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The Dudley Group
NHS Foundation Trust

PATIENT ACCESS & REFERRAL TO TREATMENT (RTT) POLICY

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The electronic version of this document is the definitive version	

CHANGE HISTORY

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1.0	March 2009	RTT Policy
2.0	October 2013	Updated Document
3.0	June 2015	Updated Document
4.0	Dec 2016	Updated Document
5.0	April 2017	Updated Document
5.1	Nov 2017	Updated Document – New contractual requirements and national guidance.

6	February 2019	This document has had a full review
6.1	November 2019	Updated document – IPT, Consultant to Consultant referrals and section 6.3 updated to reflect new national guidance.
6.2	January 2020	Updated document – DNA rules and Patient initiated Follow Ups
6.3	April 2020	DNA Rules
6.4	August 2020	Was Not Brought Rules
7.0	Feb 2022	This document has had a full review

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

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PATIENT ACCESS REFERRAL TO TREATMENT POLICY

1. INTRODUCTION

The length of time a patient waits for hospital treatment is an important quality issue and is a visible and public indicator of the efficiency of the services provided by the National Health Service (NHS).

The NHS Constitution sets out patients' rights to access services within maximum waiting times and is reiterated in the NHS Operating Framework. This policy describes the way in which this Trust and associated organisations will meet these obligations.
This policy is intended to ensure that all patients are referred and treated in line with national targets.

This policy will focus on the operational standards detailed in section 2, and places responsibilities on all sectors of the local health community (LHC) and is therefore, shared between the Clinical Commissioning Group (CCG/NHS England) (or National Commissioning Board (NHS England) for specialised services), General Practitioners (GPs) and provider Trusts.

All parties accept that patient care in the NHS should be provided in a timely and equitable manner and that they each have responsibilities in order to ensure this. In addition to this policy, each party will have detailed operational procedures describing how this policy will be implemented. This policy and any related procedures will be regularly reviewed to ensure that they deliver a timely, accessible and patient-centered service.

2. STATEMENT OF INTENT/PURPOSE

This policy aims to provide a practical and easy to follow 'guide' for those charged with managing the day-to-day administration and clinical management of outpatient clinics and waiting lists. Although the document cannot predict every eventuality decisions made outside the policy will need to be justified and documented in the patient's notes.

The key national targets relating to patient access are:

- The Referral to Treatment (RTT) Consultant-led Waiting Times (18 weeks) (including Allied Health Profession pathways where applicable)
- Cancer waiting time standards (2 weeks)
- National Service Framework targets (covers the treatment of a number of long-term conditions and stroke care)

2.1. Exceptions

It is noted that not all patients can or should be treated within 18 weeks, they are:

- Clinical Reason/Complexity - Patients for whom it is not clinically appropriate to be treated within 18 weeks
- Patient Choice - Patients who choose to wait longer for one or more elements of their care

The process of managing waiting lists will be transparent to the public and communications with patients will be timely, informative, clear and concise.

Patients will be treated equitably and according to their clinical need. Patients of the same or comparable clinical priority will be treated in chronological order. Patients will only be added to a waiting list if there is a real expectation that they are willing to make themselves available for treatment within the 18 weeks standards. This should also take into account clinical need. Waiting List Prioritisation categories are shown below. These definitions should be used when determining clinical urgency. More information can be found on the NHS England website (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/10/C0760-Clinical-validation-of-surgical-waiting-lists-1-2.pdf

<1 month	P2
<3 months	P3
>3 months Delay 3 months possible	P4
Patient wishes to postpone surgery because of COVID-19 concerns**	P5
Patient wishes to postpone surgery due to non-COVID-19 concerns**	P6

All additions to or removals from waiting lists must be made in accordance with this policy and will take into account clinical need.

The Trust's Patient Administration System (PAS), Community Information PAS, AuditBase (Audiology System) and the Information Department's Data Warehouse must be used to administer all waiting lists. All information relating to patient activity must be recorded accurately and in a timely manner.

3. OVERVIEW OF NATIONAL REFERRAL TO TREATMENT RULES

Summary of the RTT rules aligned with national guidance and cover clock starts, exclusions, new clock starts for the same condition, clock stops for first definitive treatment, clock stops for non-treatment, active monitoring, patient-initiated delays and instances when patients are unfit for treatment.

CLOCK STARTS

The RTT clock starts when any healthcare professional (or service permitted by an English NHS commissioner to make such referrals) refers to a consultant-led service. The RTT clock start date is the date the trust receives the referral. For referrals received through NHS e-Referral, the RTT clock starts the day the patient converts their unique booking reference:

- A referral is received into a consultant-led service, regardless of setting, with the intention that the patient will be assessed and if appropriate, treated before clinical responsibility is transferred back to the referrer.
- A referral is received into an interface or referral management assessment centre which may result in an onward referral to a consultant-led service before clinical responsibility is transferred back to the referrer.
- A patient self-refers into a consultant-led service for pre-agreed services agreed by providers and commissioners.

EXCLUSIONS

A referral to most consultant-led services starts an RTT clock but the following services and types of patients are excluded from RTT:

- Obstetrics and midwifery
- Planned patients
- Referrals to a non-consultant led service (other than Nurse Consultant services)
- Referrals for patients from non-English commissioners
- Genitourinary medicine (GUM) services
- Emergency pathway non-elective follow-up clinic activity

NEW CLOCK STARTS FOR THE SAME CONDITION

Following active monitoring

Some clinical pathways require patients to undergo regular monitoring or review diagnostics as part of an agreed programme of care. These events would not in themselves indicate a decision to treat or a new clock start. If a decision is made to treat after a period of active monitoring/watchful waiting, a new RTT clock would start on the date of decision to treat (DTT).

Following a decision to start a substantively new treatment plan

If a decision is made to start a substantively new or different treatment that does not already form part of that patient's agreed care plan this will start a new RTT pathway clock and the patient shall receive their first definitive treatment within a maximum of 18 weeks from that date.

For second side of a bilateral procedure

A new RTT clock should be started when a patient becomes fit and ready for the second side of a consultant-led bilateral procedure.

CLOCK STOPS FOR FIRST DEFINTIVE TREATMENT

An RTT clock stops when:

- First definitive treatment starts. This could be:
    - Treatment provided by an interface service
    - Treatment provided by a consultant-led service

- Therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions

CLOCK STOPS FOR NON TREATMENT

A waiting-time clock stops when it is communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay 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 did not attend (DNA) which results in the patient being discharged
- A decision is made to start the patient on a period of active monitoring
- A patient declines treatment having been offered it.

4. OUTPATIENT STANDARDS

These standards outline the level of service that is to be expected across the Trust to ensure the quality and consistency of service delivery meets the expectation of our patients and organisation.

- Patients offered choice of appointment date and time via E-Referral and Partial Booking systems unless specific booking rules agreed by directorate teams and Assistant Service Manager for PMC.
- Referrals entered onto the PAS system on day of receipt
- Referrals triaged within six days of receipt
- Appointment slots booked by the Patient Management Centre unless specific booking rules agreed by directorate teams and Service Manager for PMC
- Appointment letters conform to Trust template dispatched by Patient Management Centre unless specific booking rules agreed by directorate teams and Service Manager for PMC
- Patients receive one appointment letter reflecting agreed appointment date and time
- Appointments not cancelled with less than 6 weeks' notice without clinician triage and Directorate Manager authorisation. Where services must cancel appointments at short notice, patients informed as to why by specialty team
- Patients not rescheduled more than once
- Clinic templates and booking rules reflect clinic demand supporting 18 week Referral To Treatment and clinical pathways
- Patients are seen within 30 minutes of their appointment time
- 100% fully completed outcome forms cashed up within two working days
- Correspondence of clinic consultations received by patients GP within 10 calendar days

5. DEFINITIONS

The following definitions are intended to provide clear and unambiguous descriptions of terms used in relation to the RTT pathway. The definitions are listed below in alphabetical order.

Active monitoring:
An RTT clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage. E.g. Patients required to lose weight, give up smoking, patient not sure about procedure offer, monitoring of patient's health prior to procedure taking place.

Ad-hoc appointment:
Where a patient is seen on the ward as a ward attendee or when a patient is admitted under a specialty and is reviewed by another specialty for a separate condition. (Where a patient is seen for an emergency condition, RTT regulations do not apply.) An ad-hoc /walk in should only be used for urgent non-routine, unplanned care and should not be linked to the patient's existing pathway. These types of appointments should be used infrequently and only used in urgent circumstances. Adhocs/walk in should not be used due to lack of capacity within outpatient clinics. Adhocs/walk in's should not be booked in advance activity, only last minute unplanned urgent activity.

Admission:
A patient is admitted for a day case or inpatient procedure.

Allied Health Professional (AHP):
AHPs delivering NHS funded care (either fully or partially funded) in an autonomous or multidisciplinary service making clinically sound decisions about how to apply these rules in a way that is equal and consistent with how patients experience or perceive their wait from referral to treatment.

Bilateral (procedure):
A procedure that is performed on both sides of the body, at matching anatomical sites for example removal of cataracts from both eyes.

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

Clinical Service Lead (CSL):
A designated clinician with leadership and quality assurance responsibilities related to a service or group of services.

Consultant-led:
A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient

care.

Decision to admit:
Where a clinical decision is taken to admit the patient for either a day case or inpatient procedure; the patient will be entered on to the waiting list. When a date is available for the patient to have their procedure(s) the patient is then listed as a planned admission or a TCI (to come in date, see TCI definition).

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

Did Not Attend (DNA):
The definition of a DNA is that the patient arrived too late (more than 15 minutes after appointment time) and could not be seen, or the patient did not attend and no advance warning was given.

Earliest reasonable offer date (EROD):
The earliest date at which a patient could be admitted (regardless of whether they accept or not) and which gives the patient at least 3 weeks' notice. The RTT time may be adjusted to exclude the duration of the time between the EROD and the date from which the patient makes themselves available again for admission, so long as the patient has declined 2 reasonable offer dates.

E-Referral:
Previously called Choose and Book, NHS E-Referral is a national electronic referral service, which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic

First Definitive treatment:
An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. This is a matter for clinical judgment in consultation with others as appropriate, including the patient. For example, inpatient or day-case treatment or a diagnostic that results in treatment, both stop the clock.

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

PMC
Patient Management Centre

Reasonable offer:
A reasonable offer is "an offer of a time and date 3 or more weeks from the time that the offer is made".

If a second reasonable offer is declined, a clock stop should be considered. Clinical advice must be sought to confirm:

- that the delay is not contrary to their best clinical interest.
- the clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected.

If the clinician is satisfied that the proposed delay is appropriate, this should be allowed. A new clock start (of the date the offer was made/accepted) should be recorded on PAS.

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

Substantively new or different treatment:
Upon completion of an RTT period, a new 18-week clock starts when the decision to start a substantively new or different treatment is made. For example, treatment of a more aggressive or intensive nature, which does not already form part of that patient's agreed care plan.

To Come In Date (TCI):
Also referred to as a planned admission, the date a patient is given to come into hospital for their procedure.

Unique Booking Reference Number (UBRN):
The E-Referral Unique Booking Reference Number allocated to a patient on booking of an appointment.

6. DUTIES & RESPONSIBILITIES IN THE APPLICATION OF THIS POLICY

Everyone involved in patient access should have a clear understanding of his or her roles and responsibilities. This policy defines those roles and responsibilities and establishes a number of good practice guidelines to assist staff with the effective management of patients requiring outpatient, diagnostics and inpatient and/or day case treatment. This policy will be applied consistently and without exception across the Trust.
This policy will be available to NHS staff and the general public via the Intranet and Internet. All appropriate DGFT staff will be kept informed of any updates.

6.1. Clinical Commissioning Group or National Commissioning Board for Specialised Services

The achievement of the Consultant-led Waiting Times target is supported by the commissioning processes, which are led by the CCG/NHS England. The development of patient care pathways and the capacity levels required to deliver them is vital to the attainment of the RTT targets. The CCG/NHS England is responsible for ensuring it commissions (directly or through its support of member practices) activity levels that will support the provider's achievement of the required waiting times.

The CCG/NHS England has responsibilities in communicating to its patient population, the importance of their role in the achievement of the targets.

The CCG/NHS England will support General Practitioners (GP) and General Dental Practitioners (GDP) in the development of pathways and procedures that allow them to refer appropriately to other providers.

The CCG/NHS England will support the ongoing development and use of the E-Referral system for making appointments with providers. The CCG/NHS England will work with providers to ensure that the E-Referral system becomes the principal method by which appointments are made.

6.2. General Practitioners & General Dental Practitioners

The responsibilities of GPs and GDPs are both clinical and administrative. They must ensure that all relevant clinical information is provided in the referral to secondary care. They are responsible for ensuring patients demographic details are correct to support the communication process throughout the pathway. They also have a role in emphasizing to the patient, the importance of making and attending appointments.

They are responsible for the clinical decisions prior to referral. They are therefore, required to work with other parties in the local health economy to support pathways that will assist in the achievement of the RTT target. They are responsible for adherence to any care pathways that are agreed by Dudley CCG.

Referrers have a duty to inform secondary care if the patient is a temporary resident or is not eligible for NHS funded care either due to being an Overseas Visitor or Cross Border. These patients should be made known to the Trust. The referrer has a duty to inform the patient if they are unclear if they are eligible for NHS care and that charges may be incurred. The patient should also be reminded to bring their personal documents with them to any appointments in case of interview.

Referrers will not refer patients for possible elective surgical procedures if they know them to be unfit for surgery, or who are not available for surgery, because of personal commitments.

Referrers will not refer patients whose conditions are covered by the Aesthetic procedures guideline & commissioning policy or Procedures of limited clinical priority guideline & commissioning policy where the patient's condition does not satisfy the criteria set out in the policies. GPs wishing to seek a specialist opinion for patients who meet this policy criterion should ensure that when making a referral to secondary care, the basic clinical information is included in the referral letter that assures the patient has been assessed in line with that policy.

Regardless of the mode of referral, it is the responsibility of the referrer to ensure that the referral information contains, as a minimum, the following:

- Full accurate demographic information regarding the patient, including name, address, NHS number, daytime and evening contact telephone numbers
- Communication requirements, disabilities and carer information
- Clinical urgency, the nature of the referral and what is required from the secondary care clinician
- Appropriate history including any diagnostic and other relevant results
- Details of previous treatments, length of time on each treatment and the type of clinic the patient is required to be seen in
- Procedures covered by Aesthetic procedures guideline & commissioning policy or Procedures of limited clinical priority guideline & commissioning policy – referrer must stipulate how the patient's condition meets the criteria set out in the relevant policy

6.3. The Trust

All staff within the Trust will operate this policy on the basis that wherever possible, no patient should have their appointment or admission cancelled and will ensure that it has clear procedures for dealing with circumstances where cancellation by the Trust occurs as outlined in the NHS Constitution.

The Trust will work with Clinical Commissioning Groups to ensure patients are seen and treated by the hospital within the relevant targets.

The Trust will prioritise those patients who have waited over 26 weeks and work with other local providers to identify quicker waiting times where possible. This cohort of patients is managed at patient level via the weekly RTT meeting with Directorate management teams chaired by the Directorate Manager (T&O & RTT).

The Trust will adhere to CCG policies and only treat patients if the patient's condition satisfies the criteria outlined in the respective policies.

The Trust will maintain accurate and up to date electronic records of all patients on the Patient Administration System (PAS), Community Information Patient Administration System (IPM/NCRS*) and AuditBase (Audiology System). Data held should be timely, accurate, and complete and be subject to regular audit and validation.

The Trust will ensure that its appointment systems and processes are robust and easy for patients to understand. The Trust will make every effort to ensure that patients can make changes to or cancel appointments in a direct and straightforward way, thus supporting the patients in their responsibilities.

6.4. Specific Responsibilities

Clinical Service Leads (CSL) has the responsibility for clinically agreed definitions of the services within E-Referral Directory of Services (DoS) and to ensure that clinicians provide at least 6 weeks' notice of planned leave.

Service Manager – PMC is responsible for ensuring that the Hub and E-Referral system accurately reflects the services the Trust provides. They are also responsible for ensuring that clinic booking; rescheduling and cancellation processes are robust, consistent and embedded across the Trust. They are responsible for training clinical staff on the use of the E-Referral system. They are also responsible for liaising with the Head of Information to ensure that any changes to national RTT guidance are reviewed and procedures and training amended accordingly, they are also responsible for liaising with the Patient Access Manager and IT Training Team to ensure the PAS system supports the RTT procedures. is responsible for ensuring all their administration staff attends training and that issues of non-compliance are addressed. They will also regularly review the demand and capacity of the specialties they manage and highlight potential solutions to address issues to the Divisional Manager. They are also responsible for ensuring their
E-Referral Polling ranges are regularly reviewed to allow E-Referral to be effectively used and managed.

Medical and Dental Staff are responsible for triaging all referrals in a timely manner ensuring only appropriate referrals are accepted, recording the correct clinical outcome following an attendance and communicating with patients and GPs about treatment received and action taken within 10 working days.

Nursing and Midwifery Staff (who are responsible for clinical decisions e.g. CNS) are responsible for ensuring only appropriate referrals are accepted, recording the correct clinical outcome following an appointment and communicating with patients and GPs about treatment received and action taken.
The Patient Management Centre is responsible for processing referrals centrally, management of the Trusts Appointment Slot Issues (ASIs) lists and booking/rescheduling patients' appointments. They are also responsible for updating OASIS with patient information, creating new registrations, clinic template creation/management, and removing patients from waiting lists.

Medical Secretaries are responsible for participating in regular RTT training, following the RTT guidelines and ensuring that the PAS system is accurately updated. They are responsible for checking the 18 week status of patients on their consultant's waiting list and highlighting capacity or other issues to the appropriate Directorate Manager. They are responsible for completing and submitting Inter Provider Transfer Forms when patients are reassigned to another service.

Receptionists, Ward Clerks, Inpatient and Day Case Staff are responsible for

checking and amending, if necessary, the patient demographics on PAS when patients attend. For checking a patient's NHS eligibility raising any queries to the Overseas Champions. They are responsible for recording the relevant outcome code in the PAS system for both outpatients and for admitted care. All patients' times must be recorded real time including time arrived seen and the outcome. For admitted care it is the admission time, in charge of care, when they are medically fit for discharge, discharge times and appropriate outcome. All admin staff must have an appreciation of the RTT pathways, how to link/unlink appointments, and how to amend an inaccurate outcome code.

Cancer Services Manager is responsible for managing, monitoring and reporting cancer targets using the national ' Ensuring Better Treatment: Going Further on Cancer Waits' guidance, escalating concerns to achievement to the Divisional Manager.

IT Training Team is responsible for providing training to all admin staff. They will highlight issues of non-attendance or non- compliance with this policy to the relevant Directorate Manager.

Directorate Managers are ultimately responsible for ensuring that their specialties attain the 18 week targets and that actions are implemented to address any discrepancy between demand and capacity. They are responsible and accountable for managing any lack of provision of services and will instruct the PMC how to address conflicts between any demand and capacity.

Head of Information is responsible for producing regular reports to internal and external stakeholders on the Trust's performance against the RTT operational targets.

They are also responsible for:

- Monitoring the use of outcome codes ensuring that there is a consistent approach
- Reviewing and deciding any new outcome codes and ensuring they align to the correct data definitions
- Authorising any amendments to the outcome forms to ensure they meet Trust reporting requirements

All Staff- Security & Confidentiality
All staff engaged in the application of this policy are bound by The Dudley Group NHS Foundation Trust's Confidentiality Policy and the NHS Code of Confidentiality.

6.5. Patients

The following extracts are taken from the NHS Constitution and highlight the rights and pledges made to patients which relate directly to RTT:

Access to health services
You have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of alternative providers if

this is not possible. The waiting times are described in the Handbook to the NHS Constitution.

Patients also have responsibilities under the constitution to contribute to the achievement of the waiting time targets. It states (to patients):

- You should keep appointments, or reschedule within a reasonable time allowing 72 hours' notice. Receiving treatment within the maximum waiting times may be compromised unless you do
- You should provide accurate information about your health, condition and status including any special requirements needed
- You should provide your identification for confirmation of NHS eligibility funded care, or have alternative means to pay. This does not affect any emergency treatment

6.6. Armed Forces Covenant

The Armed Forces Community should enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in the area they live. For serving personnel, including mobilized Reservists; primary healthcare is provided by the MOD, whilst secondary care is provided by the local healthcare provider. For family members, primary healthcare may be provided by the MOD in some cases (e.g. when accompanying Service personnel posted overseas). They should retain their relative position on any NHS waiting list, if moved around the UK due to the Service person being posted.

Veterans receive their healthcare from the NHS and should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need.

6.7. Private Patients

The Trust welcomes private patients and uses the income generated from private patients for the benefit of all patients within the Trust. This policy document also sets the recommended standards for best practice for Trust Consultants and staff about their conduct in relation to private practice. The standards are designed to apply equally to honorary contract holders in respect of their work for the Trust. The regulations concerning private patients are identified in 'Policy and Procedure for the Management of Private Patients accessed via the Trust intranet.

6.8. Overseas Visitors

The National Health Service provides healthcare for people who are **"ordinarily resident"** in the United Kingdom. People who are not "ordinarily resident" in this country are not automatically entitled to use the NHS free of charge – regardless of their nationality or whether they hold a British passport, a NHS medical card or have lived and paid taxes in this country in the past.
The regulations concerning charges to overseas visitors are identified in 'Overseas Visitors Policy' accessed via the Trust intranet.
All New patients must complete an NHS eligibility form, any queries must be directed to the Overseas Champions.

7. REFERRAL MANAGEMENT PROCESS

From the point a patient is referred to secondary care or Community Services or until they receive their first definitive treatment, there are several processes or events that can take place in the clinical pathway. During each of these stages, stakeholders have responsibilities and this section describes what these are and the relevant actions to be taken and by whom.

7.1. Directory of Services –

In order to ensure that GPs refer to the most appropriate service and clinician, the Trust's Directory of Services (DoS) and Community (DoS) will accurately reflect the services provided by the Trust.

7.2. Referrals

Referrals to secondary care and Community Services can be submitted in a variety of ways which include:

- E-Referral
- Exclusions from E-Referrals - Paper Referrals (only accepted by those not E-Referral)
- Consultant to consultant

Dudley Group NHS Foundation Trust no longer accepts paper referrals from GP for Consultant led first acute outpatient appointments. This is part of the 'paper switch off' (PSO) programme and all referrals made should be done via the NHS e-Referral Service (eRS). There is an exclusion list for paper referrals that can be accepted.

Dudley CCG and DGFT have agreed a standard operating procedure in order to ensure the PSO programme is a success across both primary care and secondary care. This should ensure a streamlined process and reduce delays for patients receiving an outpatient appointment from an administrative stance. However, if no appointments are available at Dudley Group at the time of referral, please use "Defer to Provider" and we will accommodate the patients referral as soon as we have capacity. Paper Switch Off SOP outlines the process for the management of rejecting referrals

All staff will ensure that any data created, edited, used, or recorded on DGFT information systems within their area of responsibility is accurate and recorded within DGFT Policy timescale in order to maintain the highest standards of data quality.

The 18 week clock will start at the point at which the clinical responsibility for the patient's care transfers to the NHS. This will be the date when the Trust accepts the referral for the patient.

The date when the patient is assigned an appointment date and converts the Unique Booking Reference Number (UBRN) is the start of the waiting period for E-Referral.

In the event of no slot being available on the E-Referral system, the wait period will commence the date the referral is received via the Defer to Provider process.

7.3 Consultant to Consultant referrals

Internal specialty to specialty referrals will be done electronically and no paper internal referrals will be accepted for an outpatient appointment.
This is in line with the national paper switch off whereby we no longer accept paper GP referrals. Below is the process:

- Preferably, the typed clinic letter with internal referral details should be attached and sent to the relevant Consultant and Consultants Secretary via nhs.net email. Grading of referrals should clearly state whether the referral is routine or urgent.
- If not available, hand written referrals should be scanned in and sent.
- Once graded, send internal referral details and typed clinical letter to dgft.patientmanagementcentre@nhs.net
- All internal to internal referrals sent by email should have a read receipt request and be acknowledged by the recipient.

7.4 Cancer Referrals

All suspected cancer referrals are managed and operational standards monitored appropriately by the Trust Cancer Management Team using the national 'Going Further on Cancer Waits' guidance. All patients referred from their GP with suspected cancer will be seen for their first hospital assessment by a Consultant (or a member of the team) within 14 days of date of receipt of referral in the Trust or Unique Booking Reference Number conversion date.

Where patients reschedule their appointment or do not attend, the Department of Health document - "Cancer Waiting Times Data Collection (version 11" has been referenced to differentiate the approach to urgent (also known as Rapid Access) and non-urgent patients.

Once a decision to treat is made, a patient must be treated within 31days, or the soonest target date if for example the 62 day target is before the 31st day target.

It should be noted that the 31 day cancer pathway clock does not start when the referral is received like the 18 week RTT Clock. The 31 day cancer clock begins from the date of the "decision to treat", which is the date that the patient and consultant agree the treatment plan.

The overall pathway will be reduced to 62 days for cancer patients from receipt of the 2 week wait referral at the Trust to the 1st definitive treatment.

8. Outpatient Appointments (including community based appointments)

Communications with patients should be timely, informative, clear and concise and the process of waiting list management should be transparent to the public.

8.1 Communicating with Patients

It is the Trusts policy to ensure that any queries or questions from patients relating to secondary care treatment are answered, and not referred to the GP to deal

with. This includes communicating the results of investigations and tests carried out at the Trust (except in the case of GP direct access diagnostic services).

8.2 Fit Notes

The Trust will ensure fit notes are issued to patients in a way which is convenient to patients and which is an efficient use of clinician time. Patients should not be expected to obtain a fit note from their GP as a result of treatment or intervention at the Trust.

8.3 Demographics

Patients will have their demographic details checked and updated on the relevant clinical information system including PAS by the clinic receptionist and OBT at every outpatient and inpatient attendance.

8.4 Hospital Reschedules – Outpatient Appointments

It is the Trust's policy to avoid outpatient reschedules wherever possible. The Trust has an agreed leave policy, which states that a minimum of 6 weeks' notice **must** be given by all medical staff in order to minimise disruption to clinics and patient cancellations. Patient appointments should not be rescheduled by the hospital more than once.

8.5 Patient Reschedules – Outpatient Appointments

Patients who reschedule their appointment should be given an alternative date at the time of the reschedule so a suitable date and time can be mutually agreed.

If a patient reschedules twice or more, their case should be reviewed by medical staff to ensure there is no clinical risk in not treating the patient and it is agreed that the patient is not considered to be vulnerable (see Safeguarding Adults at Risk Policy, Child Protection Policy). Where no risk is identified, patients should be discharged back to their GP.

If an adult patient cancels an outpatient appointment, and fails to make an alternative appointment then the patient should be discharged back to their GP (clock stop). The clinical need of the patient should be taken into consideration

In the case of Rapid Access referrals patients – Please refer to Cancer Access Policy.

8.6 Adult Patient Cancellations/Reschedules

Patients who reschedule their appointment should be given an alternative date at the time of the reschedule so a suitable date and time can be mutually agreed.

If a patient reschedules twice or more, their case should be reviewed by medical staff to ensure there is no clinical risk in not treating the patient and it is agreed that the patient is not considered to be vulnerable (see Safeguarding Adults Policy) Where no risk is identified, patients should be discharged back to their GP.

Adult Outpatient Did Not Attends (DNA's) New appointments

All adult patients who DNA their first outpatient appointment will have their records reviewed by an appropriate clinician at the end of clinic to review clinical urgency. If deemed safe to do so; patients will be notified in writing of their missed appointment and offered the choice to 'Opt In' to have a second appointment arranged, without the requirement for another GP referral, it they make contact with the Outpatient Booking Team within 4 weeks of the letter date.
Should the patient not respond to the letter, they will be discharged back to their GP providing that;

- Discharging the patient is not contrary to their best clinical interest.
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure) are protected.

Where the member of staff has increased concern because of other information known to them, they should consider whether further safeguarding action is needed and whether telephone contact is more appropriate. If in doubt they should seek advice from the Safeguarding team within the hospital. Particular consideration should be given for those patients that are known to require support to attend appointments such as those with a learning or physical disability, substance dependence, mental health issues, those living in a care/nursing home or those with capacity issues.

The RTT clock will stop from the date of the DNA.

Adult Outpatient Did Not Attends (DNA's) Follow Up Appointments

If an adult patient DNA's a subsequent appointment and the clinician decides that it is against the clinical interest of the patient to discharge back to their GP, the RTT clock will continue until first definitive treatment.

In the case of Rapid Access referrals – Please refer to the Cancer Access Policy.

Adult Patients with Learning Disabilities

OASIS must always be checked by clinic staff in order to identify if patients are known to have a learning disability. If any patient with an identified learning disability does not attend 2 consecutive appointments a Learning Disability Missed Appointment Notification must be sent to the Learning Disability team at dgft.learning.disabilityteam@nhs.net

Paediatric Patient Cancellations/Reschedules

When an appointment is cancelled or rescheduled the following information should be recorded on PAS by the staff member who has taken the call:-

- Name of person making the request,
- Their relationship to the child,
- Reason for cancellation,

OASIS must be reviewed, and where a safeguarding flag has identified that the child is:-

- Subject to a Child Protection Plan (CPP)
- Looked After Child (LAC)

The responsible clinician's secretary must be advised via email in order that the allocated social worker can be informed of the cancelled appointment as per **Flowchart A**

If an appointment for a paediatric patient is rescheduled, by a parent/carer or the Trust, twice or more, their case should be reviewed by the responsible clinician to ensure there is no clinical risk in not treating/reviewing the patient and it is agreed that the patient is not considered to be vulnerable (see Safeguarding Children Policy). Where no risk is identified, patients should be discharged back to their GP.

Paediatric Cancellations/Reschedules – Diagnostic Appointments

Follow flowchart B for Diagnostic Pathways

Paediatric Was Not Brought (WNB) to New and Follow Up Appointments

An appointment is defined as any arranged contact with the family for attendance at the hospital or for a home visit; this includes appointments made for ward attendance.

Whilst recognizing the parent's right to refuse treatment or attend appointments in respect of their child, it is essential that all staff concerned consider the child's welfare when deciding what actions to take following:-

- A child or young person not being brought to their hospital appointment,
- That parents/carers have failed to make an appointment when notified for follow up
- Inability to make contact for a home visit.

Paediatric 1st WNB

Clinical Risk

Before providing a further appointment:-

The responsible clinician must review the case to decide any potential clinical risk in the child or young person not being brought to this appointment and take action to address this as per **Flowchart A**.

Safeguarding Risk

Before providing a further appointment:-

Staff should also assess for any safeguarding risks by reviewing Oasis. Where a safeguarding flag has identified the child is vulnerable, staff must follow **Flowchart A.** Where a member of staff has increased concern because of other information known to them, they should consider whether further safeguarding action is needed and whether telephone contact is more appropriate. If in doubt they should seek advice from the Safeguarding team within the hospital, in consultation with the Consultant.

If a child or young person is known to be looked after or subject to a child protection plan, the clinic staff must ensure that the allocated social worker is made aware of the WNB episode and any subsequent episodes.

The responsible clinician may inform the GP via letter and a Missed Appointment Notification form must be sent by clinic staff to the Safeguarding Team at dgft.paedsliaison@nhs.net who will review and forward to the appropriate school health advisor or health visitor within one week – please refer to **Flowchart A.**

No Risk identified

No concerns or risks identified then a 2nd appointment can be offered.

A letter must be sent from the responsible clinician, to the patient's GP, to advise them of the WNB episode.

Within paediatric outpatient clinics, the letter must be copied and forwarded to the school health advisor or health visitor, electronically where possible.

In all other hospital clinics the letter should be copied and forwarded electronically to the Safeguarding Team at dgft.paedsliaison@nhs.net who will review and forward to the appropriate Health visitor or School health advisor, within one week.

Paediatric 2nd consecutive WNB

If a child is not brought to 2 consecutive appointments, their medical notes must be reviewed by a clinician to ensure the child's welfare is considered and further action may be taken in accordance with the Safeguarding Children Policy.

Consideration by the responsible clinician must be given to the risk to the child of not being brought for medical review/treatment and whether this constitutes a concern of neglect – please refer to the Safeguarding Children Policy on the Safeguarding Hub Page. All professionals and agencies involved in the child/young person's care such as

social services, safeguarding, health visitors, GP's, should be advised on the decision to discharge.

WNB to Diagnostic Appointments

Staff within diagnostic departments must follow **Flowchart B** when a child is not brought to their appointments

WNB to Immunisation Clinic

Appointments for immunisations will be made in line with the national immunisation programme. This is not a mandatory requirement and parents have the option of not having their children vaccinated. The immunisation nurses must review OASIS and if the child is subject to a Child Protection Plan or is a Looked After Child, they must inform the social worker and GP of the child not being brought to their appointment.

If a child is not brought to an appointment for a BCG vaccination then the immunisation nurses must inform the health visitor, school nurse and GP. If the child is subject to a Child Protection Plan or is a Looked After Child the social worker must also be informed. The immunisation nurses must complete the 'Missed Appointment Notification form' and sent to the Safeguarding Team at dgft.paedsliaison@nhs.net

Video/Telephone Clinics

The same Did not Attend (Adults) and Was Not Brought (Children) processes should be actioned for all video/telephone appointments that are not attended, or where children are not brought.

Safeguarding Children

It is the responsibility of all staff to recognise that a child or young person who is not brought to their appointment may be at risk of harm due to neglect. All staff working in any clinic environment must raise concerns and seek advice if they are concerned for the safety of the child before discharging them from our care.
A monthly report for identifying WNB, rescheduling and cancellations for Children's Outpatient clinics will be sent to the Lead Nurse in Paediatric Outpatient Clinic for review and forwarding of Missed Appointment Notification to the Safeguarding Team. A copy of this report should be sent to the Safeguarding Team at dgft.paedsliaison@nhs.net for assurance purposes. A monthly report for WNB episodes in all other areas of the Trust will be sent to the Safeguarding Team at dgft.paedsliaison@nhs.net for review of compliance in respect of those children with a safeguarding flag on OASIS

0–18 years: Guidance for all doctors
Parental requests for access to child's health information
Where both parents hold parental responsibility for the child, but live separately, both parents are legally entitled to have information shared with them regarding their child's health. *In 0-18 years: guidance for all doctors*, paragraph 55, the GMC states: *"Divorce or separation does not affect parental responsibility and you should allow both parents*

reasonable access to their children's health records."
Parents should request the information in writing to the Consultant in charge of their child's care and provide evidence that they hold parental responsibility. The documents confirming parental responsibility are a birth certificate, marriage certificate, a court document stating parental responsibility or a letter from the parent's solicitor or a child's social worker confirming they retain parental responsibility. A copy of the evidence should be kept in the child's medical records.

Considerations before sharing information

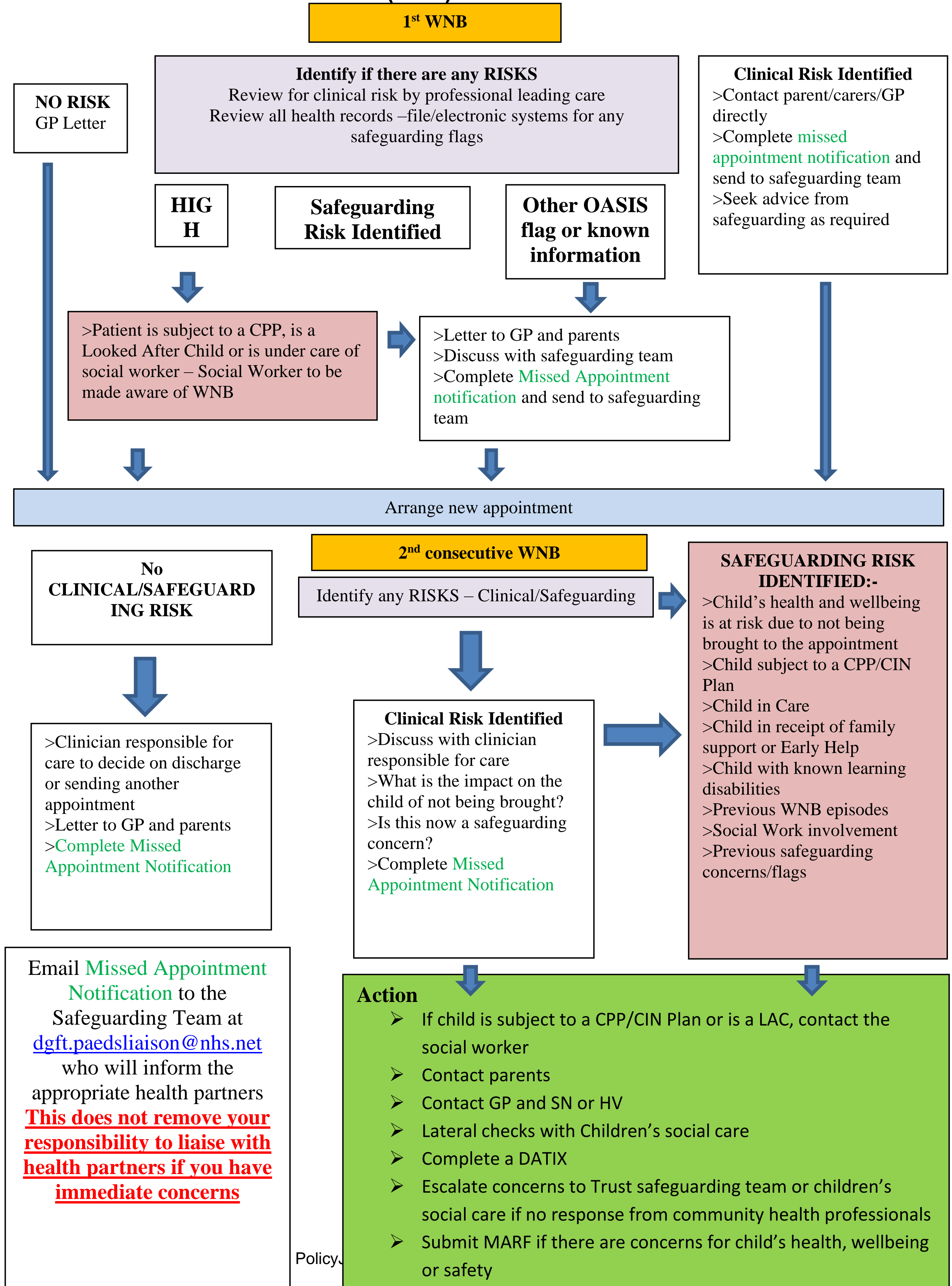
Prior to information being shared, OASIS must be checked to identify if there is a safeguarding alert for the child or young person. If there is a safeguarding alert, or staff are aware of any safeguarding concerns, they should contact the safeguarding team at dgft.safeguardingteam@nhs.net to clarify if it is safe to share this information.

Any information that is shared should only contain information relevant to the child. A senior clinician should review the records/correspondence to be shared and be satisfied that any part or parts of the record that may have potential to cause harm are redacted. This includes any addresses contained within correspondence to either parent.

In some circumstances a parent or parents may have had their parental responsibility revoked through legal proceedings. If staff are made aware that there is a court order preventing information regarding the child's health being shared with the other parent, then they must ask for evidence of the court order and place a copy in the child's medical health records. The staff member should email the Trust safeguarding team at dgft.safeguardingteam@nhs.net to request that an alert is placed on OASIS and Sunrise. If there is difficulty obtaining this evidence, the safeguarding team should be contacted for advice. The information requested should not be shared with the parent and justification for this must be documented in the child's health records.

Care must also be taken when considering sharing information regarding Looked After Children. Where OASIS indicates that the child is looked after, and there is a new request from parent/s for information, staff must contact the social worker for the child before sharing any information with a parent.

PAEDIATRIC WAS NOT BROUGHT (WNB) FLOWCHART A



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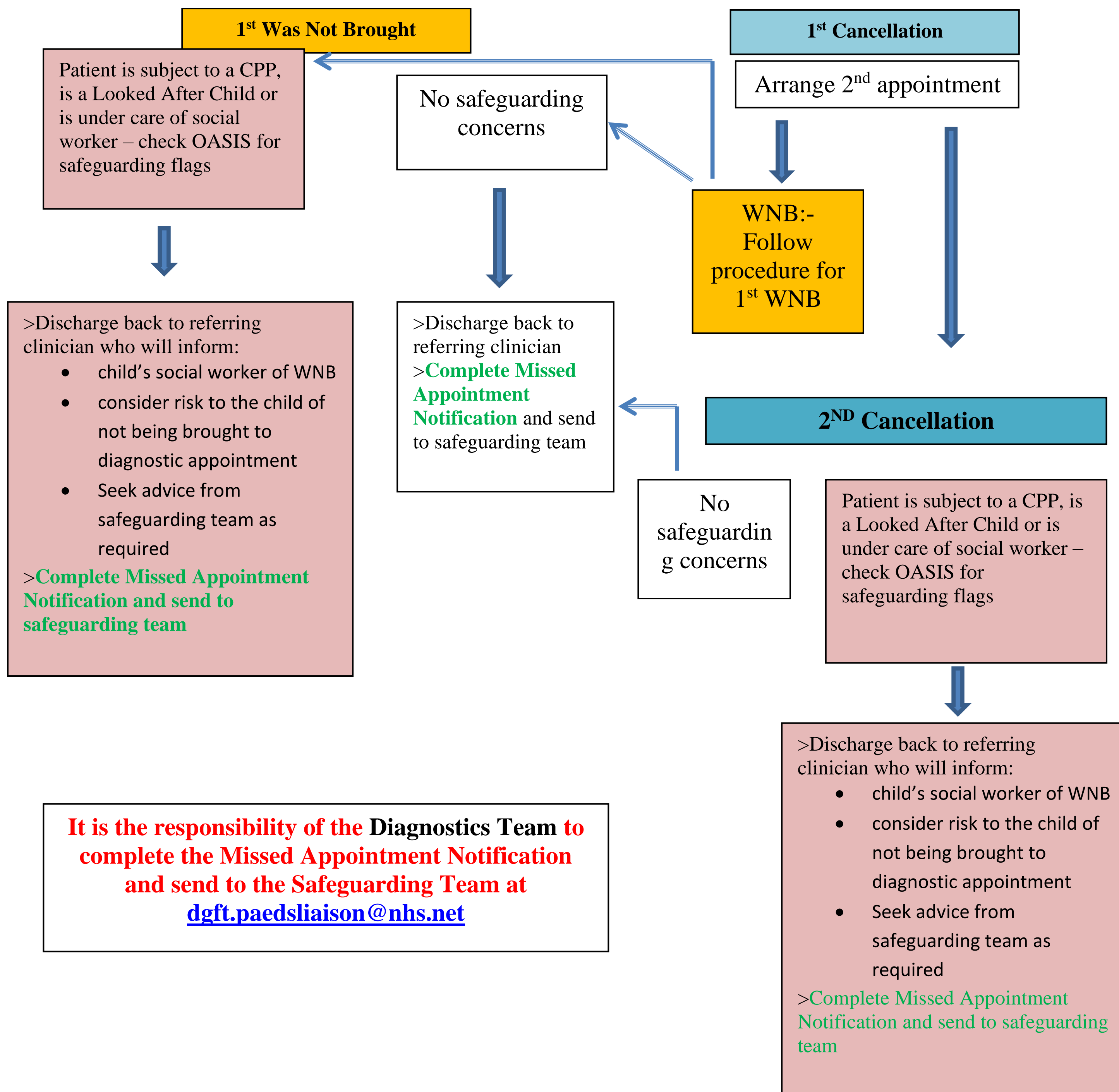
NHS Foundation Trust

PAEDIATRIC WAS NOT BROUGHT (WNB) FLOWCHART B – DIAGNOSTICS



9. Patient Contact/Outcome Forms

Every hospital clinic attendance must have a definitive outcome recorded on PAS within 2 working day. It is the responsibility of the clinician or health care professional who reviewed the patient, to complete the outcome form of each patient appointment on a "Patient Contact/Outcome Form" prior to the departure of the patient or at the end of the clinic in the case of DNAs. For community services, the timescales for recording definitive outcomes within IPM/NCRS is within 5 working days. If a clinic has run over or is a weekend clinic and no administrative support is available the clinic should then be completed (cashed up) the very next working day.

10. Outpatient Clinic Template Changes

Template should be reviewed regularly by the Directorate Management Teams to meet the demand of the service and to ensure the patient has the best patient experience.

Any suggested changes to a template, should include the review and perusal of the patients already "booked" to ensure the patient has not had a hospital reschedule previously, that the 18 week RTT clock will not breach and there is no clinical risk to the patient. The clear instructions should then be given to the Clinic Co-ordination Team.

All changes to clinic templates must be discussed and agreed by the Clinician, Medical Service Head, Divisional Manager for that service or the Head of Community Services, using the agreed proforma. This is particularly important for proposed reductions in "new appointment" slots.
Reductions can only be approved when the provision of patient access times are not compromised as a result of the proposed alterations.
10

11. Inter Provider referrals

Transfers to alternative providers must always be with the knowledge and consent of the patient and the transferring professional.
All inter provider transfers must be undertaken by the relevant medical secretary by completing an Inter Provider Transfer Form (IPTF) (See Appendix 2) in order to ascertain the patients RTT status/pathway commencement date.

The information provided should include:

- RTT ID number
- Organisation code
- RTT start date
- Decision to refer date
- RTT period status
- The clock stop date in the Trust or Community PAS system Cancer referrals between providers must adhere to the cancer treatment targets based on the original referral date.

NHS to NHS inter provider transfers can be made without approval of the GP. This also applies if the patient is an NHS patient being seen in a private setting.

Once the IPT form has been received into Dudley Group, the consultant should grade the referral, it can then be sent electronically to PMC (Via dgft.patientmanagementcentre@nhs.net for booking, clearly stating when the clock start should be if no treatment was given.

12. Private Patient Transfers

Private patients can be transferred into the NHS. If the patient is classed as routine, a letter from the GP is required to state that they are happy for care to be transferred to our Trust. If the patient is classed as clinically urgent, it can be accepted without permission from the GP. Both scenarios (Routine or Urgent) require an IPTF to be completed.

Once a referral has been made, the clock will start from the date the referral has been received into the Trust for treatment within the NHS. Any waiting time within the private sector will not be counted.

11

13. Removals from the Outpatient Waiting list

When a patient is removed from the outpatient waiting list, the free text fields within PAS should record the sequence of events. Patients will be removed when:

- Patients cannot agree a reasonable date for attendance
- Patients cancel and do not wish to rebook
- Advice only, is given by consultant
- The patient "Does Not Attend" and the clinician indicates they should be discharged back to their GP

14. Patients Returning to the Trust Post Treatment

When a patient is discharged from outpatient care any future outpatient attendance within the same Trust, specialty and consultant/nurse led clinic is classified as a first attendance and a new referral pathway followed. This is applicable for patient initiated follow ups.

Patients can initiate follow ups under the same specialty, for the same condition up to a maximum of 18 months following on from their discharge from outpatient care. Anything exceeding 18 months, will need a new GP referral.

Please note that if your service has a contract for 'self-referral' then the referral taker should complete a self-referral form and submit as a new patient referral for processing by the Trusts Patient Management Centre

15. IMAGING and DIAGNOSTICS

16.1 General Principles

- The target waiting time for Rapid Access referrals is 2 weeks
- The target waiting time for routine imaging and diagnostic referrals is 6 weeks

16.2 Booking Appointments

All patients will be offered appointments within the current guidelines for patient choice, unless the patient specifically chooses to wait outside the standard.

- Patients are sent a letter with a specified appointment date and time and are asked to contact the imaging department by phone to change the appointment if it is not convenient.
- Patients will be given 7 days' notice of their appointment date if notified by post.

16.3 Reschedules (Could not attend, Reschedules) Patient Initiated

Patients who reschedule their appointment should be given an alternative date at the time of the reschedule so a suitable date and time mutually agreed.

If a patient reschedules twice or more, their case should be reviewed by medical staff to ensure there is no clinical risk in not treating the patient and it is agreed that the patient is not considered to be vulnerable (see Safeguarding Adults at Risk Policy, Child Protection Policy). Where no risk is identified, patients should be discharged back to their GP.

16.4 Did Not Attends (DNAs) – When a patient does not attend for their Radiology appointment the requesting clinician would then be required to review the diagnostic request with a view to discharging or re requesting the diagnostic. We would only discharge the patient providing that:

- Discharging the patient is not contrary to their best clinical interest
- The clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected.

For Rapid Access Patients who DNA their diagnostic appointments – Please refer to the Cancer Access Policy
12

16.5 Active Monitoring

Active monitoring is where a decision is made that the patient does not require any form of treatment currently should be monitored in secondary care. When a decision to begin a period of active monitoring is made and communicated with the patient, the RTT clock stops. Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made.

It is not appropriate to stop a clock for a period of active monitoring if some form of diagnostic or clinical intervention is required in a couple of days' time, but it is appropriate if a longer period of active monitoring is required before further action is needed. Stopping a patient's clock for a period of active monitoring requires careful consideration case by case and needs to be consistent with the patient's perception of their wait.

Patients who do not require active monitoring in secondary care should be discharged back to the care of their GP.

17 ELECTIVE ADMISSIONS

17.1 Reasonable Offer

A reasonable offer is "an offer of a time and date 3 or more weeks from the time that the offer is made".

If a second reasonable offer is declined, a clock stop should be considered if the patient is unwilling to accept a date within six weeks or before their 18 week RTT breach date. If they are not, clinical advice must be sought to confirm that:

- the delay is not contrary to their best clinical interest.
- the clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected.

17.2 General Principles

- Patients who are added to the elective wait list must be clinically and socially ready for admission on the day the decision to admit is made
- Urgent patients will be clinically prioritised.
- Routine patients will be treated in chronological order based on their RTT breach date.
- Patients will have a clear point of contact at the Trust, which should be the secretary of the appropriate consultant.
- On the date that a patient is added to the waiting list, he or she must be clinically fit for admission and willing to proceed. Patients who are not fit, ready and able to come in should be discharged back to their GP for ongoing care. The GP should be advised to re-refer the patient when they are fit and ready to undergo the procedure and the patient will either be given an outpatient appointment, pre-admission assessment appointment or date for admission as appropriate.
- Patients who are medically not fit for treatment should be managed dependent on the nature of their condition as below:
- Acute conditions – where the patients optimisation is resolvable via an individual management plan agreed with the acute clinician, the RTT pathway clock continues and the patient will be listed for their procedure.
- ii) Chronic conditions – where the patient requires referral back to the GP for optimisation that will likely take longer than available dates for admission (i.e. hypertension, BMI), the RTT pathway clock will be stopped and they will not be listed for their procedure. Once optimised the patient should be re-referred and start a new RTT pathway at the clinically appropriate point, i.e. pre-op assessment. d) The decision to proceed with these types of patients lies entirely with the consultant anaesthetist / consultant surgeon who following a review will make a decision whether to proceed.

17.3 Patient Requested Delay and Reschedules

Patients may wish to spend time thinking about the recommended treatment options before confirming they would like to proceed. It would not be appropriate to stop their RTT clock where this thinking time amounts to only a few days or weeks (< 3 weeks). Patients should be asked to make contact within an agreed period with their decision.
It may be appropriate for the patient to be entered into active monitoring (and the
RTT clock stopped) where they state they do not anticipate deciding for a matter of months. This decision can only be made by a clinician and on an individual patient basis with their best clinical interests in mind.
In this scenario, a follow-up appointment must be arranged around the time the patient would be able to decide.
A new RTT clock should start from the date of the decision to admit if the patient decides to proceed with surgery.

17.4 Adding Patients to Waiting Lists

It is the consultant's responsibility to notify the medical secretary of any patients requiring addition to the waiting list by immediately completing the Waiting List proforma, compiling the letter, or ringing the secretary on the day of the decision to admit.

17.5 Pre Assessment

All patients requiring elective intervention if appropriate should be subject to pre-operative triage or attend a pre-assessment appointment to avoid any unnecessary theatre and ward cancellations. Patients who cancel their pre-assessment appointment should be given an alternative date at the time of the cancellation.

17.6 Elective Planned Waiting Lists

Planned waiting list patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or surgical investigation at a specific point. They will not be classified as being on an 'active' waiting list and are not included in waiting times of the 18 week RTT target. Examples include:

- "Surveillance" endoscopic procedures
- Age/growth surgery
- Investigation/treatment sequences

13

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

15

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

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

17.7 Hospital Cancellation

No patient should have his or her planned/elective admission cancelled for a non-clinical reason. However, this may occur in exceptional circumstances. Where a patient's admission date is cancelled by the hospital in advance, contact will be made with the patient and an explanation given as to the reason for the cancellation (clock continues). A new date will be provided as soon as possible.

In the event that the Trust has to cancel a patient's elective procedure on the **day of admission or day of surgery,** the patient must be offered another TCI date within their RTT breach date and within 28 days of the cancelled operation date, whichever is sooner. If the new date is not convenient to the patient, they can choose to be treated after the 28 days. The patient must be informed of this and the waiting list comments field updated to reflect their decision. The next available and convenient date for the patient is to be agreed and confirmed.

17.8 Patient Cancellation

Patients who cancel their appointment should be given an alternative date at the time of the cancellation.
Patients who cancel their admission for non-medical reasons should be given an alternative date at the time of the cancellation.
If a patient cancels an admission date on two or more consecutive occasions, their case should be reviewed by medical staff to ensure there is no clinical risk in not treating the patient and it is agreed that the patient is not considered to be vulnerable (see Safeguarding Adults at Risk policy, Child Protection Policy).

A clock stop should be considered once clinical advice is sought to confirm that:

- the delay is not contrary to their best clinical interest.
- the clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected.

17.9 Patient Did Not Attend

Providing that the admission appointment was clearly communicated to the patient and complied with 'reasonable notice', following consultant review of the clinical pathway the patient should be referred back to their GP, unless this is against the clinical interests of the patient.

Patient Unfit for Treatment

Patients who are unable to accept a date for treatment due to long term ill health will be removed from the waiting list and either monitored by consultant in charge or referred to the care of their GP.

<u>Patients who are unfit for surgery</u>

If the patient is identified as unfit for the procedure, the nature and duration of the clinical issue should be ascertained.

Short-term illnesses: If the clinical issue is short-term (< 3 weeks) and has no impact on the original clinical decision to undertake the procedure (e.g., cough, cold), the RTT clock continues.

Longer term illnesses: If the clinical issue is more serious and the patient requires optimisation and/ treatment for it, clinicians should indicate to administration staff:

- o if it is clinically appropriate for the patient to be removed from the waiting list. (This will be a clock stop event via the application of active monitoring.)
- o if the patient should be optimised/treated within secondary care (active monitoring clock stop) or if they should be discharged back to the care of their GP (clock stop).

18 TRAINING AND SUPPORT

All staff involved in the implementation of this policy, clinical, administrative, and clerical will undertake initial training and regular updating. Appropriate training programmes will support staff with special regard given to newly recruited staff and bank staff.

19 QUALITY ASSURANCE

In order to establish that the policy and procedures are appropriately carried out and reflect current standards, an audit of the processes will be undertaken on a yearly basis as one of performance monitoring compliance (see section 7). Waiting lists will also be subject to rolling validation programmes according to current best practice.

20 PROCESS FOR MONITORING COMPLIANCE

The table in **Appendix 1** sets out the monitoring details.

21 EQUALITY IMPACT ASSESSMENT

The Dudley Group NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been assessed appropriately.

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APPENDIX 1 – COMPLIANCE MONITORING TABLE

Element	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
I. The Directory of Services (DoS) provided by the Trust is up to date	Patient Administration Manager	Directory of Services (DoS)	Annually	Publish DoS to service leads	Patient Administration Manager to cross reference	Directorate Teams to notify Patient Access Manager of any changes to
II. Referral information is complete and accurate	Consultants Community Services AHPs/ Service Managers	Audit of referrals received	3 Monthly	Clinical Quality Review Meeting	Issues around the quality and timeliness of letters should be e-mailed to: quality@dudleyccg.nhs.uk	Referral information will be complete and effective
III. Outpatient & Inpatient: a) Patient initiated cancellations dealt with in accordance with	Directorate Managers Patient Administration Manger	Info Dept report. Spot audit 10 cancellations to check that	3-monthly	Report to directorate managers and Outpatient Steering	Directorate management team highlight actions taken outside of Trust policy	Directorate Manager to address noncompliance to policy with team and establish correct protocol to be
b) DNAs dealt with in accordance with policy	Directorate Managers Patient Administration Manager	Info Dept. report. Spot audit 10 DNAs to check that	3-monthly	Report to directorate Managers and Outpatient Steering	Directorate management team highlight actions taken outside of Trust policy	Directorate Manager to address noncompliance to policy with team and establish correct protocol to be

c) Hospital initiated outpatient clinic reschedules provide at least 6 weeks' notice	Directorate Managers Patient Administration Manager	Clinic cancellation and rescheduled report	Monthly	Report provided to directorate managers and Outpatient	Directorate management team to highlight noncompliance to Trust policy.	Clinical Director, Deputy Director to address noncompliance to policy with team and establish correct
d) Outpatient appointment outcome forms are completed	Information Department	Data Warehouse	Weekly	Report to show missing outcomes	Dept. Managers to identify reasons for missing outcomes. Reception and Ward	Address and rectify any recurring missing outcomes with relevant parties.
e) 95% of non-admitted patient pathways completed within 18 weeks	Information Department	Data Warehouse	Monthly	Report to show non-admitted patient wait times	RTT Training & Support Officer to review and validate report making relevant changes in Oasis where appropriate	Review root cause of any errors in recording and address with additional training for relevant users Review ways of
IV. Inpatients: a) Hospital initiated cancellations dealt with in accordance with	Information Department	Data Warehouse	Weekly	Report to show patients cancelled on the day	Directorate Managers to review and ensure that patient is given	Look into root cause of cancelled on the day to see if anything can be done to prevent
b) 90% of admitted patient pathways should be completed within 18 weeks	Information Department	Data Warehouse	Weekly	Report to show admitted patient wait times	Directorate appointed administrators to review and validate report making relevant changes in Oasis where appropriate	Review root cause of any errors in recording and address with relevant users

V.	For patients on incomplete pathways (outpatient or inpatient), no more than 92% of patients to wait more than18	Information Department	Data Warehouse	Weekly	Report to show incomplete pathway patient wait times	Directorate appointed administrators to review and validate report making relevant changes in Oasis where appropriate	Review root cause of any errors in recording and address with relevant users
VI.	Community Information Data Quality Reports	Information Department	Data Warehouse	Monthly	Closed referral clock still running Cancelled referral incorrect outcome Cancelled referrals no RTT Status	To highlight system and data errors	Intention for Community services to migrate to a single PAS, which is dependent on the Trust's IT strategy. Enable consistent reporting
VII.	Community services RTT report	Information Department	Data Warehouse	Monthly	Complete/ Incomplete Pathways by Wait Time (Weeks)	To highlight system and data errors	Ensure Service Managers adhere to NCRS WI-0066 clock starts and stops

APPENDIX 2

INTER PROVIDER TRANSFER FORM
Referrals from Dudley Group NHS Trust

NHS
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NHS Foundation Trust

To be completed and attached to the clinical referral letter on every occasion that a patient on an RTT pathway is transferred to another provider. Items in **bold** are mandatory, Items shaded in Grey are system generated.

REFERRING DETAILS:

Organisation Name: The Dudley Group	**Organisation Code:** RNA00
Referring Clinician Name:	**Ref Clinician Registration Code:**
Speciality / Treatment Function Code:	**Date Form Sent:**

CONTACT DETAILS AT DUDLEY GROUP

Name:	Designation:
Phone:	**Email:**

PATIENT DETAILS:

Patient Title & Name: **Date of Birth:**	**Patient Address:**
	Post Code:
NHS Number:	
Hospital Number:	Name of Lead Contact *(if not the Patient):*
Home Phone:	Work Phone/Mobile/Email:

PATIENT GP DETAILS:

Name of GP:	**GP Practice Code:**

REFERRAL TO TREATMENT DETAILS:

Is this referral for: **Clinical Transfer** X☐ **Diagnostic Tests Only*** ☐ **Opinion Only*** ☐

**Where there is no clinical transfer and the patient remains with the DG~~OH~~ The rest of this section does not need to be completed for these two options.*

Is the patient on an RTT pathway? **YES** ☐ **NO*** ☐

**The rest of this section does not need to be completed.*

What is the Pathway Status? **Not Yet Treated** ☐ **Treatment Started*** ☐ **Active Monitoring*** ☐

**If Treatment or Active Monitoring has started then the RTT pathway ends. The rest of this section does not need to be completed for these two options.*

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Is this referral part of an existing pathway or the start of a new RTT pathway? **EXISTING RTT PATHWAY** ☐ **NEW RTT PATHWAY** ☐	**Unique Pathway Identifier** ***(available from PAS)*** For existing RTT pathways:
For ALL pathways: Date of Decision To Refer Patient: **For existing RTT pathways only: RTT Clock Start Date:** *(available from PAS)*:	**Allocated By (Organisation Code)**
List all organisations involved in the 18 weeks pathway:	
Has the patient refused an reasonable offer date (optional local field): **YES** ☐ **NO** ☐	

RECEIVING ORGANISATION DETAILS:

Organisation Name:	Organisation Code:
Receiving Consultant Name:	**Speciality / Treatment Function Code:**

Please print this form and send it with the referral letter within 48 Hours of decision to

For receiving provider - date and time the form was received: