The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Patient Access Policy

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Executive Summary

The successful management of patients who are waiting for elective treatment is the responsibility of a number of key individuals and organisations including Hospital Doctors, General Practitioners (GP's), Clinical Commissioning Groups (CCG's), Local Health Boards (LHB's - Wales referred to as CCG for the remainder of this document), Trust Staff and NHS England. If patients who are waiting for treatment are to be managed effectively it is essential for everyone involved to have a clear understanding of their roles and responsibilities. This document defines roles and responsibilities and establishes the policy to deliver effective waiting list management.

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1.1. Executive Summary

The successful management of patients who are waiting for elective treatment is the responsibility of a number of key individuals and organisations including Hospital Doctors, General Practitioners (GP's), Clinical Commissioning Groups (CCG's), Local Health Boards (LHB's - Wales referred to as CCG for the remainder of this document), Trust Staff and NHS England. If patients who are waiting for treatment are to be managed effectively it is essential for everyone involved to have a clear understanding of their roles and responsibilities. This document defines roles and responsibilities and establishes the policy to deliver effective waiting list management.

The policy defines the good practice of waiting list management including the principles and definitions of the 18 week target which count the referral to treatment (RTT) waiting times in totality. This is a positive step and allows the Trust to focus on delivering shorter waits and quality care for patients.

The Trust acknowledges that the length of time a patient needs to wait for hospital treatment is an important quality issue and is a viable and public indicator of the efficiency of the hospital services provided by the Trust.

This policy has been designed to provide consistency and eliminate all duplicate systems throughout the Trust. It is imperative that the Hospital PAS System is the single store of data used for the management of all waiting lists.

It is essential that the electronic Hospital PAS System is fully functional and that effective training and support is given to those staff involved in waiting list management. This will help improve data quality and improve confidence in the accuracy of waiting list information.

1.2. Policy Statement

This document outlines the policy to be followed by all staff at WCFT involved with the management of patient access at WCFT. The policy outlines associated processes and procedures to be followed in conjunction with the policy statements.

1.3. Aims and Objectives

The purpose of this document is to ensure that all patients requiring access to:

- outpatient appointments
- elective inpatient treatment
- elective day case treatment
- diagnostic tests

Are managed consistently, according to national and local frameworks and definitions.

The policy aims to provide the Trust with a coherent approach to the management of waiting lists, scheduling and booking across the organisation.

This document defines the roles and responsibilities and establishes the effective management of waiting lists, scheduling and booking across the organisation.

1.4. Roles and Responsibilities in Managing Waiting Lists, Scheduling and Booking

This section outlines the key responsibilities of key groups of staff within the Trust in relation to this policy. The list is not exhaustive and each group will have other roles and responsibilities that are not listed here.

The Director of Operations & Performance - will ensure the Patient Access policy is implemented and adhered to and will ensure the Trust is maximising its clinic and theatre capacity whilst adhering to the NHS Executive guidelines regarding:

- Total number on waiting list.
- Cancelled operations/clinics
- Waiting times targets.
- Suspended Waiting List.
- Planned Waiting List

Divisional Managers - will be responsible for ensuring all patients receive treatment within national and locally agreed targets, and that all staff adheres to the Trust Patient Access Policy and associated procedures. Divisional Management Teams will be responsible for monitoring the following:-

- Total number on waiting list.
- Cancelled operations/clinics.
- Waiting times targets.
- Suspended Waiting List.
- Planned Waiting List.

Consultants - Each Consultant will decide which patients require adding to a waiting list and their clinical priority. Consultants will be responsible for the care of all patients listed on their waiting list including those suspended within National and local agreed targets.

Consultants and their clinical teams are required to provide at least six weeks notice before the date for commencement of the leave period, and submit the relevant form to the relevant Clinical Lead for approval.

Consultants will be responsible for reviewing patient's records for those requiring re-scheduling following a hospital cancellation to ensure patient care is not compromised and to ensure treatment within the 28 day cancelled operations target.

Consultants and their clinical teams will be responsible for ensuring all E-referral, and paper referrals are reviewed within three working days of receipt into the organisation.

Consultants are responsible for the timely management, to the best of their ability, for all patients and should raise any areas of concern with the Divisional Managers i.e. Capacity.

Information Management & Technology (I M &T) The PAS system trainers will work with users to ensure that training needs are met and underpinned with effective training and documentation.

The I M & T Department will ensure:

- Data entry is accurate and complies with national and local data standards.
- Consistent waiting list reporting is achieved internally and externally.

- System changes are actioned in liaison with suppliers.
- Software and process changes are implemented in liaison with users.
- Produce data quality reports on a weekly/monthly basis that are fit for the purpose of Accurate waiting list management.

Health Records - clerks will be responsible for locating case notes, preparing and delivering notes to the appropriate clinic/reception area prior to the clinic/patient admission taking place within the department remit.

Operational Service Managers - will be responsible for maintaining the Directory of Services (Dos) and ensuring outpatient referral processes are reviewed in line with the evolvement of E-Referral.

Appointments Coordinators (PAC)/Medical Secretaries - will be responsible for adding and administration of patients to the OP/IP/DC/Diagnostic waiting list(s) on the Hospital PAS System, as appropriate to their role and will highlight any capacity concerns to the Divisional Management Team. In addition the staff will generate a letter from PAS to inform GPs of any patient cancellations/DNAs where the patient is not being offered a further appointment.

Wards & Departments – must ensure patients are admitted and discharged on the Hospital PAS System; recording out-comes against pre-admissions if patients DNA or CANCEL. Ensure all case-notes are available for admission date and all patients' movements within the hospital are accurately recorded on the PAS systems i.e. ward transfers, hospital transfers, admitting consultant changes, discharged.

Theatre/Bed Managers - must contact the Divisional Management Team before cancelling patients due to lack of bed/theatre availability, advising on the patient's length of wait and relevant circumstances. Any major problems should be escalated to the Director of Operations & Performance.

Theatre Administrator – must inform Medical Secretaries/Divisional Management Team of hospital cancellations in order to facilitate a new TCI date that is within 28 days.

Medical Secretaries – must ensure all patient/GP correspondence is typed within 7/10 days of patient event and that the Hospital PAS System is updated accordingly. Medical Secretaries must also complete an Inter Provider Transfer Administrative Minimum Data Set (IPTAMDS) form for patients being referred to another provider.

The Director of Finance will, through the Data Quality Group be responsible for overall data quality within the trust. This will involve providing assurance of data quality through KPI's, assessment and associated performance management of identified actions in response to data quality risks and incidents.

The CCG Responsibilities include;

- Adhere to WCFT local Patient Access Policy and associated procedures.
- Manage patients and review them as appropriate, when informed by WCFT that the patient has DNA'd their admission/appointment and has been removed from the waiting list.
- Manage patients and review them as appropriate, when informed by WCFT that the patient has cancelled their appointment on two occasions or on day of appointment giving unreasonable notice and has been removed from the waiting list.

- Manage patients and review them as appropriate, when informed by WCFT that the patient has cancelled their admission on two occasions and has been removed from the waiting list.
- Manage patients and review them as appropriate, when informed by WCFT that they have not responded to a validation letter and have been removed from the waiting list.
- Manage patients and review them as appropriate, when informed by WCFT that the patient is not clinically fit to have required procedure at the time of decision to treat.

1.5. Key Principles

- The Trust will endeavour to work towards inclusion and equal access for all service users.
- GPs (or other referrers) should only refer patients who are 'ready' to start (and progress with) their pathway without undue delay.
- The 18 weeks pathway does not allow for any delays in patient care or in administrative processes. To ensure that patients move through pathways in a planned manner, all appointments, Diagnostics and admissions under 6 weeks will be booked in a timely manner.
- Patients should not leave one hospital attendance without knowing when the next stage of their pathway is booked or intended to be booked.
- Patients should be listed on the Decision to Admit (DTA) date and tracked according to the 18 week rules and definitions.
- Trust administrative staff must **not** keep local records of patients' choosing to wait or defer a reasonable offer of an appointment/admission.
- Patients will be treated according to their clinical priority and managed in chronological order, within national and locally agreed waiting time targets.
- Waiting lists are managed according to clinical priority. Patients not classified as a priority should be treated on a **"first come first served"** principle. **The Policy will be reviewed on a bi-annual basis, and amended as required to take account of changes to national targets.**
- The Trust will seek to make best use of its resources to the benefit of all patients by seeking to reduce the number of patients who Do Not Attend (DNA). Patients will be encouraged to be responsible for keeping their appointments.
- The Trust will hold a record of all patients waiting for an appointment/admission on the Hospital PAS System. It will be current, accurate, and complete and subject to regular audit and validation. The Trust will not hold deferred waiting lists.
- The Trust will agree a convenient date and time with patients for appointments or admission following either partially or fully booked systems.
- The Trust will support the full utilisation of GP out-patient referrals via E-referral, ensuring the Directory of Services (DOS) is up to date and the appropriate level of commissioned capacity is published to ensure patients have access to services.
- Communication with patients should be informative, clear and concise. The process of Waiting List management should be transparent to the public.
- Appropriate training programmes should support staff with special regard given to newly recruited staff. Divisions are responsible for ensuring that all staff involved in the content of this policy, both clinical and clerical, receive initial training and regular updating.
- Out-Patients should only be followed up if there is a clinical need and all clinical information is available.
- Ensure that no equality target group (Black & Minority Ethnic, Age, Gender, Disability, Religion, and Sexual Orientation & Transgender) are discriminated against or disadvantaged by this policy and associated procedures.

1.6. National and Local Targets for 2015/16

National Access Targets - Within the NHS Improvement Plan (June 2004), the following objective was stipulated "by 2008, no one will wait longer than 18 weeks from GP Referral to hospital treatment."

The NHS Constitution provides patients with a right to access services within maximum waiting times, including the right to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions. If this is not possible, the NHS Constitution requires the NHS to take all reasonable steps to offer patients a range of suitable alternative providers. CCG's should publicise this right and the options available to local people where treatment within 18 weeks is at risk. It is the responsibility of the trust to ensure patients have the information they need to exercise those options if need be. This information is included in the Outpatient Information Leaflets.

Max total wait	<18 weeks in total	<36 weeks in total	% of open pathways <26 weeks
Incomplete	92%	100%	95%

Local Access Targets - In addition to meeting the NHS operating framework targets, the Trust aspires to tighter internal step down targets. These will be reviewed on a regular basis.

Cancer;

- The **maximum** wait for a first outpatient appointment for patients referred by GPs via a Fast Track Referral Proforma is **2 weeks** (14 days).
- The **maximum** wait for all cancer patients from date of decision to treat, to first definitive treatment should be no more than **31 days** (including Diagnostics).
- In total **no** patient should wait longer than **62 days** from urgent GP referral to first treatment (including Diagnostics).

Booking Targets;

- **Outpatients** - 100% of outpatient appointments to be booked through a combination of E-referrals and manual full or partial booking processes.
- **Inpatient & Daycase** - 100% of admissions to be booked through a combination of manual full or partial booking processes.
- **Diagnostic** - 100% of diagnostic tests to be booked through a combination of manual full or partial booking processes.

18 weeks;

- All patients will be treated within 18 weeks from referral to treatment and all aspects of the patient journey will be scheduled using a combination of manual full or partial booking processes for appointments and admissions under 6 weeks.
- Where appropriate due to patient choice or clinical complexity, some patients will not be treated within 18 weeks

2. Policy Specific

2.1. Introduction

The successful management of patients who wait for non-urgent outpatient appointments and elective treatment is the responsibility of a number of key individuals and organisations including, CCG's, GP's, Hospital Doctors and Trust Staff. Service Commissioners must ensure that long-term service agreements are established with sufficient capacity to ensure that no patient waits more than the guaranteed maximum time. Failure to commission and commit resources to funding adequate capacity will lead to longer waiting lists and times.

With the introduction of "Patient Choice" the balance between patient referrals and additions to waiting lists may cause unpredicted increases or decreases in the demand for services. CCG's, GP's and "Patient Choice" are important factors and monitoring activity against service level agreements will be an integral part of this Policy.

Trust Staff have an important role in managing Waiting Lists effectively. Treating patients and delivering a high quality, efficient and responsive service ensuring prompt communications with patients is a core responsibility of the hospital and the wider local health community. Trust staff must promote a safe, clean and personal service.

It is the responsibility of the Trust and of all staff to ensure that this policy is implemented in a fair and consistent manner to ensure that no equality target groups are discriminated against or disadvantaged by the implementation of this policy and associated procedures.

The accuracy of published data is of paramount concern to the Trust. In support of data accuracy all transactions made on the Hospital PAS System will be performed by staff in accordance with the training manual. This will be given to staff on completion of the relevant training course and prior to access rights being issued. An up to date document will be made available on the Trust's Intranet.

To ensure consistency and the standardisation of reporting with Commissioners and the NHS Executive, all waiting lists are to be managed within the Hospital PAS System. Manual Waiting list systems must **not** be used within the Trust.

2.2. Booking

The 18 weeks pathway does not allow for any delays in patient care or in administrative processes. To ensure that patients move through pathways in a planned manner, all appointments, Diagnostics and admissions under 6 weeks will be booked in a timely manner.

Patients should not leave one hospital attendance without knowing when the next stage of their pathway is booked or intended to be booked.
Booking system – to ensure that the Trust meets the targets for offering "patient choice" at first outpatient appointment and ultimately at all stages of a patients journey the following booking systems will be adopted as best practice across the Trust:

- E-referrals (For definition see glossary)
- Full Booking (For definition see glossary)
- Partial Booking (For definition see glossary)

All patients will be given the opportunity to choose the date of their admission/appointment. It is essential that a record of the booking type offered to the patient is completed on the Hospital PAS System.

Reasonable notice - A "reasonable" amount of notice must be given to patients when offering appointment/admission dates. A record of the offers should be recorded on iCS PAS.

- **18 week pathway -** Where patients are on an 18 week pathway 'reasonable notice' is defined as:
  - 3 weeks' notice and a choice of 2 dates

- **Cancer patients –** Reasonable notice as above does not apply to suspected cancer patients. Any offer between the start and end point of 31 or 62 day standards is classed as reasonable.

2.3. Referrals / Requests

Referral letters/requests content – must be clear and concise stating the clinical priority, reason for referral or request. Referral letters/requests should be addressed to a specialty/service wherever possible (i.e. Dear Dr Neurology/Neurosurgery) to allow that specialty/service to direct the referral/request to the most appropriate member of the team and shortest waiting time. On the occasions that it is in the best interest of the patient to be seen by a named individual, the rationale for this must be clearly stated or the patient will be "pooled" to the referring specialty.

Referral criteria have been provided to referrers to ensure that all referrals contain sufficient information. Any that are considered not to have provided adequate information in the referral letter for the Consultant to triage adequately will be returned to the referrer. This process will be monitored in order to assess the impact.

- **Special requirements** – it is the responsibility of the referrer to indicate in the referral letter any special requirements a patient may have in terms of speech and sign interpretation, religious, cultural needs and disabilities (see section 2.4).
- **Consultant to Consultant Referrals** – all consultant to consultant referrals either internally or externally must be accompanied by a completed 18 week Inter Provider Transfer Administrative Minimum Data Set (IPTAMDS).
- **Clock Start Date** –
  - For patients on a new 18 week pathway the clock start is the date on which the paper referral is received into the organisation. (For internal referrals it is the date of the decision to refer)
  - For patients on an existing 18 week pathway the clock start date is the date indicated on the IPTAMDS.
  - **For E-referrals**, the clock start date is th UBRN conversion.
  - For all referrals for patients with a Welsh GP the clock start date is the date received into the organisation irrespective of who or where it comes from.

Inappropriate referrals / requests - If the referral/request is for a service not provided by the Trust then the referral/request must be returned to the original referrer with advice. The Patient Access Centre must be informed and the referral/ request closed off the Hospital PAS System.

Mismatch of Consultant Interest and Patient Needs - If a referral has been made to an individual who does not have the necessary skills for the needs of the patient, the

professional prioritising the referral should re-route the referral to an appropriate colleague, prior to seeing the patient.
Insufficient/illegible Clinical Information – If the referral/ request does not provide sufficient/legible information for the health care professional to make a decision, the letter should be returned to the original referrer.

Down Grading of a referral - If a healthcare professional wishes to down grade a Two Week Wait (TWW) the prioritising healthcare professional must inform the Cancer Co-ordinators to have a conversation with the original referrer before any changes to the request are made on the Hospital PAS System. If the original referrer has any queries, then a conversation must be had with the appropriate clinician.

2.4. Special Requirements

All special requirements must be notified to the appropriate department when informed of the appointment/admission date in order that the service can be booked. Where an appointment/admission date is cancelled/rescheduled, the appropriate department must be informed in order that the service required can be cancelled/rescheduled and avoid being charged.

- **Interpreter** - Where a patient requires an interpreter for an appointment /admission this must be highlighted at the top of a referral/request and also must be clearly state the exact type of interpreter required. Interpreter status on PAS must be completed.
- **Advocacy** – requests and enquires to: Patient Experience Team at WCFT.
- **Patient Transport** – patient transport for all first and subsequent outpatient attendances must be booked by the patient, subject to meeting the eligibility criteria.
- **War Veterans/Military Personnel** – War Veterans/Military Personnel should receive priority treatment but only if the condition they are referred with is directly attributable to injuries sustained during war periods. This will include working with patients CCG's to allow a smooth transition for military personnel injured in the course of duty. (Further information is available in the Trust Veterans Policy)
- **Overseas Visitors** – patient identified as an overseas visitor should be referred to the Finance Department.
- **Disabilities/Special needs** - The Trust is committed to providing, wherever possible, a booking system to support the requirements of individuals with disabilities, this may involve for example; booking an appointment time that is more suitable to their needs.

  We will continually work towards ensuring that individuals with disabilities are not disadvantaged by this policy; we will, through the Impact Assessment process & involvement with local disability groups, identify areas of concern and work in partnership to reduce or wherever possible eliminate these issues.

- **Religious/Ethnicity** – The Trust is committed to providing, wherever possible, a flexible booking system to support the ethnic/religious requirements of service users, for example, more suitable appointments times or female interpreter for female service users.
  We will continually work towards ensuring that individuals due to their ethnic/religious requirements are not disadvantaged by this policy; we will, through the Impact Assessment process, in consultation with E&D group, identify areas of concern, and work in partnership to reduce or wherever possible eliminate these issues.

2.5. Determining Priority

All patients who are added to a waiting list must be given a clinical priority of either Urgent or Routine.

2.6. Timeliness of and Adding a Patient to the Waiting List

All patients requiring an appointment or treatment must be added to the Hospital PAS System within 1 working day of the decision to refer/admit (DTA). The date of addition to the waiting list should always be the date the decision was made or receipt of referral, not the date of the transaction on the system.

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

Decision to add to wait list or refer to Diagnostics must be initiated at the point of decision.

18 week pathways - All patients identified as starting a new 18 week pathway must have an 18 week pathway unique identifier created on iCS PAS. This is created when registering a referral and/or when prompted when adding a patient to the waiting list who is not on an RTT pathway.

Elective Admissions - Only add patients to Waiting List when they have accepted Consultant advice for elective treatment and funding has been approved where required.

All elective patients must be listed for admission on iCS PAS within 1 working day of the Decision to Admit (DTA).

Patients, who subsequently become unfit to accept an offered admission date due to health reasons should be referred back to their GP or alternatively removed from the waiting list, be placed on active monitoring and a further OPD appointment arranged. However, if the patient will be fit and available within 2 weeks their pathway should continue and a further date arranged.

Patient Transfers - When accepting the transfer of a patient from another Trust's waiting list, the DTA date used must be the date that the patient was added to the originating Trust's waiting list, not the date they were added to the WCFT waiting list. Patient transfers will only be accepted with an inter-provider transfer form (IPTAMDS). This does not apply to emergency transfers.

Patients listed for bilateral procedures or for more than one procedure - Patients who require bilateral procedures will only be listed for the first side. Once the patient is fit, ready and able to have the second side done a new waiting list entry/clock start will be made.

Private Patients - If the patient is to be seen privately, the medical secretary must inform the Finance department and enter as category '2' on the Hospital PAS System.

- Where a patient has been seen privately, but needs to be listed for an NHS elective admission/appointment the patient must be treated in the same way as an NHS referral/request.
- The Trust Private Patient Policy provides further information.

2.7. Categorising Patients on the Waiting List

Patients must be added to one of three waiting types;

- **Active Waiting List:** Patients who are fit, ready and able to come for treatment
- **Suspended Waiting:** List (not applicable to outpatients/radiology): Patients on the Active List who are not ready for admission for social reasons. Patients should not be suspended longer than 90 days.
- **Planned Waiting List:** Patients who have started treatment and there is a plan for the next and subsequent stages. Patients waiting for a planned procedure as part of a course of treatment should be put on the Planned Waiting List. This will include those waiting for tests as part of a screening programme. (See Section 4.8 for planned waiting list procedure).

2.8. Patient Deferrals

The principles and definitions of the 18 week target count the referral to treatment (RTT) waiting times in totality.

Elective admissions – Deferrals: If the patient cannot agree a date within 18 week time frames or wishes to wait for a longer period of time they will be discharged and the referring clinician informed.

Elective Referrals – Unfit for Surgery: Patients who will not be clinically fit for treatment should be discharged back to their GP. If deemed clinically fit by the GP within 3 months of the discharge, the GP can contact the hospital and the patient, following pre-op assessment, will be offered a further appointment.

If the patient becomes clinically fit after 3 months of discharge and still requires the intervention then the patient will be asked to see his GP to be re referred for a new clinical assessment.

Alternatively the clinician may decide to remove the patient from the waiting list, place them on active monitoring and arrange a further OPD appointment if they feel this is in the patients best interest.

If the patient is unfit e.g. has a cold or other minor illness, or needs echo or anaesthetic review at preoperative assessment. The clock continues to run and the patient is brought back or contacted, with a maximum illness of 2 weeks.

Outpatient – Diagnostic: Patients on the outpatient/diagnostic waiting list cannot be suspended. See reasonable notice for patient deferral guidance.

2.9. Booking Appointments / Admissions

To ensure that patients move through their pathways in a planned manner, all outpatient appointments, Diagnostics and admissions within 6 weeks will need to be booked in a timely manner.

Patients should not leave one hospital attendance without knowing when the next stage of their pathway is booked or intended to be booked.

On receipt of a referral/request patients will be booked an appointment within the current waiting times target. See section 2.2.1.

For Cancer, please see section 6.

2.10. DNAs (Did not attend)

DNAs - New Patients: Where a new routine patient has agreed an appointment date with reasonable notice and this has been clearly communicated to them (except for children under 18 where relevant legislation overrides this) and then subsequently does not attend (DNA) the patient will normally be referred back to the GP (or other referrer) and/or removed from the OP waiting list.

Where clinically appropriate following review of the case notes 1 further new routine appointment may be offered by the Clinician.

In urgent cases or suspected cancer - If a patient DNA's for the first appointment then the waiting time clock can be stopped from the date of the receipt of the referral to the date the patient rebooks their appointment. Should the patient subsequently DNA, the second appointment/admission date the patient's case notes will be reviewed by the lead clinician and a decision on the further management of the patient will be made i.e. staff contacts the patient to discuss safe guards and ensures the patient is aware that an alternative appointment can be offered. There will be notification to the GP/Referring clinician that the patient has DNA'd multiple appointments and a decision reached in the best interest of the patient. The patient can be referred back to the GP/referring clinician after two DNA's.

Where it is felt clinically appropriate to retain clinical responsibility of vulnerable patients (eg children) and a further appointment is offered to the patient, the 'clock' will re-set from the date of the appointment is booked.

DNA - Follow-up/Review Patients: Routine follow-up/review, urgent and cancer patients who DNA appointments will be referred back to the GP (or other referrer), following clinical review of case notes. If a further appointment is required the patient should be appointed via the partial /full booking process and given a further appointment in line with clinical pathways and access targets.

DNA – Admission: Where a patient has agreed an admission date with reasonable notice and this has been clearly communicated to them and then subsequently does not attend (DNA) the patient will be referred back to the GP (or other referrer) and/or removed from the IP/DC waiting list following clinical review of the case notes. If a further TCI date is required the patient should be appointed via the full booking process and given a further date in line with clinical pathways and access targets.
Texting Reminder Service: The Trust operates a texting reminder service to patients were deemed clinically appropriate. Patients have the option to request exclusion from this service.

2.11. Cancellations

Patient Cancellations – Appointment: Patients will be allowed cancellations where reasonable notification has been given to the Trust, however, by offering patients choice and implementing a full booking system, patient cancellations should be minimised. Patients who cancel their appointment on the date of the appointment which waiting list management was agreed with reasonable notice or accepted by the patient with less than reasonable notice will be classed as unreasonable notice from the patient and referred back to the GP (or other referrer), following clinical review of the case notes.

Patients who cancel their appointment prior to the booked date which was agreed with reasonable notice or accepted by the patient with less than reasonable notice the patient will be offered one more date provided the patient is willing to accept a date within 2 weeks of the original appointment date.
Subsequent cancellations by the patient will result in discharge back to the referrer, following clinical review.

If the patient does not re-appoint on the day of the cancellation the referral will be returned to the referrer.

The above applies to both New Patient and Follow Up appointments.

Where a patient cancels their e-Referral appointment and does not rebook within 2 weeks the UBRN will be cancelled.

Suspected cancer patients who make contact to cancel their appointment will be provided with a safe guarding discussion and offered a re-appointment. An alert will be highlighted to the lead clinician.

If the patient declines the offer of a re-appointment, there will be a clinical discussion and a staff member will contact the patient again and attempt a further safe guarding discussion to ensure the patient understands what they are effectively refusing. At this stage, if it is felt to be appropriate, the staff will confirm with the patient that they are choosing to remove themselves from the pathway and the clock will stop and a notification will be communicated to the patients GP with immediate effect. If the patient agrees at a later date to be treated, then they will come under the 31 day rule. Alternatively, the clinician can continue to review the patient or make the decision to refer back to the GP.

If the patient accepts a re-appointment and subsequently makes contact to cancel the re-appointment (second appointment) then they will be offered a safe guarding discussion and advised that they will be referred back to the GP and removed from the pathway.

The Trust will demonstrate an audit trail and record the actions in the case notes, letters and cancer tracker accordingly.

Patient Cancellations – Admissions: Patients who cancel their admission prior to the booked date which was agreed with reasonable notice or accepted by the patient with less than reasonable notice the patient will be offered one more date provided the patient is willing to accept the next available/offered date in line with section 2.10. Subsequent cancellations by the patient will result in discharge back to the referrer, following clinical review.

Hospital Cancellations: Hospital imposed cancellations at any stage of the pathway will be minimised. As patients will only be offered NP appointments / admission within a six week window it is envisaged that all clinics / theatre sessions will be confirmed and appropriately staffed. In the event of sickness etc. divisions should attempt to cross cover clinics.
Consultants and the their clinical teams are required to provide at least six weeks' notice before the date for commencement of the leave period, and submit the relevant form to the appropriate Clinical Lead for approval.

Where a patient's appointment/admission date is cancelled by the hospital with less than 6 weeks' notice the patient will be offered an alternative date within 2 weeks ensuring that the appropriate waiting time target is not breached.

Where a patient's appointment/admission date is cancelled by the hospital on the day the patient will be given the opportunity within 3 working days to agree an alternative date no later than 28 days from the cancellation date ensuring that the appropriate waiting time target is not breached.

Where a FU appointment booked at over 6 weeks in advance is re-scheduled, the appointment will be re-scheduled within 8 weeks of the original appointment date.

2.12. Re-instatement on the waiting list

Patients who have been removed from the waiting list without being treated can be re-instated in exceptional circumstances. This may be if it is felt to be clinically appropriate to do so or if it is discovered there has been an administrative error.

Where a patient has agreed an admission or pre-op assessment date with reasonable notice and this has been clearly communicated to them and then subsequently does not attend (DNA) the patient will be referred back to the GP (or other referrer) and/or removed from the IP/DC waiting list following clinical review of the case notes. If a further TCI date is required the patient should be appointed via the full booking process and given a further date in line with clinical pathways and access targets. The exception to this will be if there are compelling medical or social reasons why the patient should remain on the waiting list.

The Trust will try to find a convenient date for patients who decline a reasonable offer of admission or who otherwise cancel an admission date so that they are treated as quickly as possible.

Re-instatement for Clinical Reasons: A patient may have been removed from the waiting list but subsequently reinstatement is judged to be clinically appropriate.

If a patient has been removed from the waiting list for reasons other than treatment and if the removal was as a result of following this policy and good practice guidance, re-instatement onto the waiting list will be a new episode of care. Patients who were removed as a result of a DNA or declining at least two reasonable offers of admission should not be re-instated using the original DTA date.

However, it may not be necessary to ask the GP to re-refer by letter or for the patient to be seen in outpatients if their clinical circumstances have not changed within a 3 month period. In this case, patients will be put onto the waiting list as a new episode of care as the result of a telephone request. All circumstances should be recorded on the Hospital PAS System to ensure a complete audit trail.

Patients will only be re-instated as the result of a consultant decision.

The consultant may also decide to take previous periods of waiting into account, change the patient's priority on the list and treat them earlier than other routine patients.

Re-instatement following an Inappropriate Removal: If the patient was removed from the waiting list and the removal was later found to be a mistake, then the patient must be re-instated without prejudice, as if he or she has never been removed. This is

achieved by deleting the incorrect cancellation on the Hospital PAS System. This maintains the original DTA date. No periods of suspension for the period that the patient was not on the waiting list must be entered.

2.13. Exceptions for removals from the waiting list

Patients should not be removed from the waiting list if;

- They have declined two reasonable offers where previously they had an appointment/admission cancelled by the hospital or
- If the patient is clinically urgent or has a life threatening condition.

2.14. Recording Clinical Outcomes ("Reconciliation of clinics"):

All patient outcomes such as removals, admission/attendance, cancellations and DNAs should be recorded on the Hospital PAS System on the same day of the event.

Clinic Outcome Form: Following all outpatient attendances/DNAs the clinic outcome form must be completed by the clinician and returned to the appropriate reception and recorded on the Hospital PAS System within 24 hours of the event (48 hours for Satellite outcomes).

The reception clerks will produce a list of patients from the Hospital PAS System without an outcome at the end of each clinic session. Secretaries and consultants are responsible for supplying the missing data within 2 working days of the clinic.

Active Monitoring: An 18 week clock maybe stopped when it is clinically appropriate to start a period of monitoring without clinical intervention or diagnostic procedures at this stage. If a patient who is being actively monitored whilst deciding upon surgery decides within a one week period to proceed with their treatment, the active monitoring clock stop should be deleted and the pathway remains on-going.

2.15. Patient Correspondence

As soon as a mutually agreed date has been arranged with the patient a confirmation letter must be sent to the patient. The letter is an audit trail of the arrangements and should contain the following core details:

- Patient's name
- Date letter sent to patient
- Date and time of admission/appointment agreed
- Where to report on arrival
- Response required from the patient
- Named contact for queries relating to admission/appointment
- Reference to instructions for admission/appointment and/or booklet
- Request to check bed is available on day of admission
- Reasons for checking bed availability
- Information about the planned treatment

Any relevant patient Information must be sent or given to the patient prior to the admission/appointment date.

Copying Letters to Patients: According to the NHS Plan, 2000 (paragraph 10.3) clinicians are required to ask patients if they would like to receive copies of correspondence written about them to another professional relating to their medical problem. Frequently this correspondence is from a clinician back to the referring GP.

Guidelines pertaining to the content and set out of letters is available on the DoH website: www.doh.gov.uk/patientlettersissues.htm.

The Trust has requested that were appropriate all clinicians copy letters to patients. All patients have the right to request a copy of an individual letter; this is communicated in the Patient Information leaflets.

2.16. Maintaining and Monitoring Waiting Lists and Patient Tracking Lists (PTL)

The day-to-day maintenance and management of waiting lists and PTLS is the responsibility of all Trust staff involved in the operational management of scheduling and booking admission/appointments, as outlined in the roles and responsibility section. The waiting list/PTLs must be validated routinely to ensure that that the waiting list does not contain patients who no longer require an admission/appointment.

PTLs will contain a list of patients who are on the waiting list who require an admission/appointment within a defined period to meeting local/national waiting time targets.

2.17. Retrieval of Case Notes

Case notes are an integral part of patient care and must be made available according to the agreed standards and targets outlined in the Health Record Policy.

2.18. Clinic Template Changes

Clinicians wishing to change templates must contact the Divisional Manager for approval. They will complete a clinic mandate form and circulate to the Outpatients, Medical Records, Secretariat and Finance Managers to highlight any implications caused by the change.

To avoid patients being inconvenienced a ‘go-live’ commencement date for template changes must be agreed with the Divisional Manager and PAC. This will usually be 6 weeks.

All clinic templates will be reviewed, as part of appraisal, on a yearly basis

2.19. Management Information

- **Information for Hospital Management and Clinicians** - Waiting list and PTL information is circulated weekly to all relevant staff groups.
- **Information Department of Health** - Statistical information is submitted to the Department of Health to meet the statutory requirements as published in the data manual.

2.20. Policy Implementation

As the Patient Access Policy replaces previous Policies, the majority of the practices described are already implemented. It is the responsibility of the Divisional Management team to deliver regular update training sessions to Divisional staff. This should encompass staff, clinical and non-clinical who are responsible for patient access.

Key Staff Groups: The following staff are responsible for ensuring that an effective Trust-wide training schedule exists:

- IT Department
- IT Training Officer

- Divisional Managers
- Senior Managers/Lead Managers
- Lead Nurses
- Consultants
- AHP Managers (including Pharmacy, Psychology)

Training and Development will display details of training sessions, which may form part of the Trust's Mandatory Training Programme.

IT Training Officer will provide training on the iCS PAS system to all as appropriate. Refresher training sessions will be arranged in accordance iCS PAS system upgrades and procedural changes

Divisional Managers are responsible for:
- Identifying staff who require training/update sessions
- Updates to the Patient Access Policy

Senior Managers are responsible for:
- Nomination of staff to attend training/update sessions.
- Requesting additional training sessions for significant numbers of staff, when attendance at the planned sessions is clinically difficult
- Ensure that clinical staff receive update training on patient access standards/targets from their own professional group
- Identify training needs and, where deemed appropriate, deliver required training

Medical Staff are responsible for ensuring that they are aware of the key issues relating to Patient Access Policy, including;
- Observing the guidance given in this policy
- Attending pre-arranged Awareness Sessions, including the Junior Doctors' induction, or requesting specific dates for sessions from the Divisional Managers
- Ensuring that junior medical staff are aware of their responsibilities via the above mechanism.

Training/Update Sessions: Service operational management teams will be responsible for the development of local operational procedures and training of staff to ensure the implementation of Patient Access Policy is adhered to.

Updates to the Patient Access Policy will be communicated/discussed at the weekly PTL Review Meeting and monthly via the Divisional meetings.

Outpatient/Diagnostic/Inpatient PTL performance meetings:
- Monitoring and review of the effectiveness of the Policy will be carried out by the following groups
- Weekly PTL assurance meeting
- Data Quality group which subsequently reports through the Information Governance & Security group to the Trust Business Performance Committee

Patient Access Procedures: will be available on the Trust Intranet. Hard copies are available from the appropriate Senior Manager.

2.21. Policy monitoring and review

Monitoring Achievement of Standards in the Patient Access Policy: The aim of the Patient Access Policy is to improve access to services for patients. It is essential that performance against the standards within the policy are monitored and improved upon to protect patients' access to the Trust's services.

The monitoring of internal systems, rather than purely monitoring data outputs of the systems (e.g. spells, attendances etc), is an integral part of the Trust's plans to modernise its services and reduce waiting times.

Divisional Teams will be responsible for looking at the information and deciding appropriate action. The Data Quality Manager and Clinical/PAS Systems Trainers will be instrumental in working with Trust staff to implement changes to practice.

The standards to be achieved, the department responsible for collecting the information, and the frequency of the collection are outlined in the table below.

Standard	**Person/Dept. responsible for monitoring**	**Frequency of monitoring**
All patients will be added to the waiting list within 1 working day of the decision to admit/refer. Satellite patients 2 days.	Weekly PTL Assurance meeting	Weekly
Waiting lists are validated regularly including planned and suspended waiting lists.	Medical Secretaries and Divisional Managers	Weekly
Maximum 5% of patients on waiting lists suspended and no suspensions longer than 90 days	Divisional Managers	Monthly
The outpatient waiting list will not include new patients who have declined 2 or more reasonable offers of appointment.	PAC	Weekly
All patients will be contacted/seen pre-operatively to assess fitness for procedure and screened in line with the MRSA screening policy	Divisional Managers	Quarterly
Patients who DNA under the DNA rules will be removed from the waiting list.	Medical Secretaries/ PAC clerks and Divisional Managers	Monthly
Number of patients cancelled on the day of admission/operation for non-clinical reasons will not exceed the agreed target.	Divisional Managers	Daily
Written and telephone contact with patients will be recorded on iCS PAS	PAC Managers PAS & Data Quality team	Monthly Quarterly

3. Outpatient Booking and Scheduling

3.1. Introduction

There are two systems in operation comprising of electronic (e-Referral) and paper referrals. To accommodate these system changes, the policy will describe both processes.

3.2. E-referral

E-referral is the national electronic means for referring clinicians to refer a patient for their first outpatient appointment. The implementation of e-Referral is now mainstream within the Trust and is the preferred option for receiving referrals.

Referral Letters must be electronically attached to e-Referral by the referrer within 5 working days of the appointment request (decision to refer), where the appointment is more than 5 days in advance. Where the appointment is within less than 5 days then the referral must be attached within 24 hours.

If a referral is not attached within the above timescales, the PAC staff will contact the GP and request that they attach the referral within the next 5 days.
If a referral is still not attached after 10 days, the referral will be rejected and the GP informed.

For urgent referrals, the PAC staff will contact the GP the day following receipt, and the above process will be followed.

Accept and Reject Referrals – all referrals must be accepted or rejected by the receiving clinical team within 3 working days. Clinical teams will have a responsibility to review any patients booked into the wrong service whose referral was not accepted or rejected by the clinical team.

Rejected Referrals - where a referral has been clearly referred into a clinically inappropriate service the referral must be rejected on E-referral with a clear definitive reason and possible alternative action to be taken by the referrer.

Redirection – where a referral has been booked into a clinically inappropriate clinic within a service then the referral must be redirected in the appropriate clinic.

Slot Availability – it is the responsibility of the divisional management teams to ensure that there are 'sufficient' slots available on e-Referral to ensure patients have reasonable choice of dates and times within the agreed national/local waiting times. Divisional Management teams must utilise the 'Future Slot Utilisation' report on e-Referral to monitor slot availability and forward plan for any identified capacity constraints. The PAC team will also alert divisional management teams when there are risks to slot availability.

Polling Range – the maximum Polling ranges for slot availability on e-Referral will be managed by the divisional management team in line with national/local guidelines on waiting times.

Directory of Services (DOS) - the General Managers will manage the Trust's DoS on E-referrals. The DoS must provide a clear description of the service and the clinics provided.

3.3. Paper / Other referral letters

Paper/Other referrals letters –. these include non e-Referral GP referrals, tertiary referrals, internal consultant to consultant referrals, external consultant to consultant

referrals. All paper referrals must be processed within the following policy guidance in order to avoid patients being disadvantaged or delayed in accessing appointments.

Receipt & Registration of Paper Referrals - All paper referrals must be sent directly to the PAC department at WCFT. Referrals received directly by a service or consultant must be date stamped and sent to the PAC Department at WCFT immediately (folders located in each secretariat office are collected twice daily by PAC staff to avoid

- **Registration of tertiary referrals** - When registering a tertiary referral on the Hospital PAS System the name of the referring hospital must be entered in the referring organisation field and the clinician and specialty must be recorded in the relevant fields.
- **Referral Date** – see section 2.3.1.

Arranging a 1st Outpatient Appointments for Paper Referrals – Paper referrals will be processed in line with E-referrals in order to that patients have fair and equitable access to services.

Accepting and rejecting paper referrals – the same principles outlined in section 3.2.3, 3.2.4 and 3.2.5 will apply to paper referrals other than the outcome of the review of the referral will be manually recorded on the referral and returned directly to the Appointments Team with 5 working days.

WCFT Electronic Referral Triage System – In 2012 the Trust introduced an electronic system for the triage of referrals to reduce the delays with paper referrals being transported around the organisation. This has been piloted and will be rolled out to all Clinicians during 2016 following its inclusion with the ePortal project

Booking process for paper referrals – Patients will be contacted either by telephone or invite letter to agree an appointment date with reasonable notice.

Patients will be given 7 days to respond to the invite letter prior to sending a reminder letter. Patients who have not responded to the reminder letter within 10 days will be removed from the outpatient waiting list and returned to the referrer.

Patients who contact the Patient Access Centre within 24 hours of removal, following receipt of the removal letter, will be re-instated on the outpatient waiting list at their original date and an appointment agreed.

Patients who contact the Patient Access Centre later than 24 hours of removal, following receipt of the removal letter, will be advised to contact their GP or referring clinician to be re-referred.

3.4. Follow-up appointments

Patients requiring follow up appointments within six weeks should be offered a mutually agreed appointment time at hospital attendance using the 'Clinic Outcome Form'.
This must be recorded on the Hospital PAS System as 'follow-up booked in clinic' and will be counted as a fully booked appointment.
Following the implementation of partial booking for follow-ups, all Neurology & Pain Relief appointments are now booked this way. This system will be implemented in Neurosurgery in 2016.

Diagnostic Intervention Follow-up - Directorates will need to put in place full booking for all diagnostic interventions, coordinated with the relevant clinical follow up.

3.5. Waiting List Management

Waiting times – see section 1.6

Reasonable notice – see section 2.2

Booking appointments – see section 2.9

Did Not Attends – see section 2.10

Cancellations – see section 2.11

Suspensions/Deferrals – see section 2.8

3.6. Overbooking of Clinic Templates

Overbooking of clinic templates is only permitted following authorisation from the clinic consultant and is booked by his/her medical secretary.

3.7. New to review ratios

The Information Department will provide, to Clinical Teams, regular information on ratios. Divisions should regularly review their follow-up ratios in comparison with regional and national norms and ensure that internal policies are reviewed to ensure optimum use of outpatient capacity.

4. Inpatient / Daycase waiting lists

4.1. Introduction

The administration and management of Inpatient/Daycase waiting lists must be consistent, easily understood, patient focused and responsive to clinical decision making. If patients who are waiting for treatment are to be managed effectively it is essential for everyone involved to have a clear understanding of their roles and responsibilities.

4.2. Waiting List Management

Listing patients for Admission:

All patients must be listed for admission on iCS PAS on the day the Decision to Admit (DTA) was made.

Where there is a possibility that the waiting list may be pooled and the patient treated by a different consultant, the patient must be notified and agree to this at the time of listing.

This must be recorded in the patient's case notes.

Patients who subsequently become unfit to accept an offered admission date due to health reasons should be referred back to their GP or alternatively removed from the waiting list, be placed on active monitoring and a further OPD appointment arranged. However, if the patient will be fit and available within 2 weeks their pathway should continue and a further date arranged.

Decision to Admit Date (DTA): The DTA date for patients on an existing 18 week pathway to be recorded on iCS PAS is the date DTA was made and the waiting list entry must be linked to the appropriate 18 week pathway on iCS PAS via the referral.

Waiting times: see section 1.6

Reasonable notice: see section 2.2

Booking Admissions: see section 2.9

Did Not Attends: see section 2.10

Cancellations: see section 2.11

Deferrals: see section 2.8

4.3. Pre-op Assessment Service

Pre-op assessment minimises the risk of late cancellations by ensuring that the patient is as fit as possible for surgery and anaesthetic and that the patient wishes to undergo the procedure. It is therefore essential that the Pre-Op Assessment procedure is followed by all staff.

All patients must be screened in line with the MRSA Screening Policy.

4.4. Selection patients for admission

The process of selecting patients for admission and subsequent treatment is a complex activity. It entails balancing the needs and priorities of the patient and Commissioners against the available resources of theatre time and staffed beds.

To ensure that the Trust meets the targets for offering "patient choice" of admission date, booking systems will adopt best practice offering partial or fully booked dates.

The following key principles apply:

- Patients will be treated in a timely and effective manner
- Clinically urgent patients will be treated as a priority and within the shortest waiting times possible
- Non-clinically urgent patients (routine) will be treated in turn based on their length of time on the waiting lists if no other factors need consideration
- All patients will be treated within locally and nationally agreed maximum waiting times targets

Primary Targeting Lists (PTL) methodology will be used to facilitate equity for non-clinically urgent patients.

The only exceptions are "booked patients". These patients will have agreed their admission date within 1 working day of the decision to add to the waiting list but booked patients must be given a date that is commensurate with this principle.

4.5. Patient Transfers

Transfers to other Hospitals / Consultants: The Trust's resources must be used efficiently to ensure the maximum numbers of patients are treated within the resources available.

The Trust and its Consultants will work in partnership to create additional capacity to treat patients from its waiting lists when necessary and in line with commissioner contractual obligations. This may involve working with other NHS Trusts and independent providers. This will help ensure shorter waiting times for treatment.

Transfers between Waiting Lists within the Trust: This may be appropriate where the patient has been added to a waiting list for a specific procedure, and it is subsequently possible to treat the patient sooner or more effectively in an alternative manner, e.g. as a day case instead of inpatient.

If transferring the patient from an inpatient to a day case list the intended management code needs to be altered within iCS PAS.

If a transfer will result in treatment by a different consultant, the patient has the right to refuse the transfer unless they were notified and agreed to this possibility at the time of

listing. If the patient refuses to be transferred to the care of a different consultant their waiting time should not be affected.

The decision to admit details must be transferred to the new waiting list code in iCS PAS following the transfer of consultant procedure.

4.6. Treatment at Private or Independent Hospitals under WCFT contract

In the event that patients may be offered the opportunity for treatment at a private or independent hospital to shorten their waiting time.
These patients will be identified by Consultant/Divisional Management team.

The transfer must always be with the consent of the patient, their GP and the transferring consultant.

The patient has the right to refuse transfer, and remain on the Trust's waiting lists with no change in status.

WCFT Activity - Divisional Management teams must ensure that the patients TCI date is entered onto iCS PAS prior to the admission date and ensure the patients are admitted and discharged on iCS PAS within 24 hours of the patient discharge.

If a patient DNA's the clinician will decide if they should be removed from the waiting list, not offered a further date and referred back to the CCG.

4.7. Patient Choice

The NHS Constitution gives patients the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of alternative providers if this is not possible.

DH document 'Implementation of the right to access services within maximum waiting times' provides guidance for CCG's and Providers.

CCG's are legally required to:-

- Make arrangements to ensure providers meet the waiting times standards;
- Take all reasonable steps to ensure that any patients for whom the 18 week or 2 week waiting time is not met are offered a quicker appointment to start treatment at a range of clinically appropriate alternative providers, if the patient requests this; and
- Provide patients on 18 week or 2 week pathways with a dedicated contact point to approach if the maximum waiting time has been, or will be, breached and if they wish to seek an alternative.

The Divisional Management Team will aim to reduce the time patients have to wait for their operations by giving them a choice of where and when they have their treatment if applicable. It is important that the patients remain on WCFT's waiting list until they have been accepted by the new provider.

Patients are informed of their right to treatment within National Waiting times in the Outpatient Information Leaflet. Further information can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132960

4.8. Planned Waiting List

Planned waiting list patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or surgical intervention. These patients are not waiting for treatment, only for planned continuation of treatment.

Patients added to the planned waiting list must have an approximate date of treatment at the time the decision to admit was made. The waiting list request must clearly state the reason why the patient is to be added to the planned waiting list.

Examples include:

- Infusion of Therapeutic substance i.e. IVIG/Methyl Pred
- Replacement of batteries and adjustment to SCS devices
- Cranioplasty

Planned patients must be allocated time in operating sessions and given admission dates, either as an inpatient or daycase; they should be put on a separate planned waiting list to ensure they are not overlooked for admission.

It is the responsibility of the medical secretary to ensure planned patients are allocated an admission date within the planned month of treatment.

Planned patients should not be counted as being part of the waiting list. They do not need to be suspended however the same waiting list management rules should apply if a patient cancels or DNA's an admission date.

Patients attending for a planned admission will not be on an 18 week RTT pathway.
When a patient on a planned list does not have their consultant-led treatment procedure on or around the planned date they should be transferred to an active list and an RTT clock should start i.e. an RTT clock should start if the due date for the planned consultant-led procedure is reached and the patient has not yet received treatment. Thereafter, 'normal' RTT rules should apply.

4.9. Suspended Waiting List

Suspended waiting list patients are those who are currently not available to accept a date for admission due to clinical or personal reasons.

- Only patients on the Elective Waiting List can be suspended
- The suspension should start on the date the patient is unavailable/unfit from
- Planned patients should not be suspended
- Suspension periods **should not** exceed 3 months
- Patients **must** be fit for treatment at the time of listing
- Patients can be suspended for clinical reasons provided the need arises **after** the date of listing.
- Patients can be suspended for non-clinical reasons
- Only Patients suspended for non-clinical reasons can be paused on their pathway
- The pause should start on the EROD (Earliest Reasonable Offer Date)
- EROD is the first TCI date (giving 2 weeks notice) that you would be able to offer the patient
- The EROD should be recorded on iCS PAS when you create the TCI
- **NOTE – The Suspended and Paused start dates will usually be different**

5. Diagnostic Waiting List

5.1. Introduction

The administration and management of waiting lists must be consistent, easily understood, patient focused and responsive to clinical decision making. Diagnostic tests are performed as both inpatients and outpatients – so both sections 3.0 and 4.0 of the Patient Access Policy should be referred to for further guidance, as well as the key policy principles outlined in section 2.0

5.2. Referrals

Radiology referrals will only be accepted by the Trust Order Comms system. (OCS)
Neurophysiology referrals will only be accepted on the appropriate proforma.

The diagnostic PAC team will communicate all diagnostic appointments.
Patient Access Centre staff are based within the above departments to ensure uniformity of processes.

Requests will be processed on the date of receipt.

The date that the decision to refer was made will be logged as the referral date.

If the radiologist feels that the test requested does not match the clinical question, the request will be returned to the referrer for further information.

Fast track suspected cancer referrals will be highlighted on the clinic outcome forms.

5.3. Data Definitions

Please refer to Section 2.0 (Outpatients) or Section 4.0 (Inpatients) as appropriate for the setting of a diagnostic test.

In addition, definitions that are pertinent to Diagnostics are as follows:

- **Diagnostic waiting list** - All tests/procedures for which patients are waiting. irrespective of the referral route, and also irrespective of the setting in which they are carried out (e.g. inpatient ward, x-ray department, outpatient clinic etc.).
- **Planned tests/procedures (surveillance) -** A procedure or 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.

Examples include:

- Follow up MRI scan
- Follow up Angio

5.4. Waiting List Management

Patients attending for a diagnostic test will all be treated as outpatients (see Section 3) except where indicated below.

Referral/Request Date – Waiting starts on the date of the decision to refer.
Waiting times – see section 1.6
Reasonable notice – see section 2.2.2
Booking appointments – see section 2.9
Did Not Attends – see section 2.10

Cancellations – see section 2.11
Suspected cancer – see section 6

Cancer patients

5.5. Cancer Waiting Times

The waiting time for patients diagnosed with cancer and requiring treatment or have a suspected diagnosis of cancer are an exception to this policy.

For those patients the pathway is monitored as follows:

- The **maximum** wait for all cancer patients from date of decision to treat, to first definitive treatment should be **no** more than 31 days (including Diagnostics).
- The **maximum** wait for a first clinic appointment for patients referred by GPs via a Fast Track Referral Proforma is **2 weeks**.
- The maximum wait for a Diagnostics appointment is 21 days from day 1.
- In total no patient should wait no longer than 62 days from receipt of the urgent GP referral to first treatment (including Diagnostics).

5.6. Cancer Referrals

Referrals proformas should clearly highlight that the referral is a suspected cancer. If desired, this can be accompanied by a detailed letter with relevant additional history. The referral proformas are compliant with the referral requirements and reflect national guidance.

The procedure for requesting an appointment for a suspected cancer patient is as follows:

Paper Referrals;

- Patient attends GP surgery and requires Cancer Fast Track referral – 2 week rule applies
- Patient is given written information outlining the need to contact the hospital within 24 hours to negotiate appointment if there is no contact from the Trust
- Fast track referral is faxed directly to the Trust
- Fast track referral is identified as a 2 week wait and logged as per guidelines
- PAC staff contact the patient and negotiate appointment at the patient's convenience within the two week time frame. Every effort will be made to aim to agree an appointment within 7 days. A choice of time will be offered.
- Appointment confirmed and information sent out in the post.
- PAC will communicate status of appointment confirmation will Cancer Services Team.
- If the patient is not contactable in this time frame an appointment will be sent out in the post and a standard letter sent to GP. Further attempts to contact the patient by telephone will be made and a written appointment posted.
- If the patient does not respond or declines an offer of appointment within the 2 week time frame, PAC staff will notify the Cancer Services Team who will then alert the Oncology Nurse Specialist to contact the patient and explain the importance of this appointment. If the patient decides not to attend, then the GP will be informed.

5.7. Auditing Cancer Referrals

The 'quality' of suspected cancer referrals needs to be subject to regular audit, with appropriate feedback to individual GP's, and the CCG. If there is evidence of training needs in General Practice in relation to cancer symptoms, or that this route is being abused to secure 'fast-track' appointments for inappropriate patients, suitable responses will be agreed with the CCG. This will be monitored by the Cancer Services Team.

5.8. Cancer Diagnostics

To meet NHS standards cancer patients on the 62 day pathway must have a decision for treatment by day 31 of the patient pathway (internal target 28 days) the internal Trust target is to achieve diagnosis by day 28.

If following a cancer fast track outpatient appointment the consultant decides a patient requires any diagnostic tests, the radiology request form should be marked to highlight they are a suspected cancer patient.

Patients with suspected cancer who require a diagnostic procedure will be tracked using the cancer tracking system. Individual tumour pathways identify the turnaround times for tests and reporting. Departmental systems (CRIS – Radiology etc.) will identify the patient as requiring rapid reporting.If the patient requires several diagnostic tests, these must be managed within the pathway and tracked using the tracking system.

6. Related Policy(s) and Local Procedures

Each operational area will have a user's guide detailing the procedures and processes to follow to support this policy.

6.1. Bibliography / References

- NHS Choices – your health, your choices – 15.06.15
- http://www.nhs.uk/choiceintheNHS/Yourchoices/appointment-booking/Pages/about-the-referral-system.aspx
- NHS Interim Management and Support – Elective Care Guide
- http://www.nhsimas.nhs.uk/fileadmin/Files/Documents/Referral_to_Treatment_Pathways__second_edition_.pdf
- DoH RTT Rules Suite October 2015
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464956/RTT_Rules_Suite_October_2015.pdf
- Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care October 2015
- https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting-RTT-guidance-v24-2-PDF-703K.pdf
- The NHS Constitution July 2015
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf
- The NHS Commissioning Board and CCG's (Responsibilities and Standing Rules) Regulations 2012 http://www.legislation.gov.uk/uksi/2012/2996/contents/made
- NHS Wales delivery framework 2013-14 and future plans
- http://gov.wales/topics/health/publications/health/strategies/framework/?lang=en

Appendix 1 - Glossary of Terms

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

Active Waiting List	Patients awaiting elective admission for treatment and are currently available to be called for admission.
Clinical Commissioning Group (CCG)	Organisations responsible for primary care services including GPs, dental practitioners, optometrists and community pharmacists.
Could Not Attend (CNA)	Patients who notify the hospital that they are unable to attend a previously agreed appointment.
Day Cases (DC)	Patients who require admission to the hospital for treatment and will need the use of a bed/trolley/recliner but who are not intended to stay in hospital over night.
Department of Health (DH)	The Department of Health works to improve the quality and convenience of care provided by the NHS and social services.
Did Not Attend (DNA)	Patients, who have been informed or agreed their admission date (inpatients/day cases) or appointment date (outpatients) and who, without notifying the hospital, did not attend for admission/OP appointment.
Elective Admissions	Where a decision to admit a patient for treatment is made that is not an emergency. The patient will be placed on an elective admission waiting list.
e-Referral	Electronic system by which GPs can refer patients directly to a service and can either book the appointment with the patient or the patient can book at their own convenience via Health space on the Internet or the National Telephone appointment line.
Fully Booking	Patients awaiting an elective admission/appointment who have been given an opportunity to agree an appointment/admission date with 24 hours of the decision to refer/admit. These patients form part of the active waiting list. This process should also be used where the waiting time is less than 6 weeks.
Hospital Initiated Cancellation	A cancellation of admission by the hospital
iCS PAS	The computer system used by the Trust to record patient transactions.
Independent Booking Service (IBS)	A telephone appointments service that makes the link between the referral sent using the e-Referral system but

	there is no IT interface with the provider units booking system.
Individual Treatment Plan	A plan prepared with patients who are on suspension to ensure that they are treated to meet the maximum waiting time.
Inpatients (IP)	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night.
Local Health Board (LHB)	Organisations in Wales responsible for primary care services including GPs, dental practitioners, optometrists and community pharmacists.
NCEOPD	National Confidential Enquiry into Patient Outcome & Death
Outpatients (OP)	Patients referred by a general practitioner or another clinical professional i.e. another Consultant/Dental Practitioner for clinical advice or treatment not requiring admission
Partial Booking	Where the waiting time is greater than 6 weeks for an admission/appointment the patients will be placed on the appropriate Consultant waiting list. A letter of acknowledgement of the referral is sent to the patient with an indication of the length of wait. An appointment will be agreed with the patient a minimum of 3 weeks in advance of the expected due date.
Patient Tracking List	A list of all patients whose treatment needs to be planned to meet target wait times
Planned Admissions	Patients who are to be admitted as part of a planned sequence of treatment or investigation. They may or may not have been given a firm date.
Suspended Waiting List	A list of patients awaiting elective admission who are currently unsuitable for admission due to some underlying medical or social reason.
TCI	To Come In, the date of a patient's admission to hospital
Unique Booking Reference Number	A unique number allocated to all patient booking via e-Referral

Abbreviations include;

CRIS	Computerised Radiology Information System
DA	Date Agreed
DNA	Did Not Attend
DOL	Date on List
DTA	Decision to Admit
DTL	Decision to List
GDP	General Dental Practitioner
GP	General Practitioner
IPTAMDS	Inter Provider Administrative Minimum Data Set
PAC	Patient Access Centre
PTL	Patient Tracking List
SOT	Stage of Treatment
TCI	To Come In
UBRN	Unique Booking Reference Number
E-referrals	E-Referral (formerly Choose and Book)

<table>
<tr><th>ENGLAND</th><th>OUTPATIENT</th><th>DIAGNOSTIC</th><th>INPATIENT</th></tr>
<tr><td>STAGES OF TREATMENT</td><td>• From date referral received
• 3 weeks' notice required to patient
• Appt cancelled by patient resets DOL
• NP appt DNA resets DOL</td><td>• From date of decision to refer</td><td>• From Date on List (DOL)
• Can be suspended for clinical and social reasons
• 3 weeks' notice required</td></tr>
<tr><td>RTT PATHWAY</td><td colspan="3">18 WEEKS 92% of patients on open pathways to be treated within 18 weeks</td></tr>
<tr><td></td><td colspan="2">• New Pathway Clock start date =
GP Date referral received
CONSULTANT AT OTHER HOSPITAL Date referral received
CONSULTANT AT WCFT Date referral made

• On-going Pathway Clock start date = Date original GP referral rec'd

• Appt cancelled by Patient Clock keeps ticking unless discharged
• Appt DNA (First Appt) Clock can be reset if re-booked
• Appt DNA (FU) Clock keeps ticking unless discharged</td><td>• Patient allowed 7 days thinking time before being put on active monitoring to think about surgery.

• Patients unfit for over 2 weeks should be discharged to GP or alternatively removed from W/L, put on active monitoring and a further OPD appointment arranged.</td></tr>
<tr><td>INTERNAL STEP DOWN TARGET</td><td>5 WEEKS NS & ONC
8 WEEKS NEU & PR
13 WEEKS NPY, NSY, OPH, PMP & REHAB</td><td>4 WEEKS</td><td>6 WEEKS</td></tr>
</table>

WALES	OUTPATIENT	DIAGNOSTIC	INPATIENT
STAGE OF TREATMENT	• From date referral received • 3 weeks' notice required to patient • Appt cancelled by patient resets DOL • NP appt DNA resets DOL	• From date of receipt • 8 week target applies to patients not on an RTT pathway having MRI/CT/EMG tests only	• From Date on List (DOL) • Can be suspended for clinical and social reasons • 3 weeks' notice required
RTT PATHWAY	**26 WEEKS 95% of patients on open pathways to be treated within 26 weeks** **36 WEEKS (Admitted 100%) (Non-admitted 100%)**		
	• New Pathway Clock start date = GP — Date referral received CONSULTANT AT OTHER HOSPITAL — Date referral received CONSULTANT AT WCFT — Date referral received • Ongoing Pathway Clock start date = Date referral received • Appt cancelled by Patient — Clock can be re-set by RTT team only • Appt DNA (First Appt) — Clock can be reset if re-booked • Appt DNA (FU) — Clock can be re-set by RTT team only		• Patient allowed 7 days thinking time before being put on active monitoring to think about surgery. • Patients unfit for over 3 weeks should be discharged to GP or alternatively removed from W/L, put on active monitoring and a further OPD appointment arranged.
INTERNAL STEP DOWN TARGET	**21 WEEKS**	**5 WEEKS**	**8 WEEKS**

Appendix 2 - Version Control

Version	Section/Para/ Appendix	Version/description of amendments	Date	Author/Amended by
3.0	All	Update into new policy format	Aug 15	Jonathan McGregor
4.0	All	Updated to reflect name change from Choose and Book to E-Referrals	Jan 16	J. Thompson
4.0	All	Updated to reflect change in National RTT target	Jan 16	J. Thompson

Translation Service

This information can be translated on request or if preferred an interpreter can be arranged. For additional information regarding these services please contact The Walton centre on 0151 525 3611

Gellir gofyn am gael cyfieithiad o'r deunydd hwn neu gellir trefnu cyfieithydd ar y pryd os yw hynny'n well gennych. I wybod rhagor am y gwasanaethau hyn cysylltwch â chanolfan Walton ar 0151 525 3611.

هذه المعلومات يمكن أن تُتَرْجَم عند الطّلب أو إذا فضّل المترجم يمكن أن يُرَتَّب للمعلومة الإضافيّة بخصوص هذه الخدمات من فضلك اتّصل بالمركز ولتون على 0151 5253611

ئەم زانیاریە دەکرێت وەربگێڕدرێت کاتێك کە داواکرێت یان ئەگەر بەباش زانرا دەکرێت وەرگێڕێك ئامادە بکرێت (ڕێك بخرێت) ، بۆ زانیاری زیاتر دەربارەی ئەم خزمەتگوزاریانە تکایە پەیوەندی بکە بە Walton Centre بە ژمارە تەلەفۆنی ١٥١٥٢٥٣٦١١ .

一经要求，可对此信息进行翻译，或者如果愿意的话，可以安排口译员。如需这些服务的额外信息，请联络Walton中心，电话是：0151 525 3611。