Brighton and Sussex University Hospitals NHS Trust

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Patient Access Policy

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APPENDICES

1 INTRODUCTION

1.1 Purpose and Scope

The purpose of this document is twofold: it sets out how BSUH should administer its elective services and provides an operational guide for staff. It is intended to provide patients with certainty and choice about the timing of the appointments/admissions.

The Director of Clinical Service for each Directorate has overall responsibility for implementing the policy in their area. All managers are responsible for ensuring their staff have read, understood and comply with the policy.

This policy necessarily has a lot of detail about how patient waiting times are recorded. The length of time a patient waits for hospital treatment is an important quality indicator, as well as being an issue of great importance to patients.

This policy reflects the core principles established within the NHS Constitution, which can be downloaded here: http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

Any future guidance about the patient access or patient choice from the Department of Health or commissioners will supersede any guidance in this document.

1.2 Values and Behaviours

In order to ensure that our staff are engaged, motivated and valued and able to provide the best service to our patients, we are committed to the following values:

- Communication that is respectful, personal, honest and helpful
- Kindness and understanding so that we feel supported and enabled to do our jobs
- Fairness and transparency in our decisions and actions
- Working together to get the best outcome for patients
- Excellence – always striving to be the best we can be.

2 ABBREVIATIONS AND GLOSSARY

CAB – Choose and Book. An online tool which patients (and their GPs) may use to determine where they would like to be seen, at what time, within the acute hospital setting.

CCG - Clinical Commissioning Group

CIU – Central Information Unit

DNA – Did not attend

DTT – Decision to Treat

DTA – Decision to Admit

Elective surgery - surgery that is scheduled in advance because it does not involve a medical emergency.

GP – General Practitioner

KPI – Key Performance Indicator

IPT – Inter-Provider Transfer. A patient transferred to BSUH from another provider

LPP – Low Priority Procedures. Procedures which have specific referral criteria

MDT – Multi-disciplinary team

MDS – Minimum Data Set. A specific set of information required to be provided at the point of referral or transfer

PTL – Patient Tracking List. Used to record the current 18 week waiting status of patients referred to and under the care of, but not yet discharged from, the Trust

RTT – Referral to Treatment. The point of referral (usually from the general practitioner) to the first definitive treatment, measured in weeks and days from the point of receipt of referral

TCI – To come in. Refers to an expected date of (elective) admission

3 POLICIES

3.1 Overview of standards

The NHS Operating Framework sets out the following standards for patient access:

3.1.1 18 weeks pathway (Referral to Treatment)

- 90% of admitted patients will be seen within 18 weeks
- 95% of non-admitted patients will be seen within 18 weeks

- 92% of patients on an incomplete pathway (admitted and non-admitted pathways) should have been waiting no longer than 18 weeks

3.1.2 Diagnostics

- Less than 1% of patients are expected to wait longer than 6 weeks for a diagnostic test

3.1.3 Cancer waiting times

- **Two week wait (2WW) standard**

  - 93% of patients to be seen within two weeks of an urgent GP referral for suspected cancer

  - 93% of patients to be seen within two weeks of a GP referral with breast symptoms (where cancer is not suspected)

- **31 day standards [DTT to Treatment]**

  - 96% of patients to receive their first definitive treatment for cancer within 31 days of the decision to treat

  - 94% of patients to receive subsequent treatment for cancer within 31 days of the decision to treat/earliest clinically appropriate date to start a second or subsequent treatment where that treatment is surgery

  - 98% of patients to receive subsequent treatment for cancer within 31 days of the decision to treat/earliest clinically appropriate date to start a second or subsequent treatment where that treatment is an anti-cancer drug regime

  - 94% of patients to receive subsequent treatment for cancer within 31 days of the decision to treat/earliest clinically appropriate date to start a second or subsequent treatment where that treatment is a course of radiotherapy

  - Maximum wait of 31 days from urgent GP referral to first treatment for children's cancer, testicular cancer and acute leukaemia. BSUH works in partnership with the Royal Marsden to deliver this service

- **62 day standards [Referral to Treatment]**

- 85% of patients to receive their first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

- 90% of patients to receive their first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service (breast, bowel and cervical)

3.1.4 Patients not on a referral to treatment pathway

Not all patients are on pathways that are covered by the access targets above. Some require regular follow up, others need to wait a period before the next step of their treatment can go ahead. However all patients should be seen and treated in a timely and equitable manner. Patients should be seen and treated in order of clinical priority, and then by order of waiting time.

3.2 18 Week terminology

Prior to implementation of the 18 Week target in 2008, the NHS measured waiting times for outpatient appointments and inpatient treatment separately, and did not measure waiting times for diagnostics. The 18 Week target joins these waits together and offers a guarantee to patients that they should wait no longer than 18 weeks from referral by their GP to first definitive treatment.

We measure 18 Weeks in terms of ‘clocks’, which refers to the length of time a patient has been waiting from referral, through outpatient and diagnostic appointments, up to their first definitive treatment, whether that is surgery, a medical treatment, or advice and guidance. Patients may have more than one clock running at a time for different conditions. Patients may also generate a number of clocks for the same condition over a period of time.

Details of what starts and stops an NHS clock and details of how we handle DNA s and cancellations are set out at Appendix One.

3.3 Cancer Services

Patients with suspected cancer have an additional set of standards to ensure their safe and timely treatment – details are set out at Appendix Two.

4 ROLES AND RESPONSIBILITIES

The application and implementation of this policy is the responsibility of all staff and services relating to patient access managed by BSUH, including outpatient, inpatient, day case, therapies, diagnostic and administrative services. Overall accountability for compliance with the Access Policy lies with the Chief Executive who has delegated responsibility to the Chief Operating Officer.

It is the responsibility of all members of staff to understand the principles and definitions which underpin delivery of all elective access performance measures; cancer, referral to treatment (18 weeks), and diagnostics.

An on line training package is available in relation to 18 weeks and BSUH is developing a competency based training package for all administrative staff involved in booking patients and administering waiting time targets.

4.1 Application and compliance

This policy applies to all clinical and administrative staff and services relating to patient access managed by BSUH including outpatient, inpatient, day case, therapies, diagnostic and administrative services.
All staff involved in the management of patients' access to the organisation is expected to follow this policy and associated operating procedures. Key performance indicators (KPIs) will be used to monitor compliance. Specific roles and responsibilities are set out below:

4.2 Chief Executive

The Chief Executive is the responsible person for meeting this policy and ensures that there are adequate resources for its implementation.

4.3 Centralised Booking and Clinical Administration

Central Booking Team

- Confirms that the patient demographics on the system are up to date and accurate
- Upon receipt of referral, makes a partial booking for that patient
- Upon completion triage, makes a fixed booking for that patient with a reasonable offer of appointment
- If the appointment is within 10 working days the Booking Centre telephones the patient directly to agree arrangement

- If the appointment is booked with more than 10 days' notice, a letter will be sent

Clinic Preparation Staff (Health Records) provide:

- Clinic outcome sheet, including 18 Week clock status
- Referral letter – for new appointments
- Results of tests and investigations
- Last correspondence for Follow Ups
- Main hospital records file

Clinic receptionist

- Books patients into clinic on their arrival and checks patient details updating demographic details as appropriate
- Records outcome of appointment on PAS from information on the Clinic Outcome Sheet. Returns any blank sheets to the clinician for completion
- Books follow up appointments as per clinical instructions where capacity available, or partially books patient with a target date where capacity is not available
- Forwards admission forms to the relevant inpatient booking clerk at the end of the clinic
- Informs reception manager when Clinic Outcome Sheets are not completed or returned for cashing-up so s/he will resolve if possible
- Ensure the DNA policy is adhered to and that patients are transacted accordingly

Staff involved in the booking or management of patients across the elective pathway will complete regular competency based training.

4.4 Patient Access Managers

- Ensure the flow of patients into available clinics and theatre slots by setting up accurate templates
- Manage outpatient and inpatient waiting lists , including managing the allocation of extra capacity to deal with peaks in demand
- Work with the Directorate Manager to identify capacity issues affecting delivery of referral to treatment standards

- Work with the validation team and the booking team to ensure patient data is accurately reflected on PAS
- Support colleagues on the correct utilisation of PAS
- Provide a point of contact for patients, relatives and GPs for with queries and questions that cannot be resolved by the booking team
- Works with clinical teams to ensure they fully understand the requirements of the Patient Access Policy, ensuring adherence across their areas of responsibility

4.5 Directorate Managers / Clinical Directors

- Monitor and oversees clinician's leave plans and ensure that these are appropriately communicated
- Signs off and confirm clinic and operating list cancellations
- Identifies alternative arrangements for clinics and theatre sessions when demand outstrips capacity
- Run effective weekly PTL meetings within their service areas

4.6 Performance and Assurance Manager

- Leads on implementation of the Patient Access Policy, to ensure delivery of the 18 week diagnostic standards and inpatient targets
- Supports and develops the patient access managers (PAMs) within the Clinical Directorates and ensure effective weekly reviews and look forward in relation to performance
- Provides professional management for the validation team, and in some cases line management support. Drawing on their work, identifies data errors that affect ongoing performance and ensures these are addressed and eliminated through training and development.

4.7 Clinicians

- Provide at least six weeks' notice for annual and study leave
- Ensure Clinic Outcome Sheets are completed in the OP clinic clearly identifying the clinical decision taken in real time
- Advise on the Clinic Outcome Sheet whether patients who have DNA'd should be discharged or reappointed

- Ensure waiting list admission cards are completed for patients needing an IP or DC procedure.

4.8 All staff

- As a healthcare provider BSUH is required to act in an open and transparent way with service users and their representatives as regards care and treatment (generally), including accurate and transparent application of counting rules and the actual reporting of waiting times

- In the event of any member of staff finding that they are being asked to work outside the requirements of this policy, they need to bring this to the attention of their line manager. If they remain unhappy with the result of that conversation they should pursue through the Whistle Blowing (Raising Concerns) Policy and Procedure

- Any breach of this policy in order to present a false impression of Trust performance will be subject to further investigation under the Trust's Disciplinary Policy and procedure and /or referral to the Trust's Local Counter Fraud Specialist

5 REFERRAL MANAGEMENT

Referrals should only be sent to the Trust if the patient is willing and able to be consulted and treated within the maximum access times target and should not be sent if the referrer knows the patient is unavailable (e.g. on a tour of duty, extended holiday or work / study commitments). Choose and Book is the Trust's preferred method of GP referral but manual written referrals from GPs and other referrers will be accepted and processed without delay.

Referrals should contain information on any special needs of the patients including the patient's entitlement to priority treatment in the case of veterans of the armed forces.

The majority of clinical specialties will be managed via the Central Booking Hub at Elliot House in Brighton. Letters will be opened and stamped on the date of receipt. All referrals received will be registered on PAS and partially booked within 24 hours of receipt. The waiting time target will be calculated from the date that the referral was received, or the date that the Unique Booking Reference Number (UBRN), which is generated by Choose and Book, was converted on PAS.

Referral letters are required to include an agreed minimum data set:

- Name, address, post code, date of birth, NHS number, local patient identifier
- Contact number and/or email address
- GP name, medical practice code, organisation name and code, professional name
- The service to which the patient is being referred
- For IPTs, RTT status, clock start date, decision to refer date, referral reason

Those referrals that are not considered appropriate by the receiving clinician, not in line with local guidelines or do not include the complete minimum data set will be referred back to the referrer clearly stating the reason for return. The referral letter will be registered on PAS and rejected. Cancer referrals are an exception to this rule: only the GP can agree to downgrade the referral, so consultants must speak to the patient's GP if they believe the referral should be downgraded.

All referrals will be scanned on an electronic referral system where they are sent for triaging to the relevant specialty.

Clinicians will only refer to consultant colleagues from other specialties, patients that require further advice / consultation for urgent conditions, pre- operative work-up and suspected cancer. If the patient requires non-urgent treatment for a condition unrelated to their original referral they will be referred back to their GP. These referrals will follow the same pathway as external referrals. Internal referrals must be actioned within 2 weeks of their request, in order to avoid delays in the patient's pathway.

Clinicians may refer to consultant colleagues for a further opinion for the condition related to the original referral. The 18 Week clock will continue to run in this instance.

5.1 Choose and Book

Choose and Book is an electronic booking service which has been created in line with the NHS national Choose and Book programme. It allows patients in England to choose the hospital of their choice for treatment; patients can book hospital appointments at a time/date convenient to them.

BSUH encourages the use of Choose and Book and will maintain the associated Directory of Services in accordance with national guidelines. Every Directory of Services will be agreed and signed off by the Trust's

Directorate Managers, as will any major changes to the existing Directory Of Services.

The Trust will improve communications between primary and secondary care and educating professionals by maintaining and improving the ability for a referrer to ask for electronic 'Advice & Guidance'. This is used if it is uncertain as to whether a patient should be referred or unsure of how to find the most appropriate service and in turn will prevent the patient being inconvenienced by an inappropriate referral into BSUH. Note that a request for such Advice and Guidance for a new patient can also be sent by a conventional letter.

5.2 Veterans of the Armed Forces

When referring a patient who is known to be an armed forces veteran, GPs have been asked to consider if the condition may be related to the patient's military Service. If the GP decides that a condition is related to Service any referral for treatment should make this clear. Where hospital clinicians agree that a veteran's condition is likely to be Service-related, they have been asked to prioritise veterans over other patients with the same level of clinical need. However, veterans will not be given priority over patients with more urgent clinical needs.

5.3 BSUH Staff

BSUH staff can be prioritised by a clinician if earlier treatment will assist the staff member to return to work sooner and in turn supporting hospital services. Patients who are clinically urgent must always take priority.

5.4 Referral Letters through Intermediate Services

Referrals which are required to go through other primary care based services (e.g. triage centres, physiotherapy) prior to coming to one of the Trust's clinicians, should be clearly marked as having done so on the referral letter or form by the intermediate service. Failure to do so could result in the Trust returning the referral. Inter Provider Transfer minimum data sets need to accompany these referrals and should state clock start date, decision to refer date, and reason for referral.

6 OUTPATIENT, INPATIENT AND DIAGNOSTIC ACTIVITY

This policy applies to all patients who are waiting for outpatient and diagnostic appointments, and those who will be admitted as an inpatient or day case on an elective basis. The procedures outline how the hospital will communicate with patients and plan with their involvement their admission within maximum waiting time standards.

6.1 Objective

To ensure that all outpatient clinics, diagnostic and theatre sessions are fully utilised, maximising resources and to ensure that all patients are diagnosed and treated in accordance to their clinical priority, waiting time, and receive equitable access to services in line with NHS guidelines.

6.2 Key Principles

- All patients will be offered appointment or admission dates in order of clinical priority and length of wait

- Patients waiting for an outpatient appointment will be offered a choice of at least two dates with at least two weeks' notice. Patients who are sent a fixed appointment by post will be informed how to contact us to change the appointment if it is not convenient

- If the appointment is clinically urgent within 10 working days, the patient will be telephoned. Two attempts must be made to contact the patient on two different days at two different times, after which a letter will be sent by first class post

- For short notice clinics, patients will be contacted by telephone. Two attempts will be made on two different days at two different times. If not contact is made, the patient remains in the queue and will be sent a fixed appointment letter by post with at least two weeks' notice and informing them how to contact us to change the appointment if it is not convenient

- If the patient refuses to accept the two offers of appointments within the period the referral will be closed and passed back to the Referrer

- If a patient wishes to wait longer for an appointment, then they can be returned back to the referrer and re-referred when they are available to attend

- Where multiple appointments are needed across specialties, the Trust will endeavor to organise appointments on the same day provided this is what the patient would like and it this can be done without compromising any urgent appointments

- Patients waiting for a diagnostic test will be offered a choice of at least two dates with at least three weeks' notice. Again the patient may be offered a sooner appointment and if the patient is clinically urgent will be encouraged to accept the earliest available slot.

- The decision to add a patient to an inpatient or day case waiting list must be made by the Consultant unless there are separate protocols in place

- On the date that a patient is added, he or she must be clinically fit for admission and willing to proceed

- Patients will be seen and treated in accordance with their clinical priority. There are two categories: urgent and routine. Patients marked urgent should have a target date specified. Clinically non-urgent patients will be managed on a "next in turn" basis

- Where patients cannot be treated within maximum waiting times they should be kept informed of their position on the waiting list, as set out in the NHS Constitution

- All patients will be involved in the planning of their admission and offered a choice of when it takes place. Patients should be given at least three weeks' notice of their TCI date and offered at least two dates

- Patients can be offered earlier dates if available – for example when waiting times are shorter than three weeks or there are available admission/theatre dates, however patients will have the opportunity to decline without any adverse effect on their waiting times

- Patients who are not fit (i.e. co morbidities or a chronic illness making surgery risky), ready and able to come in will normally be discharged back to their GP for ongoing care. The GP should be advised to re-refer the patient when they are fit and ready to undergo the procedure and the patient will either be given an outpatient appointment, pre-admission assessment appointment or date for admission as appropriate

- The only exception is where a patient has multiple conditions or co-morbid factors requiring management by their treating consultant to ensure a safe and optimum treatment. In these cases the 18 week clock will stop for active monitoring

- All patients who have their operations cancelled for non-clinical reasons on the day of admission will be offered a binding date within 28 days, and within the maximum waiting time guarantee

- All patient interactions must be logged on PAS as a record of contact and what transaction took place. For example: a patient is phoned and offered a date for admission but declines. This must clearly be recorded within the patient pathway

6.3 Patient Information

Patients should be given information about their appointment about what the can expect to happen at their appointment, including who they might see, how long the appointment will take, any information they are likely to be asked, what medication they are taking, and whether they should bring someone with them. This should include information on how to change or cancel an appointment, what happens if they do not attend and how this will affect their overall pathway and waiting time.

Patients will be given copies of letters and reports with a covering explanation if needed.

6.4 DNAs

A DNA is defined as where a patient fails to attend an appointment/admission without prior notice. Patients who cancel their appointments in advance should not be classed as a DNA.

Outpatients

If a patient fails to attend the first outpatient appointment on their 18 Week pathway, the consultant will review the referral at the end of clinic and complete a Clinic Outcome Sheet stating whether the patient should be discharged or reappointed. Patients who are discharged to their GP will have their 18 Week pathway nullified.

If the consultant decides that the first outpatient appointment should be rebooked, then the original 18 week clock will be nullified and a new 18 week clock will start from the date the Trust books a new appointment.

Two appointment times will be offered within the 18 week RTT rules with at least 2 weeks' notice given, unless a shorter amount of time is accepted by the patient.

If a patient fails to attend a second or subsequent outpatient appointment the patient's notes should be reviewed again by the consultant and can be discharged back to their GP if the consultant agrees that it is not contrary to their clinical interest. A letter should be sent to the patient and their GP. Discharging the patient will stop their 18 Week clock.

If a clinical risk has been identified, then the Consultant will contact the GP to agree a plan for the provision of appropriate care.

Diagnostics

If a patient turns down reasonable appointments (two dates with three weeks notice), the diagnostic waiting time for that test/procedure can be set to zero from the first date offered.

If a patient cancels or DNA's a 'reasonable' appointment the diagnostic waiting time for that test/procedure is set to zero and the waiting time starts again from the date of the appointment that the patient cancelled / DNA'd. The 18W clock however keeps ticking.

If a patient DNAs the diagnostic department may send the request back to the referring consultant for them to review and return to the referring GP.

Pre-admission or admission

If a patient does not attend their TCI or pre admission date for reason unknown they should be removed from the waiting list and referred back to their GP or referrer. This will stop their 18 week clock and their status will be nullified.

Exceptions should be made for:

- Cancer patients (see Appendix 2)
- Children under 16 (see Appendix 3)
- Urgent referrals
- Other clinical exceptions or exceptions for vulnerable adults, as agreed by the patients' consultant

The Trust must be able to demonstrate that the appointment was clearly communicated to the patient, and that discharging the patient is not contrary to their best clinical interests.

The Trust will take steps to reduce the number of DNAs by offering a choice of appointment times and dates where possible; giving patients reasonable notice of appointments (two weeks' notice for outpatient and three weeks' notice for inpatient and diagnostic appointment appointments) and by sending reminder texts where permission has been granted and the mobile telephone number provided.

6.5 Waiting List Management

6.5.1 Planned Inpatient Waiting Lists

Planned patients should be treated at the right time. Patients requiring initial or follow-up appointments for clinical assessment, review, monitoring, procedures, or treatment must be given a specific date and time, as required by best clinical evidence. Patients should only be added to a planned list where clinically they need to wait for a period of time. This includes planned diagnostic tests or treatments or a series of procedures carried out as part of a treatment plan, where the first treatment is recorded as RTT activity but the rest planned. The course of treatment is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.

Patients on planned lists should be booked in for an appointment at the clinically appropriate time and they should not have to wait a further period after this time has elapsed. For example, a patient due to have a re-test in six months' time should be booked in around six months later and they should not get to six months, and then have to wait again for non-clinical reasons. This is not an acceptable use of a planned list.

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

6.5.2 Age Related Procedures

Ideally children should be kept under outpatient review and only listed when they reach an age when they are ready for surgery. However where a child has been added to the waiting list with explicit clinical instructions that they cannot have surgery until they reach an optimum age, this patient can be classed as planned. The planned waiting list should be monitored by the patient access managers to ensure that patients are being brought in, in accordance with their planned dates.
No patient should be placed on the waiting list (planned or otherwise) if the patient is unsure whether he or she wants to proceed with the recommended treatment.

6.5.3 Active Inpatient Waiting List

All patients on the active waiting list need to be admitted within the maximum waiting time target. The only exceptions to this principle are patients who are clinically complex, for whom an allowance is made in the waiting time standards. All patients will be included in the formal waiting list statistics.

Under the 18-week pathway the waiting time for diagnostics is included in the total waiting time and for this reason patients awaiting specific diagnostic tests will either be directly booked, referred directly from the GP for the diagnostic or be added to the active waiting list to have the test done within the target date of 6 weeks.

6.5.4 Adding Patients to the Inpatient Waiting List

The following principles must be complied with:

- Patients should be added to the waiting list only if they are clinically fit for admission and willing to proceed on the day the decision to admit is made
- Patients who are not fit, ready or able to come in at the time the decision to admit must not be added to the waiting list. Examples of such patients are;
    - Patients with high blood pressure
    - Patients needing to lose weight
    - Patients with cardiac or respiratory problems
    - Patients requiring any diagnostic test before a definitive decision to admit can be made
- All patients must be added to the waiting list on Oasis PAS within 3 working days of the decision to treat
- The decision to treat date should be the date upon which the patient agreed to treatment (this could be the clinic date or a later contact with the patient)
- Patients should receive a letter confirming they have been added to the waiting list within 7 days of the decision to treat

6.5.5 Clinical Urgency

All patients added to the waiting list must be given a clinical priority. Patients should be classified as either:

- Urgent to be admitted within individual Consultants timeframe
- Routine to be admitted on a next in turn basis within guarantee waiting times

In some cases, in addition to selecting a priority, the consultant may stipulate the patient should be admitted within a specific time frame,

usually the more urgent or planned patients. This information should be recorded in PAS when adding patients to the waiting list.

6.5.6 PAS Standards

PAS is the prime source of waiting list information. All waiting lists are to be maintained on PAS in real time, this ensures consistency and standardisation of reporting.

6.5.7 Managing the Patient's Waiting Time

To ensure waiting times are kept as low as possible, it is important to ensure that the waiting list is managed appropriately and transparently. Pooling of the waiting list, i.e. keeping patients in one queue, rather than a separate queue for each consultant, improves access and should be considered wherever clinically appropriate. The waiting list is subject to external scrutiny hence the management of patient level data in a systematic manner is a core responsibility for all. Mismanagement of waiting list information may lead to disciplinary action being taken.
The following principles must be complied with:

- All waiting lists must be maintained and managed on PAS
- Patients should be appointed on a next-in-turn basis, with due respect given to clinical priorities
- Each Directorate should have a formal arrangement for monitoring the waiting list, ensuring that it is systematically validated
- Each Directorate should have an agreed definition of the procedures to be listed as 'planned'
- All patients on the waiting list will be categorized as on an outpatient or inpatient - 'active' or 'planned' list

6.5.8 Scheduling Patients from the Inpatient waiting list

Co-ordination of the patient's admission will ensure fair access to all patients.

The following principles must be complied with:

- All TCI dates must be agreed with the patient
- Patients should be given at least 3 weeks' notice of their TCI date and offered at least 2 dates. Where available patients can be offered earlier dates, e.g. when waiting times are shorter than three weeks or there are available admission/theatre dates, however

patients will have the opportunity to decline without any adverse effect on their waiting times

- When patients are of equal clinical priority, preference should be given to those patients who have waited the longest
- Patients should be selected from the 18 week PTL available from the CIU
- Theatre lists should be fully booked to ensure maximum use of resources
- War pensioners and service personnel injured in conflict must receive priority treatment if their condition is directly attributable to injuries sustained in conflict

6.6 Pre Admission Assessment

Pre Admission Assessment appointments are considered to be an integral part of the patient's admission. The policy of the Trust is to ensure that assessment starts at the point the decision to admit is taken, i.e. at the start of the waiting time. However, many patients will still require assessment and investigation within a month prior to admission. Pre Admission Assessments should be managed on an outpatient basis.

If a patient is deemed unsuitable to proceed to surgery, this must be clearly communicated to the booking staff. This will avoid wasted theatre slots. If a patient requires onward referral to another service or will require more than four weeks to be optimal for surgery, the patient should be removed from the active waiting list or discharged back to the GP depending on the level of intervention required.

6.7 Patient Initiated Pause (PIPs)

There is no longer provision to pause or suspend an RTT waiting time clock under any circumstances. However :

- it is still important that our booking teams know if a patient is going to be unavailable for an extended period of time, both start and finish dates. This still needs to be clearly recorded on PAS
- for each specialty and patient condition there will be a point beyond which it would not be safe to admit the patient for surgery without further review by the treating clinician as the presentation may have changed. It is the role of each consultant to have that discussion before any patient is listed for surgery.

Where the patient is requesting that their operation can only be within a particular time period – for example during school holiday periods – the patient needs to advised that this cannot be guaranteed.

In specialties where there are longer waiting times, consultants will need to manage the patient's expectations, make clear current waiting times and ensure that an outpatient review is triggered where the patient is waiting for an extended period.

6.8 Cancellations

The objective of the Trust is to treat all patients added to the waiting list. However, it is inevitable that for a variety of reasons some admission dates will be cancelled.

6.8.1 Patient Cancellations

Initial outpatient cancellations should be offered alternative dates within the 18 week RTT timeline.

Cancellation of follow up outpatient appointments will be offered the soonest available appointment after the original appointment date, ensuring that this is within the 18 week RTT timeline.

For outpatient appointments, if a patient cancels two or more new (first) appointments, the referral will be closed and passed back to the referrer.

If a patient cancels two or more follow up appointments, the patient notes should be clinically reviewed and can be discharged back to their GP if the consultant agrees that it is not contrary to their clinical interest. A letter should be sent to the patient and their GP. This will stop the patient's 18 Week clock.

If a clinical risk has been identified, then the Consultant will contact the GP to agree a plan for the provision of appropriate care.

For inpatient and daycase procedures, if a patient cancels an agreed date for admission, they should be offered a new date and told that a third date will not be offered. If they subsequently cancel the second date the patient notes should be reviewed and can be discharged and returned to their GP if the consultant agrees that it is not contrary to their clinical interest.

Patients who cancel for medical reasons which can be quickly resolved, i.e. a cold or other infection, should have a new date offered for 2-3 weeks' time. The 18 week clock will keep running.

This should not adversely impact on those patients deemed vulnerable or at risk e.g. children, cancer patients and vulnerable adults and therefore must be agreed with the consultant responsible for the patient.

6.8.2 Hospital Cancellations

A minimum of 6 weeks' notice is required if a Consultant or Clinician needs an outpatient clinic or inpatient theatre list cancelled or reduced.

If less than 6 weeks' notice for planned absence is given, Specialties will be expected to cover the clinic or the theatre list and not cancel it. This may involve giving an additional clinic date or theatre list date rather than holding the specific clinic / list

Short notice (less than 6 weeks' notice) cancellations must only take place for genuine unforeseen circumstances such as staff sickness

Once a TCI has been agreed with the patient, the date should not be cancelled without approval by the Directorate Manager or delegated authority. The following principles apply:

- All patients who have their operations cancelled for non-clinical reasons on the day of admission will be offered a binding date within 28 days from the date of the cancellation, or before their 18 week breach date, whichever is soonest.
- All theatre session cancellations (less than 6 weeks) must be authorised by the appropriate authority.
- Where possible all cancelled theatre sessions should be taken up by another clinician/specialty to ensure maximum utilisation of theatre space.
- All clinic session cancellations (less than 6 weeks' notice) must be authorized by the appropriate authority

6.9 Upgrading and downgrading of referrals

Referrals can be upgraded if a clinician suspects there is a possibility of cancer. The GP or referrer should be informed that their patient has been upgraded. The following clinical priorities apply:

- Suspected cancer 2WW patients
- Clinically urgent patients
- Routine patients

Referrals should not be downgraded without agreement between the consultant and the referring clinician. Only the referring clinician can agree to downgrade a referral. Such decisions should be recorded in the patient notes and the patient should be informed.

6.10 Low Priority Procedures

A list of procedures requiring prior approval by Brighton and Hove CCG can be found here:

http://www.brightonandhoveccg.nhs.uk/staff/primary-care/clinical-areas/prior-approval-procedures

A list of procedures requiring prior approval by Horsham and Mid-Sussex CCG can be found here

http://www.horshamandmidsussexccg.nhs.uk/your-health/individual-funding-requests/

Where a GP referral is definitely for one of these procedures, the GP should have already applied to the CCG for approval. The referral should include a copy of the application form to the CCG with an approval number.

Where there is a clinical decision made within the Trust that the patient requires an LPP, the patient should be added to the waiting list as usual and the Trust should apply to the CCG for approval. The CCG should respond within 10 working days.

If the CCG approves the procedure, the patient stays on the list until they are treated, upon which their 18 Week clock will stop. If there is no response from the CCG, we will assume that the treatment will be paid for and will treat the patient accordingly.

If the CCG rejects the procedure, the patient should be discharged from the list and their clock should stop.

6.11 Validation of Waiting Lists

A rolling programme of validating the waiting list should be incorporated into the booking process. It is essential to good waiting list management. BSUH will continue an ongoing validation programme to ensure the patient access policy is being followed. Any additional validation will be agreed with the CCG.

6.12 Removal from the Waiting List

Patients may be removed from the Waiting List without treatment for several reasons:

- Intended treatment is no longer required
- The patient has moved out of the area and opted to transfer to an alternative hospital
- The patient has personal circumstances that prevent acceptance if an offer date for the foreseeable future
- The patient has not attended an agreed TCI date and efforts to contact the patient have failed
- The patient has cancelled a TCI date more than once
- The patient is unfit for surgery
- Non-response to validation

Reason for removal must be recorded on PAS an in the patient's medical case notes and the referring clinician should be informed. The responsible clinician should ensure that removal from the waiting list does not compromise clinical safety or quality.

6.13 Patients moving between NHS and private care and treatment

Patients can choose to convert between an NHS and private status at any point during their treatment without prejudice. Where it has been agreed in private practice, for example, that a surgical procedure is necessary the patient can be added directly to the elective waiting list. The RTT clock starts at the point the GP or original referrer's letter arrived in the hospital.
The elective access pathways of patients who notify the Trust of their decision to seek private care will be closed as a pathway stop event on the date of this being disclosed by the patient, and if the patient is on a waiting list they will be removed from the list.

6.14 Vulnerable Patients

It is essential that patients who are vulnerable for whatever reason have their needs identified at the point of referral.
This group of patients includes:

- Patients with learning difficulties, mental health problems, dementia or psychiatric problems
- Patients with physical disabilities or mobility problems
- Patients who require an interpreter/advocate

- Patients who pose an increased anaesthetic risk (e.g. uncontrolled epilepsy, diabetes, congenital heart disease)

- Elderly patients who require community care

These patients should not be discharged on their first DNA, another appointment should be offered. The Consultant should be informed of a vulnerable patient DNA and may want to follow up directly with the patient or GP before offering another appointment.

All the relevant information must be recorded on the PAS system to ensure that when selecting a patient for any appointment within the Trust (outpatient, therapy, day case, admission), their needs are identified and appropriate arrangements made.

6.15 Change of Patient Address

Patients who change address whilst they are waiting for elective admission should not be disadvantaged by the change in circumstances. In this scenario, the DNA procedure would lead to the GP being informed that the patient has not responded or attended and has been removed from the waiting list. The patient should be returned to the waiting list. The patient should be returned to the waiting list from the date that the hospital is made aware of the patient's new address.

6.16 Transfer between Providers

Transfers to and from other providers must be managed with the consent of the patient and consultant. A Minimum Data Set (MDS) form must be included with all transfers. The patients guaranteed waiting time should be honoured by the receiving hospital.

6.17 Transfer of Consultant

On occasion, patients may be offered the opportunity to reduce their waiting time by having their procedure performed by another Consultant within the same Specialty. Where a patient declines a reasonable offer it would not be acceptable to stop the clock and their RTT clock will continue to run.

7 MANAGEMENT INFORMATION & REPORTING

The CIU make available a wide range of detailed and summary information to management and operational staff in the Trust, to help manage and monitor performance against internal and external waiting targets. Information is either emailed directly to staff or published via web-based reporting tool.

7.1 Internal Information & Reports

7.1.1 18 Weeks Referral To Treatment (RTT)

This report contains all patients on an open pathway and clock stops month to date, summary information at specialty level on compliance and other performance indicators

7.1.2 Diagnostic Waiting Times.

This report lists all patients at risk of breaching the six week target at the end of the current month.

7.1.3 Stage of Treatment.

PTL. This shows the position as at midnight on the previous day and is refreshed daily. There is one report for inpatient and day case waiting lists, one for dated outpatients, and one for undated outpatients. These include both summarised and patient level information and include parameters that can be set by the users. Lists of projected breaches of the standards of care are also sent directly to appropriate staff at the beginning of the month in which they are due to breach.

7.2 External Information & Reports

7.2.1 18 Weeks Referral to Treatment (RTT)

Monthly returns are uploaded to the DH via Unify2 as per the national timetables. Weekly returns are provided to the CCG and TDA.

7.2.2 Diagnostic Waiting Times

Monthly and quarterly returns are uploaded to the DH via Unify2 as per the national timetables.

7.2.3 Stage of Treatment

An Elective Admission List (EAL) CDS showing the waiting list at month end is sent to the CCGs by the last day of the following month.

APPENDIX 1 - 18 week clock starts and stops

Introduction

This appendix sets out the detailed rules which govern when 18 Week clocks start and stop. It has been developed in accordance with the national rules for 18 Weeks contained in the DH guidance Referral to treatment: consultant-led waiting times rules suite.

An 18-week clock starts with:

- Referral from a GP to a consultant-led service – the clock starts on the date that the referral is received by the provider
- CAB referrals – the clock starts on the date that the patient converts their Unique Booking Reference Number (UBRN)
- Other primary care referrals including
- Nurse Practitioners
- GPs with specialist interest
- AHPs
- General Dental Practitioner
- An interface or referral management service which may result in an onward referral to a consultant led service before responsibility is transferred back to the referring health professional or GP. If a referral is received from a referral management service (RMS) the clock will have been started when the RMS received the referral
- When a patient needs surgery on both sides of their body, for example both hips is fit and ready to proceed with their second operation. When a new treatment plan is started which is not already part of the existing care plan
- A re-referral to a consultant-led service having previously been discharged with a clock stop event
- When a decision is made to treat following a period of active monitoring e.g. at a follow-up OPA
- When a patient rebooks their OPA following a first appointment DNA that stopped and nullified their earlier clock

An 18-week clock stops when first definitive treatment starts, which could be:

- Treatment provided by an interface service
- Treatment provided by a consultant-led service
- Date of admission as a day case or as an inpatient for an elective procedure
- Date treatment given or started in outpatients

Treatment from an 18-week pathway perspective is defined as "the start of the first treatment intended to manage the patient's disease, condition or injury and includes:

- Drug therapy
- Advice and guidance to the patient
- Minor procedure undertaken in outpatients
- Inpatient/day case admission for a treatment procedure
- Physiotherapy
- Fitting of medical device
- Therapy or health-care science intervention provided in secondary or interface service. Decision to add patient to a transplant list. Patient referred back to primary care for treatment. Starting a period of active monitoring. Patient receives treatment following an attendance for a diagnostic test – for example starting medication following an endoscopy; have a polyp removed at colonoscopy

The clock also stops if:

- There is a decision not to treat
- The patient declines treatment
- The patient DNAs their first appointment and is subsequently discharged back to the GP (the clock is nullified and removed completely from the denominator)

Clock Pause

There is no longer any provision to pause an 18 week clock.

APPENDIX 2 - CANCER PATHWAYS

Introduction

This appendix sets out the processes and approach of BSUH in the management of patients against national cancer waiting times. It has been developed in accordance with national objectives, targets and guidance from the Department of Health, including the NHS Constitution and Cancer Waiting Times: A Guide (version 8.0).The overall purpose of the document is to ensure a consistent approach to the management of patients on a cancer pathway across the organisation.

Objectives

To provide operational guidance for all staff involved in the booking and management of patients on a cancer pathway to ensure compliance with national rules and guidelines.

For patients this will ensure:

- Patients with suspected and/or confirmed cancer diagnosis receive treatment according to clinical priority and national cancer waiting time rules
- Patient experience is improved as they move through their clinical pathway

For staff this will ensure:

- Teams and individuals are aware of their responsibilities for moving patients through their clinical pathway in accordance with national cancer waiting time rules
- Departments monitor performance and adhere to waiting time rules in relation to tests, investigations and treatment
- Delays in cancer pathways are escalated at an early stage to Directorate management teams
- Accurate, timely and complete data is recorded on the Trust Patient Administration System and Somerset Cancer Registry for reporting performance to the National Cancer Waiting Times Database within statutory timescales

Cancer Waiting Time Standards

Cancer waits – 2 week wait
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – Operational Standard 93%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – Operational Standard 93%
Cancer waits – 31 days
Maximum one month (31-day) wait from decision to treat to first definitive treatment for all cancers – Operational Standard 96%

Maximum 31-day wait for subsequent treatment where that treatment is surgery - Operational Standard 94%
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – Operational Standard 98%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – Operational Standard 94%
Cancer waits – 62 days
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – Operational Standard 85%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – Operational Standard 90%
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set

Cancer Patient Access Standards

General principles

- All patients with suspected or diagnosed cancer will be managed in line with national cancer targets
- All patients will be recorded on PAS to ensure they can be tracked through their clinical pathway
- All relevant patients will be recorded on the Somerset Cancer Registry database (SCR) which will hold comprehensive records for each patient. The record will include a full Cancer Outcomes and Services Dataset (COSD) detailing cancer waiting time and multi-disciplinary team (MDT) discussion notes
- Patients will be tracked against national standards with delays actioned and pathway breaches escalated as appropriate
- Compliance and breaches of the targets will be reported in line with national reporting guidelines
- Data quality checks will be undertaken to ensure data collection systems and the tracking of patient pathways is compliant with cancer waiting times rules

2 week wait critical referrals clock starts

- Receipt of referral is day 0 for the two week wait national target
- For referrals received electronically the clock start date is the date the referrer emailed
- For paper referrals the date the referral is received is the clock start date
- All referrals will be registered on PAS within 24 hours of receipt
- When registering the referral on PAS the outpatient priority type must be recorded as referral type "critical (2 week rule) referral"

- All referrals registered on PAS as “critical (2 week rule) referral” will automatically interface from PAS to SCR daily as part of an overnight extract from the Trust’s data warehouse so the patient can be tracked
- When making an outpatient appointment the booking item on PAS must be recorded as NEW 2 WK RULE
- Where patients are at the outset referred direct for a test / investigation (e.g. Endoscopy), they must be identified on PAS by adding to the inpatient or day case waiting list as referral type “critical (2 week rule) referral” and referral urgency “urgent – critical referral”
- Where patients are undergoing surgery as treatment for primary or recurrence of cancer, they must be identified on PAS by adding to the relevant consultant inpatient or day case waiting list with a referral urgency “urgent – critical referral”

2 week wait critical referral clock stops

- The 2 week wait clock stops when the patients is first seen by a consultant (or member of the team) or in a diagnostic clinic following receipt of referral
- If cancer is excluded at the attendance then the 62 day pathway clock also stops and the patient is either managed on an 18 week pathway or discharged
- If cancer is not excluded the patient remains on the 62 day pathway and will continue to be monitored

2 week wait bookings/cancellations/DNA’s

- It is best practice to offer patients an appointment within 7 days of the referral being received to ensure the 2WW standard is achieved over holiday and bank holiday periods
- Patients who choose to wait longer than 2 weeks for social reasons must not be referred back to their GP or have their clocks stopped. It is expected that some patients will choose to wait longer and will be recorded as a breach - the operational standard/tolerance takes account of this
- Patients must not be referred back to their GP or adjustments made to their pathway if they cancel their appointment – patients are permitted to cancel as many times as they wish
- Patients must not be discharged if they DNA their first appointment. The patient must be contacted and rebooked with the 2ww clock restarting from the date the appointment is rescheduled

- Patients that DNA their 2nd appointment can be discharged back to the GP with agreement of the clinician – the GP must be informed that no further appointment will be offered without a new referral

2 week wait inappropriate referrals

- If a referral is received with insufficient information to process it then the referrer must be contacted immediately to minimize delay to the patient. Referrals must not be rejected for this reason or the pathway paused or delayed
- Referrals can only be downgraded by a GP. If a clinician believes a referral to be inappropriate this must be discussed with the GP who can authorize for the referral to be converted to a non 2WW referral. If the GP chooses not to downgrade the referral their decision is final and the patient must remain on a cancer pathway

62 day clock starts

- The clock start date for the 62 day pathway is the receipt of the 2WW referral from the GP, referral from a screening programme or consultant decision to upgrade
- The receipt of referral or upgrade is day 0 in the 62 day pathway

62 day clock stops

- The clock stops when cancer is excluded
- The clock stops when first definitive treatment is given, for example:
    - For surgical intervention it will be the date the patient is admitted for surgery
    - For anti-cancer drug therapy it is the date the first drug in an agreed treatment plan is given
    - For radiotherapy it is the date the first fraction is given
    - For patients receiving palliative care with no specific anti-cancer treatment it is the date this plan of care was agreed with the patient
- The clock stops if the patient refuses all diagnostic tests and therefore opts out of the 62 day pathway. If the patient chooses to have the tests at a later stage and cancer is diagnosed, a new 31 day clock would commence

31 day clock starts

- The clock starts on the date the patient agrees a plan for their treatment

  - This can be either at a face to face consultation or telephone consultation with the patient

  - Signing of the consent form by the patient may often occur after they have agreed their treatment plan and it therefore should be noted that this is **not** the decision to treat date

  - If the patient subsequently changes their mind about their treatment plan (i.e. agrees surgery but later decide to have chemotherapy instead) then the decision to treat date can be amended to the new decision date, **however** the 62 day period would continue unchanged

  - If a patient has seen a consultant in the private sector and a decision to treat is made, if the patient requests NHS treatment the decision to treat date is the date that the Trust accepts the referral

- For subsequent treatments the clock start is as above or the earliest clinically appropriate date (ECAD) where there is no new decision to treat, but there has previously been agreed and clinically appropriate period of delay before the next treatment can commence. This might not be the start of subsequent treatment itself, but could be the next activity that actively progresses a patient along the pathway for that treatment to take place, i.e.:
  - A patient with rectal cancer who is to have radiotherapy then surgery, the patient would not be clinically fit for surgery so the ECAD would be set for six weeks after the radiotherapy is complete

31 day clock stops

The 31 day standard stops with first definitive treatment. A treatment is 'an *intervention intended to manage the patient's disease, condition or injury and avoid further intervention. It is a matter of clinical judgement, in consultation with the patient. '* For cancer waits a first definitive treatment is further defined as the start of the treatment aimed at removing or eradicating the cancer completely or at reducing tumour bulk.

- The clock stops when first definitive treatment is given, for example:
    - For surgical intervention it will be the date the patient is admitted for surgery
    - For anti-cancer drug therapy it is the date the first drug in an agreed treatment plan is given
    - For radiotherapy it is the date the first fraction is given
    - For patients receiving palliative care with no specific anti-cancer treatment it is the date this plan of care was agreed with the patient

Active monitoring

- If a diagnosis has been reached but it is not appropriate to give any active treatment at that time, but active treatment is still intended or may be given in the future then patients can be recorded as on active monitoring. I.e.;
    - a patient with a prostate tumour that it is not causing significant problems decides not to pursue active treatment but enter into a period of monitoring

- This must be agreed with the patient; it should be an informed choice to be monitored rather than receive treatment and should not be used for thinking time. For example if a patient is offered a range of treatments and wants to take a couple of weeks to think about it this is **not** active monitoring

- This option must **not** be used if a cancer diagnosis is not yet confirmed

Consultant upgrades

- A consultant must upgrade a patient onto a cancer pathway if there is a suspicion of a cancer diagnosis using the ‘upgrade’ form

- An upgrade onto a cancer pathway can be made at any point on a patient’s pathway as long as it is before the decision to treat date is confirmed with the patient

APPENDIX 3 - CHILDREN

Introduction

This appendix sets out the processes and approach of BSUH in the management of children up to the age of sixteen.

Hospital Cancellations

- Hospital cancellations should be kept to a minimum
- Urgency of follow up or new appointment must be taken into account when rebooking
- Consultants must be advised if patients cannot be rebooked due to capacity

Patient Cancellations

- Children do not cancel themselves – their appointments are cancelled for them. Repeated cancellation may constitute medical neglect.
- Should a patient be cancelled more than twice, the consultant, patient access manager and safeguarding team must be made aware. This is a standard “safety net”, and in the majority of cases would generate no further action; in order to prevent undue patient/carer anxiety it is unnecessary to communicate this to them. The reason for cancellation should be sought if this occurs via telephone contact with the Hub
- If a child’s appointment is cancelled and a request is made for their discharge, the consultant must be made aware as they need to make a clinical decision to decide if this is appropriate for the child

DNAs

- Children do not fail to attend; they fail to be brought to appointments. Repeated DNAs may constitute medical neglect
- If a child DNAs the consultant needs to be given the notes with an explanation of whether the patient was sent a letter or not, what date the letter was sent, if there was any phone contact to make the appointment, to ensure they can make the most informed decision as to whether this is detrimental to the child or not. The consultant should review all DNAs and assess for clinical/social risk. Write to GP (copying to parent, HV and social worker if they have one) to inform of DNA and decision to reappoint or not

- If a child DNAs more than twice, the consultant, patient access manager and child protection team must be made aware. If there is a medical or social risk, the consultant should contact the carers/GP/social worker by telephone or letter clearly explaining the concern

Fracture Bookings

- Children with fractures must be booked 7-14 days after the injury, or in the time period specified by the consultant. This cannot be exceeded in any way as it may mean children need to have operations instead of simple outpatient's procedures

- If there are capacity constraints when booking fractures, please let the patient access manager know and they will ensure sufficient capacity is found

Baby Hip (DDH) Bookings

- Baby's referrals to the baby hip clinic must be seen at 6 weeks of age, unless a sooner time is stipulated by the consultant

- This time frame cannot be exceeded in any way, as it may mean the baby needs to be operated on rather than have a simple outpatient's procedure

- If there are capacity constraints, the clinician will notify the patient access manager