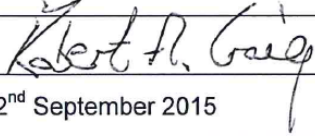


## WAITING LIST AND ACCESS POLICY FOR ELECTIVE INPATIENTS AND OUTPATIENTS

### OPERATIONS DIRECTORATE

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## 2 SUMMARY

This policy defines the roles and responsibilities and establishes a number of good practice guidelines to assist staff with the effective management of access across the whole elective patient pathway. The principles underlying this policy are in accordance with the Royal College of Surgeons Guidelines and current best practice as outlined by the Department of Health.

Patients who are awaiting treatment in the Trust are under our care, and their successful management while they are waiting for treatment is the responsibility of all involved in the care pathway, including those in the Trust, General Practitioners, referring Hospital Doctors and commissioners. If patients who are waiting for treatment are to be managed effectively it is essential for all individuals involved with access to understand why it is important, the key principles involved and their roles and responsibilities in delivering this primary quality standard.

This policy aims to align the Trust's waiting-list management processes with being a safe, effective, caring, responsive and well-led healthcare organisation.

## 3 TIMETABLE

The policy was circulated for consultation on 2nd of December 2014. The policy was reviewed and approved at the OMT Operations meeting on 2nd of September 2015.

Dissemination:	All departments
Review:	To commence July 2016
Reissue date:	Anticipated September 2016

The authorised policy will be distributed to all clinical areas and posted on Trust Intranet Policies & Guidelines/Policies and Procedures/Risk Management.

The policy will be available on the Trust's website.

## 4 VERSION CONTROL

This is version 5 of this policy. All preceding versions should be removed from the local policy folders and replaced with the latest version.

## 5 CONSULTATION

Divisional Managers and Service Managers

Outpatient Managers  
Waiting List Co-ordinators  
PAS Team  
Patient and Public Involvement (PPI)  
Performance and Information Team  
Clinical Divisional Directors  
Elective Care Intensive Support Team (IMAS)

## 6 INTRODUCTION

**The inpatient, outpatient and diagnostic waiting lists must be managed in a spirit of transparency and reasonableness to the patient and honesty to the public.**

Under the NHS Constitution, patients have the right to start consultant led treatment in line with the prevailing standards set by government (currently within 18 weeks of referral for 92% of all patients), unless the patient chooses not to be treated within that time, or it is clinically appropriate for that patient to wait longer.

Treatment may include:

- Being admitted to hospital for a procedure
- Starting a program of medication in outpatients, where that medication is intended to treat the patient's condition
- Receiving advice on how to manage the condition
- Agreeing that treatment is not required at this stage

According to patient advice on NHS Choices, the right to be seen within maximum waiting times does not apply where:

- The patient chooses to be treated outside of the timescale
- Delaying treatment would improve the outcome for the patient e.g. should they need to lose weight or stop smoking
- It is clinically appropriate for the patient to be monitored without clinical intervention for a period of time (active monitoring)
- If the patient fails to attend appointments / admissions offered with reasonable notice
- If treatment is no longer required

The DH guide, "Referral to Treatment Consultant-led Waiting Times Rules Suite" (October 2015) states that there are very few national waiting times rules as models of service provision vary. The NHS locally has been given autonomy to make sensible and clinically appropriate decisions about how 18 week monitoring rules apply to patients, pathways and specialties.

The national rules form the framework for this Trust waiting list policy. However, due to the specialist nature of our patient pathways, there are local exceptions. This is particularly so where national rules suggest referring a patient back to their GP e.g. if the patient is unavailable for several months. This can be clinically inappropriate for the majority of our patients. As such the policy has local rules, particularly with regard to 'Active Monitoring'/'Watchful Waiting' that refer patients to an active monitoring list held within the Trust or the Trust's outpatient clinics rather than to their GP. These rules are set out in the relevant section of the policy.

Whether national or local rules are applied to the patient's wait, these must be transparent, in the best clinical interests of the patient, and make every effort to offer 18-week access for those patients who would like to be treated within that timescale.

Where patients are waiting for an outpatient appointment or inpatient admission, but are not on an 18-week pathway, they must be treated fairly, have appropriate access to services and transparent information about their treatment plan.

## **7 EQUALITY STATEMENT**

Royal Brompton & Harefield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the Human Rights Act 1998 and promotes equal opportunities for all. This document has been assessed to ensure that no patient receives less favourable treatment on grounds of their gender, sexual orientation, marital status, race, religion, age, ethnic origin, nationality, or disability.

## **8 PURPOSE OF THE POLICY**

The key principles outlined below aim to ensure that the Royal Brompton & Harefield NHS Foundation Trust delivers a good quality Access Policy based on the needs of patients. These are as follows:

- Waiting lists should be managed according to clinical priority. Patients with the same clinical need will be treated in chronological order, starting with the patients who have waited the longest.
- Patients should only be added to a waiting list for first definitive treatment if it is in the best clinical interest of the patient to be treated within 18 weeks. If it is not possible to offer a patient first definitive treatment within 18 weeks, the patient is

entitled in line with their NHS constitutional rights to request that the possibility of their being treated elsewhere is investigated.

- Clinical professionals in charge of a patient's care should decide whether waiting longer than 18 weeks corresponds to a clinically optimum timescale for treatment go-ahead, and to communicate this to the patients concerned. If so, the patient could be considered a 'clinical exception' and be part of a 'planned' waiting list and exempt from the 18-week clock.
- A clinically complex condition or patient does not constitute 'clinical exception' under this policy. These patients should still have their first definitive treatment within 18 weeks, as it is in their best interest to be treated at the earliest opportunity.<sup>1</sup>
- Processes for managing the waiting list must adhere to national standards and this policy on Waiting List Management.
- The process of Waiting List management should be transparent to the public. Communication with patients, General Practitioners and other providers should be informative, clear and concise.
- Monitoring - The Trust should have controls in place to ensure operational reports are used and regular reviews take place to facilitate patients through the patient pathway in the most clinically appropriate timeframe
- Good internal communication, team working and cross-cover between site, departments, services, clinicians and administrative staff is imperative for the complexities of the 18-week access target to be met.
- User training - Appropriate training programmes should support staff, with special regard given to newly recruited staff. All staff should be identified as being required to implement this policy according to their role and job description. All staff involved in the implementation of this policy should undertake initial training and regular updates. Data quality – All staff involved in access are responsible for ensuring good data quality through maintaining an up-to-date electronic and paper patient record. Line managers (e.g. Divisional Managers and Heads of Department) will be responsible for ensuring this happens. Divisional staff should regularly check accuracy of key pathway data items to ensure that monitoring reports are an accurate reflection of patients' current waiting times
- Special needs – Patients with special needs, e.g. physical, sensory or learning disabilities, may require extra resources involved in planning and delivering their treatment. The Trust must strive to ensure these needs are met.

## 9 ACCESS TARGETS

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<sup>1</sup> See page 27 of the October 2015 RTT Rules Suite document



### **9.1 18 week referral to treatment (RTT) target**

Monitor, the regulatory body for foundation trusts, require us to have a minimum of:

- 92% of incomplete pathways - current waiters, inpatients and outpatients combined, waiting less than 18 weeks.

The contracts held with our commissioners allow them to levy financial penalties for breaches of the standard.

“Everyone Counts: Planning for Patients 2013/14” states that there will be a zero tolerance of any patient waiting more than 52 weeks.

There are some patients who are waiting for admission, but who will not be on an 18-week pathway e.g. planned follow ups, diagnostic tests for patients in ‘watchful waiting’. These patients must have fair access to appointments or treatment appropriate to their clinical requirements.

### **9.2 New outpatient referral target**

The Trust aims to see new outpatients within 5 weeks of referral date.

### **9.3 Waiting times for diagnostic tests and diagnostic admissions**

All imaging patients must be seen within 6 weeks (42 days) of the request for a test / investigation (this includes internal requests and requests from other clinicians e.g. Trust to Trust requests for specialist imaging). Planned and follow up investigations are excluded from the waiting time targets.

All diagnostic admissions e.g. for angiogram, must take place within 6 weeks (42 days) of date on list.

### **9.4 Waiting times for rapid access chest pain clinic (RACP)**

All RACP patients must be seen within 2 weeks from the date the referral was made.

### **9.5 Welsh referral to treatment targets**

Patients resident in Wales referred to a consultant led service from GPs, other clinicians and self-referrals will wait no longer than 36 weeks from referral to treatment.

### **9.6 Scottish waiting times targets and prior approval**

Scottish patients must wait no longer than 8 weeks for a new outpatient appointment.

### **9.7 Prior Approval - Scotland and Northern Ireland**

Prior approval must be sought for any referrals for cross-border elective (planned) treatment or outpatient referrals which occur outside SLAs/contracts. For 2012/13,

this only applies to Scotland and Northern Ireland. An SLA is currently held with Wales.

Referral by a GP or Consultant from Scotland or Northern Ireland does not in itself constitute prior approval.

Prior approval must be sought in a timely fashion for elective inpatients and outpatients to avoid delays to the patient's treatment.

Prior approval should cover all steps of a patient's elective pathway, however for clarity, confirmation of that prior approval should be requested from the Service Development office at Harefield when a patient is added to the waiting list or an 18-week pathway begins for patients from Scotland or Northern Ireland.

Prior approval requests should be sent to the Service Development office at Harefield who will co-ordinate these and liaise with the appropriate Health Board to obtain funding approval

### **9.8 Clinical Trial Volunteers**

Patients who agree to take part in a clinical trial after being referred by their GP on an RTT pathway should be made aware that treatment waiting times will be variable and not necessarily within 18 weeks from their referral.

### **9.9 Suspected cancer waiting times**

Cancer waiting times targets are monitored by the Department of Health, Care Quality Commission and NHS England, and form part of the Monitor compliance framework. Similar to 18 week waits, failure to achieve the waiting times targets can affect patients' clinical outcomes and the Trust's Monitor compliance rating.

The Trust works closely with the London Cancer Alliance (LCA) and the NWL CCG Cancer Performance Team in order to ensure that the Trust complies with their expectations of treating cancer patients as set out in the national guidance for Cancer Waiting Times (CWTs)<sup>2</sup> and the LCA Clinical Guidelines for Lung Cancer.

All cancer referrals must be emailed or faxed from the GP at 'decision to refer' date. The Department of Health cancer targets are as follows:

- Maximum 14 days wait from urgent GP referral to first appointment date
- Maximum 62 days wait from urgent GP referral for suspected cancer to first definitive treatment for all cancers
- Maximum 62 days wait from where a consultant considers cancer a possible diagnosis to first definitive treatment for all cancers

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<sup>2</sup> See References Section, Item 6

- Maximum 62 days wait from GP referral for consultant upgrade to first definitive treatment for all cancers
- Maximum 31 days waits from “decision to treat date” to first definitive treatment for all cancers
- Maximum 31 days wait from urgent GP referral to first treatment for children’s cancers, testicular cancer and acute leukaemia
- Maximum 31 days wait for subsequent treatments for cancer, including those diagnosed with a recurrence

Patients who are referred on a pathway that originated from an urgent GP referral for suspected cancer (62 day cancer pathway) should be immediately flagged to the consultant and management team. If the patient has had all the relevant diagnostic tests and is fit for surgery, the patient should be treated no later than 62 days after the GP referral date and no later than 20 days after being received by the Trust.

If patients on a 62 day cancer pathway are referred to the Trust after 42 days on the pathway, the consultant and management team should seek to expedite the availability of theatre capacity and reschedule non-urgent patients, if necessary and clinically appropriate, in order to accommodate treatment.

Patients who are on a 62 day cancer pathway with a scheduled operation date must not have their operation cancelled.

### **9.10 Booking and choice**

Where possible, Trust staff should have a phone conversation with the patient in order to agree their appointment and admission dates. This will allow the Trust to identify any problems that the patient may have prior to their appointment/admission, and reduce the likelihood of cancellation or postponement of treatment.

### **9.11 e-Referral Service**

All suitable clinics that accept GP referrals to be available through the e-Referral Service direct booking. Patients should be offered choice in accordance with the agreements with the North West London Collaboration of Clinical Commissioning Groups.

### **9.12 Cancelled procedures and offer of new procedure date**

As far as possible an elective inpatient or daycase patient should not be cancelled at the “last minute” for non-clinical reasons.

9.12.1 A “last minute” cancellation occurs when a patient has their procedure cancelled under one of the following circumstances:

- On the day the patient is due to arrive in hospital

- After the patient has arrived in hospital
- On the day the patient is scheduled to have their operation or surgery

9.12.2 A cancellation for non-clinical reasons is represented by the following cancellation types<sup>3</sup>:

- Ward bed unavailable
- Appropriate staff (e.g. surgeon, anaesthetist, perfusionist) unavailable
- Emergency/more clinically-urgent patient taking priority
- Theatre list over-run (i.e. insufficient operating time available)
- Equipment failure
- Administrative error
- Critical care bed unavailable (i.e. for post-operative care)

9.12.3 All elective inpatient or daycase operations that are cancelled and rescheduled (strictly) within 24 hours of the originally-scheduled operation should be recorded as a 'postponement' and not as a "last minute" cancellation:

Where an urgent operation is likely to be cancelled, a robust process should be in place to inform the relevant consultant and divisional manager (or nominated representative) to facilitate immediate rescheduling of that case wherever possible.

9.12.4 All patients who have their operation cancelled at the "last minute" for non-clinical reasons must be rescheduled within 28 days of the date the operation was originally scheduled:

"Everyone Counts: Planning for Patients 2014/15 to 2018/19" highlights that the NHS Constitution includes a pledge that any patients who are cancelled at the "last minute" for non-clinical reasons are offered a date within 28 days of the cancellation. If the Trust is unable to readmit the patient within this time period, the patient has choice to remain on the Trust's waiting list, or to be treated at another provider who can offer treatment more quickly, including private providers.

"Everyone Counts: Planning for Patients 2014/15 to 2018/19" expects that no urgent patient should have to tolerate being cancelled for the second time.

### **9.13 Three weeks reasonable notice period for appointment or TCI date**

Inpatient and daycase patients should be offered dates with reasonable notice i.e. 3 weeks before admission with a minimum choice of 2 separate dates. To avoid repeated cancellation, and ensure patients are clinically ready for their procedure, cardiac surgery patients may receive less than three weeks' notice.

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<sup>3</sup> These examples are based on information from the former NHS Modernisation Agency's Theatres project and do not necessarily cover all non-clinical reasons.

## **10 RTT REFERRAL TO TREATMENT PATHWAY STAGES**

### **10.1 Clock Start**

The 18 week wait clock starts when a care professional such as a GP or consultant refers to a consultant-led service for a new pathway.

Patients may self-refer only if that referral is accepted by the receiving consultant, commissioner and provider.

The clock starts on:

- The date a referral is received from the GP;
- The date an e-Referral is received from the GP and the Unique Booking Reference Number (UBRN) is converted to book the patient into the appointment slot;
- The date a referral is received from a consultant colleague within the Trust, for a separate condition;
- The originating date of referral received from the GP by another provider, if the management of the patient is transferred to the Trust, with the intention to complete the same care plan originally requested by the GP;
- The date the referral is received from another provider requesting a specialist opinion from the Trust, triggering a new Trust-led care pathway for the patient;
- The date the referral is received from another provider requesting a diagnostic assessment from the Trust, triggering a new Trust led care plan for the patient;
- The date initial treatment was given, but failed to be effective and a new pathway is started.
- The date a decision is made by the Trust consultant that a substantively new or different treatment plan is required
- The date a decision to treat is made following a period of medical 'active monitoring'
- The date a patient becomes available following a period of patient initiated active monitoring / thinking time

### **10.2 Clock Stop**

#### **10.2.1 Clock stops for treatment**

The clock stops for treatment when:

- Treatment is provided in an outpatient setting
- Treatment is provided in an inpatient setting
- The patient is accepted onto the transplant waiting list

#### **10.2.2 Clock stops for non-treatment**

The clock stops for non-treatment when:

- A clinical decision is made not to treat
- A clinical decision is made to start a period of active monitoring
- The patient is clinically unable to go ahead with treatment at this time e.g. unfit for surgery, requiring weight loss, requiring another condition resolved first
- The patient is referred to another consultant to start a substantially new or different treatment plan
- The patient is returned to primary care for non-consultant led treatment
- The patient is referred back to their GP following multiple DNAs or multiple failed attempts to contact
- The patient declines treatment

### 10.3 Clock Ticking

- The clock continues to tick until the patient has first treatment, unless the decision not to treat, or the decision to place into active monitoring has been made
- The clock continues to tick where the patient has a short-term illness that will take less than 3 weeks to resolve
- The clock continues to tick through any decision making process, further diagnostics or opinions, MDT meetings and commissioner-led 'prior approval' processes. If the 'prior approval' process is a factor in any delay leading to a penalty imposed by a commissioner, the Trust will challenge the penalty.

## 11 REFERRALS

### 11.1 Referrals to outpatients

All referral letters should be date stamped on receipt in the Trust.

The prompt turnaround of referrals (48 hours) requires cross cover arrangements to be in place, both for clinicians and also secretarial and administrative roles (e.g. in the absence of the consultant for whatever reason, arrangements should be made for referral letters to be seen and prioritised by another member of the clinical team to whom the patient has been referred and thence forwarded to the Appointments Office as soon as possible).

Patients who are referred as 'open' referrals to a specialty will be allocated to the consultant with that special interest having the shortest waiting time. All referral letters sent directly to consultants should be forwarded on a daily basis to the appropriate booking office in a timely fashion and securely, e.g. Appointments Office, Waiting List Co-coordinators.

Where a letter is received in a department directly, staff should avoid using the internal post and should instead walk or scan/email the letter to the appropriate booking office on the date of receipt to ensure no unnecessary delay. Urgent

referrals can also be faxed to the appointments office, although staff should avoid sending duplicate copies of referral letters.

The appointments team or appropriate department will input/compare GP and patient's details against the Patient Administration System (PAS) and Summary Care Record (SCR), ensuring that details are up-to-date.

If the patient contacts the Trust and advises us that they do not require the appointment then their name will be removed from the Waiting List and the original referrer notified accordingly if appropriate.

All referrals sent into the Trust from other Acute Trusts should be accompanied by an Inter-Provider Transfer Minimum Dataset form (IPT form). All referral letters will be reviewed to ensure that the 18-week minimum dataset is recorded on PAS appropriately. If an IPT form has not been sent and the referral letter does not contain the required information, the referrer will be contacted by the 18 Week Coordinators and requested to provide the required information.

### **11.2 Internal referrals**

Internal referrals for an on-going pathway should be made in clinic using the Outpatient outcome form. This must be completed in clinic at the point of decision to refer and the appointment is to be booked on the same day. This is necessary because the 18-week pathway clock continues and therefore an appointment will be needed within a short timeframe. A follow up letter must be dictated as usual by the clinician and the referral letter must be sent within 3 working days.

If the internal referral is for a new pathway, then a new 18 week dataset must be created and the normal booking rules apply.

### **11.3 Referrals for an opinion**

This is where a patient on an 18 week pathway at another hospital is referred to a RBHFT consultant for an opinion/advice only, and the initiating hospital intends to keep the patient's pathway. If the referral is to review the notes only, no further action is needed and the patient is not on an 18-week pathway. If the patient is to be seen here they are placed on the inpatient waiting list as 'follow up/not 18w' or outpatient with outcome of 'D/D2' and a nullified dataset.

### **11.4 Inappropriate referrals**

If a referral has been made and the special interest of the consultant does not match the needs of the patient, the consultant should cross-refer the patient to an appropriate colleague where such a service is provided. If the referral is for a service not provided by the Trust, then the referral letter will be returned to the referrer with a note advising that the patient needs to be referred elsewhere.

If a referral letter is illegible or does not contain enough clinical information to enable allocation to a specialty, the referral letter will be faxed back to the GP or referrer with a note advising that clarification or further clinical information is needed.

### **11.5 Tertiary referrals sent out**

All tertiary referrals going externally from the Trust must be accompanied by an Inter-provider Transfer Minimum Dataset form (IPT form); this should ideally be sent with the referral letter, but at most within 48 hours of referral (DoH requirement). Tertiary referrals include referrals for new conditions, existing conditions, referrals for diagnostic tests and also referring back to the original referrer after treatment. Clinician's secretaries are to complete the form and send with the referral letter.

## **12 OUTPATIENTS**

### **12.1 General principles for outpatient clinics**

Good practice within outpatients enables:

- New patients to be seen within 5 weeks of referral;
- Follow-up patients to be seen when considered appropriate by their physician/surgeon, bearing in mind the 18 week referral to treatment (RTT) target;
- Follow-up patients who have not been seen by the planned review date should have their case reviewed by their consultant and decision made whether to expedite the booking of another clinic date;
- All outpatients to receive appropriate attention from the multidisciplinary team;
- Efficient and timely discharge of patients following conclusion of treatment;
- Minimum disruption to patients resulting from cancelled and reduced clinics;
- Outpatient access rules apply equally to all patients.

### **12.2 New Appointments**

A new appointment is the first appointment following a referral letter. Typically this is the first appointment that a patient has with Royal Brompton and Harefield NHS Foundation Trust (whether within the Trust or at an 'outreach' clinic) or the first appointment in a different specialty.

The date of referral indicated on the referral letter and the date of receipt of the referral letter by the Trust will be recorded on the outpatient waiting list so that a calculation of the wait time to first appointment can be made.

All patients who are discharged from clinic should be classed as a New Patient if they are re-referred at a later date.



When a Paediatric patient becomes an adult they will have a type “NEW2” appointment with the referrer set to “FA” and the 18 week dataset will need to be nullified. This also applies where a patient seen for long term follow up by a Trust clinician in an outreach clinic starts to be seen within the Trust.

### **12.3 Follow Up Appointments**

A follow up appointment is a subsequent appointment in a series of contacts with Royal Brompton and Harefield NHS Foundation Trust, or following an inpatient admission to the Trust.

Referrals by a consultant from their outreach clinic to their own clinic at RBH must be booked as follow-ups. Referral to a different consultant within the Trust from their outreach clinic must be booked as a New appointment.

### **12.4 e-Referral Service appointments**

e-Referral Service is the national electronic referral service that provides patients with a choice of place, date and time for their first consultant appointment. All clinics that are suitable for GP referrals via e-Referral Service should be on e-Referral Service direct booking system.

Any changes to services are to be notified to the Outpatient Services Manager (RBH), Modern Matron (HH), PAS Team and Service Development in advance of the change in order that the Directory of Services (DoS) is maintained and up to date. This is important in order to meet the access targets and in particular to ensure that e-Referral Service direct booking is effective.

### **12.5 Outpatient Outcome Form**

Choosing the correct patient pathway is imperative for accurately recording patients' waiting times. This is based on ticking the relevant box on the outpatient outcome form in clinic.

All outpatients must have a completed outpatient outcome form at the end of each visit to ensure the patient's pathway for treatment is transparent. It is the clinician's responsibility to complete the form. Clinic Receptionists ensure all forms are collected at the end of clinic and input on to the system within 24 hours. Without the outpatient outcome the Trust is unable to track where a patient is on their care pathway (whether or not it is part of 18-week monitoring).

### **12.6 Outpatient Discharge Policy**

Clinics must have discharge criteria for follow-up patients. The purpose of this is to ensure that patients are not re-booked more times than are necessary and to ensure that clinic capacity is available for new patients and those requiring acute treatment.

Commissioners continue to challenge the Trust on the rate of follow up outpatient appointments. The Trust is at risk of not being reimbursed for follow up outpatient appointments where it is deemed to be over a contracted new to follow up ratio limit.

- Patients stable and no research interest – patient to be discharged.
- Patients stable with a research interest – follow-up under formally-approved and funded research study protocol.
- Patients unstable – follow-up as appropriate.

All patients who are discharged from clinic and later re-referred should be classed as a New Patient.

### **12.7 Outpatient – DNA first appointment**

A DNA (did not attend) is defined as a patient failing to attend their appointment, and not giving prior notice of their intention not to attend.

When a routine GP referral is received and an appointment is agreed with the patient; either verbally with a Trust appointments officer or via a converted e-Referral Service System UBRN, the patient has started their clinical relationship with the Trust. If the patient goes on to DNA their agreed appointment, then the Trust will immediately refer the patient back to the GP.

When other referral types are received alternative arrangements should apply:

- Under DH 18 week rules, if a patient DNAs the first (new) appointment of their 18 week pathway, where the Trust clearly communicated the appointment to the patient, the 18w clock should be nullified. If the patient subsequently contacts the Trust to rebook their appointment a new pathway and clock start should be started, when the patient agreed their new appointment date with the Trust.
- Where the patient does not contact the Trust within 7 days of the previous appointment date and the patient is referred back to GP or referrer. The 18 week pathway will be nullified. This is because no clinical relationship has yet been established with such patients;
- Where there is a safeguarding concern, suspected cancer or urgent referral the patient should be rebooked within a week but not exceeding 2 weeks from the date of decision to rebook, even if this requires an overbooking of a clinic;
- Where a patient DNAs consecutive appointments made the patient will be referred back to the referrer; subject to RTT rules requirements.
- When the intention is to refer back a patient with suspected cancer, other urgent condition or a safeguarding concern, then there must be clear and effective communication with the service manager, safeguarding lead, carers and social services when applicable;

- Where the patient did not receive notice of their appointment (e.g. an admin error), the patient should be offered a second appointment and the 18w clock will continue ticking;

The Summary Care Record (SCR) should be used to confirm patient contact details are correct;

Communication of the patient's responsibility is important to ensure DNAs are minimised. This will be placed on the Trust's website and within outpatient letters.

## 12.8 Outpatient – DNA follow up appointment

**Follow Up appointments** – after DNA the casenotes and history are referred to the consultant in clinic and a decision based on clinical need is made.

In the main, patients that DNA will be referred back to their GP or referrer; however if there are sound clinical reasons then a second date may be given. This will be exceptional; offering a second appointment is limited to:

- 2 week suspected cancer referral – all patients to be offered a second appointment within 14 days;
- Clinically urgent cases reviewed by a clinician within the clinic;
- Children in special circumstances e.g. under Child Protection Orders;
- Patients with a compromised mental health capacity;
- Long term patients e.g. CF, ACHD;
- Patients with special needs, where requested by a clinician within the clinic.

Where the patient had reasonable cause for the DNA (Trust administrative error in informing them of their admission or appointment), they will remain on the waiting list and be issued a further date. Their 18 week clock will continue to tick. Where a decision has been made to discharge the patient back - the GP and referring physician (if different from GP) must be informed, and the reason given. A record of the reason for removal must be made in the patient notes and/or applicable information system. Where the consultant wishes to retain some contact with the patient, this may be best achieved through the specialist nursing team or phone clinics. Any future request for an appointment will be treated as a new referral.

If the patient is to be rebooked Summary Care Record (SCR) must be checked to ensure the correct demographics are held *before* calling patient to agree another appointment.

National rules would require a referral back to the GP at this point, who could then re-refer which would start a new 18 week clock. This is often not appropriate care for specialist, tertiary referrals, so the re-referral is implied.

### **12.9 Patient self-referral following DNA**

If a patient contacts the Trust within 2 weeks following a DNA and indicates that they would like to rebook, the Trust will use its discretion and allow patients to rebook. The 18 week pathway clock and other waiting times will start from the date of self-referral.

### **12.10 Impact of DNA on cancer waiting time targets**

This rule applies to the first DNA of the first appointment (as specified in the North West London Cancer Network access policy September 2009). If a patient DNAs their initial outpatient appointment - this would allow for a clock pause from the receipt of the referral to the date upon which the patient rebooks their appointment. This pause is relevant to the cancer two week wait and the 62-day standard (this is handled differently within 18 week rules).

### **12.11 Outpatient – patient cancellation**

All new outpatients requesting to reschedule their appointments should contact the appointments office. Patients who cancel their outpatient appointment should agree an alternative date by the Appointments Office at the time of cancellation. If a patient cancels more than twice, their casenotes should be reviewed by medical staff to ensure that there is no clinical risk involved in not treating the patient. If the consultant feels it is appropriate, their patient may be referred back to their referring consultant/GP and a letter sent to this effect by the consultant. The patient should then be discharged on PAS. In extenuating circumstances a patient can be offered a third appointment.

Patients have a responsibility to attend any appointments, diagnostic tests or admissions once they have agreed the date with the Trust. Failing to attend appointments will delay their 18 week pathway, particularly where a large number of tests are required prior to admission for specialist treatment. As such, where patients agree an appointment with the Trust and then cancel this date, the patient must be offered 2 alternative dates with reasonable notice. Where a patient declines these alternative dates then the referral should be reviewed by a clinician to determine whether the patient is subject to clinical harm by the implied delay. If clinical harm is considered a risk, the GP should be notified immediately. The clock for the patient continues to tick under these circumstances. A clinical decision should be made whether discharge the patient back to the GP under these circumstances (which would stop the clock).

If a patient attends their appointment but cannot wait to be seen, the appointment should be recorded as 'unable to wait':

If the patient does not wish to rebook the appointment, their 18 week pathway clock will be stopped. The GP and/or referring doctor will need to be notified in writing by

the consultant and the patient will need to be re-referred should they wish to be seen again.

### **12.12 Outpatient – hospital cancellation**

Clinic cancellations cause great inconvenience to patients and a huge workload to Trust staff and must be avoided wherever possible, unless there are exceptional circumstances.

It is imperative that when clinics have to be unavoidably cancelled the Modern Matron (HH)/ Outpatient Services Manager (RB)/ Appointments Supervisor (HH)/ Clinic Co-coordinator (RB) are notified immediately.

All 'routine' clinic cancellations (e.g. for public holidays and clinical governance days) will be cancelled/removed from the clinic template at least one year in advance.

Only Clinic Managers or Outpatient administrators nominated by the Outpatient Service Manager should have access to cancel clinic lists since there is an impact on e-Referral Service Direct Booking.

The number of clinic sessions cancelled/reduced should be undertaken on a pro rata basis agreed with the General Manager of each Division. The number of clinics cancelled will be monitored by the Outpatient Service Managers. If clinics do need to be cancelled, it should be reviewed whether adhoc clinics are required to meet any backlog in demand, with support from the divisional service managers.

Clinicians must give at least 6 weeks' notice of planned leave or absence from a clinic so that alternative arrangements can be made. If a clinician is unable to attend a clinic they should firstly try to seek cover from a colleague. Appointments Supervisor (HH)/ Clinic Manager (RB) will provide a list of patients booked into the clinic to the consultant to ensure any clinical need is not overlooked. Consultants must advise if any patient is to be seen with some urgency. The outpatient team will advise the consultant of the first available appointments to allow rebooking so they can decide if their clinic is to be overbooked to accommodate any particular patient(s)

Patients who have a previous clinic appointment cancelled should be flagged in the system, so that repeated cancellation is avoided.

To avoid subsequent patient cancellations, action must be taken to contact a patient who has been cancelled by the hospital in order to arrange another, binding appointment date. Engagement of the divisional service managers is required where waits are pushed out for patients along a pathway that cannot incur a delay. Additional clinics should be provided where whole clinic lists are cancelled within 6 weeks of the date the patient is being notified.

Changes to clinics may only be made once the clinic list has been reviewed by the Consultant and Outpatients have received a completed notification to cancel/reduce a clinic session. The Outpatient Clinic Managers (RBH) / Appointment Office (HH) /

Modern Matrons (HH) will notify patients by letter of the cancelled clinic and the new appointment date.

### **12.13 Clinic requirements**

Clinics must have a template that ensures the recommended waiting time of 30 minutes is not exceeded. The NHS plan stipulates “At the outpatient clinic you should be seen within 30 minutes of your appointment time”. Clinicians must complete the “Seen” and “Left” times on the Outcome form so that waiting times can be monitored.

Clinics must have space to ensure that follow up patients on an 18-week pathway can be booked in time.

If a consultant wishes to change a clinic to another time or day, they must first notify and obtain agreement from all relevant departments that this change affects. Such examples are: X-ray, Echo, ECG, Phlebotomy etc.

The consultant should have the appropriate number of clinics open as agreed within the Divisions, excluding sessions when the consultant is away due to meetings, teaching sessions etc. A notice period of a minimum of 6 weeks is required for changing clinics.

Outpatient Service Manager is responsible for monitoring their outpatient performance, with the engagement of divisional service managers when addressing arising issues concerning the ability to book first or subsequent appointments to meet pathway milestone targets. In consultation with the Divisional Service Managers (RB), the Modern Matron (HH), the Appointments Supervisor and consultants, all clinic templates will be reviewed at as part of the annual business planning processes or when there's a marked change in demand. It is important that relevant changes in patient activity are suitably accommodated.

## **13 DIAGNOSTIC IMAGING**

NHS England monitor the proportion of patients waiting 6 weeks (42 days) or more for all diagnostic tests/procedures. This applies equally to all patients excluding patients who are on planned (or surveillance) pathway. This measure is monitored via the Trusts Monthly Diagnostic Waiting Times and Activity returns (DM01), submitted to Unify2.

A **planned** (or surveillance) diagnostic test/procedure is a procedure or series of procedures as part of a treatment plan which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency, e.g. 6-month check Bronchoscopy.

Patients awaiting diagnostics cannot have their waiting time adjusted if they are not available. The patient will be given 3 weeks reasonable notice and at least two offers of a date. If the Trust is unable to offer this the 18 week clock will continue ticking. If the patient cannot attend any of the dates then the DM01 waiting time is set to zero.

### **13.1 Diagnostic imaging – patient cancellation**

If a patient cancels an appointment for a diagnostic test/procedure, then the DM01 waiting time for that booking starts again from the date of the appointment that the patient cancelled.

### **13.2 Diagnostic imaging – hospital cancellation**

Any diagnostic imaging test cancelled by the Trust must be rebooked within the existing 6 week target and the DM01 waiting time is not adjusted.

### **13.3 Diagnostic Imaging – patient DNA**

Where a patient DNAs their diagnostic imaging appointment, they are referred back to their GP or referrer unless the DNA was due to an administrative error. Where the patient did not receive the appointment details, they will be given another appointment.

## **14 INPATIENT AND DAYCASE WAITING LIST**

### **14.1 Decision to Admit**

A patient should only be added to the waiting list for admission (as recommended by the Royal College of Surgeons) if:

**5.4.2 there is a sound clinical indication for the procedure**

**6.4.2 there is a real expectation of performing the procedure within current government guidelines**

**7.4.2 the patient is clinically ready to undergo the procedure and has agreed to accept treatment.**

Consultants are responsible for the decision to add patients to the waiting list and for managing their own waiting lists appropriately.

To ensure patients are treated swiftly consultants may consider cross referring or pooling patients to another consultant within the Trust to expedite their treatment. This is particularly so where the original consultant is unlikely to be able to admit the patient within the allowable waiting time. The referring and receiving consultant must review the patient's notes to ensure that pooling is clinically appropriate. Patients must be made aware, where there are pooled waiting lists in operation that they will be added to the pooled list and may be treated by any of the consultants within that pool.

Where a patient is placed on the list for a complex/rare procedure, this may cause their wait to increase (e.g. to coordinate a second consultant's availability), or their treatment may impact on the length of wait of another patient requiring a less complex procedure. In such cases, the Consultant should inform their Divisional Manager about a potential difficulty in the management of these waiting list patients.

#### **14.2 Recording of additions to the list**

All patients waiting for elective admission for treatment must be entered onto the waiting list module of PAS. This ensures that the patient's need for treatment is recorded, and they are included within patient validation reports and waiting list returns. The record for patients newly added to the waiting list must be entered on to PAS as soon as administratively possible, and no more than 2 days after the decision is made. Divisions will use the regular reports produced by the Performance and Information team to reconcile patients with their expected lists.

#### **14.3 Date on list**

The date on list is the start date for the inpatient or daycase stage of the patient journey. This may be the same as the patient's 18 week clock start, but is often different where the patient has already been waiting in outpatients or at another hospital on their 18 week pathway.

- For patients referred from outpatients or outreach clinic, the date on list is the clinic date.
- For patients referred from other Trusts directly onto the waiting list, without having been seen in outpatients or outreach, or as a result of having diagnostic tests at another Trust, the date on list is the date the referral letter was received by this Trust (not the date the data was input).
- For patients referred across specialty within this Trust, the date on list is the date the referral letter was sent.
- For patients referred as a result of having diagnostic tests at this Trust (e.g. angiogram or sleep study), the date on list is the date the consultant reviewed the test results and decided to proceed to treatment.
- For patients transferring from another Trust's waiting list as a result of a waiting list initiative, or to assist that Trust with long waiters, the date on list at this Trust is the same as the date on list at the referring Trust. However the Trust should have an explicit understanding with the other Trust of who will be responsible for reporting the patient pathway to Unify2. In the event the Trust does not take responsibility for reporting the pathway, the Trust should agree a target waiting time with the other Trust from the date the Trust receives the patient.



#### **14.4 TCI Dates**

Patients must be offered a choice of two TCI dates with reasonable notice. For non-surgical patients, reasonable notice is >3 weeks. For cardiac surgery patients, reasonable notice may be slightly shorter in order to decrease the risk of cancellation/ensure patients are clinically 'fit for surgery'.

All TCI dates must be entered onto PAS as soon as they are agreed.

TCI dates must be offered within the 18 week timescale allowed.

#### **14.5 Patient unavailability – 'Socially unready' patients**

DH makes no provision to adjust RTT waiting times because of clock pauses and suspension in external RTT returns submitted to Unify2. <sup>4</sup> Instances of patient-initiated delays may still be reported locally, to aid good waiting list management and to ensure that patients are treated in clinical priority order.

It is imperative to document in adequate detail, in the paper and electronic patient records, instances of a patient declining the Trust offer of an admission date with reasonable notice.

PAS may be used to record a period of patient unavailability by recording a clock pause from the date of the first offered TCI to the date the patient becomes available.

Where a patient has indicated they would like a specific date for their admission, e.g. waiting for school holidays, then offering TCI dates prior to this time would not be reasonable. As such the PAS patient record might include a period of unavailability from the 'earliest reasonable offer date' which is the date the Trust could have admitted the patient if they had been available to come in. The unavailability period would end on the date the patient indicated they are available for admission.

Where a patient has indicated they are not available for a substantial period, the consultant should determine whether the patient is having doubts about having their treatment. If the patient explicitly states that they no longer wish to have treatment as planned, the patient's clock should stop and the referrer notified.

When attempting to contact patients to offer their TCI dates, it can happen that the patient does not respond to letter or telephone communication. If contact is not re-established within 3 weeks, the patient's clock will stop at the date the lost contact process was initiated.

#### **14.6 Active Monitoring – 'Socially unready' patients**

Where a patient who has been offered a procedure wishes to take time to think about whether they are ready for treatment for a period of time longer than 3 weeks,

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<sup>4</sup> See page 5 of October 2015 RTT Rules Suite document

they must be removed from an 18 week pathway and placed into Active Monitoring / Watchful Waiting. This applies to inpatient and day case waits. The patient will have a clock stop.

Where appropriate, the patient should be referred back to their GP for on-going monitoring. Where the patient's clinical condition is of a complexity such that they should continue to be monitored by the trust they will be re-entered onto the PAS waiting list as an 'Active Monitoring' patient with no 18 week wait. This is a local solution driven by the specialist nature of the Trust's patients who may require clinically complex support. Active monitoring in this instance is a virtual waiting list to record that the patient has been identified as requiring treatment, but does not want to proceed at this time.

Where the patient who has been referred back to their GP decides to proceed with treatment after a period of Active Monitoring/Watchful waiting, the GP must re-refer the patient to the Trust which will start a new 18 week pathway.

Where the patient has been on active monitoring within the trust and monitored here, they must inform their consultant when they feel ready to proceed with treatment. This will start a new 18 week pathway.

The Trust should communicate to the patient and GP the impact that a period of active monitoring will have on their 18 week pathway so that they understand how their wait is progressing.

#### **14.7 Active Monitoring – 'Medically unready' patients**

Where a patient has a long term health problems requiring treatment prior to admission that would otherwise prevent their treatment going ahead (e.g. uncontrolled diabetes), this should be managed by the GP, referring hospital or outpatient clinic at this trust. Their 18 week clock will stop, and a new 18 week pathway will start when the patient becomes fit to proceed to treatment. Where patients have no outpatient appointment, they may be placed on the active monitoring inpatient waiting list module to ensure a record is kept of their need for future treatment.

In order to assess that they are fit and would like to proceed to surgery, patients should be preoperatively assessed before being added to the inpatient waiting list.

When a patient currently on the waiting list becomes medically unfit for over 3 weeks, it should be reviewed whether it is appropriate for the patient to be on the inpatient waiting list or whether alternative management (e.g. outpatient appointment, follow up by a specialist nurse, return to GP/referrer) would be more appropriate. Where the patient has a minor condition e.g. a cold that will be of short duration, they should remain on the waiting list and their 18 week clock will continue. Where a patient has developed a more serious condition and will not be fit to proceed to treatment for some time, they should be removed from the list which will

clock stop their pathway. A new pathway must be restarted when the patient becomes fit for the intended treatment.

The overarching principle is that patients on the waiting list should be fit and available for surgery, if this is not the case they should be referred back to their General Practitioner and/or Referrer if clinically appropriate, monitored in the Trust's outpatient clinics or in active monitoring.

#### **14.8 Active monitoring list**

The Active Monitoring List is a record of patients that are currently being actively monitored and who may or may not be booked into Outpatient clinics. The reason for this list is so patients that will require treatment in the future (but not fit/accepted currently) can be tracked. This list is used purely to keep a record of patients and is not a waiting list. The purpose of this is so that processes are transparent. The Divisions will receive a weekly list of patients that are in active monitoring and it is vital that they review the patients on this list regularly.

#### **14.9 Patient DNA**

When a patient DNAs an accepted inpatient TCI date the consultant will review the notes and decide whether the patient is to remain on the waiting list. If the consultant wishes to continue to offer treatment to the patient, the 18 week clock continues to tick.

Where the patient DNA was due to an administrative error, the patient's 18 week clock will continue to tick and a further choice of TCI dates offered. The patient's details must be checked on Summary Care Record (SCR) and verbal contact to confirm that the new TCI date has been received and accepted must be made.

#### **14.10 Patient Cancellations**

Where a patient has a period of unavailability recorded in PAS for turning down two reasonable TCI dates, and the patient then cancels an accepted TCI date, the original period of unavailability may be extended from the first date of patient unavailability to the date the patient makes themselves available for admission.

Where a patient cancels an accepted TCI date due to unforeseen and severe personal circumstances the clock may continue to tick. If it is unlikely that those circumstances will be quickly resolved a period of patient unavailability from the TCI date (earliest reasonable offer date) to the date the patient is likely to become available for admission may be appropriate.

#### **14.11 Hospital Cancellations**

Section 9.12 of this policy outlines the rules concerning patients who are cancelled and the targets associated with offering the patient another date to have their treatment.

When an admitted patient is cancelled and discharged untreated, clinical staff are responsible for notifying the appropriate PAS waiting list schedulers by completing and ensuring delivery of the correct waiting list request documentation.

Where a patient has been admitted, the procedure cancelled after admission and the patient discharged untreated, this will have closed the waiting list entry on PAS and the patient will no longer show on any waiting list report.

The entry must be re-entered with the original dates, including details of any patient unavailability, to match the original waiting list record. Divisions **must** have a standard operating procedure documented and followed to ensure that all patients cancelled after admission are re-waitlisted.

Any patient cancelled by the Trust on the day of admission, or following their admission but prior to the procedure being carried out, **must** be re-admitted and treated within 28 calendar days of the cancellation. This applies to all patients, including those treated by visiting consultants who may have infrequent sessions held at this Trust.

If such a patient cannot be offered a date within 28 days, they must be offered choice of treatment at another (NHS or Private) hospital, or in private patient accommodation at this Trust within that timescale, funded by this Trust.

“Everyone Counts: Planning for Patients 2013/14” states that no patient should have to tolerate having an urgent operation cancelled for the second time.

Whenever an accepted offer of admission is cancelled by the hospital prior to their day of admission, the patient must be contacted as soon as possible with a new proposed admission date.

Wherever possible patients that have been previously cancelled, require transport or are having other tests the same day should not be cancelled a second time.

Where the Trust cancels a patient this must be recorded in PAS or relevant clinical system in real time. Clinics or theatre lists should only be cancelled in exceptional circumstances. In cases of planned annual/study leave/audit sessions, there will be at least 6 weeks’ notice in which to make alternative arrangements. In cases of unplanned sickness absence, all endeavours to cross cover lists / clinics should be employed.

A minimum of six weeks’ notice of planned annual leave or study leave should be given when a consultant requires to change or relinquish a theatre list. The clinician is required to arrange for the completion of a “Leave Notification” form authorised by the Divisional Manager.

#### **14.12 Cancellations and Cancer Waiting Times**

For cancer waiting times, no pauses are allowed:

- for medical suspensions at any point in the patient pathway;
- during the diagnostic phase of the 62-day standard (there can be no pauses between the 'date first seen' and 'decision to treat');
- For waits for treatment that will take place in non-admitted (outpatient) settings.

Two types of pause (and therefore adjustments for these pauses) will now be used:

- If a patient DNAs their initial outpatient appointment - this would allow for a clock pause from the receipt of the referral to the date upon which the patient rebooks their appointment. This pause is relevant to the cancer two week wait and the 62-day standard (this is handled differently within 18 week rules).
- If a patient declines a treatment in an inpatient setting provided the offer of the date was deemed "reasonable". For cancer patients under the 31 day or 62 day standard 'reasonable' is classed as any offered admission between the start and end point of 31 and 62 day standards. The pause would be the time between the date of the declined admission to the point when the patient could make themselves available for the alternative appointment.

#### **14.13 Removals from the Waiting List**

Patients can be removed for one of the following reasons

- Admission at another hospital or emergency admission at the trust (emergency or elective)
- After failing to attend (DNA)
- After cancelling admissions
- At patient's request
- Patient deceased
- At the request of the consultant or GP

Where a patient on a waiting list is admitted (electively or as an emergency) for treatment that is unrelated to their proposed procedure/test/appointment on the waiting list, the ward/outpatient/diagnostic administrative staff must ensure on discharge of the patient that a check has taken place to determine whether the condition specified on the waiting list has also been carried out and if the patient can be removed from that list. If this is the case, the administrator will inform the Divisional/Service Manager who will ensure the correct waiting list co-ordinator verifies from the notes, and if necessary, the consultant and patient that the waiting list entry, diagnostic test or outpatient appointment is no longer required. The waiting list entry should be removed as soon as possible.

Where a patient is deceased, has been treated at another hospital, or no longer needs their procedure, they must be removed from the waiting list. Care must be

taken to verify that the procedure is no longer required prior to removal from the waiting list.

Where patients initiate the removal by refusing treatment or the patient no longer requires their procedure the consultant must consider the decision to remove the patient from the list. The consultant may wish to discuss this with the patient prior to removal. Patient notes and PAS must be updated with the removal reason details.

Where contact is lost with a patient, every effort must be made to trace their whereabouts via the Summary Care Record, and by contacting their GP. Lost contact patients may only be removed from the list when every attempt to locate them has failed.

All removals must be checked with the relevant consultant, and the patient's GP and referring physician notified in writing. PAS and the patient's clinical notes must be updated by the medical secretary or waiting list co-ordinator. The removal date entered on PAS must be the date the decision to remove the patient was made, not the date the record was edited.

Where a patient currently showing as unavailable is identified for removal, the unavailability period must be ended prior to removing the patient. PAS does not allow a patient unavailability end date to be entered on the same day as a removal date. Therefore, the patient unavailability end date must be entered, and the record re-edited the following day to apply the remove date. This is the only instance where system restrictions dictate that the remove date entered is the current date. Patient unavailability periods should never be deleted in order to admit or remove a patient

#### **14.14 Planned Waiting Lists**

'Planned' waiting lists will show patients waiting for first definitive treatment where a 'clinical exception' has been determined or a further stage of their treatment where this is a continuation of that treatment:

- Example of a 'clinical exception' includes a child who will require surgery but must wait to be a specific age to be medically fit;
- Examples of further stage treatment include a series of admissions for intravenous drugs, allergy testing, a 'check' bronchoscopy, or transplant M.O.T. The first entry in a series of planned admissions should be shown as an 'active' (waiting list or booked) admission and is likely also to be part of an 18 week pathway. Subsequent admissions in the care pathway will be recorded as 'planned'.

Patients are usually placed on the waiting list upon discharge from their previous admission, or given a series of waiting list entries, and are normally issued a TCI date when being placed on the list.

#### **14.14.1 Suggested good practice**

The Trust should locally determine the appropriate arrangements for each individual patient case, applying this key principle on a common-sense basis to achieve the best possible clinical outcomes for the patient.

The Trust needs to plan and manage services so that active and planned patients are treated at the right time and in order of clinical priority. Patients requiring initial or follow-up appointments for clinical assessment, review, monitoring or treatment must be given a clear expectation of the timeframe for this, as required by best clinical evidence.

The Trust should have systems in place to review any planned lists regularly to ensure planned appointments are booked for the right time and 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 planned lists, including the review date. Effective communication removes uncertainty for patients and on-going review ensures that patients' treatment is not delayed inappropriately.

There are very strong clinical governance and safety reasons why planned care should not be deferred. A significant proportion of planned patient activity is done for surveillance of high risk groups of patients associated with high rates of mortality and poorer outcomes if not managed correctly.

The Trust will govern the planned waiting lists by having a regular meeting to discuss the patient detail and ensure patients are not being deferred inappropriately and action for each patient are established and/or understood.

#### **14.15 Transplant waiting lists**

Patients awaiting a transplant operation are entered on to PAS for ease of management, but are excluded from the waiting list reports.

Patients awaiting transplant Annual Review are placed on the waiting list as planned waiters.

Patients awaiting a transplant assessment are on the active waiting list and 18 week wait pathway.

#### **14.16 Waiting list exclusions**

Patients should not be placed on the waiting list if they are currently an inpatient at another hospital, even where they are expected to be admitted at a later date to this Trust. Patients transferred directly from another Trust, whether electively or as an emergency have an admission method of '**transfer**' on PAS.

Inpatient transfers may be placed on the PAS waiting list for ease of day to-day management, but are excluded from waiting list reports.

## **15 ADMINISTRATIVE CLOCK STOP**

An 18 week pathway may end without an associated appointment or admission, for example a consultant may review diagnostic test results outside of clinic and decide that treatment is not currently required. This is an administrative clock stop, and the date this decision was made should be entered into the clock stop field on the 18 week screen on PAS to close the 18 week pathway.

## **16 PATIENT COMMUNICATION**

The 18 week target has a significant impact on the way we provide services for patients, the main one being that patients are required to be fit and available for treatment at the time of referral / addition to a waiting list.

It is therefore imperative that patient responsibilities are clearly communicated to patients, particularly with regard to making themselves as available as possible for admission. The following communication routes should be used:

- Internet
- Patient leaflets
- Posters in GP surgeries, outpatient, diagnostic and ward areas
- Patient electronic letters to include waiting times information of 18 weeks and patient responsibilities

### **16.1 Booking and confirmation to the patient**

All patients should be fully or partially booked for admission. The waiting list co-ordinators will hold a telephone conversation with the patient to offer a series of dates with reasonable notice for the patient to choose. Patients must be offered a minimum of two dates with reasonable notice within the maximum waiting time allowed for their procedure. A letter that confirms the agreed date must be sent to the patient.

Patient letters should contain:

- Patient's name and address
- Consultant
- Date on list
- TCI date where agreed or approximate waiting time

Letters should remind the patient to inform the hospital of any change in address/GP or other circumstances. A named contact at the hospital should be given for queries. Systems should be in place to ensure that phone contact points are up to date and



will be responded to. Letters should advise the patient that if they feel there has been significant change in their condition they should, in the first instance request advice.

Special consideration should be given to communicating with patients with special needs, e.g. sensory or learning disabilities. The Patient Advice and Liaison (PALS) service can help signpost staff to support services.

## **16.2 Information to the GP**

Following a decision to add a patient to the waiting list, the patient's registered GP should be informed of the decision to admit and intended treatment.

## **17 DUTIES**

**CHIEF EXECUTIVE** - The Chief Executive has overall responsibility for the Trust's performance and fulfilment of its obligations.

The **CHIEF OPERATING OFFICER** has been designated by the Chief Executive with responsibility for patient access times and waiting-lists, and for oversight of this policy.

The **DIRECTOR OF PERFORMANCE AND TRUST SECRETARY** is responsible for reporting accurate waiting time information to the Trust Board and to external bodies.

**CONSULTANTS** are responsible for their patients on the waiting list and the order of decision to treat. They are responsible for treating patients within the timescale where clinically appropriate, and for communicating any workload or capacity issues that may affect the ability to meet the waiting time targets. Consultants must assist with resolving waiting list capacity issues, including pooling of lists.

Consultants are also responsible for ensuring that 18 week decisions are clearly recorded, and that Outpatient Outcome forms are completed for their clinics. Waiting times are the responsibility of the Consultants but are administered by administrative, secretarial and clerical staff within each division.

**DIVISIONAL MANAGERS AND SERVICE MANAGERS** have responsibility for the day to day management of patient waiting times. Responsibility includes management and validation of lists, monitoring patients currently unavailable, ensuring prompt and accurate use of PAS records and responding to data quality or process issues raised within the Trust.

**PERFORMANCE AND INFORMATION TEAM** are responsible for reporting the waiting list position, and for ensuring that the queries and methodology for producing central returns, Commissioner reports and Trust internal reports is accurate and complies with DH rules and the NHS Data Dictionary. The Director of Performance and Trust Secretary is responsible for the approval of waiting time figures reported

externally, and internally to the Trust Board and reporting issues or potential waiting list problems to the Chief Operating Officer that may not be immediately resolved within the Divisions. The team is also responsible for monitoring, reporting on and aiding those departments responsible for data entry to improve their performance.

**INFORMATION & TECHNOLOGY** must ensure that data collection systems are fit for purpose. and ensuring that suitable training programs are delivered and PAS procedures for maintaining the waiting list must be made available to all staff by placing it on the Trust intranet.

**ADMISSIONS / WAITING LIST / PATHWAY CO-ORDINATORS / SCHEDULERS** are responsible for management of admissions to comply with waiting times standards, validation of waiting lists, especially long waiters, updating of the patient notes and PAS and discussions with patients regarding their waiting times and TCI date as appropriate. They must take into account any special needs of the patient which have been highlighted.

**ADMISSIONS / WARD CLERKS** are responsible for the admission of patients from the waiting list, ensuring that the admission is recorded in a timely fashion, the correct admission method is used and the PAS waiting list entry is closed.

**MEDICAL SECRETARIES** are responsible for maintenance of consultant based waiting lists, updating of the patient notes and PAS records. Discussions with patients regarding their waiting list and TCI date as appropriate, taking into account any special needs of the patient which have been highlighted.

**APPOINTMENT / OUTPATIENT RECEPTION CLERKS / DIAGNOSTIC ADMINISTRATION STAFF** are responsible for booking appointments and updating demographics, ensuring that the appointment and outpatient waiting list entry is recorded in a timely and accurate fashion.

**18 WEEK COORDINATORS** are responsible for recording of 18 week pathway information, ensuring that the data is recorded in a timely and accurate fashion.

**ALL STAFF** - This policy and related procedures should be fully explained to all staff associated with 18 week pathways, cancer pathways, outpatient, diagnostic and elective admission waiting lists and times, with particular regard to their responsibility for the quality and accuracy of the data collected. A copy of this policy is available to all staff on the Trust intranet.

**ALL STAFF** are responsible for the accuracy and timeliness of data entry and quality, and for compliance with the Data Protection Act, Caldicott guidance, principles of information governance and the Freedom of Information Act.

## **18 REFERENCES AND FURTHER READING**

- 1 The NHS Information Centre: <http://www.ic.nhs.uk/>
- 2 NHS England Diagnostic and Waiting Times and Activity Guidance: <http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01-guidance-v-5.31.doc>
- 3 NHS e-Referral Service: [www.chooseandbook.nhs.uk](http://www.chooseandbook.nhs.uk)
- 4 Department of Health Waiting Times guidance: <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/Waitingtimes/Pages/Guide%20to%20waiting%20times.aspx>
- 5 Referral to Treatment Rules Suite: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/440443/RTT\\_Rules\\_Suite\\_October\\_2015.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/440443/RTT_Rules_Suite_October_2015.pdf)
- 6 Cancer Waiting Times: A Guide (Version 8.1): <http://systems.hscic.gov.uk/ssd/cancerwaiting/cwtguide8-1.pdf>
- 7 London Cancer Alliance: <http://www.londoncanceralliance.nhs.uk/information-for-healthcare-professionals/forms-and-guidelines/north-west-london-cancer-network/>
- 8 “Everyone Counts: Planning for Patients 2013/14” : <http://www.commissioningboard.nhs.uk/everyonecounts/>
- 9 “Everyone Counts: Planning for Patients 2014/15 – 2018/19: Technical Definitions for Clinical Commissioning Groups and Area Teams ” : <http://www.england.nhs.uk/wp-content/uploads/2013/12/every-count-tech-def.pdf>
- 10 NHS Interim Management and Support: <http://www.nhsimas.nhs.uk/ist/>

## 19 RELATED TRUST POLICIES

- 1 Confidentiality & Data Protection Policy
- 2 Data Quality Policy
- 3 IM&T Security Policy
- 4 Information Governance Policy
- 5 Clinical Records Policy
- 6 Copying letters to patients Policy
- 7 Lung Cancer MDT Operational Policies

## 20 GLOSSARY

**18-week referral to treatment period (RTT):** The part of a patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other 18 week clock stop point.

**Active monitoring:** An 18-week clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage.

**Admission:** The act of admitting a patient for a day case or inpatient procedure.

**Admitted pathway:** pathway that ends in a clock stop for admission (day case or inpatient).

**Booked Admission:** Patients are requested to contact the Trust within 24 hours of being placed on the waiting list to agree their TCI date.

**Cancelled by Patient (CP/CNA):** this is defined as where a patient notifies the Trust with prior notice that they cannot attend an appointment/admission. (CP – the patient cancels appointment but doesn't rebook at the time, CNA – the patient cancels and rebooks the appointment at the same time).

**Cancelled by Hospital (CC):** this is defined as where Trust cancels a patient's appointment/admission.

**e-Referral Service:** A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic.

**Clinical decision:** A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements.

**Clinical exception:** Cases where a patient should wait longer than 18 weeks because it is in the patient's clinical interest. This does not include clinically complex patients who nevertheless can and should start treatment within 18 weeks.

**Consultant:** A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. 18 weeks excludes non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.

**Decision to admit:** Where a clinical decision is taken to admit the patient for either a day case or inpatient.

**Decision to treat:** Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatments performed in other settings e.g. as an outpatient.

**DNA – Did Not Attend DNA:** this is defined as where a patient fails to attend an appointment/admission without prior notice.

**Duration of Referral to Treatment (RTT) Wait:** The length of time between the clock start date and the clock stop date. **Elective Admission:** An admission that has been arranged in advance. This does not include emergency admissions or transfers from another provider (these have their own admission types on PAS). All elective admissions must have a date on list.

**Elective Admission Type:** The type of waiting list entry (planned, waiting list, booked or part of booked admission project).

**First definitive treatment:** An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes First Definitive Treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.

**Fit (and ready):** A new 18 week clock should start once the patient is fit and ready for a procedure. In this context, fit and ready means that the clock should start from the date that it is clinically appropriate for the patient to undergo that procedure, and from when the patient says they are available.

**Intended Management:** This categorises whether the patient is intended to be admitted as an inpatient or daycase when placed on the waiting list.

**Intended Procedure:** This is the main procedure for which the patient is to be admitted. When using OPCS coding, up to three procedures may be recorded.

**Interprovider Transfer Minimum Dataset (IPTMDS / IPT form):** This form is mandated by the DoH and contains the data required to be able to monitor the 18 week Referral to Treatment pathway across different Trusts. This form must accompany all referrals in and out of the Trust.

**Non-admitted pathway:** A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment' (e.g. outpatients, patients awaiting diagnostics, waiting list removals, patients where clock stopped as a result of diagnostic tests indicating no treatment required).

**Partially Booked Admission:** Patients are told of the approximate date of their admission and are contacted by the Trust 4 weeks before this date to agree a TCI date.

**PTL:** List of patients currently waiting for treatment on an 18 week Referral to Treatment Pathway.

**RTT:** Referral to Treatment – current target is 18 weeks.

**Reasonable offer:** Where a decision to admit, as either a day case or inpatient has been made, many patients will choose to be admitted at the earliest opportunity. However, not all will, and it would not be appropriate to adjust a patient's waiting time for patients who cannot commit to come in at short notice.

**To Come In (TCI) Date / Offer of Admission:** This is the formal offer of a date of admission. The DoH recommends a minimum of 3 weeks' notice for an offer of admission, for patients other than booked admissions, and a choice of two TCI dates.

**UBRN (Unique Booking Reference Number):** The reference number that a patient receives on their appointment request letter when generated by the referrer through E-Referral Service. The UBRN is used in conjunction with the patient password to make or change an appointment.