for their care during their inpatient stay will be booked as "follow-up appointments".

These patients should not be placed on an 18-week RTT pathway and appointments should be agreed with the patient and booked by the ward before the patient is discharged.

Patients who require an outpatient appointment with a different specialty or new Consultant Team following an inpatient admission will be booked as "New appointments". These patients fall under the 18-Week RTT requirements, and a RTT clock will start at this point.

Appointments should be agreed with the patient and booked by the ward before the patient is discharged.

Patients who require an outpatient appointment with a different specialty or new Consultant Team following an inpatient admission who are already under the care of that Consultant Team for outpatient treatment will be booked as "follow-up appointments". The appointment should be booked under the existing outpatient registration for that Consultant Team.

The guidance on Consultant-to-Consultant referrals (section 3.10) must be applied when booking appointments for this group of patients

7.6. Patient Contact Outpatients

7.6.1. Reasonable offers

A written appointment or admission offer will only be considered reasonable if it is "an offer of a time and date 3 or more weeks from the time that the offer is made" or a mutually agreed earlier time.

7.6.2. Outpatient Letters

A letter inviting the patient to contact the Trust to agree an appointment date will contain the following information:

- Patient name and case note / hospital number
- Date of letter
- Who to contact (named contact where possible)
- Response required from patient within locally agreed timeframe
- Details of what will happen if no contact is made (removed from list with GP or referrer informed)

After the patient makes contact and an appointment date has been agreed, this conversation should be followed up with a confirmation letter providing explicit instructions.

7.6.3. Booking Outpatient Appointments

All patients will be offered appointments within the current guidelines for patient choice and in line with the national guidance for waiting times.

A reasonable offer is "an offer of a time and date 3 or more weeks from the time that the offer is made" or a shorter period may be considered reasonable subject to mutual agreement; outpatient-scheduling staff will ensure that all appointments offered are recorded on the current OPA waiting list. (When new PA system is live this will be amended to reflect the new procedure) If possible, patients should be contacted by telephone in order to agree their first outpatient appointment.

Patients who decline one reasonable offer must be offered at least one further reasonable offer. Patients should be warned that after declining the first reasonable offer only one other date may be offered, subject to a clinical decision and the completion of a Harm form (Appendix 3).

If a second reasonable offer is declined, a clock stop should be considered if the patient is unwilling to accept a date within six weeks or before their 18-Week RTT breach date. In such circumstances, clinical guidance is to be sought to confirm that:

- The delay is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Safeguarding Children NGH PO 243) are protected. Always contact the safeguarding team if you have any concerns

Three attempts are to be made to contact the patient over a 24-hour period (one attempt to be after 5.00pm). If this is unsuccessful, the patient will then be sent a letter requesting that they make contact with the relevant booking team. This is known as partial booking. Where this is not in place, the patient will be sent an appointment.

If the patient does not make contact with the relevant team within two weeks (as per the letter) and the patient's address details have been confirmed as correct, the patient should be removed from the outpatient waiting list and a standard PAS letter sent to the patient and GP confirming the patient's removal.

Any written appointment to a patient must be deemed reasonable.

It is accepted that while all offers have to be reasonable, some patients may be willing to attend at short notice. If a patient accepts a short notice offer, this will be considered a reasonable offer if the patient subsequently cancels the appointment. However if a patient declines such an offer the patient's 18-Week RTT waiting time must continue.

Patients who are not referred via NHS e-Referral will receive an invitation or acknowledgement letter confirming their first outpatient appointment.

Patients will be booked for their first outpatient appointment in line with speciality pathway milestones using locally agreed timelines. i.e. 11 weeks from referral.

NHS e-Referral patients will receive a confirmation letter once the referral has been reviewed and accepted by the Clinical Team.

7.6.4. Patients Requesting Time to Consider Treatment Options (Thinking Time)

Patients may wish to spend time thinking about the recommended treatment options before confirming they are willing and able to proceed. It would not be appropriate to stop the 18-Week RTT clock where this amounts to only a few days however, it may be appropriate to stop the 18-Week RTT clock (patient active monitoring) where the patient requests a delay of two or more weeks before coming to a decision, provided the following have been confirmed:

- A delay it is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Safeguarding Children NGH PO 243) are protected. Always contact the safeguarding team if you have any concerns

If the patient decides to go ahead with the recommended treatment, he/she can be added to the waiting list and a new clock started when the patient confirms they are willing to proceed. They can be added directly to the waiting list again within a 12-week period.
The Consultant in charge of the patient's care may decide to add the patient straight on to the waiting list, or may offer the patient an outpatient appointment.

7.6.5. New appointment DNA

For patients who DNA their first outpatient appointment for the first time, the responsible clinician and/or outpatient nurse will review the patient notes at the end of clinic with a view to discharging the patient providing that:

- All the patients' demographic details must be rechecked. Should the patient details be incorrect a new appointment must be offered as soon as possible within 2 weeks of the DNA
- Discharging the patient is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Safeguarding Children NGH PO 243) are protected. Always contact the safeguarding team if you have any concerns

If the decision is made not to rebook, the patient will be removed from the outpatient waiting list with a DNA Clock stop and an automated PAS letter will be sent to the GP and the patient notifying them of this removal. The patient will be discharged from PAS, and cancelled on NHS e-Referral if appropriate.

If the Consultant decides that it is necessary to re-book then a clock start will be added.

7.6.6. Follow Up Appointment DNA

Patients who DNA their follow up outpatient appointment will be discharged back to their GP providing that:

- Discharging the patient is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Safeguarding Children NGH PO 243) are protected. Always contact the safeguarding team if you have any concerns

This is to be confirmed by the Consultant at the end of the clinic and a letter sent to this effect to the patient and their GP. Where the patient is on an active/open pathway a clock stop needs to be recorded on PAS at time of the patient DNA.

7.6.7. 2 Week Wait First Appointment DNA's

If patients DNAs a two week wait (2WW) first appointment, another appointment should be booked automatically. The patient should not be discharged or referred back to their GP. However, it is good practice to contact the GP to make them aware that the patient had DNA would and ask them to find out why.
Patients referred on a 2WW can be referred back to their GP after two consecutive DNAs; the responsible clinician will review the patient notes at the end of clinic that the patient was due to attend with a view to discharging the patient providing that:

- Discharging the patient is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Safeguarding Children NGH PO 243) are protected. Always contact the safeguarding team if you have any concerns

If the decision is made not to rebook and discharge the patient, the patient will be removed from the outpatient waiting list and an automated PAS letter will be sent to the GP and the patient notifying them of this removal. The patient will be discharged from PAS, and cancelled on NHS e-Referral if appropriate.

7.6.8. 2 Week Wait First Appointment Cancellations

Patients should not be referred back to their GP after a single appointment cancellation.

Patients should not be referred back to their GP after multiple (two or more) appointment cancellations unless this has been agreed with the patient – by cancelling an appointment a patient has shown a willingness to engage with the NHS. The quality of suspected cancer referrals will be the subject of regular audit, with the appropriate feedback to individual GPs and the CCG.

7.6.9. Patient Cancellations (CNA – Could Not Attend)

Patients who cancel their appointment should be given an alternative date at the time of the cancellation. The Choose and Book system must be monitored to manage cancelations.

Patients that cancel an appointment:

- On two or more consecutive occasions (and causes delay to their appointment by more than two weeks).
- Are unable to re-book their appointment within their breach date,

Should be reviewed by the clinician to ensure there is no clinical risk in not treating the patient and it is agreed that the patient is not considered to be vulnerable (see Safeguarding Adults at Risk Policy, Safeguarding Children NGH PO 243). Where no risk is identified, patients should be discharged back to their GP.

7.6.10. Hospital Cancellations

Patients who are cancelled by the hospital must be offered an alternative date which is within the following two weeks and/or within their 18-Week RTT breach date.

The only acceptable reason for clinic cancellations is absence of medical staff is because of planned annual / study leave, audit activities, on call commitments or unplanned sickness absence.

A minimum of six weeks' notice of planned annual/study leave should be given. Clinics should not be cancelled for any other reason unless there are exceptional circumstances and the cancellation has been authorised by the Deputy Chief Executive Officer or a nominated deputy.

7.6.11. Outpatient Clinic Cancellations with six weeks' or more notice

- Only leave approved by the relevant clinical lead will be actioned.
- Session cancellation notifications will only be accepted if submitted on the appropriate form, unless there are exceptional circumstances.
- Session cancellation notification must be passed to the relevant administrative manager for action.
- Session cancellation requests will be actioned at the earliest opportunity and within a maximum of five working days.

- Where patients have to be cancelled, the relevant clinician should review clinical priorities and waiting times and identify the rebooking requirement.
- Patients who have previously been cancelled should not be cancelled a second time.

7.6.12. Outpatient Clinic Cancellations with less than six weeks' notice

- Clinics should not be cancelled with less than six weeks' notice unless there are exceptional circumstances.
- No clinic should be cancelled without the authorisation of the Deputy Chief Executive Officer or a nominated deputy.

When clinics have to be unavoidably cancelled at short notice, liaison with nursing staff, the Outpatient Manager and relevant Directorate Manager is essential.

Identifying appropriate capacity for these patients to be rebooked remains the responsibility of the Consultant and the division, not the outpatient department.

7.7. Diagnostics and Imaging Appointments

7.7.1. Diagnostic Referrals/Requests

Referrals received from both primary and secondary care clinicians for diagnostic investigations must be received on the appropriate request forms, completed correctly and signed electronically or on paper.

Any form that is incomplete or unsigned will be returned to the requester.

Record the request on CRIS/ICE as received with the status as "awaiting clinical information"

The diagnostic waiting time clock starts when the request for a diagnostic test or procedure is made. This is when the request for a diagnostic procedure is entered on to CRIS/ICE or by using the date written on the diagnostic request form by the referring clinician.

The appropriate administration process for prioritisation will follow. Incomplete forms should be returned to the referrer for correct completion.

For direct access referrals, where it is the responsibility of the patient to arrange booking of the diagnostic appointment, the diagnostic waiting time will start at the point when the request is received for the Trust to arrange the diagnostic appointment.

7.7.2. Diagnostic Prioritisation

Referral requests will be allocated to the appropriate person for prioritisation according to the protocol for each service. Once requests have been allocated to a specific person, patients will be treated equally.

Following acceptance of the request, the CRIS/ICE status requires up dating to record "Request Accepted". This applies to both GP and Consultant-to-Consultant referrals, where they exist.

It should be noted that outpatient imaging might be offered to a patient at any site within the Trust, although consideration will be given to the patient's place of residence where possible.

7.7.3. Diagnostic Reasonable Offers

The definition of a reasonable offer is an offer of an appointment with at least 3 weeks' notice of the appointment date.

7.7.4. Diagnostic Patient Declines Reasonable Appointment Offers

If a patient declines two reasonable offers, the clock for the 6-week diagnostic standard can be re-set from the first appointment offered.

The clock cannot be reset if there is no evidence that the appointments offered to and declined by the patient were reasonable.

Adjustments to the 6-week diagnostic standard as outlined above do not affect the patient's 18-Week RTT waiting time. It is therefore important that staff are aware of patients who are on both a diagnostic 6 week and 18-Week RTT pathway and that their care is delivered in line with both national standards.

7.7.5. Diagnostic Inappropriate Referrals

If a referral has been made that does not follow referral protocols the diagnostic lead must add comments on CRIS/ICE detailing the reasons why the referral is considered inappropriate.

The request status on CRIS/ICE requires up-dating by entering "Requested Unjustified" or Request Rejected" ensuring that the reason for rejection is recorded in the comments box, providing a clear audit trail should the reason for rejection be required in the future.

7.7.6. Diagnostic Cancer Referrals

Cancer referrals are received from hospital Consultants into the Radiology department in the same way as all other referrals but should be clearly marked as a cancer referral.

The diagnostic waiting time clock starts when the request for a diagnostic test or procedure is made. This is when the request for a diagnostic procedure is entered on to Order Communications or by using the date written on the diagnostic request form by the referring clinician and confirmed as a cancer referral by the vetting Radiologist.

An urgent appointment is made for the patient in order to meet the 31 day National Cancer Waiting Times Target. This appointment should be made within a maximum of 14 days from receipt of the imaging request.

Should insufficient capacity exist in order to meet the target, immediate escalation is required to the Radiology Services Manager.

7.7.7. Diagnostic Urgent Referrals

Referrals justified as urgent by a Radiologist, Radiographer or Sonographer must be given priority. Regular review of session templates must take place to ensure best use of available slots.

7.7.8. Diagnostic Routine Referrals

Routine referrals should be given appointments in turn, providing equity of access.

7.7.9. Diagnostic Imaging Appointments

Following prioritisation, patients will be contacted by telephone to arrange a convenient appointment or an appointment letter will be sent directly to the patient confirming the appointment.

7.7.10. Diagnostic Waiting Lists

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

Care and consideration must be given to the procedures set to manage these lists in line with departmental Policy and this guidance.

The RTT rules do not allow for a 'pause' for a diagnostic stage of a pathway.

7.7.11. Diagnostic Active Waiting List

The active waiting list should consist of patients awaiting diagnostic tests/procedures, who are available to attend within the waiting time standard.

7.7.12. Diagnostic Planned Waiting List

For some patients, the timing of their diagnostic test is dependent upon other clinical factors. In these circumstances, patients are called for an appointment at a clinically indicated time and these requests are classed as planned.

When patients on planned lists are clinically ready for their test to commence and reach the date for their planned appointment, they either should receive that appointment or be transferred to an active waiting list and a waiting time clock should start (and be reported in the relevant waiting time return).

7.7.13. Therapeutic Procedures

The following procedures carried out within the Radiology Department are therapeutic procedures and not diagnostic procedures and as such, the 6-week diagnostic waiting time's standard does not apply. These procedures are governed by the 18-Week RTT rules.

- Radiologically guided steroid injections
- Angioplasty

7.7.14. Diagnostic Patient Discharged - Treatment not Taken Place

In the event of a patient being unable to tolerate the examination and this being abandoned (e.g. because of claustrophobia), details must entered on to CRIS (including the reason) and the referrer notified. Where possible, consideration will be given to an alternative imaging procedure.

7.7.15. Diagnostic Did Not Attend

Standard Radiology DNA protocol will apply (in line with Trust Policy on outpatient appointment DNAs (section 10), when a patient does not attend for the first time. A radiology clinician will review the diagnostic request with a view to discharging the patient providing that:

- This is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Safeguarding Children NGH PO 243) are protected. Always contact the safeguarding team if you have any concerns
- A copy of the request form plus the CRIS generated DNA letter will be sent to the referring Consultant/GP.

If a further appointment is to be offered the request should be treated as a new referral and re-entered on to CRIS as a new event, ensuring a new request received date is entered accordingly.

Patients who DNA should not be offered a further appointment unless requested by a Consultant or where there are exceptional circumstances.

If a patient does not attend their diagnostic appointment but is then rebooked under the instruction of the Consultant, the diagnostic waiting time for that test/procedure is set to zero and the waiting time starts again from the date of the appointment that the patient missed. This adjustment has no effect on the patient's 18-Week RTT pathway.

- Failure to attend an agreed appointment date will result in the referrer being informed of the failure to attend and removal. The patient may be re-referred at the General Practitioner /referrer's discretion.

7.7.16. Diagnostic Patient Cancellations

Patients who cancel their appointment once should be given an alternative date at the time of cancellation.

If a patient cancels their appointment, more than once the imaging request should be returned to the referring clinician for consideration of a re-referral, providing the referral is not for a suspected/confirmed cancer.

The patient should be removed from the waiting list and cancelled on CRIS, noting the appropriate reason. All patient cancellations should be recorded by following the patient cancellation process on CRIS.

Suspected cancer patients who DNA will be offered one further appointment before the above process is followed

7.7.17. Diagnostic Session Cancellation

The only acceptable reason for session cancellation is absence of medical staff as a result of planned annual / study leave (following the Consultant Radiologist and Radiology Associate Specialist Annual/Study Leave Guidelines), audit activities, on call commitments or unplanned sickness absence.

A minimum of six weeks' notice of planned leave should be given. Sessions should not be cancelled for any other purpose unless there are exceptional circumstances.

When a session has to be unavoidably cancelled, rebooking should take place within 5 working days.

7.7.18. Diagnostic Session Cancellation with six weeks' or more notice

- Only leave approved by the relevant clinical lead will be actioned.
- Session cancellation notification must be passed to the relevant clerical officer for action.
- Session cancellation requests will be actioned at the earliest opportunity and within a maximum of five working days.
- Where patients have to be cancelled, the relevant clinician should review clinical priorities and waiting times and identify the rebooking requirement.
- Patients who have previously been cancelled should not be cancelled a second time.

7.7.19. Session Cancellation with less than six weeks' notice

- Sessions should not be cancelled with less than six weeks' notice unless there are exceptional circumstances.
- No session should be cancelled without the authorisation of the Deputy Chief Executive Officer or a nominated deputy.

7.8. Patient Contact Inpatients

7.8.1. Reasonable offers

A reasonable offer is "an offer of a time and date 3 or more weeks from the time that the offer is made". The Admissions Office will ensure that all appointments offered are recorded on PAS

If a second reasonable offer is declined, a clock stop should be considered if the patient is unwilling to accept a date before their 18-Week RTT breach date. Clinical advice must be sought to confirm:

- That any delay in treatment is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Safeguarding Children NGH PO 243) are protected. Always contact the safeguarding team if you have any concerns

Providing the above has been confirmed and the clinician is satisfied that the proposed delay is appropriate, the patient may be offered a date beyond their 18-Week RTT breach date. This is taken into account within the incomplete reporting of 92%

Patients requesting a delay of more than twelve weeks should have a clinical review. If the clinician feels the delay is inappropriate and not in the best clinical interests of the patient, and the patient does not accept the advice of the clinician, the patient must be discharged back to the care of their GP provided:

- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Safeguarding Children NGH PO 243) are protected. Always contact the safeguarding team if you have any concerns

This is called a “Failure to progress” and a letter to the relevant referrer sent.

It is accepted that while all offers have to be reasonable it is possible some patients may be willing to attend at short notice. However if a patient declines such an offer the patient’s 18-Week RTT waiting time must continue.

Should a patient accept an admission date with less than three weeks’ notice, this will become a reasonable offer and should be appropriately documented.

7.8.2. Pre-operative assessment (POA)

Where possible, patients will be offered pre-operative assessment on the day that they are added to the waiting list in outpatients. In the event that this is not possible, the patient will be offered a subsequent appointment to attend for pre-operative assessment.

7.8.3. Patient Assessed As Fit to Proceed

If the patient is considered fit for treatment and prior approval is not required, the admissions department will negotiate a date for treatment with the patient in due course. The patient will be treated within their 18-week pathway unless this is not clinically appropriate or the patient chooses to wait longer for treatment.

7.8.4. Patients Assessed As Not Fit to Proceed

If the patient is not fit for treatment but the clinical issue is short term (3 weeks or less) and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold), confirmation that the clinical issue has resolved must be obtained before the patient is considered fit to proceed. The clock will continue running during this time.

If the clinical issue is expected to last for 4 weeks or more the patient must be removed from the waiting list. This will be a clock stop for the purpose of RTT monitoring.

The patient will be re-listed and a new clock started when confirmation is received that the patient is fit to undertake the procedure. They can be added directly to the waiting list again within a 12-week period. Any delay over 12 weeks will require a new referral from the GP.

7.8.5. POA Appointment DNA

Patients who DNA a first or any subsequent pre-operative assessment appointment will be discharged back to the requesting clinician if a further review appointment is assessed as not clinically important providing the following can be confirmed:

- That discharge is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Safeguarding Children NGH PO 243) are protected. Always contact the safeguarding team if you have any concerns

The patient and Clinician will be notified of this by letter. It will then be the responsibility of the clinician to manage the patient's condition.

Should there be any Safeguarding concerns about a child relating to a paediatric DNA, Safeguarding Practice Guidelines will be followed. With children who do not attend (were not brought), the GP will be asked to consider why the child did not attend and to include safeguarding concerns within this. For children who already have safeguarding issues, the failure to attend will be highlighted to the appropriate professionals.

The patient and GP will be notified of this by letter. It will then be the responsibility of the GP to manage the patient's condition.

7.8.6. Booking Admissions

All patients will be offered admission dates within the current guidelines for patient choice and in line with the national guidance for waiting times, wherever possible patients must be contacted by telephone to agree their admission date.
Three attempts are to be made to contact the patient over a 24-hour period. If this is unsuccessful, the patient will then be sent a letter requesting that they make contact with the relevant booking team.
If the patient does not make contact with the relevant team within two weeks (as per the letter), the patient should be removed from the inpatient waiting list and a standard PAS letter sent to the patient and GP confirming the patient's removal providing the following can be confirmed:

- That any delay in treatment is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Safeguarding Children NGH PO 243) are protected. Always contact the safeguarding team if you have any concerns

7.8.7. Admission Letters

A letter inviting the patient to contact the Trust to agree an admission date will contain the following information:

- Patient name and case note / hospital number
- Date of letter
- Who to contact (named contact where possible)
- Response required from patient and timeframe
- Details of what will happen if no contact is made (removed from list with GP or referrer informed)

After the patient makes contact and an admission date has been agreed, this conversation should be followed up with a confirmation letter providing explicit instructions.

This letter is known as the “to come in letter “which should contain the following details:

- Patient name and case note / hospital number
- Date of letter
- Day, date and time of admission
- Arrangements for transport
- Where to report to on arrival
- Response required from the patient (if any since this confirms a previously agreed date)
- Clear named contact telephone number for queries relating to admission or to advice of unavailability or late cancellation
- All instructions for admission and / or booklet if not already advised at POA.
- Request to check bed is available on day of admission (if appropriate)
- Reasons for checking bed availability (if appropriate)
- Information about the planned treatment if not already advised
- This letter should be sent out in the name of the Consultant or contain the Consultant’s name.

7.8.8. Patient Request for Review of Treatment Decision/Plan

If a patient on an inpatient waiting list on an RTT 18-Week pathway, at any time wishes to discuss their intended procedure with the Consultant in charge of their care before they wish to proceed to surgery, the patient should be removed from the waiting list and offered a follow up appointment, provided the following can be confirmed:

- That any delay in treatment is not contrary to their best clinical interest.
- The clinical interests of vulnerable their patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Safeguarding Children NGH PO 243) are protected

The patient can be added directly to the waiting list again within a 12-week period. Any delay over 12 weeks will require a new referral from the GP.

7.8.9. Patients Requesting Time to Consider Treatment Options (Thinking Time)

Patients may wish to spend time thinking about the recommended treatment options before confirming they are willing and able to proceed. It would not be appropriate to stop the 18-Week RTT clock where this amounts to only a few days however, it may be appropriate to stop the 18-Week RTT clock (patient active monitoring) where the patient requests a delay of two or more weeks before coming to a decision, provided the following have been confirmed:

- A delay it is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Safeguarding Children NGH PO 243) are protected. Always contact the safeguarding team if you have any concerns.

If the patient decides to go ahead with the recommended treatment, he/she can be added to the waiting list and a new clock started when the patient confirms they are willing to proceed. They can be added directly to the waiting list again within a 12-week period.

The Consultant in charge of the patient’s care may decide to add the patient straight on to the waiting list, or may offer the patient an outpatient appointment.

7.8.10. Principles of Waiting List Management

The decision to add a patient to a waiting list must be made by a Consultant, or under an arrangement agreed with the Consultant.

- Patients should not be added to the waiting list unless:
- They are fit, i.e. if a bed was available the following day the patient is medically fit to proceed
- The patient is able to accept a date before the 18-week breach date.

Patients who are considered to be insufficiently fit/well enough to proceed must be discharged back to their GP with a full explanation and clear details of the criteria that need to be met in order for the patient to be reconsidered for treatment at a later date.

The Consultant may choose to continue to review them in outpatient department but take them off the waiting list for surgery. This includes patients with a high BMI, smokers, drug users and heavy drinkers. A decision not to treat or an active monitoring clock stop should be applied to the patient’s 18-Week RTT pathway.

The use of effective early pre-operative clinics (POA) forms the basis of efficient waiting list management. The attendance at a POA clinic following the decision to treat determines the suitability and fitness to treat at an early stage. In cases where fitness is an issue, continuing care via POA may be appropriate.

7.8.11. Planned Waiting Lists

Patients should only be added to a planned list where clinically they need to wait for a period of time. This includes planned diagnostic tests (e.g. check cystoscopy) or treatments or a series of procedures carried out as part of a treatment plan - which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.

Patients on planned lists should be booked at the clinically appropriate time and they should not have to wait a further period after this time has elapsed.

For example, a patient due to have a re-test in six months' time should be booked six months later and they should not get to six months, then have to wait again for non-clinical reasons. This is not an acceptable use of a planned list.

When patients on planned lists are clinically ready for their care to commence and reach the date for their planned appointment, they either should receive that appointment or be transferred to an active waiting list and a new RTT clock start is made.

The key principle is that where patients' treatment can be started immediately, then they should start treatment or be added to an active waiting list.

7.8.12. Endoscopy Pathways

Elective Planned (EP) patients need to have repeat endoscopies at clinically indicated intervals. The Endoscopy Booking Clerk enters the date for repeat endoscopy into a diary system.

A 'bring forward' system is then used by the Endoscopy Booking Clerk to ensure patients are contacted at the appropriate interval. Dedicated surveillance lists are run, and each patient is allowed to choose their date of attendance on one of these lists.

The booking clerk must regularly review any planned lists for their service to ensure that patient safety and standards of care are not compromised to the detriment of outcomes for patients. Patients should also be given written confirmation if they are placed on such lists, including the review date.

7.8.13. Maintaining Waiting Lists

Waiting Lists should be kept up to date by waiting list co-ordinators or identified staff managing individual lists using the 18-Week RTT Patient Tracking List (PTL). They need to ensure that patients are listed promptly and that the list does not contain patients who no longer need their procedures.

All waiting lists are to be maintained in the PAS system. Manual card based systems remain only as a backup to the main database. A full audit trail must be kept updated on the system.

Details of listed patients must be entered onto the computer system within 24 hours of the decision to admit being made. Patients will be added to the waiting list with the date the decision to admit was made.

The waiting list episode needs to be attached to the correct 18-Week RTT pathway.

7.8.14. Patient-initiated delays and RTT pathways/ Patients Not Available

With effect from October 2015, the RTT Rules Suite has been updated to reflect the removal of the provision to apply adjustments to RTT pathways for patient-initiated delays. We can no longer report pauses or suspensions in RTT waiting time clocks.

As a Trust, we will still maintain a record of all patient-initiated delays, to aid good waiting list management and to ensure patients are treated in order of clinical priority. The dates of the reasonable offers declined will need to be recorded in the Consultant diary if the date is agreed in clinic or by the waiting list office if the date is agreed with the waiting list staff. All reasonable offers must be logged in the waiting list comments field using the format RTCI DD/MM/YY.

It is not acceptable to refer patients back to their GP simply because they wish to delay their treatment. We must not use blanket rules that apply to a maximum length to patient-initiated delays that does not take account of individual patient circumstances.
We should be aware of the possible harm that can come to patients if they delay their treatment.
Patients should only be allowed to delay their treatment if the clinician is satisfied that the proposed delay is appropriate; a Consultant should use a Harm form to record this. This form is used both as a validation tool and a record of patient initiated delays.(Appendix 3) The Trust should allow the delay, regardless of the length of wait reported.

If the patient refuses to accept the advice of the clinician then the responsible clinician must act in the best interest of the patient.

If the clinician feels that it is 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. However, it would be acceptable where referring patients back to their GP is in their best clinical interests. Such decisions should be made by the treating clinician on a case-by-case basis.

A reasonable offer of a TCI is one for a time and date three or more weeks from the time that the offer was made, or a mutually agreed date that is earlier.

7.8.15. The Active Waiting List (PTL)

The active waiting list should consist of patients awaiting inpatient or day case admission, who are currently fit and able to proceed with treatment. This includes local anaesthetic procedures and first endoscopic procedures.

All patients irrespective of procedure, form part of the elective waiting list and must be treated in line with Department of Health guidance.

- Clinical priority should be defined as urgent or routine only.

- to aid both the clinical and administrative management of the waiting list, elective waiting lists and planned lists will be listed separately but must be managed in line with this Policy guidance and the intended management.

7.8.16. Patients Requiring Commissioner Funding Approval (LCP)

When funding prior approval for treatment is required, this must be obtained before adding a patient to the active waiting list. (See section 11.7)

7.8.17. Adding Patients to Active Inpatient / Day Case Waiting Lists

The definition of an inpatient is any patient admitted electively or by other means with the expectation that they will remain in hospital for at least one night, including any patient admitted with this intention who leaves hospital for any reason without staying overnight.

The definition of a day case is “A patient admitted electively during the course of a day with the intention of receiving care who does not require the use of a hospital bed overnight and who returns home as scheduled. If this original intention is not fulfilled and the patient stays overnight, such a patient should be counted as an ordinary admission.”

- A day case must be an elective admission
- A Consultant is responsible for the patient’s medical care
- The patient uses a hospital bed for recovery purposes. If a bed or trolley is used for a specific short procedure rather than because of the patient’s condition, this does not count as a hospital bed.
- The patient is not intended to occupy a hospital bed overnight, and does not actually occupy a bed overnight.

7.8.18. Patients Listed For More Than One Procedure

If more than one procedure is to be performed at one time by the same surgeon, the patient should be added to the waiting list with additional procedures noted.

If different surgeons are working together to perform more than one procedure the patient should be added to the waiting list of the Consultant Surgeon for the priority procedure with additional procedures noted. List the additional procedures and the other Consultant required to assist with the joint procedure

- If a patient requires more than one procedure performed on separate occasions by different (or the same) surgeon(s):
- The patient should be added to the active waiting list for the primary (1st) procedure.
- The patient should not be added to the waiting list for any subsequent procedures, as they are not “fit or willing” to proceed with any additional treatment at this stage.
- When the first procedure is complete and the patient is fit, willing and able to undergo the second procedure the patient should be added to the waiting list.

7.8.19. Did Not Attend (DNA)

Where a patient does not attend a reasonably offered admission date they should be removed from the waiting list and returned to the care of their GP provided the following is confirmed:

- That it is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Safeguarding Children NGH PO 243) are protected. Always contact the safeguarding team if you have any concerns

Clinical teams must be notified of any patients on a cancer pathway who do not attend. The clinical team must contact the patient and/or the patient's GP to ascertain the reason for non-attendance. The clinical team will liaise with the scheduler when rebooking the admission to ensure the most clinically appropriate date is offered to the patient.

7.8.20. Patient Cancellations (CNA – Could not attend)

Patients who cancel their admission for non-medical reasons should be given an alternative date at the time of the cancellation.

For those patients who cancel an admission:

- On two or more consecutive occasions (and causes delay to their treatment by more than two weeks),
- And are unable to re-book their admission within their breach date

Should be reviewed by a clinician to ensure there is no clinical risk in not treating the patient and it is agreed that the patient is not considered to be vulnerable (see Safeguarding Adults at Risk Policy, Safeguarding Children NGH PO 243).
Where no risk is identified, patients should be discharged back to their GP and a clock stop recorded.
A clock stop should also be considered if the patient is unwilling to accept a date within six weeks or before their 18-Week RTT breach date, under which circumstances clinical advice must be sought to confirm:

- That any delay in treatment is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Safeguarding Children NGH PO 243) are protected. Always contact the safeguarding team if you have any concerns

Providing the above has been confirmed, the patient may be offered a date beyond their 18-Week RTT breach date.

Patients requesting a delay of more than twelve weeks should have a clinical review. If the clinician feels the delay is inappropriate and not in the best clinical interests of the patient, and the patient does not accept the advice of the clinician, the patient must be discharged back to the care of their GP provided:

- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Safeguarding Children NGH PO 243) are protected. Always contact the safeguarding team if you have any concerns.

7.8.21. Cancer Admissions

Clinicians must be notified of any patients on a cancer pathway who wishes to cancel their admission. If the clinician feels the delay is inappropriate and not in the best clinical interests of the patient a member of the clinical team must contact the patient to discuss this further.

7.8.22. Patients Who Become Medically Unfit Prior to Admission

If a patient is listed for surgery but is identified, or self-reports, as unfit for that procedure, the nature and duration of the clinical issue should be ascertained.

If the clinical issue is short term (3 weeks or less) and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold), the patient must be offered a new TCI date within their 18-Week breach date. The clock will continue running during this time.

If the clinical issue is expected to last for 4 weeks or more the patient should be removed from the waiting list and where appropriate discharged back to primary care or referred to another specialty for any further management/treatment that is required before admission can be rearranged. This will be a clock stop for RTT monitoring.

The patient will be re-listed and a new clock started when confirmation is received that the patient is fit to undertake the procedure. They can be added directly to the waiting list again within a 12-week period. Any delay over 12 weeks will require a new referral from the GP.

7.8.23. On the day cancellations

Non-Clinical Reasons (Hospital Initiated)

On the day, cancellations are defined as occurring “on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. For example, the patient is to be admitted to hospital on a Monday for an operation scheduled for the following day (Tuesday).

If the hospital cancels the operation for non-clinical reasons on the Monday then this would count as a last-minute cancellation. This includes patients who have not actually arrived in hospital and have been telephoned at home prior to their arrival” on the day, they were due to arrive.

Where theatre lists or patients are cancelled on the day of admission or day of surgery, patients must be booked as close to their original admission as possible, and within a maximum of 28 days of the cancellation date.

When contacting the patient to arrange a suitable date within the 28-day guarantee window, Trusts should offer patients a choice of at least two dates (assuming the offer is a verbal one) with a minimum of 3 weeks’ notice.

However, if the dates that are offered with less than 3 weeks' notice and the patient choose to accept a date, this constitutes an acceptable offer.

Two reasonable offers must be made to the patient within 28 days of the date of cancellation.

The patient may choose not to accept a date within 28 days as long as the offer of a new date was reasonable but the patient prefers to be treated after the 28-day period then that is not counted as a breach. Where possible, NHS Trusts should work with the patient to offer a date that is suitable to them.

If the Trust cannot offer the patient a date within 28 days of the cancellation, the Trust must offer to fund the patient's treatment at the time and hospital of the patient's choice where appropriate.

Clinical Reasons (Hospital Initiated)

Where a patient is cancelled on the day of admission or day of surgery for clinical reasons, the nature and duration of the clinical issue should be ascertained.

If the clinical issue is short term (3 weeks or less) and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold), the patient must be offered a new admission date within their 18-Week breach date. The clock will continue running during this time.

If the reason for cancellation is expected to last for 4 weeks or more, or there is a clinical reason to defer surgery for 4 weeks or more, the patient must be removed from the waiting list. This will be a clock stop for RTT monitoring.

A treatment plan must be agreed for the patient, or the patient discharged back to the care of their GP. The patient will be re-listed and a new clock started when confirmation is received that the patient is fit to undertake the procedure. They can be added directly to the waiting list again within a 12-week period. Any delay over 12 weeks will require a new referral from the GP.

Cancellation of session by hospital

Patients who are cancelled by the hospital prior to the day of admission must be offered an alternative date which is within the following two weeks and/or within their 18-Week RTT breach date.

The only acceptable reason for theatre list cancellation is absence of medical staff because of planned annual / study leave, audit activities, on call commitments or unplanned sickness absence.

A minimum of six weeks' notice of planned leave should be given. Theatre lists should not be cancelled for any other reason unless there are exceptional circumstances and the cancellation has been authorised by the Deputy Chief Executive Officer.

7.8.24. Operation Session Cancellation with six weeks' or more notice

- Only leave approved by the relevant clinical lead will be actioned.
- Session cancellation notifications will only be accepted if submitted on the appropriate form, unless there are exceptional circumstances.
- Session cancellation notification must be passed to the relevant administrative manager for action.
- Session cancellation requests will be actioned at the earliest opportunity and within a maximum of five working days.
- Where patients have to be cancelled, the relevant clinician should review clinical priorities and waiting times and identify the rebooking requirement.
- Patients who have previously been cancelled should not be cancelled a second time.

7.8.25. Operation Session Cancellation with less than six weeks' notice

- Sessions should not be cancelled with less than six weeks' notice unless there are exceptional circumstances.
- No session should be cancelled without the authorisation of the Deputy Chief Executive Officer or a nominated deputy.
- When theatre lists have to be unavoidably cancelled at short notice, liaison with the Divisional Manager, Assistant Divisional Manager for Theatre and Theatre Manager is essential. Identifying appropriate capacity remains the responsibility of the Consultants and the division.

7.8.26. IP Waiting List Validation and Review

All waiting lists must be validated at least once a month by the waiting list co-ordinators. This process will ensure that lists are always as up-to-date as possible, and that the most efficient use is made of the Trust's inpatient and Daycase resources.

8. IMPLEMENTATION & TRAINING

The Policy will be ratified by the Procedural Document Group and circulated to all areas of the Trust. Additionally the Policy will also be available on the intranet and as a summary version.

It is the responsibility of the Divisional Managers and Clinical Directors to remove previous Policy versions and to ensure all relevant staff receive the Policy and are adhering to the latest ratified version.

Ensure that Access Policy Training is in Local Induction and in individual training portfolios.

Develop a Question and Answer forum on the Intranet accessible to all – that will be interactive.

Continued support from Information team.

9. MONITORING & REVIEW

Minimum policy requirement to be monitored	Process for monitoring	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/ group/ committee for monitoring of action plan
Application of Policy	18 week walk through audits	Information Department	Monthly	Data Quality Steering Group	Relevant Specialty Lead	Data Quality Steering Group
	18 week standards Outside threshold trigger an audit/ training	Information Department	Weekly	Performance Meeting	Relevant Specialty Lead	Performance Meeting
	RTT Status Audit	Service teams	Monthly	Data Quality Steering Group	Relevant Specialty Lead	Data Quality Steering Group
	Clinic Outcome Sheet Audit	Information Department	Quarterly	Data Quality Steering Group	Relevant Lead	Data Quality Steering Group
	Internal Audit	Internal Audit	Annual	Chief Operating Officer	Chief Operating Officer	
	External Audit	External Audit	Minimum every 3 years	Chief Operating Officer	Chief Operating Officer	
Application of Policy for Cancer	Internal Audit	Cancer Services	Quarterly	Cancer Steering Group	Head of Cancer	Cancer Steering Group

10. REFERENCES & ASSOCIATED DOCUMENTATION

Department of Health (2015). *NHS Constitution: the NHS belongs to all of us.* [Online]. London. Department of Health. Available from: https://www.gov.uk/government/publications/the-nhs-constitution-for-england [Accessed 12 October 2017]

Department of Health (2007) *Access to health services for military veterans.* [online] London, DH. Available from: http://webarchive.nationalarchives.gov.uk/20130105031100/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081268.pdf [Accessed 12 October 2017]

NHS Choices (2016) *Appointment booking: NHS waiting times.* [online] Available from: http://www.nhs.uk/NHSEngland/appointment-booking/Pages/nhs-waiting-times.aspx [Accessed 12 October 2017]

NHS England (2015) *Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care.* [online] Available from: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/ [Accessed 12 October 2017]

NHS England (2013) *Everyone counts: planning for patients 2014/15 – 2018/19.* [online] London, NHSE. Available from: https://www.england.nhs.uk/publication/everyone-counts-planning-for-patients-201415-201819/ [Accessed 12 October 2017]

Northampton General Hospital NHS Trust (2017) *Safeguarding Children and young people* NGH-PO-243. Northampton, NGHT

Northampton General Hospital NHS Trust (2015) *Safeguarding vulnerable adults.* NGH-PO-241. Northampton, NGHT

APPENDICES

Appendix 1 18-Week REFERRAL TO TREATMENT CODES
Appendix 2 GLOSSARY OF TERMS
Appendix 3 HARM REVIEW FORM

Appendix 1 18-Week REFERRAL TO TREATMENT CODES

Code Status Code Patient Status

Stops

30

- Start of first definitive treatment
- Patient has received first definitive treatment that is intended to manage their disease, condition or injury

32

- Active Monitoring / Watchful Waiting
- Start of active monitoring initiated by the clinician – not to be used for thinking time

33

- DNA (did not attend)
- The patient failed to attend the appointment / admission

34

- Decision not to treat
- Patient does not require treatment

35

- Patient declined treatment
- Patient not treated but discharged

New clocks

10

- First activity in RTT period
- Not yet treated (awaiting test results/add to waiting list/refer for outpatient treatment or diagnostics)

11

- Active monitoring end
- First activity at the start of a new RTT period following active monitoring

12

- Consultant referral
- First activity at the start of a new RTT period following a decision to refer directly to a new Consultant for separate condition

Ongoing/Incomplete patients

20

- Transfer to another Clinician
- Subsequent activity during RTT period - further activities anticipated

21

- Transfer to another provider
- Not yet treated - subsequent activity RTT period anticipated by another Health Care Provider - clock still ticks

No longer on a pathway/Not applicable

90

- Activity following First Treatment
- First treatment occurred previously (e.g. admitted as an emergency from A&E or the activity is after the start of treatment). Ongoing management post treatment.

91

- Activity following a clock stop during active monitoring / watchful waiting
- Activity during period of active monitoring

98

- Not Applicable
- Activity not applicable to RTT period

Appendix 2 GLOSSARY OF TERMS

ASI (appointment Slot Issues)

List of patients who were not able to book an appointment through the NHS e-Referral system because there were no appointment slots available

Active Waiting List

Patients awaiting elective admission and are currently available i.e. fit, able and ready, to be called for admission at entry to waiting list.

Booked Admissions
Patients that are provided with the opportunity to book their admission or treatment date immediately following their clinic appointment or very shortly after.

Booked Patients
Patients awaiting elective admission who have been given an admission date at the time of the decision to admit. These patients form part of the active waiting list. Elective Booked.

Choice
Patients Value Choice to be offered to all patients waiting for 6 months for elective care by summer 2004. Choice at point of referral for elective care by December 2005.

Cancer Waiting Times (CWT)
NHS cancer plan 2000 has set a specific goal of reducing cancer-waiting times (CWT) in UK.

CCG
Clinical Commissioning Group commissioning of services and acute care

Day cases
Patients who required admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.

DTA
Decision to Admit.

Did Not Attend (DNA)
Patients who have been informed of their admission date (inpatients/day cases) or appointment date (outpatients) and who without notifying the hospital did not attend admission /outpatient appointment.

Inpatients
Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night.

Outpatients
Patients referred by a General Practitioner, General Dental Practitioner or another Consultant for clinical advice or treatment.

Partial Booking List or waiting list
A holding list for patients waiting for an Outpatient Appointment. This process ensures patients are seen in chronological order and have the opportunity to choose a convenient date.

PAS
Patient Administration System

PTL
Patient Tracking List

Referral to Treatment (RTT)
18-week pathway from referral from GP to commencement of treatment in secondary care
.

Self-deferrals
Patients, who, on receipt offer of admission, notify the hospital that they are unable to come in.

SITREPS
Situation Reports made to Area Teams on current indicators.

TCI
To come in date or letter.

Appendix 3 HARM REVIEW FORM

HARM REVIEW FORM FOR PATIENTS WAITING 45 WEEKS AND OVER

Date:_____________ Patient's Consultant:_________________ Reviewer:________________
Speciality:_______________

Term	Definition	Tick	Describe where appropriate
No harm	**Where no harm came to the patient**		
Low (minor) harm	**Where the delayed review resulted in harm that required further treatment, extra observation or medication.**		
Moderate harm Datix to be completed	**Where the delayed review resulted in harm that was likely to require ongoing outpatient treatment, admission to hospital, surgery.**		Datix no
Severe (major) harm Datix to be completed	**Where permanent harm has occurred,**		Datix no
Diagnosis / Procedure:			

Action Required	Tick or circle as appropriate
Discharge with letter to GP	
Review in OPD: URGENTLY / Within 1 month / within 3 months / 6 months / 9 months 12 months / Other / Refer to GMU with letter to DCM or SM	
Need notes to review and decide	
Datix completed	
Other: please detail	

Signed / stamp ____

FORM 1 & 2 - To be completed by document lead

FORM 1a- RATIFICATION FORM - FOR COMPLETION BY DOCUMENT LEAD Note: Delegated ratification groups may use alternative ratification documents approved by the procedural document groups.	
DOCUMENT DETAILS	
Document Name:	Patient Access Policy
Is the document new?	~~Yes /~~ No
If yes a new number will be allocated by Governance	New Number
If No - quote old Document Reference Number	NGH-PO-263
This Version Number:	6
Date originally ratified:	2009?
Date reviewed:	28 October 2017
Date of next review: a 3 year date will be given unless you specify different	28 October 2020
DETAILS OF NOMINATED LEAD	
Full Name:	Sean McGarvey
Job Title:	Head of Informatics
Directorate:	Information & ICT
Email Address:	sean.mcgarvey@ngh.nhs.uk
Ext No:	4670
DOCUMENT IDENTIFICATION	
Keywords: **please give up to 10** – to assist a search on intranet	Access, Outpatients, Inpatients, referrals, waiting lists, RTT, Diagnostics, Pathways

GROUPS WHO THIS DOCUMENT WILL AFFECT? (please highlight the Directorates below who will need to take note of this updated / new policy)		
Anaesthetics & Critical Care	Gynaecology	Medicine
Child Health	Haematology	Nursing & Patient Services
Corporate Affairs	Head & Neck - inc Ophthalmology	Obstetrics
Diagnostics	Human Resources	Oncology
Facilities	Infection Control	Planning & Development
Finance	Information Governance	Trauma & Orthopaedics
General Surgery		Trustwide

TO BE DISSEMINATED TO: NB – if Trust wide document it should be electronically disseminated to Head Nurses/ Dm's and CD's .List below all additional ways you as document lead intend to implement this policy such as; as presentations at groups, forums, meetings, workshops, The Point, Insight, newsletters, training etc below:

Where	When	Who

Northampton General Hospital NHS Trust

FORM 1 & 2 - To be completed by document lead

FORM 1b - EQUALITY ANALYSIS REQUIRED FOR ALL PROCEDURAL DOCUMENTS (I.E. POLICIES, PROCEDURES, PROTOCOLS, GUIDELINES) - FOR COMPLETION BY THE EQUALITY ANALYST	
Is there potential for, or evidence that, this procedural document **will not** promote equality of opportunity for all or promote good relations between different groups?	~~Yes /~~ No
Is there potential for, or evidence that, this proposed procedural document **will affect** different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics – see below)? • Age • Disability • Gender Reassignment • Marriage and Civil Partnership • Pregnancy and Maternity • Race • Religion or Belief • Sex • Sexual Orientation	~~Yes /~~ No
If the answer to one or both of the questions above is 'yes' a full Equality Analysis must be undertaken by a trained Equality Analyst using the Trust's Equality Analysis Online Toolkit. The electronic report (PDF) must be submitted with this form for ratification. If the answer to both of the questions above is 'no' the full Equality Analysis process is not required. The Equality Analysis must be logged on the Trust's Equality Analysis Online Toolkit through the completion of the Screen & Sign Off sections by a trained Equality Analyst. The electronic report (PDF) must be submitted with this form for ratification.	

FORM 2 - RATIFICATION FORM to be completed by the document lead **Please Note:** Document will not be uploaded onto the intranet without completion of this form			
CONSULTATION PROCESS *NB: You MUST request and record a response from those you consult, even if their response requires no changes. Consider* Relevant staff groups that the document affects/ will be used by, Directorate Managers, Head of Department ,CDs, Head Nurses , NGH library regarding References made, Staff Side (Unions), HR Others please specify			
Name, Committee or Group Consulted	Date Policy Sent for Consultation	Amendments requested?	Amendments Made - Comments
DL_Clinical Directors	20/03/2017		
DL_Clinical Nurse Specialists	20/03/2017		
DL_Consultants	20/03/2017		
DL_Divisional Directors	20/03/2017		
DL_Divisional Managers	20/03/2017	Additional detail around Cancer Pathways provided	Yes, updated as requested
DL_Heads of Department	20/03/2017		
DL_Service Managers	20/03/2017		
DL_Senior Clinical Nurses	20/03/2017	Specific reference to T&O and elective cancellations	Not added as this is generically covered
Existing document only - FOR COMPLETION BY DOCUMENT LEAD			
Have there been any significant changes to this document? *if no you do not need to complete a consultation process*	~~YES /~~ NO		

FORM 1 & 2 - To be completed by document lead

Sections Amended:	YES / NO	Specific area amended within this section
Re-formatted into current Trust format	YES ~~/ NO~~	
Summary/ Introduction/Purpose	~~YES /~~ NO	
Scope	YES ~~/ NO~~	**Removed reference to "Adults" as should include children**
Definitions	~~YES /~~ NO	
Roles and responsibilities	~~YES /~~ NO	
Substantive content	~~YES /~~ NO	
Monitoring	~~YES /~~ NO	
Refs & Assoc Docs	~~YES /~~ NO	
Appendices	~~YES /~~ NO	

Northampton General Hospital NHS Trust

FORM 3- RATIFICATION FORM (FOR PROCEDURAL DOCUMENTS GROUP USE ONLY) Read in conjunction with FORM 2			
Document Name:	**Patient Access Policy**	**Document No:**	**NGH-PO-263**
Overall Comments from PDG			
	YES / NO / NA	**Recommendations**	**Recommendations completed**
Consultation Do you feel that a reasonable attempt has been made to ensure relevant expertise has been used?	YES / NO / NA		
Title -Is the title clear and unambiguous?	YES / NO / NA		
Is it clear whether the document is a strategy, policy, protocol, guideline or standard?	YES / NO / NA		
Summary Is it brief and to the point?	YES / NO / NA		
Introduction Is it brief and to the point?	YES / NO / NA	Remove the bullet points from introduction	Completed
Purpose Is the purpose for the development of the document clearly stated?	YES / NO / NA		
Scope -Is the target audience clear and unambiguous?	YES / NO / NA	Scope needs to be rewritten to be who it applies to	Completed
Compliance statements – Is it the latest version?	YES / NO / NA	Old Compliance statements need updating	Completed
Definitions –is it clear what definitions have been used in the	YES / NO / NA	Definitions need adding to table format Need to add CRIS and ICE to definitions	Completed Completed
Roles & Responsibilities Do the individuals listed understand about their role in managing and implementing the policy?	YES / NO / NA	Need to add set wording into R&R Update General Manager title in R&R	Completed Completed
Substantive Content is the Information presented clear/concise and sufficient?	YES / NO / NA	Key principles to be moved to substantive National Performance Measures to be moved to substantive All headings after Data Quality/Data Protection up to Implementation & Training to be added to substantive	Completed Completed Completed
Implementation & Training – is it clear how this will procedural document will be implemented and what training is required?	YES / NO / NA	Update General Manager title in I&T Remove mandatory and add local in third paragraph in I&T	Completed Completed
Monitoring & Review (policy only) -Are you satisfied that the information given will in fact monitor compliance with the policy?	YES / NO / NA		
References & Associated Documentation / Appendices- are these up to date and in Harvard Format? Does the information provide a clear evidence base?	YES / NO / NA		
Are the keywords relevant	YES / NO / NA		

Name of Ratification Group: Procedural Documents Group	Ratified Yes/No: Ratified pending minor amendments and chair approval	Date of Meeting: 17/10/2017