University College London Hospitals NHS

NHS Foundation Trust

Patient Access User Manual

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Symbols

Through out this manual are information boxes highlighting key points, actions or responsibilities. They are described below:

	These information boxes explain what happens to a patient's RTT clock

	These information boxes explain what should be inputted on to Trust electronic systems

	These information boxes describe a clinical responsibility or process

	These information boxes describe a managerial responsibility or process

1. Summary

This policy details how patients will be managed administratively at all points of contact with University College London Hospitals NHS Foundation Trust.

The Referral to Treatment standard

The Referral to Treatment (RTT) standard is concerned with the time between the patient's referral from a primary care practitioner being received by a provider and the time the patient receives treatment. Running parallel to this target are others that mandate the maximum wait for certain stages of a patient pathway or for treatment of certain conditions. The referral to treatment target applies to all consultant led services within secondary and tertiary care except maternity services.

Non-Admitted Pathway

All referrals received by the Trust will be recorded and scanned onto the Trust's systems within 24 hours of arrival. Letters will be reviewed clinically and patient contact made within a further four days. To arrange new outpatient and diagnostic appointments all patients will be contacted by telephone or by writing within four days of receipt of referral in the first instance. All patients will be given a maximum of 10 working days to respond; if contact cannot be made they will be returned to the referring clinician. All patients who, without notification, do not attend a new outpatient consultation will be referred back to the care of their referring health professional.

Diagnostics

Diagnostic services form part of the RTT pathway provided the patient will be assessed and, if appropriate, treated by a medical or surgical consultant led-service before responsibility is transferred back to the referring health professional. Where a diagnostic procedure is being undertaken in an outpatient setting (non-admitted) the outpatient section of the policy will be adhered to. Where a patient is being admitted as a day-case or inpatient for a diagnostic test then the inpatient and day case section of the policy (admitted pathway) will be adhered to.

Admitted Pathway

Patients will only be added to elective waiting lists when it is medically appropriate for them to have the procedure for which they are listed. Patients cannot be listed when medically unfit for surgery and cannot be 'suspended' or paused when medically unfit, and should be removed from the waiting list. Patients can be paused on an elective waiting list only if they are unavailable to be admitted for social reasons.

When using this manual, unless otherwise stated, days refer to working days.

2. Key Principles

This Policy covers the way in which the Trust will manage patients who are referred for treatment on admitted, non-admitted or diagnostic pathways. It covers the management of patients at all sites where the Trust operates, including outreach clinics.

- Every process in the management of patients who are waiting for treatment must be clear and transparent to the patients and to partner organisations and must be open to inspection, monitoring and audit.
- The Trust will give priority to clinically urgent patients and treat everyone else in turn.
- The Trust will, whenever possible, negotiate appointment and admission dates and times with patients.
- War pensioners and service personnel injured in conflict must receive priority treatment if the condition is directly attributable to injuries sustained in conflict.
- The Trust will work to ensure fair and equal access to services for all patients, and ensure it meets its obligations towards people who have had, or have disabilities under the Equality Act (2010). This places a legal obligation on organisations to make reasonable adjustments to facilitate the care of people with disabilities. The decision as to what adjustments to make is not prescriptive, and must be agreed with the patient, their carer and the team caring for the person. By Law, if the adjustment is reasonable, then it should be made. Examples of reasonable adjustments can be found in the practice guideline: ‘supporting people with learning disabilities.’
- In accordance with training needs analysis, staff involved in the implementation of this policy, both clinical and clerical, will undertake training provided by the Trust and regular annual updates. Policy adherence will be part of the staff appraisal process.
- The Trust will ensure that management information on all waiting lists and activity is recorded on an appropriate Trust system. This must be Carecast or other approved reporting systems authorised by the Director of Performance & Partnerships, e.g. Radiology Information System (RIS). All approved reporting systems form part of the Trust’s electronic patient record (EPR). Stand-alone or paper based systems must not be used in isolation.
- The Trust will monitor the Referral To Treatment (RTT) pathway by measuring the patients length of wait from referral to new outpatient appointment, diagnostic test, elective admission and open pathway follow-up appointments.
- Although referred to as the general practitioner (GP) throughout the document, the referring clinician may be any health care professional with referring rights, including nurse specialists / consultants, allied health professionals within primary care, primary care assessment & triaging service, general dental practitioners (GDP) or consultants from other secondary care providers.
- No patient should leave the hospital without knowing the date of their next activity at the hospital, where applicable.

3. Corporate Roles and Responsibilities

The Operational Medical Directors for the Clinical Boards through Divisional Managers and Clinical Directors are accountable for implementing the Patient Access Policy, monitoring waiting list management and ensuring compliance with the policy.

The Operational Medical Directors are accountable for ensuring that the waiting times standards are monitored and delivered. It is, however, the Service / General Managers (or equivalent) through the Divisional Managers who are responsible for achieving these targets.

Waiting List Administrators, be they clinic staff, secretaries or booking clerks, are responsible to the Service / General Managers with regard to compliance of all aspects of the Trust's Patient Access Policy.

Waiting List Administrators are responsible for the day-to-day management of their lists and are supported in this function by the Service / General Managers and Divisional Managers who are responsible for achieving access targets. General Managers through Divisional Managers are responsible for ensuring the data is accurate.

The Director of ICT is accountable for the maintenance of Carecast and other reporting systems on which all waiting lists are held.

The Director of Performance and Partnerships is accountable for the management of data once it has been entered onto Carecast and on other reporting systems on which all waiting lists are held.

The Head of Performance is responsible for the reporting of information to the Medical Directors, monitoring performance against locally or nationally agreed targets and ensuring this is fed into appropriate operational and performance forums.

The Head of Information is responsible for providing regular data quality audits of standards of data collection and recording the submission of central returns produced by the Information Services Department.

GPs play a pivotal role in ensuring patients are made aware during their consultation of the likely waiting times for a new outpatient consultation and of the need to be contactable and available when referred.

All clinical staff are responsible through their Clinical Director to the Medical Director for ensuring they comply with their responsibilities as outlined in this manual.

Any staff not following the policy or this manual will have this reported to their line manager and this may result in action under the Trust's disciplinary policies.

Staff involved in managing patients' pathways for elective care must not carry out any action about which they feel uncertain or that might contradict this policy.

4. National Access Targets and Standards

As of June 2010 these are:

4.1 Referral to Treatment (RTT) Standard

(NHS Constitutional right)

- 90 per cent of pathways where patients need to receive their treatment in an inpatient or day case setting must be completed within 18 weeks.
- 95 per cent of pathways where patients receive their first definitive treatment in an outpatient setting must be completed within 18 weeks.

4.2 Median waiting times

The Department of Health uses RTT measurement to report median waiting times nationally.

4.3 Stages of treatment standards

In order to ensure a coordinated approach to waiting times the Trust will set internal waiting time standards. These will be for both inpatients and outpatients and will fit with political market needs and the Trust's ability to deliver against these.

4.4 Cancer Targets

See Cancer Targets section Appendix 1.

4.5 Rapid Access Chest Pain

(Internal standard)

All patients with new or recent onset of exertional chest pain suggestive of ischaemic heart disease or worsening symptoms in a patient with known ischaemic heart disease who is not under active follow-up by a cardiologist, must be seen in outpatients within 14 days of date of a GP referral (NB chest pain target measured from time of GP referral not time of receipt by provider).

4.6 Diagnostics Target

(Commissioner Target)

6 Weeks maximum wait from time that the request for the diagnostic test or procedure was made, to point of receiving the diagnostic test (this does not include receiving subsequent report). This applies to all diagnostic procedures.

4.7 Cancelled Operations

(NHS Constitutional right)

All patients who have elective operations cancelled on the day of surgery / day of admission / after admission for non-clinical reasons must be offered another binding date within 28 days or are eligible for private treatment paid for by the Trust. This also applies to elective admission for non-invasive diagnostic procedures.

4.8 Cardiac Revascularisation (CABG & PTCA)

(Internal standard)

A maximum wait of 13 weeks (91 days) from decision to treat to admission date.

4.9 Audiology

(NHS Constitutional right)

A maximum wait of 18-weeks for those patients who are directly referred from primary and community care to an audiology service for both diagnostic assessment and treatment, and are therefore not referred to, and under the care of, a medical or surgical consultant. (Please note direct access Audiology services are not offered at the Trust).

5 Context

In order to ensure all patients are seen as efficiently as possible, Trust will use the Referral to Treatment (RTT) target measurement process for monitoring where patients are on their pathway.

This is also how all Hospital Trusts in England report against national access targets. These measurements will be used by the DH to report comparative national median waiting times.

6 Referral to Treatment Consultant-Led Waiting Times Rules Overview

From March 2008 the concept of waiting times for the different stages of treatment (outpatient, diagnostic and elective admission) was replaced with RTT rules.
These rules were revised in June 2010 and are now known as the Referral To Treatment Consultant-Led Waiting Times Rules.

They are concerned with the length of the patient journey from referral to first definitive treatment, rather than measuring the time spent waiting at different stages of the pathway.

The RTT measurement recognises two distinct patient pathways. A non-admitted pathway is one that results in an RTT clock stop that does not require an admission to hospital. An admitted pathway is one that ends in a RTT clock stop for admission for treatment (either day case or inpatient).

6.1 RTT Clock Starts

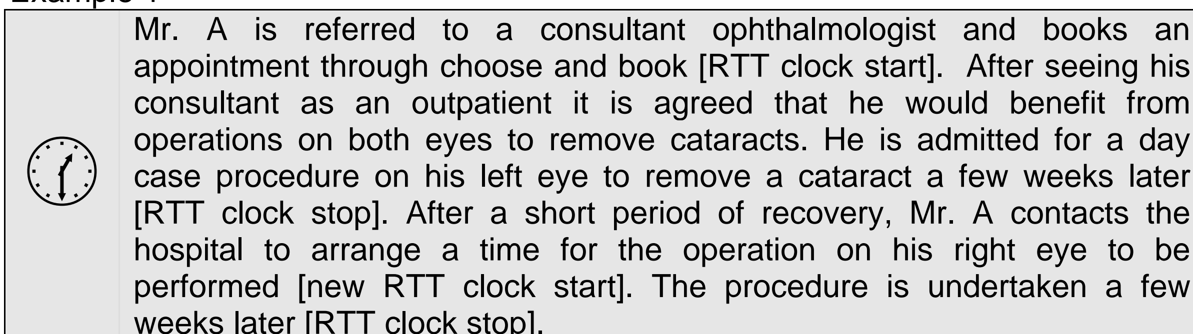
An RTT clock starts when any health professional (or service permitted by an English NHS commissioner to make such referrals) refers to a consultant led service with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner.

The RTT clock start date is the date that the original provider receives the referral. For referrals made through Choose and Book (CAB) the RTT clock starts on the date the patient converts their Unique Booking Reference Number (UBRN).

An RTT pathway can also start upon a self referral by a patient to the above services where this arrangement has been agreed locally by the commissioner and provider, and once the referral has been ratified by a care professional. Upon completion of an RTT pathway a new RTT clock starts:

When a patient becomes fit and ready for the second of a consultant-led bilateral procedure (see section 8.6).

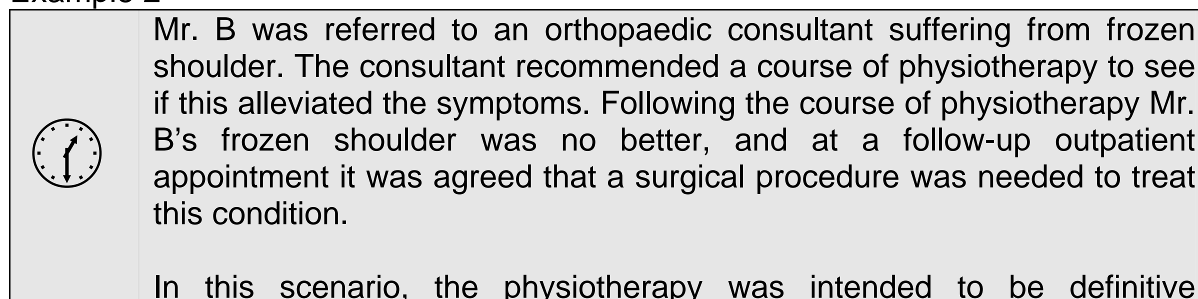
Example 1



Mr. A is referred to a consultant ophthalmologist and books an appointment through choose and book [RTT clock start]. After seeing his consultant as an outpatient it is agreed that he would benefit from operations on both eyes to remove cataracts. He is admitted for a day case procedure on his left eye to remove a cataract a few weeks later [RTT clock stop]. After a short period of recovery, Mr. A contacts the hospital to arrange a time for the operation on his right eye to be performed [new RTT clock start]. The procedure is undertaken a few weeks later [RTT clock stop].

Upon decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.

Example 2



Mr. B was referred to an orthopaedic consultant suffering from frozen shoulder. The consultant recommended a course of physiotherapy to see if this alleviated the symptoms. Following the course of physiotherapy Mr. B's frozen shoulder was no better, and at a follow-up outpatient appointment it was agreed that a surgical procedure was needed to treat this condition.

In this scenario, the physiotherapy was intended to be definitive

	treatment and would have stopped the new RTT clock. Unfortunately the physiotherapy did not relieve Mr. B's symptoms so further intervention was required. When it was agreed that surgery was necessary this would start a new RTT clock which would stop when the patient was admitted to have the surgery carried out.

Upon a patient being re-referred into a consultant-led service as a new referral.

Example 3

	Some time ago, Mrs C was referred by her GP [RTT clock start] to a consultant physician who prescribed a course of medication and provided the GP with a treatment plan for management of her condition in primary care [RTT clock stop]. Recently, Mrs C's condition has worsened and her GP felt it necessary to refer her back to the consultant for further opinion [new RTT clock start]. In this instance, a new RTT clock would start on the date that the provider receives Mrs C's referral.

When a decision to treat is made following a period of active monitoring.

Example 4

	A child in a family at risk of familial breast cancer is referred to the genetics service for pre-symptomatic testing. It is not appropriate to proceed until the child is old enough to consider the implications of having genetic test for themselves as there is no risk until they are an adult [RTT clock stop as active monitoring or alternatively treatment not required]. A new RTT clock will start at the point it becomes appropriate for the service to see the patient, or where a new referral is made by the patient's GP if the patient had been discharged back to the care of their GP.

When a patient rebooks their appointment following a new appointment DNA that stopped and nullified their earlier RTT clock (see section 6.17).

Example 5

	Mr. D was referred by his GP to a consultant rheumatologist, however on the day of his appointment due to unforeseen circumstances he was unable to attend [RTT clock nullified]. The consultant was concerned that if Mr. D was not seen his condition could have significant detrimental consequences so he should be offered another appointment. Mr. D was contacted by the hospital and a further appointment arranged [new RTT clock start on the date that the rebooking of the new appointment takes place].

6.2 RTT Clock Pauses

An RTT clock may be paused only where a decision to admit has been made and the patient has declined at least two reasonable offers of admission. The RTT clock is paused from the date of the earliest reasonable offer, to the date from which the patient makes themselves available again for admission (see section 8.12). RTT clock pauses cannot be applied to patients being admitted for a diagnostic test or procedure.

6.3 RTT Clock Stops for Treatment

An RTT clock stops when first definitive treatment starts. This could be a treatment provided by a consultant led service, or a therapy or healthcare science intervention provided in secondary care, if this is what the consultant led service decides is the best way to manage the patient's disease, injury or condition. Where the treatment requires inpatient or day case admission the clock stops on the day of admission (it does not stop where admission is for diagnostic tests only). A diagnostic procedure that turns into a therapeutic procedure or the fitting of a medical device also stops an RTT clock.

Pain relief administered prior to treatment for the disease, condition or injury for which the patient was referred does not stop the RTT clock unless it is the definitive treatment for the referring complaint.

6.4 RTT Clock Stops for Non-Treatment

An RTT clock stops when it is communicated to the patient and, subsequently, their GP that:

- It is clinically appropriate to return the patient to primary care for any non-consultant led treatment in primary care.
- A clinical decision is made not to treat.
- A patient DNA that results in patient being discharged (see section 6.17 and 8.16).
- Decision is made to add the patient to a transplant waiting list.
- A patient declines treatment having been offered it.
- A decision is made to start on a period of watchful wait / active monitoring.

In all of the cases above, the RTT clock stops on the date that the decision is communicated to the patient.

6.5 Scope of RTT Standard

The RTT standard covers all consultant led secondary care services including consultant led mental health services and therapy services that form part of a consultant led pathway. Referrals to obstetrics are included although pregnancy referrals only start an RTT clock when there is a separate condition or complication requiring medical or surgical consultant led attention.

The RTT target only applies to patients whose care is commissioned by a Primary Care Trust in England, and does include prisoners and PCT commissioned care to in service military personnel.

Tertiary referrals cannot be rejected because of an impending or past RTT breach date.

6.6 Active Monitoring / Watchful Waiting

Active monitoring / watchful waiting is when a patient's condition is being clinically monitored or a treatment plan observed, without further clinical intervention or diagnostic procedures. This can be initiated by the clinician or the patient themselves and in both cases would result in the stopping of an RTT clock. If a decision is made to treat after a period of active monitoring / watchful waiting then a new RTT clock would start.

Where it is decided to start a period of active monitoring or watchful waiting, the clinician must record this as 'Commence watchful waiting / active monitoring' on the clinic outcome form.

7 Low Priority Treatments

Low priority procedures are those that PCTs prefer not to fund or only fund in exceptional circumstances. These procedures tend to be classified either as cosmetic procedures or not cost effective and are normally written into Practice Based Commissioning (PBC) referral protocols. GPs are required to adhere to their PBC referral protocols and it is not for the Trust to check GP adherence to such protocols.

Therefore, a GP referral is authorisation to treat, and where such a referral is received, the procedure will be undertaken as appropriate and the Trust will be remunerated for the service provided.

8 Internal Referrals (Within UCLH)

8.1 Principles

The principal responsibility for commissioning healthcare lies with GPs who have access to all the patient's records, and have the most detailed knowledge of local service availability.

The GP should be kept informed of all management decisions made in secondary care relating to their patients

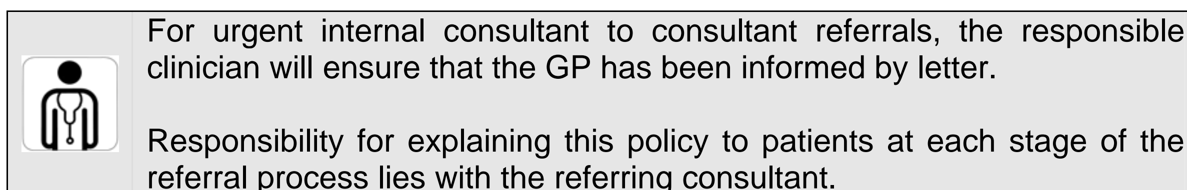
Generally the GP/patient partnership can most satisfactorily decide, at each stage of a patient's journey, the most appropriate service provider

GPs must give written consent for any referrals made between hospital consultants with the exception of urgent situations:

Patient treatment or care should not be delayed or compromised by the need to involve GPs in decisions regarding the appropriate provider for urgent care.

Where an exclusion applies and written consent from the GP is not required for a consultant to consultant referral, then there should still be a record that the GP was informed of the decision to refer.

Responsibility for explaining this policy to patients at each stage of the referral process lies with the referring consultant.



For urgent internal consultant to consultant referrals, the responsible clinician will ensure that the GP has been informed by letter.

Responsibility for explaining this policy to patients at each stage of the referral process lies with the referring consultant.

8.2 Consultant to consultant referrals requiring GP consent

Where a hospital consultant believes a patient would benefit from a non-urgent opinion from a specialist for a condition unrelated to the presenting complaint, this information should be provided to the patient's GP. This will enable the GP and patient to make a decision as to whether the referral is appropriate and to which provider.

This covers:

- Non-urgent referrals for a condition not related to the presenting complaint
- Non-urgent referrals from A&E (see exceptions below)
- All other non-urgent consultant to consultant referrals not covered by the exceptions below.

8.3 Process

Hospital clinicians who believe a non-urgent consultant to consultant referral is appropriate, will explain to the patient that they are writing to the patient's GP advising them of this, and will copy the letter to the patient.

The GP will discuss the recommendation with the patient and refer onwards if deemed appropriate by the GP and the patient. Under 18 week rule definitions this is a new pathway.

If the patient is not registered with a GP they will be advised by the hospital to register with one as soon as possible.

8.4 Exceptions

The following types of referrals between hospital consultants can be made without prior approval from a GP, but the GP should be informed in all instances:

- Referrals classified by the referring consultant as clinically urgent (i.e. required to be seen within two weeks).
- Referrals from A & E to Fracture Clinic
- Referrals from A&E to acute podiatry
- Referrals related to managing the same presenting complaint, which includes:
- Referrals from a generalist to a sub-specialty
- Referrals from medical specialties to surgical specialties
- Referrals for assessment and preparation of suitability of patients for surgery or intervention. This includes thrombophilia screening, cardiac assessment, transplant recipient or donor, hyperglycaemia, haematology, dentistry treatment prior to cardiac surgery, and referrals to cardiology and respiratory medicine from anaesthetic led pre-assessment where assessment and/or stabilisation is required prior to surgery
- Referrals for the management of complications or sequel of ongoing treatment. This includes assessment of drug reactions, referrals for immuno-suppressed patients experiencing complications needing hospital treatment.
- Process

Consultants who believe that one of the exceptions above applies to a clinically appropriate consultant to consultant referral, will refer, and, if the patient is registered with a GP, will ensure that the GP is informed.

Internal referrals by hospital clinicians to which the above exceptions do not apply, or for which there is no evidence of GP prior approval, will be returned to the referring clinician to be forwarded to the GP, and a letter will be sent to the patient by the same referring clinician explaining that the patient should contact their GP regarding their ongoing care.

	For internal consultant to consultant referrals, the RTT clock will start from the original referral received date if the referral is for the same condition. For new or significantly different treatment an onward referral will start a new RTT clock, on the date the referral is received by the receiving organisation.

9 Overseas Visitors

Patients who are identified as overseas visitors must be referred to the Overseas Patients Officer for clarification of status regarding entitlement to NHS treatment before registration takes place (see Overseas Patients Policy).

	Overseas patients entitled to NHS funded treatment and British & Foreign Commonwealth Office funded patients (via International SOS) are not included within the RTT rules.

	Referrals from Scotland, Republic of Ireland and Wales start a new RTT clock on receipt of the referral at the Trust.

10 Outpatient Consultation (Non-admitted Pathway)

10.1 Outpatient Booking Processes

Routine practice will see referrals made to a service rather than a named clinician. This should be stated in communication from the Trust to those organisation / practitioners referring patients to the Trust. This will ensure that there is an equalisation of waiting times. However, in exceptional circumstances, specific specialist requirements may require a referral to a named consultant. Booking systems used at the Trust are:

Choose and Book: The patient is given the choice of place, date and time for their new outpatient appointment in a hospital or clinic. The patient can choose their hospital or service and then book their appointment to see a specialist with a member of the practice team at the GP surgery, later by telephone or over the internet at a time more convenient to them.

	For Choose and Book, the RTT clock starts from the point at which the UBRN (Unique Booking Reference Number) is converted. This may be when the patient books their outpatient appointment in the GP Surgery, over the telephone or via the internet, or failing this being possible, from the date the patient contacts the National Appointments Line.

Partial booking: The patient is able to choose and confirm their appointment in advance.

No patient choice: The patient is given an appointment by the health care provider with no consultation or choice. At the Trust all appointment dates must be agreed with the patient. This method should only be used in exceptional circumstances such as the need to coincide clinical treatments.

Full booking: The patient is able to choose an appointment on the day it is identified as being required. This process is used predominantly for booking of follow-up out patient appointments and some diagnostics at the Trust.

	For referrals from a GP the RTT clock starts when the referral letter is received by the secondary care provider. For tertiary referrals the patient's RTT clock status and breach date must be provided on a Minimum Data Set (MDS) form from the referring hospital. For

	referrals within secondary care that start a new pathway, the RTT clock starts at the point the receiving organisation receives the referral.

10.2 Process for Receipt & Chasing of Inter Provider Transfer Administrative Minimum Data Sets (IPTAMDS)

Inter Provider Transfer Administrative Minimum Data Set (IPT MDS) forms were mandated as a statutory requirement for all patients on an RTT pathway when transferring patients care between acute providers in England, from October 2007 onward. This form contains details of the patient's RTT clock start date and treatment status.

This data set is referred to as MDS throughout this document. Standard practice must be that all referrals to the Trust from secondary providers or from a primary care run interface service must be accompanied by a MDS form. To ensure that the Trust has this information for every referral from other providers, the centralised MDS team within the Trust will follow the escalation process, as below.

Stage 1
For all referrals received each week the MDS team will immediately contact the referring organisation to request the MDS data where not provided with the referral.

Stage 2
Where no MDS form is received within two weeks of initial request the MDS coordinator will lodge the request directly with the MDS coordinator / RTT lead at the appropriate organisation.

Stage 3
Where still no MDS received within three weeks of original request, the start date will be assumed to be the date the referral is received by the Trust with a treatment status of 'definitive treatment plan yet to be agreed'.
If at a later date a response is received, the information can be updated on the online RTT form.

10.3 MDS Forms for referrals from UCLH

A MDS form must be completed with every referral from the Trust to a consultant in a different organisation; this became a Department of Health mandated responsibility for all secondary care organisations in England from 1st October 2007 (DSCN 17/2006). The responsibility for ensuring this MDS is provided with onward referrals lies with medical secretary typing the referral letter onward.

	When a patient is referred onward their RTT status and breach date remain the same. If the referral is for a new condition or significantly different treatment for an existing condition a new RTT clock will start.

	Where a referral is typed for a clinician in a different organisation, a copy of the referral must be sent to the MDS team for production and sending of an MDS form (ucl-tr.18weekMDS@nhs.net), or an MDS form must be produced on the on-line RTT form via Carecast or CDR and sent with the referral letter.

10.4 Escalation for missing MDS data for referrals made onward

Should a receiving organisation find they have not been provided with MDS data by the Trust this will be provided immediately by contacting the Trust MDS team contactable at ucl-tr.18weekMDS@nhs.net.

Should a receiving organisation not receive MDS not when requested the escalation process has been created as follows:

- Trust MDS Team
- MDS Team Manager
- Head of Operations with lead responsibility for RTT standards

Those listed above will ensure this data is provided should a request reach them. The above escalation will be made available to any secondary care provider on request.

10.5 Booking process

The various booking processes implemented across the Trust must be consistent and ensure a high level of care is provided to all patients. The following principles must therefore be adhered to.

10.5.1 Registration

All referrals must be registered on Carecast within 24 hours of receipt. The details from the MDS form for tertiary referrals must be entered onto the on-line RTT form via Clinical Data Repository (CDR) or Carecast within 24 hours.

Due to reduced waiting times the Trust will not acknowledge receipt of referrals to the patient or referring clinician.

10.5.2 Scanning

All letters and accompanying MDS form must be clearly date stamped and scanned into CDR: this must be done within 24 hours of receipt. Scanning of referral letters and the MDS form enables them to be electronically stored and retrieved.

10.5.3 Clinical referral review

Once registered on Carecast, referrals must be reviewed by an appropriate clinician; this must be done within three working days of receipt of referral by the

Trust. Clinical Directorates must have arrangements in place for reviewing referrals to meet the above timescales. After this timescale has elapsed the referral will be considered as accepted, routine and the booking process commenced. Departments managing their own referrals must ensure they adhere to the same three working day timescale and record all activity on Carecast.

Clinical review of referrals within 3 days of receipt.

All appointments should be made via a registered referral on Carecast to enable tracking and management of the patient’s treatment pathway.

As the waiting time for outpatient consultation continues to decrease, less need exists to differentiate between routine and urgent patients. Urgent patients (excluding suspect cancer or rapid access chest pain) are those considered to require an appointment within 4 weeks or less, unless specifically indicated differently by the clinician at the time of review.

After clinical referral review, referrals will be updated on Carecast within one working day.

10.5.4 Patient Contact

Patient contact will be through one of two processes, these being:

By telephone: Within four days of receipt of referral (or earlier where clinically reviewed sooner) the patient will be telephoned. Where contact cannot be made by telephone (after a minimum of two attempts 12 hours apart where possible), a letter will be sent requesting the patient contact the relevant contact booking team within five working days to arrange a suitable appointment.

By letter: Within four days of the referral being received (or earlier where clinically reviewed sooner) a letter will be sent requesting the patient contact the relevant contact booking team within five working days to arrange a suitable appointment.

10.5.5 Partial Booking of Follow-up Appointments

Patients that require follow-up appointments in more than 3 months time will be added to a partial booking waiting list and contacted by letter 4 weeks prior to the time their appointment is required to request them to call to arrange an appointment.

10.6 Patient non-response to Contact Letters

If the patient does not respond to the first invitation letter, after five working days a further attempt to contact the patient by telephone should be made, if this is

unsuccessful a second contact letter will be sent. After five working days one further attempt must be made to contact the patient by telephone.

If unable to contact the patient they will be referred back to their GP / referring practitioner. The patient's referring clinician / GP will be written to outlining the position, the receiving clinician and the patient themselves will be copied to this letter. This must be done by the person or department responsible for booking the appointment.

For partial booking Follow-up appointments, patients that do not respond within 3 weeks of the first contact letter being sent will be sent a second contact letter.
If after two weeks there has still been no response then patients not identified as being at risk will be discharged back to the GP. Patients identified as being at risk will be escalated to the responsible clinician to decide if the patients should be discharged or contacted again.

New Outpatient Appointment

Where it has not been possible to contact the patient the RTT clock is nullified when the patient is discharged. For the purposes of reporting no pathway is deemed to have started. A new clock would start should they be re-referred by their GP.

Where it has not been possible to contact the patient to arrange a new outpatient consultation the referral should be removed from Carecast. This must be done by the person or department responsible for booking for appointment.

Follow-up Outpatient Appointment

Where it has not been possible to contact the patient to arrange a follow-up appointment, the responsible clinician will be informed and decide if patient should be discharged back to the GP.

Where it has not been possible to contact the patient to arrange a follow-up appointment the RTT clock is stopped when the patient is referred back to their GP. A new clock would start should they be re-referred by their GP.

Where it has not been possible to contact the patient to arrange a follow-up appointment an RTT status of 'Decision not to treat' must be recorded on the on-line RTT Form via Carecast or CDR. This must be done by the person or department responsible for booking for appointment.

Partial booking Follow-up Appointment

Where it has not been possible to contact the patient to arrange a partial booking follow-up appointment and the patient is considered to be at risk, the responsible clinician will be informed and decide if the patient is to be discharged back to the GP.

	Where it has not been possible to contact the patient to arrange a partial booking follow-up appointment and the patient is not considered to be at risk, the RTT clock is stopped when the patient is referred back to their GP. A new clock would start should they be re-referred by their GP.

	Where it has not been possible to contact the patient to arrange a partial booking follow-up appointment an RTT status of 'Decision not to treat' must be recorded on the on-line RTT Form via Carecast or CDR. This must be done by the person or department responsible for booking for appointment.

10.7 Reasonable Offer

For an offer to be considered 'reasonable' it is required that patient is offered a date that is at least three weeks from the time of the offer being made. Should a patient accept an appointment earlier than three weeks, this then becomes a reasonable offer. Target patients (suspected cancer / rapid access chest pain) must be offered dates within fourteen calendar days.

Patients who decline one reasonable offer of an appointment date must be offered at least one further reasonable date. This refusal should be recorded on Carecast. Patients should be advised that after declining one date only one further date can be offered.

10.7.1 Patients Declining Two Reasonable Offers

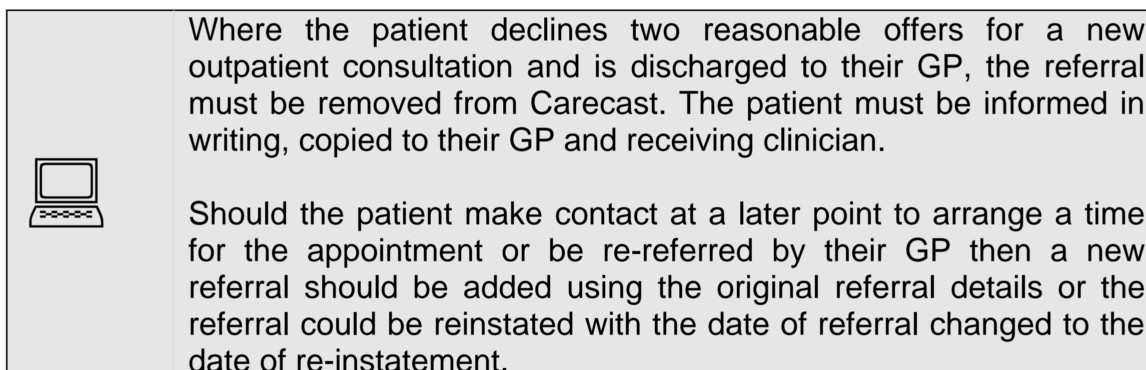
Some patients will turn down reasonable appointments because they prefer, for example, to go on holiday or because of work commitments. Beyond a certain point, a patient initiated delay like this makes it unreasonable or impossible for the Trust to provide treatment within the RTT target. Prior to referral onto an RTT pathway GPs must establish that patients are ready and available to receive treatment within this timeframe where appropriate and the patient has clear expectations of RTT timescales and their own responsibilities within this.

If a patient declines two reasonable offers of a date for either a new or follow-up outpatient consultation they will be discharged to their GP and advised either to return to their GP or to make contact with the hospital directly closer to the time they wish to be seen. This must be confirmed in writing to the patient copied to their GP and receiving clinician, and is the responsibility of the person / department booking the appointment.

New Outpatient Appointment

	Where the patient declines two reasonable offers for a new outpatient consultation and is discharged, the RTT clock is nullified. If the patient is not discharged their RTT clock continues to tick. Should the patient arrange an appointment at a later date or be re-referred by their GP a new RTT clock will start from the date the new referral is received or date when patient makes contact and

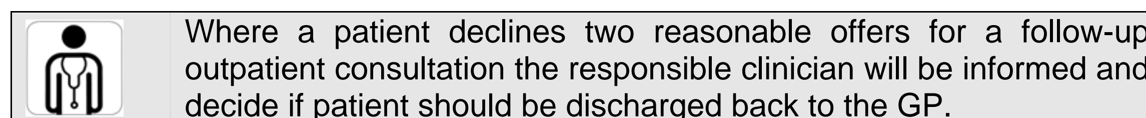
arranges a new appointment.



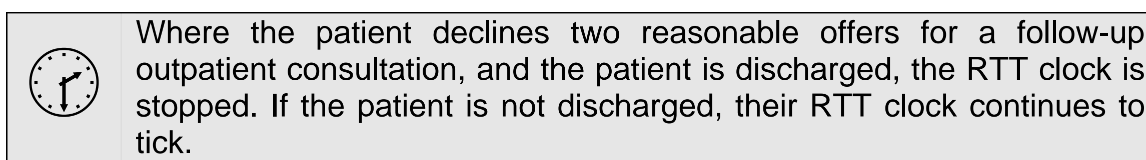
Where the patient declines two reasonable offers for a new outpatient consultation and is discharged to their GP, the referral must be removed from Carecast. The patient must be informed in writing, copied to their GP and receiving clinician.

Should the patient make contact at a later point to arrange a time for the appointment or be re-referred by their GP then a new referral should be added using the original referral details or the referral could be reinstated with the date of referral changed to the date of re-instatement.

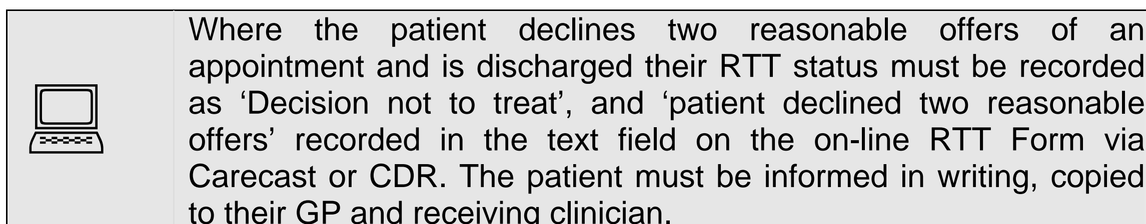
Follow-up Outpatient Appointment



Where a patient declines two reasonable offers for a follow-up outpatient consultation the responsible clinician will be informed and decide if patient should be discharged back to the GP.



Where the patient declines two reasonable offers for a follow-up outpatient consultation, and the patient is discharged, the RTT clock is stopped. If the patient is not discharged, their RTT clock continues to tick.



Where the patient declines two reasonable offers of an appointment and is discharged their RTT status must be recorded as 'Decision not to treat', and 'patient declined two reasonable offers' recorded in the text field on the on-line RTT Form via Carecast or CDR. The patient must be informed in writing, copied to their GP and receiving clinician.

Patients on an outpatient waiting list cannot be suspended or paused.

10.8 Appointment Confirmation

When an appointment is arranged between the hospital and a patient, a letter confirming the appointment date and time must be given or sent to the patient on the same day as part of the appointment booking process.

All patients regardless of their method of booking (including Choose and Book) must be sent a letter confirming the time, date and location of their appointment. Where appropriate additional information required for their appointment, e.g. health questionnaires etc. must also be included at this stage. This must be done by the person / department booking the appointment.

The appointment confirmation letter should contain the following core details:

- Patient's name
- Date letter sent to patient
- Date and time of appointment
- Where to report on arrival at the hospital
- Contact telephone number for queries relating to appointment
- Any response required from the patient
- The importance of attending the appointment or informing hospital if unable to attend
- RTT timescales and likely wait for all stages of treatment

10.9 War Pensioners and Service Personnel

War pensioners and service personnel injured in conflict must receive priority treatment if the condition is directly attributable to injuries sustained in conflict.

10.10 Booking Process for Rapid Access Chest Pain

All patients with new or recent onset of exertional chest pain suggestive of ischaemic heart disease or worsening symptoms in a patient with known ischaemic heart disease who is not under active follow-up by a cardiologist must be seen in outpatients within 14 days of the date of the GP referral.

The chest pain standard is measured from date of GP referral, not time of receipt by provider.

10.11 Booking Process for Cancer

To ensure these 14 day targets are met, the process to be followed for managing the referral, contacting the patient and arranging an appointment are different from those followed for routine referrals; this process is outlined below:

Two week cancer referrals will be received on the dedicated fax machine within the Cancer Service Division and allocated to the relevant department. Referrals to the rapid access chest pain clinics are received on a separate dedicated fax machine.

Referrals must be registered on Carecast and scanned onto CDR within 24 hours of receipt.

The patient must be contacted by telephone within three days of the referral being received to arrange their appointment.

The patient must be offered an appointment date within 14 days of the referral from the GP being received. A booked appointment must be showing on Carecast within five days of the referral being received.

After agreement of appointment on the telephone a confirmation letter should be sent by 1st class mail.

If the patient is not contactable by telephone the GP should be contacted to ensure the correct details are being used and to find out whether the GP has any further telephone numbers for the patient.

If the patient still cannot be contacted by telephone an appointment within 14 days should be made and sent to the patient by 1st class mail. The letter should be copied to the GP.
(See Cancer Network Policy for further information on cancer process).

10.12 Choice of Consultant

After a referral has been graded and a patient has chosen a specific provider or consultant to treat them, it is redundant to make offers to the patient which are with a different consultant or a different provider unless the patient is willing to accept these (or the change of consultant is due to ill health, retirement or is not clinically appropriate).

When it is clear where a patient is willing to be treated by a different consultant or different provider, the normal rules of reasonableness apply.

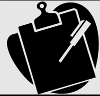
	A patient should not be forced to move to a new consultant, a refusal to do so will not affect the patient's RTT breach date or status.

10.13 Overbooking rules

The over booking of a clinic template needs to be discussed between clinicians and relevant senior manager and agreed. The authoriser's name and contact numbers are to be entered onto Carecast next to the overbooked appointment. Any request to book a follow-up patient into a new slot (or vice versa) must be approved by an appropriate manager.

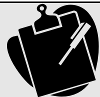
10.14 Clinic Utilisation

The Trust has a target of >85% clinic slot utilisation. In order to achieve this, managers responsible for staff booking outpatient appointments must make sure that the prospective clinic utilisation reports are used. This will make bookers aware of future available slots to target when offering patients appointments. Utilisation reports are available from Information and KPI reports. The responsible member of staff must also monitor the clinic use to see if clinic templates need to be adjusted if utilisation is continually low. Retrospective clinic utilisation reports are available from Information and KPI.

	Managers should ensure they use clinic utilisation reports to keep clinic templates up to date.

10.15 Validation and Monitoring

It is the responsibility of individual Divisional Management Teams to validate and manage their outpatient waiting lists. Any potential or real breach of Trust or national access targets must be reported, in advance, to the responsible Medical Director and the Director of Performance and Partnerships via the appropriate Divisional Manager / Head of Operations.

	Management teams are responsible for validating outpatient waiting lists.

10.16 Monitoring RTT Access Standards

The Trust has a performance management forum, Access and Data Quality group, where operational managers will provide assurance on patients approaching breach of access or RTT targets and escalate as appropriate. This is also covered at Board level by the Executive Board Performance subgroup.

10.17 Hospital Cancellations

The Trust will avoid cancelling outpatient appointments whenever possible as it is both confusing and distressing for patients. Patients must not be cancelled more than once.

In rescheduling cancelled appointments the patient must not be disadvantaged against other patients of equal priority whose referrals were received at a later date. If a cancelled clinic cannot be 'block rebooked' within four weeks of the initial appointment the affected patients must be re-booked individually.

All requests for clinic cancellations must be submitted in accordance with medical and dental staff leave policy giving a minimum of six weeks notice and including the relevant authorisation. Clinic cancellations with fewer than six weeks notice must be approved in writing by the appropriate Divisional Manager or Clinical Director.

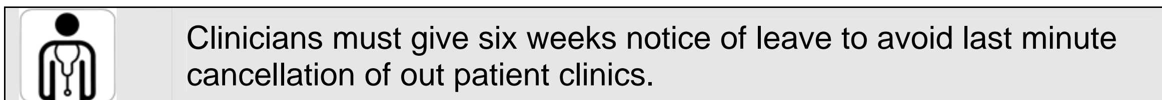
	Requests for clinic cancellations must be submitted in accordance with medical and dental staff leave policy giving a minimum of six weeks notice.

	Hospital cancellations do not affect the patients' RTT clock or breach date.

Departments must be flexible in the use of their capacity in order to reduce the impact on patients. Patients must be given as much notice as possible of all appointment changes. Note must be taken of breach and target patients when cancelling clinics and re-arranging appointment dates.

10.18 Hospital Cancellations – Staff Notice of Leave

Where patient appointments or dates for elective admission are affected all medical, dental and Allied Health Professionals (AHP) must give six weeks notice of leave. Rotas must be completed for all medical and clinical staff at least six weeks in advance to ensure the effectiveness of booking procedures and protocols. Medical staff job plans must be reviewed on a regular basis to ensure that capacity and demand flows are in balance to achieve waiting times as mandated by the Department of Health.



Clinicians must give six weeks notice of leave to avoid last minute cancellation of out patient clinics.

10.19 Patient Reminders

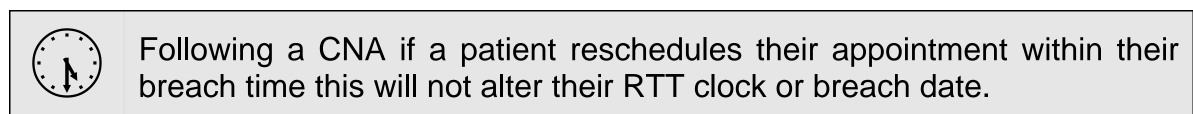
All departments should ensure patients are reminded of their appointment in the week preceding the appointment. Where appointments are managed via Carecast a text message reminder service can be used. Reminder letters will be generated via CDR or patients will be telephoned directly where text message reminders not used, the department booking the appointment is responsible for ensuring appropriate reminders are actioned.

10.20 Patient Cancellations - Cannot Attend (CNA)

All patients have the right to cancel their outpatient appointment because they Cannot Attend (CNA). Patients are able to cancel their outpatient appointment at any time before their agreed appointment time. Patients that give notice of their appointment cancellation, no matter how small, should not be treated as a 'did not attend' (DNA).

10.20.1 CNA – Re-arrange

If a patient wishes to make an alternative appointment after cancelling they must be offered appropriate slots within their breach date.



Following a CNA if a patient reschedules their appointment within their breach time this will not alter their RTT clock or breach date.

The reason for the patient cancellation must be recorded on Carecast as Patient Cancellation.

10.20.2 Consecutive CNA or Unable to Re-arrange Within Breach

If a patient cancels their appointment on more than one occasion (and causes delay to their appointment by more than two weeks) or they are unable to re-book their appointment within their breach date they will be discharged to their GP with an open outpatient appointment. If the patient wishes to re-book they can contact the hospital directly or choose to be re-referred by their GP. A letter will be sent to the patient to confirm this, copied to the GP and receiving clinician. This is the responsibility of the person / department booking the appointment.

New Outpatient Appointment

Where the patient CNA their new appointment and is discharged their RTT clock will be nullified.

Where the patient CNA their new appointment and is discharged an RTT status of 'Decision not to treat' must be recorded on the on-line RTT Form via Carecast or CDR. This is the responsibility of the person or department booking the appointment.

Follow-up Outpatient Appointment

Where a patient CNA their follow-up appointment the responsible clinician will be informed and decide if patient should be discharged back to the GP.

Where the patient CNA their follow-up appointment and is discharged their RTT clock will be stopped.

Where the patient CNA their follow-up appointment and is discharged an RTT status of 'Decision not to treat' must be recorded on the on-line RTT Form via Carecast or CDR.

10.21 Patient Did Not Attend (DNA)

As all patients at the Trust have the opportunity to negotiate the time and date of their appointment, either through Choose and Book or via telephone, then the onus is on the patient to attend the hospital.

The clinician should review the notes of all patients that DNA a clinic appointment. They can then choose from 3 options:

- discharged back to the GP
- discharged back to the GP
- offered a further appointment

10.21.1 DNA – Discharge to GP

All routinely referred patients who DNA their new outpatient appointment (that is the first outpatient consultation in their RTT pathway) will be returned to the care of their GP, unless specifically requested by a responsible clinician to action differently. The recording of the DNA / discharge, and generation of appropriate letters to the patient is the responsibility of the person administering the clinic, usually clinic receptionist or clinic coordinator.

At the end of each clinic, clinicians must review the notes of all patients that DNA and decide if the patient should be:

- discharged back to the GP
- discharged back to the GP offered a further appointment.

They should record their decision on the outpatient clinic outcome form.

New Appointment

For DNA of a new outpatient appointment the RTT Clock is nullified. For the purposes of reporting no pathway is deemed to have started. If the patient is re-referred by their GP a new RTT clock will start when the new referral is received.

On the clinic outcome screen on Carecast, visit type must be recorded as 'DNA', Visit outcome recorded as 'Discharge from care' and Treatment Status recorded as 'decision not to treat'. This must be done by the member of staff administering the clinic, usually a clinic receptionist or clinic coordinator.

Follow-up Appointment

Where a patient is discharged following DNA of follow-up outpatient appointment the RTT Clock is stopped. If the patient is re-referred by their GP a new RTT clock will start when the new referral is received.

On the clinic outcome screen on Carecast, visit type must be recorded as 'DNA', Visit outcome recorded as 'Discharge from care' and Treatment Status recorded as 'decision not to treat'. This must be done by the member of staff administering the clinic, usually a clinic receptionist or clinic coordinator.

10.21.2 DNA – Discharge to GP

In some instances it may be considered clinically appropriate to discharge a patient to their GP. In this instance should the patient wish to arrange a further appointment, they can do so by being re-referred by their GP or by contacting the Trust directly. This will be explained in the letter sent to the patient and their GP.

New Appointment

	For DNA of a new outpatient appointment the RTT Clock is nullified when the patient is discharged. For the purposes of reporting, no pathway is deemed to have started. If the patient is not discharged their RTT clock will continue to tick and be reset to the date new appointment is given for all primary care referrals.

Follow-up Appointment

	For DNA of follow-up outpatient appointment the RTT Clock is stopped when the patient is discharged. If the patient is not discharged their RTT clock status will remain unchanged.

New and Follow-up Appointments

	On the clinic outcome screen on Carecast, visit type must be recorded as 'DNA', Visit outcome recorded as DNA and Treatment Status recorded as 'decision not to treat'. This must be done by the member of staff administering the clinic, usually a clinic receptionist or clinic coordinator.

10.21.3 DNA – Offer further appointment

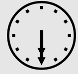
In exceptional circumstances the clinician may wish to highlight a patient as requiring a further outpatient appointment date following a DNA. Clinical priority admissions such as urgent, suspected cancer and paediatric patients can be offered one further appointment for outpatient consultation following initial DNA.
Every effort should be made to contact the patient by telephone to offer another appointment. If unable to contact the patient the GP should be called to confirm the contact details are correct.

New Appointment

	If a patient referred by their GP or another provider on a new pathway, DNAs their new appointment, and is offered another appointment then a new RTT clock starts from the date on which the new appointment was arranged with the patient. For a tertiary referral on an existing RTT pathway (where the RTT clock start date is prior to the secondary referral date) their RTT status and breach date is unaffected by the DNA and their RTT clock continues to

	tick.

Follow-up Appointment

	A DNA does not affect the RTT status or breach date of a follow-up patient if it is decided to offer them another appointment.

New and Follow-up Appointment

	Where a further appointment is to be offered following DNA, on the clinic outcome screen on Carecast, visit type must be recorded as 'DNA', visit outcome recorded as 'Request patient to call and make another appointment' and treatment status recorded as 'definitive treatment plan yet to be agreed'. This must be done by the member of staff administering the clinic, usually a clinic receptionist or clinic coordinator.

10.21.4 DNA – Second Consecutive Appointment

Where a patient DNA a second consecutive appointment date, the Trust will check the patient's telephone number and address with the GP. If the contact details are correct all patients should be discharged at this point. A letter explaining this and the need for re-referral will be sent to the patient, copied to the GP and receiving clinician.

10.21.5 DNA – Suspected Tuberculosis

In the case of suspected tuberculosis continued effort will be made to contact patients that DNA in partnership with health protection agency and North East London TB network (www.nelondontbnetwork.nhs.uk).

10.21.6 DNA – Paediatrics & Vulnerable Adults

In the case of paediatrics and vulnerable adults, the clinician responsible for the care of the patient will review the notes and decide on the most appropriate action to be taken (Refer to the Policy for the Safeguarding of Children in Relation to Administration of Appointments in the case of paediatric patients). If the patient fails to attend a second appointment the clinician should discharge the patient.

If, at any point, the clinician feels the patient's health is being compromised then the patient must be referred to other appropriate authorities. In this case the patient must not be discharged. Where a child is known to Social Services any DNA must be communicated to the appropriate department.

If the patient continues to DNA new appointments following a GP referral or other provider referral that starts a new clock period, and is continually contacted to arrange a further appointment, a new RTT clock is started only after the first rebooking. The start date remains the same for further re-booking of DNA appointments and the RTT clock continues to tick.

For the purposes of this policy, a vulnerable adult is used to refer to a person who is over the age of eighteen, is vulnerable by reason of old age, infirmity or disability (including mental disorder within the meaning of the mental health act 1983) she/he is unable to take care of her/himself, or unable to protect her/himself from others.

10.22 Patients Referred on for Diagnostics

Where patients are referred on to a diagnostic department the responsible clinician must ensure the patient is aware of the timescales for the diagnostic appointment and any possible subsequent outpatient appointment or elective admission and is aware of their responsibilities for attending these appointments.

Ideally they should be informed of the date of both the diagnostic test and follow up appointment at this time.

Patients with a ticking RTT clock referred on for diagnostic must be re-booked for follow-up appointment within six weeks of the test requested date.

10.23 Booking Future Follow-up Appointments

All patients with a ticking RTT clock at the end of an outpatient consultation must have an appropriate plan to ensure they receive definitive treatment within their RTT breach date. Diagnostics tests, follow-up appointments and elective admission where required prior to, or to receive definitive treatment, must be before the RTT breach date.

For patients who do not have a ticking RTT clock, follow-up appointments can be booked as far into the future as clinically required.

In whichever case the patient should be given the date of the future appointment at this time.

10.24 Pre-operative Assessment Clinics

The administrative process for managing pre-operative assessment clinic appointments should be managed in accordance with the standards described for outpatient clinics. However where the administration of pre-operative assessment clinics is linked with booking of dates for admission, or dates for admission are already confirmed, some discretion can be exercised in terms of dealing with patient DNA where a pre-operative assessment appointment can be

re-booked without causing the date for surgery to be cancelled or to be booked after the RTT breach date.

DNA of pre-operative assessment clinic appointment does not affect RTT status or breach date; however where admission date is known and can remain unaffected, discretion can be used in when dealing with patient DNA or non-response to contact letters.

Any patient who DNAs a second consecutive pre-operative assessment appointment should be discharged by the responsible clinician. Any patient who makes contact with the Trust and cannot attend (CNA) a previously agreed date for pre-operative assessment should where possible be given the opportunity to re-arrange. Where re-scheduling a pre-operative assessment appointment will cause delay to a patient's agreed date for surgery this should be made clear. If the patient wishes to delay the date of their surgery a patient initiated pause will be recorded.

If a patient chooses to delay their admission date, they should be paused on the appropriate waiting list for patient choice and a reason of "Patient on Holiday" or "Patient has other commitments" should be recorded on the Carecast.

11 Diagnostics (Non-admitted & Admitted Pathway)

Diagnostic services can form part of the RTT pathway. A 'diagnostic' test is defined as a test or procedure used to identify a person's disease or condition and which allows a medical diagnosis to be made.

A patient's wait for a diagnostic test begins when the request for the diagnostic is made, and ends when the patient undergoes the test.
This is sometimes measured as a national target in its own right and is referred to as 'diagnostic wait'.

The management of patients for diagnostic appointments or admission may differ slightly as outlined in this chapter. Where exceptions are not detailed in this section, the principals of the Patient Access Policy as outlined for administration of outpatient appointments and elective admission apply.

11.1 General Principles

All patients will be seen in order of clinical priority and length of wait.
Patients should able to negotiate their appointment time and date.
Patients will be fully informed of their waiting list status and have a clear point of contact at the Trust.

No patient waiting for a diagnostic outpatient appointment or elective admission will be suspended or paused for any reason.

It is acknowledged some patients require expedited diagnostic tests due to reasons of clinical urgency or RTT breach date, and in such cases the timescales laid out below for booking such appointments are mitigated.

11.2 Referring Clinician Obligations Regarding Patient Expectations

Prior to referral onto Diagnostics, the referring clinician must inform the patient of the likely timescale within which they will receive the required diagnostic(s) and establish that patients are ready and available within this time. The patient must have clear expectations of RTT timescales and their own responsibilities within this.

The referring / responsible consultant will be informed by the appropriate diagnostic department if the patient cannot agree a date within the required timescale, fails to attend an agreed appointment or cannot be contacted. The responsible clinician will take the appropriate action having reviewed the patient's case.

Some services will add a referral to Carecast for the purpose of waiting list management. As this is not a referral for treatment the correct reason for referral should be recorded.

Unless the patient is discharged to their GP their original RTT status and breach date remain the same.

The patient and their GP/ referring clinician must be informed in writing of the responsible consultant's decision.

Where a patient is to be discharged the patient's RTT clock will be stopped, and an RTT status of 'decision not to treat' must be recorded on the on-line RTT form via Carecast or CDR.

Unless local protocol specifically states otherwise, the responsibility of writing to the patient and recording their RTT status lies with the medical secretary or the responsible consultant.

11.3 Direct Access

Direct access diagnostics are those where the GP refers for diagnostic test only and, upon receiving the results, make the decision whether or not to refer the patient on to secondary care.

Direct access diagnostics are not covered by RRT rules as the patient has not yet been referred to secondary care. An RTT clock only commences if the GP has made the decision to refer following the diagnostic procedure, in which case, the RTT clock starts when the referral for treatment is received by the Trust.

Direct access diagnostics are subject to the 'diagnostic wait' target

Where a referral is added to Carecast for a direct access diagnostic, the reason for referral 'Diagnostic only – no transition of care' should be recorded. No RTT waiting time clock will start.

11.4 Subsequent Diagnostics

Subsequent diagnostics are those where a patient already undergoing treatment for their condition may have further diagnostics to both asses and monitor change in their condition, or consider suitability for an alternative treatment.

Should a patient already undergoing treatment for their condition, undergo diagnostics to assess for suitability for alternative treatment, a new RTT clock would start when the decision was made to commence the new treatment, an RTT clock status of 'decision to treat following watchful wait' must be recorded at that point.
These are subject to the 'diagnostic wait' target.

11.5 Surveillance & Planned Appointments

Planned (or surveillance) diagnostics are defined as a diagnostic procedure or series of diagnostic procedures which is required for clinical reasons to be carried out at a specific time or repeated at a particular frequency for example a six monthly check cystoscopy.

Please note the timescales for booking in this section refers to patients attending for a diagnostic test prior to treatment, not patients on a surveillance pathway. Patients requiring a diagnostic test for surveillance or as a specific stage of their pathway pending other intervention or treatment should be recorded as planned. The date arranged with these patients should then be in accordance with the appropriate time as outlined by the clinician whose care they are under.
These appointments are not subject to the 'diagnostic wait' target.

Where a referral is added to Carecast for a surveillance or planned diagnostic, the reason for referral 'Planned check diagnostic' should be recorded, and the referral linked to the relevant specialty if appropriate.

11.6 Patients Attending as an Outpatient

11.7 Registration

All diagnostic requests must be registered on an approved information system (for example Carecast, RIS or TomCat) within one working day of the request being received.

Where a referral is added to Carecast for a diagnostic, the correct reason for referral should be recorded, and the referral linked to the relevant specialty if appropriate.

11.8 Clinical Referral Review

In some departments it is important that referrals are reviewed and prioritised in order to ensure the referral is dealt with correctly i.e. requests for specialist examinations. All referrals received will be forwarded to the individual tasked with responsibility for allocating appointments in the investigation speciality; allocation will be completed within two working days of receipt. Where significant volumes of requests are received from a particular speciality local protocol should be agreed to support this process.

11.9 Inappropriate Referrals

Where an investigation is deemed not to be appropriate the referral will be returned to the responsible consultant with appropriate guidance.

11.10 Patient Contact

Patients must be given a choice of date / time for their appointment and must not be simply given an appointment. In order to arrange the date and time of their appointment, patient contact will be through one of three processes, these being:

- By telephone: Where contact cannot be made by telephone (after a minimum of two attempts 12 hours apart where possible), a letter will be sent requesting the patient contact the relevant booking team within five working days to arrange a suitable appointment.
- By letter: A letter will be sent requesting the patient contact the relevant contact booking team within five working days to arrange a suitable appointment.
- In person, at the diagnostic booking station in outpatient departments at some sites, or in the relevant diagnostic department in line with individual departmental protocol.

11.11 Patient non-response to Contact Letters

If the patient does not respond to the 1st invitation letter, after five working days, one further attempt must be made to contact the patient by telephone. If unable to contact the patient they will be referred back to the referring / responsible consultant for the appropriate action to be taken.

11.12 Reasonable Offer

For appointments for diagnostic investigation, the Trust will offer dates as they become available. Should a patient be unable to accept a date within two weeks, at least one date with at least two weeks notice will be offered.

11.13 Patients Declining Two Reasonable Offers

If a patient declines two dates for a diagnostic appointment within five weeks of the date of the diagnostic request, at least one of the appointment offers being with at least two weeks notice, the referral will be returned to the requesting / responsible consultant.

Where a patient declines dates for a diagnostic test or appointment their RTT clock remains the same.

The responsible clinician will take the appropriate action having reviewed the patient's case. Unless the patient is discharged to their GP their RTT clock will continue to tick.

Patients waiting for a diagnostic appointment or admission cannot be paused or suspended for any reason.

11.14 Appointment Confirmation

When a diagnostic appointment is arranged between the hospital and a patient, a letter confirming the appointment date and time must be sent or handed to the patient immediately as part of the appointment booking process. Where appropriate additional information is required for their appointment, e.g. health questionnaires etc. this must also be included at this stage.

The appointment confirmation letter should contain the following core details:

- Patient's name.
- Date letter sent to patient.
- Date and time of appointment.
- Where to report on arrival at the hospital.
- Contact telephone number for queries relating to appointment.
- Any response required from the patient.
- The importance of attending the appointment or informing hospital if unable to attend.

11.15 Patient Reminders

All diagnostic departments should ensure patients are reminded of their appointment in the week preceding the appointment. Where appointments are held on Carecast or RIS a text message reminder service can be used.

11.16 Hospital Cancellations

In extreme circumstances, for example staff sickness or breakdown of equipment, it may be necessary to cancel a patient's date for a diagnostic test. Such appointments should be re-booked as soon as possible.

Where a patient's diagnostic test is cancelled due to hospital reasons, their RTT status and breach date remain unaffected.

Where the information system used allows, the reason for cancellation should be recorded.

11.17 Patient Cancellations - Cannot Attend (CNA)

A patient may cancel their outpatient appointment because they cannot Attend (CNA). Patients are able to cancel their diagnostic appointment at any time before their agreed appointment time. Patients that give notice of their appointment cancellation, no matter how small, should not be treated as a 'did not attend' (DNA).

11.18 CNA – Re-arrange

Should a patient wish to change their appointment they must be offered an appropriate slot within five weeks of the diagnostic request date.

Following a CNA if a patient reschedules their appointment within their breach time this will not alter their RTT clock or breach date.

Where the information system used allows, the reason for cancellation should be recorded.

If a patient cancels their appointment on more than one occasion or they are unable to re-book their appointment within five weeks of the diagnostic request date, the referral will be returned to the requesting / responsible consultant.

The responsible clinician will take the appropriate action having reviewed the patient's case.

Should a patient cancel their diagnostic appointment on two consecutive occasions and is allowed to re-arrange outside the required timeframe, the RTT clock and breach date remain unchanged unless the patient is being discharged, in which case the RTT clock should stop. The responsible consultant should make the decision to discharge.

When a patient cancels their appointment and does not wish to re-arrange an alternative, a discharge letter should be sent to the patient, copied to their GP and referring / responsible consultant outlining the need for re-referral should the patient wish to be seen again.

Where a patient does not wish to proceed with a diagnostic, the patient's RTT clock must be stopped and an RTT status of 'patient declined treatment' recorded on the on-line RTT form via Carecast or CDR.

11.19 *Patient Did Not Attend (DNA)*

As all patients at the Trust have the opportunity to negotiate the time and date of their appointment, the onus is on the patient to attend the hospital. All routinely referred patients who DNA their diagnostic appointment will be returned to the requesting / responsible consultant.

Where a patient does not attend their diagnostic appointment the RTT clock and breach date remain unchanged.

The clinician responsible for the diagnostic must review the case notes of all patients that DNA and decide if the patient should be:

- returned to the requesting / referring clinician
- offered a further diagnostic appointment.

The responsible clinician will take the appropriate action having reviewed the patient's case. Unless the patient is discharged to their GP their RTT status and breach date remain unchanged. If the patient is discharged, their RTT clock should be stopped. In some cases local arrangement regarding re-booking of DNAs may be desired, providing this can still be done within five weeks of the request being received. This local level agreement is permitted.

11.20 *DNA – Offer further appointment*

In exceptional circumstances the clinician may wish to highlight a patient as requiring a further appointment date. Clinical priority appointments such as

urgent and suspected cancer patients, paediatrics and vulnerable adults can be offered one further appointment for diagnostic test following initial DNA before being returned to their referring / responsible consultant.

Where a patient DNA an appointment for a diagnostic and is re-booked, their RTT breach date and status remain unaffected.

11.21 Results Reporting

Subsequent results reporting must be available in time to allow progress through all likely stages of the RTT pathway. Local arrangement at some sites or with particular clinical services may require subsequent reporting sooner.

The results will be displayed on PAS/PACS or sent in hard copy to the requesting clinician.

Results for tertiary patients will be dispatched in hard copy to the clinician who requested the investigation.

Results for direct access patients will be dispatched in hard copy to the GP who requested the investigation or electronically where direct links exist.

11.22 Patients Admitted For Their Diagnostics

Patients that are added to the waiting list for a diagnostic test must be admitted for this procedure within 6 weeks of it being requested. This request date is the date a decision is made to add the patient to the elective admission waiting list.

Patients waiting for admission for a diagnostic test / procedure cannot be paused or suspended for any reason.

Where a referral is added to Carecast to enable addition to the inpatient or day case waiting list, the correct reason for referral should be chosen and the waiting list entry linked to the appropriate referral.

12 Elective Admission (Admitted Pathway)

This is the final stage of the RTT pathway. On the date of admission for elective treatment the RTT clock stops. The patient should not have waited longer than the RTT target time unless they have chosen to do so.

12.1 Types of Booking Process For Elective Admission

Full booking (Clinician)	At the point the clinician decides to admit the patient they may agree a date for this admission with the patient and record this date in their diary or equivalent.
Full booking (administrative)	The patient is given the opportunity to agree a date at the time of, or within one working day of the Decision To Admit (DTA).
Partial booking	The patient is advised of the total waiting time during the consultation between themselves and the health care provider / practitioner. The patient is able to choose and confirm their admission date at least three weeks in advance.
No patient choice	The patient is given an admission date by the health care provider with no consultation or choice. At the Trust all admission dates must be agreed with the patient. 'No patient choice' or 'date given' systems should only be used in exceptional circumstances such as where two or more consultant surgeons are required.

Some patients may have an RTT clock stop event prior to a decision to admit for intervention. In this case a new RTT clock starts when the Decision to Admit (DTA) was made and communicated to the patient.

12.2 Additions to a Day Case / 23 Hour / Inpatient Waiting List

The decision to admit a patient must be made by a consultant or under an arrangement agreed with the consultant.

Patients who are added to the waiting list must be deemed medically fit, ready, able and willing for admission on the day the decision to admit is made.

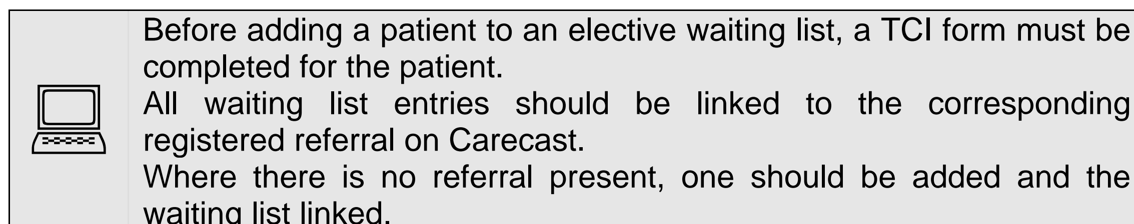
Patients who require a further outpatient consultation or investigation to decide if they require / want the procedure, must not be placed on the waiting list until the consultation is complete and the results received and the patient confirms that they want the procedure.

Patients should not be placed on a waiting list before they are ready for surgery. Patients with slowly deteriorating surgical pathologies should not be placed on a waiting list whilst they 'mature' for operation.

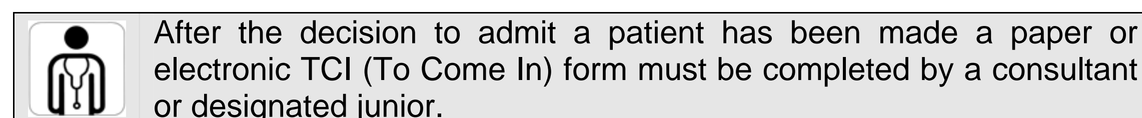
Patients must not be added to an elective waiting list if they need to lose weight, are unfit for the procedure, not ready for the surgical phase of

treatment, there is no serious intention to treat them, if the procedure is not currently available or funded within the Trust or if they are awaiting the funding decision.

At the time of adding to an elective waiting list it is known that the patient is unavailable for a period greater than 12 weeks the responsible consultant must decide whether the patient should be added to the waiting list or put on a watchful wait and clinically reviewed at a later stage before adding to the waiting list. Where it is known at time of listing a patient for surgery they have a period(s) of unavailability this must be recorded on the To Come In (TCI) form.



Before adding a patient to an elective waiting list, a TCI form must be completed for the patient.
All waiting list entries should be linked to the corresponding registered referral on Carecast.
Where there is no referral present, one should be added and the waiting list linked.



After the decision to admit a patient has been made a paper or electronic TCI (To Come In) form must be completed by a consultant or designated junior.

12.3 Managing a Day Case / 23 hour / Inpatient Waiting List

All elective admissions must be booked and admitted through the Carecast waiting list. It is only emergency admissions that are not required to be placed on a waiting list (definition – admit within 24 hours of the decision to admit or admitted from outpatient or via A&E).

All additions to the elective waiting list must be recorded on Carecast within one working day of decision to admit (DTA).

All day case / 23 hour / inpatient waiting lists must be coded with the appropriate intended management and procedure codes. Consultants can refer to British Association of Day Surgery (BADS) or other lists of procedures to ensure the appropriate intended management for that procedure is given.

Due to short waiting times UCLH will not send a separate letter to the patient to inform them they have been added to an elective waiting list.

12.4 Use of Planned Waiting List

Planned waiting list patients are those who are waiting to be admitted to hospital for a further stage in their course of treatment or surgical investigation repeated at a specific frequency. Planned activity is also sometimes called “surveillance” or “follow-up”.

Patients should only be included on planned waiting lists if there are clinical reasons why the patient cannot have the procedure or treatment until a specified time.

Examples include:
- ‘Check / Review’ endoscopic procedures
- Treatment sequences, e.g. skin grafting / second stage breast / plastic reconstruction.
- Patient requiring chemotherapy. - New admission will come through the elective admission list; subsequent admissions should be on the planned list until the chemotherapy regimen has been completed.

Do not add patients to the planned admission list if:
- They will require another procedure but it is unknown when this will occur e.g. bilateral joint replacements will require the new to take place and the patient to become fit again before the second can occur (see section 8.6).
- The second admission is not related to the initial admission.
- The course of treatment is uncertain.

Patients on planned waiting list will have an RTT clock status of ‘treatment already commenced or ongoing’ or ‘watchful wait / active monitoring’.

Patients on planned waiting lists are not included in RTT measurement.

12.5 Age Restriction to Elective Admission

No child under the age of 1 year must be listed for elective surgery under general anaesthetic at the Trust. Children must be kept under outpatient review, and an appointment should be made at the time that the patient is removed from the wait list and only listed when they reach an age when they are ready for surgery or added to a planned waiting list until procedure can be performed.

Should a paediatric patient be added to a planned waiting list until they reach the age of one year, an RTT clock status of ‘commence watchful waiting’ should be recorded at the time of decision to admit (DTA).

12.6 Bilateral procedures

For patients undergoing two separate operations for similar procedures i.e. a procedure that is performed on both sides of the body at matching anatomical sites (for example removal of cataracts from both eyes; or right and left hip replacements), then the initial RTT clock will stop at first definitive treatment for the first procedure. Once the patient is fit and ready for the second procedure

then a new RTT clock should start from the date the decision is made to proceed with the procedure and the patient agreed to start the treatment.

For patients requiring bilateral procedure the RTT clock will stop on the date of admission for their first procedure. A new RTT clock starts on the date the patient is fit and the decision to admit (DTA) for their second procedure has been made.
Patients should only be added to the waiting list for the second treatment once the first has been completed.

12.7 Selecting Patients for Admission

An RTT waiting list report is generated by the Information department and used to select and manage patients on waiting lists. All patients will be chronologically managed according to the RTT breach date, with the exception of clinical priorities.

12.7.1 War Pensioners and Service Personnel

War pensioners and service personnel injured in conflict must receive priority treatment if the condition is directly attributable to injuries sustained in conflict.

12.8 Contacting patients to arrange a date for elective admission

Patients should be contacted by telephone to arrange their admission date within five days of being added to the elective waiting list.

A minimum of two attempts at least 12 hours apart must be made.

Where contact cannot be made by telephone a letter will be sent within 24 hours of the last telephone call requesting the patient contact the relevant administrator within ten working days to arrange a suitable admission date.

For cancer and urgent patients the GP should be contacted, before sending the letter, to check that telephone numbers held for the patient are correct and find out whether any further telephone contact numbers are held by the GP.

This is the responsibility of the person or department booking the patient usually medical secretary or admissions officer.

12.8.1 Patient Non-Response to Contact Letters

If the patient does not respond to the invitation letter after ten working days the patient's GP must be contacted to check that the patient's address and telephone number(s) held on Carecast are correct or whether any additional

contact details are held by the GP. One further attempt must then be made to contact the patient by telephone within 24 hours.

The appropriate consultant must be informed and the patient then removed from the waiting list. Following clinical advice the patient can either be discharged back to their GP/ referring clinician or discharged back to their GP. The patient and GP will be informed in writing. The responsibility for these undertakings lies with the person/department booking the elective admission.

Where a patient does not respond to two attempts at contact, the responsible clinician will decide whether to discharge the patient to the GP, or discharge the patient to the GP.

12.8.2 Discharge to GP

If the patient wishes to be reinstated to the elective waiting list they must be referred back to the Trust by their GP.

Where it has not been possible to contact the patient to arrange a date for elective admission, the patient will be discharged and their RTT clock stopped. A new RTT clock will start should the patient be re-referred by their GP.

Where it has not been possible to contact the patient to arrange a date for elective admission, the patient should be removed from the elective waiting list and an RTT status of 'Decision not to treat' must be recorded on the on-line RTT Form via Carecast or CDR.

12.8.3 Discharge to GP

It may be appropriate to discharge a patient to their GP.

Where it has not been possible to contact the patient to arrange a date for elective admission, the patient will be discharged and their RTT clock stopped. A new RTT clock will start should the patient be re-referred by their GP or make contact with the Trust.

Where it has not been possible to contact the patient to arrange a date for elective admission, the patient should be removed from the elective waiting list and an RTT status of 'Decision not to treat' must be recorded on the on-line RTT Form via Carecast or CDR.

12.9 Reasonable Offer

For an offer to be considered 'reasonable' it is required that a patient is offered a date that is at least three weeks from the time of the offer being made. It is acceptable for patients to be given the opportunity of short notice admission

(i.e. less than three weeks), however, a patient must agree to such an offer and must not be penalised if they decline, i.e. they must still be offered a further two dates with reasonable notice prior to pausing their RTT clock.

Should a patient accept an admission date earlier than three weeks, this then becomes a reasonable offer. For urgent admission the patient will be given as much choice as is consistent with the clinical urgency of the treatment.

12.9.1 Patients Declining Offer Dates

Patients who decline one reasonable offer of an admission date must be offered at least one further reasonable date. This new refusal should be recorded on Carecast. Patients should be advised that after declining one date only one further date can be offered. If a second reasonable offer is declined a clock pause should be considered if the patient is willing to accept a date within twelve weeks (see section 8.12). If they are not, clinical advice must be sought as to:

- offering a longer pause
- clinical review at a later stage with clinician / pre-operative assessment

Where a patient declines two reasonable offers for admission the consultant should decide whether to:

- offer a pause commence watchful waiting and clinically review patient at a later stage.

12.10 Admission Date Confirmation

When a date for admission is arranged between the hospital and the patient, a letter confirming the admission date and time must be sent to the patient immediately as part of the admission booking process.

The letter will explain the consequences of the patient cancelling the admission or failing to attend their pre-admission clinic appointment or admission date and provide a telephone number to contact if they cannot attend or need to re-arrange.

Each division is responsible for reviewing the details of all outgoing letters e.g. telephone numbers on an annual basis; this is the responsibility of each appropriate Divisional Manager.

Patients who have already agreed a date for their admission (booked patients) must also be written to confirming the arrangements for their admission.

The TCI letter should contain the following core details:

- Patient’s name
- Date letter sent to patient
- Date and time of admission

- Where to report on arrival at the hospital
- Contact telephone number for queries relating to admission
- Reference to instructions for admission and / or booklet
- Request to check bed is available on day of admission (if for admission the night before surgery) and reasons for this
- Any specific information about the planned treatment
- Any response required from the patient
- Expected discharge date and need for arrangements to be made for discharge by 11:00 a.m. on the day of discharge
- Reference to the discharge lounge (appropriate sites only)

12.11 Patient Requested Review of Treatment Decision

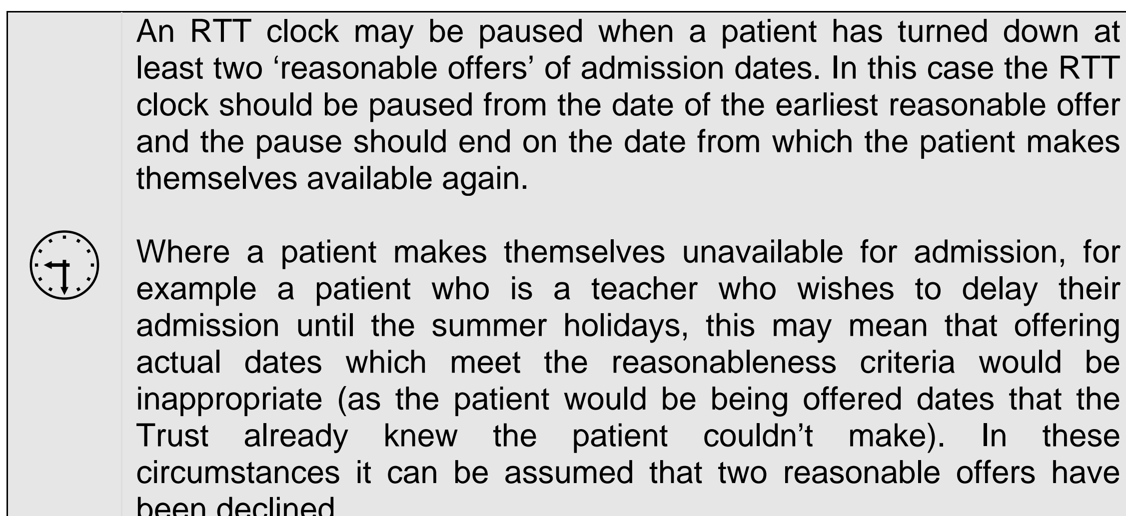
If a patient on an elective waiting list at any time wishes to discuss their intended procedure with the admitting consultant team before proceeding, the patient should be removed from the elective waiting list and booked a convenient follow-up appointment.

Where a patient wishes to discuss their procedure with the admitting consultant team before proceeding to surgery their RTT clock will be stopped and recorded as patient declined treatment. A new RTT clock will start should the patient decide to opt for surgery and is added back to the consultant's waiting list. Where this consultation can be arranged prior to an agreed TCI date, the patient will not be removed from the elective waiting list, and their RTT breach date and status will not be affected.

Where a patient wishes to discuss their procedure with the admitting consultant team before proceeding to surgery the patient must be removed from the elective waiting list and an RTT status of 'Treatment Declined by Patient' must be recorded on the on-line RTT Form via Carecast or CDR. Where this consultation can be arranged prior to the agreed TCI date, the patient will not be removed from the elective waiting list, and their RTT breach date and status will not be affected, unless they decline the treatment at the time of consultation.

12.12 Patient Initiated Delays

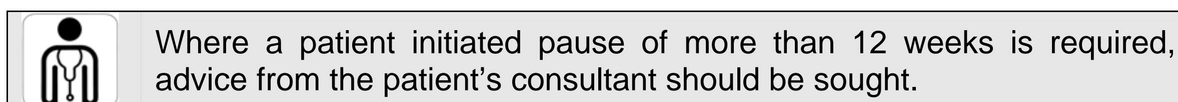
Where a decision to admit has been made as either a day case or inpatient many patients will choose to be admitted at the earliest opportunity. For some patients, however, being seen within the RTT target is personally inconvenient; in this case the patient's RTT clock can be paused.



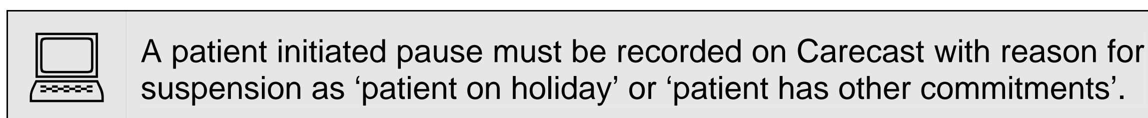
An RTT clock may be paused when a patient has turned down at least two ‘reasonable offers’ of admission dates. In this case the RTT clock should be paused from the date of the earliest reasonable offer and the pause should end on the date from which the patient makes themselves available again.

Where a patient makes themselves unavailable for admission, for example a patient who is a teacher who wishes to delay their admission until the summer holidays, this may mean that offering actual dates which meet the reasonableness criteria would be inappropriate (as the patient would be being offered dates that the Trust already knew the patient couldn’t make). In these circumstances it can be assumed that two reasonable offers have been declined.

A pause of up to 12 weeks either in one period or the sum of more than one period for the same elective admission can be applied without clinical advice. If a patient initiated pause longer than 12 weeks is required, advice must be sought from the responsible consultant. There is no minimum time period for this pausing.



Where a patient initiated pause of more than 12 weeks is required, advice from the patient’s consultant should be sought.



A patient initiated pause must be recorded on Carecast with reason for suspension as ‘patient on holiday’ or ‘patient has other commitments’.

NOTE: Patients cannot be suspended for medical reasons.

12.12.1 Validation of Patients whose RTT clock is ‘Paused’

Operational managers will regularly review patient initiated pauses longer than three months for trends and appropriateness.

The information department will provide adhoc reports for this purpose.

12.13 Patient Reminders

All patients who have been on an elective waiting list for over ten weeks (inclusive of pauses) must be contacted via telephone three weeks prior to their TCI to ascertain that they are still aware of their agreed date and happy to attend. This is the responsibility of the person / department managing the waiting list.

12.14 *Patients that Cannot Attend (CNA) Elective Admission Date*

Patients may find that once they have agreed a TCI date it then becomes inconvenient for personal or social reasons. A patient pause will be added from the date the patient makes contact to the date that they make themselves available for admission, and the TCI date re-arranged as required.

12.15 *Patients Medically Unfit for Treatment*

No patient must be added to the waiting list if they are unfit for their treatment at the time of decision to admit. It is, however, recognised that patients may become unfit or be deemed to be unfit after they have been added to the waiting list. In this event the patient should be removed from the waiting list.

Once on an elective waiting list a patient may be identified as medically unfit at pre-operative assessment clinic, subsequent outpatient follow-up prior to admission, from communication by the patient or their GP or at time of admission for procedure.

	Becoming medically unfit while waiting for an elective procedure does not stop a patient's RTT clock. Short-term periods of unavailability (two weeks or less) must be absorbed into the overall patient waiting time.

12.15.1 Medically Unfit – Discharge to GP

In the event of long-term periods of the patient being medically unfit (over two weeks) the responsible / listing consultant (or anaesthetist, as per local agreement, in the case of pre-operative assessment) can decide to refer the patient back to the care of their GP for management of the condition rendering the patient unfit for the required surgical procedure. The letter back to the GP will state the optimisation required and need for re-referral once resolved. It should be copied to the patient and the responsible consultant surgeon.

	Discharging the patient to their GP / referring clinician stops their RTT clock. A new RTT clock is started if the patient is re-referred back to the consultant for the identified procedure.

	At the time of removing from the waiting list, the patient's RTT status must be recorded as 'decision not to treat' on the on-line RTT Form via Carecast or CDR.

	The responsible consultant should decide whether to discharge the patient back to the GP.

12.15.2 Medically Unfit – Discharge To GP and Refer Onward

The responsible clinician may decide to discharge the patient from their care but refer onward to the appropriate service (within the consultant to consultant referral guidance outlined in this policy page: XX), to the required specialty or advise the patient on action to take.
The patient may be seen again at an appropriate point in the future when a re-assessment can be made and the patient added to the elective waiting list if appropriate. If this action is taken the patient must be removed from the elective waiting list. The referral letter onward will be copied to the patient, their GP and the responsible consultant surgeon.

	Where a patient is discharged and referred onward their RTT clock is stopped. A new RTT clock starts for the surgical procedure when the patient makes contact and is reviewed as being medically fit.

	At the time of removing from the waiting list, the patient's RTT status must be recorded as 'decision not to treat' on the on-line RTT Form via Carecast or CDR. This is the responsibility of the person or department managing the elective waiting list.

	Clinical advice must be taken as to the appropriate timescales for when a patient can be added directly back to the elective waiting list, or may need to be reviewed in pre-assessment or reviewed clinically in outpatients.

NOTE: Patients cannot be suspended for medical reasons.

12.16 Patient DNA Elective Admission Date

As all patients at the Trust have an opportunity to negotiate the time and date of their TCI date as laid out in this policy then the onus is on the patient to attend the hospital.

	The responsible clinician(s) must review the medical notes of the patient; the decision to discharge a patient rests with clinician and will be dependent on the patient's medical needs and personal circumstances. The 3 options available to the clinician are: • Discharge to GP • Discharge • Offer another date

12.16.1 Admission DNA – Discharge to GP

Patients who DNA their TCI date will be discharged to their GP, where clinically appropriate. A letter will be sent to the patient and the GP / referring clinician outlining the need for re-referral.

	Discharge to GP/ referring clinician for a patient who DNA their admission date stops their RTT clock. A new RTT clock would start upon a new GP referral for the patient.

	Following DNA for admission where the patient is to be discharged back to the care of their GP, their waiting list entry must be removed and RTT status of 'decision not to treat' must be recorded on the on-line RTT Form via Carecast or CDR. This is the responsibility of the person or department managing the elective waiting list.

12.16.2 Admission DNA - Discharge to GP

Clinical circumstances may dictate that it may be more appropriate to discharge the patient to their GP.
In this case the patient can make contact directly with the hospital in order to re-start their process of care with the Trust, without the need for being re-referred by their GP. A letter will be sent to the patient's GP and copied to the patient outlining the situation.

	A new RTT clock and decision to admit date would start when the patient made contact to re-arrange a new TCI and was added back the elective waiting list.

	Following DNA where the patient is to be discharged to their GP, their waiting list entry must be removed and RTT status of 'decision not to treat' must be recorded on the on-line RTT Form via Carecast or CDR. This is the responsibility of the person or department managing the elective waiting list.

	Clinical advice must be taken as to the appropriate timescales for when a patient can be added directly back to the elective waiting list, or may need to be reviewed in pre-assessment or reviewed clinically in outpatients.

12.16.3 Admissions DNA – Re-Book

Clinical priority admissions such as urgent and suspected cancer patients can be offered one further admission date after initial DNA.

	For any patient who DNA a date for admission and is not discharged their RTT clock and breach date remain unchanged. Should a second opportunity be given to the patient this must be given within their existing RTT breach date. If when contacted the patient wishes to delay their surgery, a patient initiated pause can only be made from the time of contact following the DNA to the point at which the

	patient makes themselves available for surgery.

12.16.4 Second Consecutive DNA

If the patient DNAs a second TCI date, with approval of the responsible consultant, they will be discharged and returned to the care of their GP / referring clinician. A letter will be sent to the patient's GP and copied to the patient outlining the need for re-referral.

	The patients RTT clock will stop when the patient is discharged back to the GP following a DNA. Should the patient be re-referred to the Trust having been discharged due to DNA, then a new RTT clock will start on the date the GP referral is received.

	Following DNA where the patient is to be discharged back to the care of their GP, their waiting list entry must be removed and an RTT status of 'decision not to treat' must be recorded on the on-line RTT Form via Carecast or CDR.

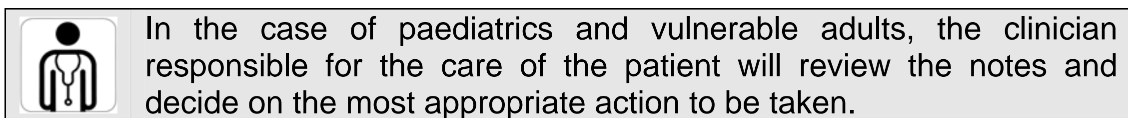
	Care should be taken to identify paediatrics and any vulnerable adults and ensure appropriate action is taken in accordance with Trust policy.

12.16.5 DNA – Paediatrics & Vulnerable Adults

In the case of paediatrics and vulnerable adults, the clinician responsible for the care of the patient will review the notes and decide on the most appropriate action to be taken (Refer to the Policy for the Safeguarding of Children in Relation to Administration of Appointments in the case of paediatric patients).

If the patient fails to attend a second date for admission the clinician should discharge the patient. If, at any point, the clinician feels the patient's health is being compromised then the patient must be referred to other appropriate authorities. In this case the patient must not be discharged. Where a child is known to Social Services any DNA must be communicated to the appropriate department.

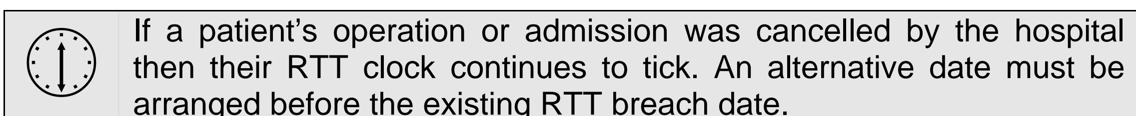
For the purposes of this policy, a vulnerable adult is used to refer to a person who is over the age of eighteen, is vulnerable by reason of old age, infirmity or disability (including mental disorder within the meaning of the mental health act 1983) she/he is unable to take care of her/himself, or unable to protect her/himself from others.

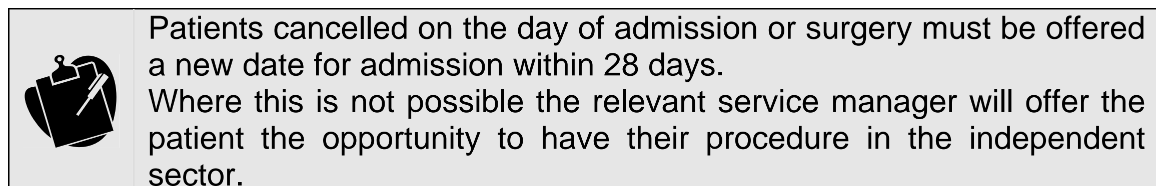

In the case of paediatrics and vulnerable adults, the clinician responsible for the care of the patient will review the notes and decide on the most appropriate action to be taken.

12.17 Hospital Cancellations

Short-notice cancellations of elective patients must be avoided where possible. Ideally, any decision to cancel elective activity should be taken at least one day in advance of the date of admission. Every effort must be made not to cancel patients on the day of surgery as this causes maximum anxiety and inconvenience to our patients.

Following a “last minute cancellation” (on the day of surgery, day of admission or following admission), patients must be re-booked within 28-days of their cancelled appointment, and must be booked within the patient’s RTT breach date. Patients whose surgery is cancelled should be given a re-booked date within their RTT breach date. Ideally patients should be given a re-booked date before they are sent away from the hospital or at the time they are informed of the cancellation while still at home.


If a patient’s operation or admission was cancelled by the hospital then their RTT clock continues to tick. An alternative date must be arranged before the existing RTT breach date.


Patients cancelled on the day of admission or surgery must be offered a new date for admission within 28 days.
Where this is not possible the relevant service manager will offer the patient the opportunity to have their procedure in the independent sector.

Where a patient cannot be re-booked with 28-days following an on the day cancellation by the Trust, they will be entitled to choose to have the procedure in the private sector. The private sector date must also be within both 28-days of cancellation and within their RTT breach date.

Where a patient cannot be booked within 28-days this must be escalated to the relevant Service Manager or equivalent to offer the patient opportunity to have their procedure in the independent sector and arrange where required (See section ‘Transfers between Clinicians & Providers’ of this manual section 12.9).

If, due to unforeseen circumstances, it is necessary to cancel an admission date the relevant admissions team will contact the patient immediately via telephone on a number of occasions during the day, if necessary, also contacting the referrer to obtain correct contact details.

All patients will be offered the next available date for admission and, if not acceptable, up to two further offers of admission date. Patients must be re-booked for their treatment before their RTT breach date.

If a patient cannot be re-booked before their breach date the appropriate Service Manager or equivalent must be informed immediately who will consider and implement additional measures to ensure the patient can be re-dated within the required timeframe.

12.18 Removals Other Than Treatment (ROTT)

Patients may need to be removed from the waiting list before they are treated, for example patients may wish to transfer to the private sector, or decide that they no longer wish to have the procedure.

Where a patient wishes to be removed from the elective waiting list their RTT clock will be stopped.

Where a patient wishes to be removed from the waiting list they should be removed on Carecast. Their RTT clock must be stopped by recording a status of ‘treatment declined by patient’ using the on-line RTT form via Carecast or CDR.

12.19 Transfers between Clinicians & Providers After Decision to Admit (DTA)

12.19.1 Patient Choice of Consultant

Once a patient has chosen a specific consultant to treat them, it is redundant to make offers to the patient to be treated by a different consultant unless the patient is willing to accept these (or the change of consultant is due to ill health, retirement or is not clinically appropriate). When it is clear where a patient is willing to be treated by a different consultant, the normal rules of reasonableness apply and if two or more reasonable offers of treatment with the different consultant/provider chosen by the patient are declined, then the patient's RTT clock can be paused (admitted pathways only). A patient should not be forced to move either to a new consultant or to a different provider.

When a patient is willing to be transferred to an alternative consultant and declines two reasonable offers for admission, their clock can be paused. Where a patient is not willing to be transferred to an alternative consultant this decision will not affect their RTT status or breach date.

Where consultants operate in teams or use ‘pool’ waiting lists, this must be made explicit to the patient at the earliest opportunity.

12.19.2 Transfers between Providers

Transfers to alternative providers for a diagnostic test / opinion or treatment must always be done with the consent of the patient and their Trust consultant. The patient’s waiting time will continue uninterrupted. The patient must not

experience an extended waiting time in their RTT pathway due to the transfer. A completed RTT Minimum Data Set (MDS) proforma must be sent with all inter-provider transfers (see section 6.2.1).

If a patient does not wish to be transferred the original provider must ensure the patient is admitted for treatment within their RTT breach date.

If a patient is transferred to another provider for a diagnostic test / opinion or treatment this will not affect their RTT status or breach date (Maximum waiting times for outpatients, diagnostics and elective admission still apply).

12.19.3 Transfer from the Trust to Private Providers

Where patients are transferred to the private sector by the Trust under the same Trust Hospitals consultant, the patient and the consultant will be notified of the new venue emphasising that the surgeon will remain the same. Where intending to transfer to a Private Provider and a new consultant, this must be made clear to the patient and accepted by the patient before proceeding.
The process of transferring to the private sector will then follow Private Patient Policy 2010 available on ‘insight’.

For patients transferred to the private sector their RTT status and breach date remains the same. For recording purposes the patient remains under the Trust reporting of compliance to the RTT target.

Patients may decide to transfer from the Trust to undergo treatment as a private patient.

For patients that decide to continue their treatment in the private sector their RTT clock will stop when they decide to transfer to be seen privately.

12.19.4 Transfer from the Private Sector to the Trust

Patients transferring into the Trust from the private sector must be referred into the Trust by their GP. A private outpatient who elects to have NHS treatment after an initial private consultation must join the appropriate waiting list at the same point as if their consultation has been under the NHS once their GP referral has been received.

For patients transferred to the Trust from the private sector their RTT clock will start when the Trust receives a referral from their GP.

12.20 Patients Who Choose to Move to a Different NHS Provider

Patients may decide to move their care from the Trust to an alternative provider because for example they wish to have ongoing care provided at a hospital closer to their home or they move house. Once the Trust they will be treated at is identified, a consultant referral and Inter-Provider Transfer form can be sent including details of the patient's RTT pathway at the Trust.

	Patients wishing to transfer their care from the Trust will not have their RTT status or breach date affected, this information on the patient's RTT status and breach date will be transferred to the new provider via a Minimum Data Set (MDS) form.

13 Management Information Reports

13.1 Management Information

Information will be available to the Executive Management Team, Consultants, Divisional Managers, General Managers, and Waiting List Administrators and others on a strictly need to know basis.

Detailed summary information on the waiting list will be circulated weekly. This information will be available electronically via the KPIs and hard copies made available only where appropriate.

13.2 Reports and Frequency

The Information Services or Performance teams will be responsible for providing the following reports which will be generated weekly or as stated.

- Performance scorecard available from 'Insight'
- Trust performance scorecard
- Board scorecard
- RTT scorecard
- Ad-hoc reports will also be available on request from the Performance Department.
- Patient Tracking List (PTL) / waiting list
- RTT reports on Key Performance Indicators (KPI)

13.3 Data Quality Audits

The Data Quality is monitored by the Access Data Quality Group which reports to the Performance Review Group. Audits included in the programme include: Divisions should undertake audit of 5% of activity on a quarterly basis on the following:

- Reasons for removals other than treatment
- Date on Waiting Lists

- Paused Waiting List
- Planned Waiting List

14 Patient Access Policy Review

The Patient Access Policy and accompanying Patient Access Procedure Manual will be reviewed every two years to take account of any changes in national guidance / new directives.

Necessary changes throughout the year will be issued as amendments to the Policy. Such amendments will be clearly identifiable to the section to which they refer and the date issued. They will be clearly communicated through weekly ADQ meetings.

14.1 Training & Communication

All medical and clinical staff must have appropriate training regarding RTT rules and their responsibilities as set out in the Patient Access Policy.

Computer based training modules are available for the following staff groups:

- Patient booking teams/ Contact centres
- Clinic coordinators
- In patient waiting list administrators
- Ward administrators
- Clinicians
- Managers

Email: E18WEEKS@uclh.nhs.uk to request a user name and password.

All staff who use hospital information systems must have training, e.g. Carecast training and be competent before they receive access.

14.2 New starters

As soon as Managers have a starting date for their new member of staff, they need to refer to the IT Training site on the intranet or training administrator for advice when the next courses are. They must prompt the new starter to undertake the ICT Essentials on induction and then book them on to the relevant courses.

14.3 Policy Awareness

All new staff

15. References

Camden Primary Care Trust Partnership Board Commissioning Committee Appendix Di Service Access Criteria
http://www.documentstore.candinet.nhs.uk/store/camden/board/CPCT-PB%20Appendix%20Di%20-%20Effective%20Commissioning%20Initiative%2030_10_06.doc

Camden Primary Care Trust Partnership Board Service Access Criteria Board Decision (restricted treatments and referral managed interventions) January 2007
http://www.documentstore.candinet.nhs.uk/store/camden/board/CPCT-PB%20Service%20Access%20Criteria%20Board%20-%20Jan%202007.doc

Department of health – Getting patients treated; the Waiting List Action Team handbook. August 1999.
DH 18 Week Website – http://www.18weeks.nhs.uk/secure/default.aspx

Department of health - Referral to Treatment Consultant-Led Waiting Times Rules.
June 2010 -
http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ReferraltoTreatmentstatistics/DH_089757

Department of Health, Handbook on the Management of Private Practice in Health Service Hospitals. 1989.

Department of Health policy document "Tackling hospital waiting: the 18 Week patient pathway, an implementation framework "(Gateway reference 6468).

Department of Health – The 18 week Rules Suite, A 'how to' guide to applying national 18 week rules locally. 2008

Department of Health – Your guide to the NHS [Replaces the Patient's Charter] – 2001

Department of Health – The NHS Plan – July 2000

Information Standards Board for Health and Social Care – DSC Notice 07/2008: Data Standards: Inter-Provider Transfer Administrative Minimum Data Set (IPTAMDS).

Information Standards Board for Health and Social Care – DSC Notice 44/2007: Data Standards: Inter-Provider Transfer Administrative Minimum Data Set (IPTAMDS).

Information Standards Board for Health and Social Care – DSC Notice 05/2008: Data Standards: 18 Week Rules Suite

NHS Executive – A step-by-step guide to improving outpatient services. Variations in NHS Outpatient Performance, Project Report ii July 2000

10 High Impact Changes

NHS Executive – EL(97)42 – Access to Secondary Care Services - 1997

NHS Executive – NHS Waiting Times Good Practice Guide – 1996

NHS Executive – EL(95)57 – Transfer of Patients to Shorter Waiting Lists

NHS Information Authority – DSC notice: 20/2001: NHS Plan Booking Systems – June 2001

NHS Information Authority – NHS Data Dictionary – Version 3 – May 2007 http://www.conectingforhealth.nhs.uk/datadictionary/

NHS Modernisation Agency – Ready, Steady, Book: a guide to implementing booked admissions and appointments for patients – 2001.

Royal British Legion, Honour the Covenant; Policy Briefing Healthcare for Veterans.

Royal College of Surgeons of England – Guidelines for the Management of Surgical Waiting Lists – 1991

Appendix 1

16. Cancer Waiting Times.

16.1 National Targets

The cancer waiting times service standards are:

a) Maximum 2 weeks from:

i) Urgent GP/GDP referral for suspected cancer to first hospital assessment Operational Standard of 93%

ii) Referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment –Operational Standard of 93%

b) Maximum 31 days from:

i) Decision to treat to first treatment Operational Standard of 96%

ii) Decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where:.

(1) By where the subsequent treatment is surgery or drug treatment Operational Standard of 94% & 98% respectively.

(2) By where the subsequent treatment is radiotherapy or any other treatment Operational Standard of 94% for radiotherapy

c) Maximum 62 days from:

i) Urgent GP/GDP referral for suspected cancer to first treatment operational standard of 85%

ii) Urgent referral from NHS Cancer Screening Programmes (breast, cervical and bowel) for suspected cancer to first treatment – operational standard of 90%

iii) Consultant upgrade of urgency of a referral to first treatment.

d) Maximum 31 days from urgent GP referral to first treatment for children's cancer, testicular cancer, and acute leukaemia who wait for first treatment: All cancers, should wait no more than 62 Days.