Milton Keynes University Hospital NHS Foundation Trust

Patient Access Policy

Classification :	**Policy**
Authors Name:	**Hitesh Patel**
Authors Job Title:	**Associate Director of Performance and Information**
Authors Division:	**Performance and Information**
Departments/Group this Document applies to:	All staff with a responsibility for elective patient care

Approval Group: Trust Documentation Committee	**Date of Approval:**	**Mar 2019**
	Last Review:	**Dec 2018**
	Review Date:	**Dec 2020**

Unique Identifier: ORG/GL/4	**Status:** Approved	**Version No:** 9.0

Policy to be followed by (target staff): All areas

CQC Fundamental standards:

Regulation 9 – Person-centred care
Regulation 10 – Dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 14 – Meeting nutritional and hydration needs
Regulation 15 – Premises and equipment
Regulation 16 – Receiving and acting on complaints
Regulation 17 – Good governance
Regulation 18 – Staffing
Regulation 19 – Fit and proper persons employed

Policy Statement

Milton Keynes University Hospital NHS Foundation Trust (MKUH or 'the Trust') is committed to the delivery of both safe and effective patient care under the terms of the NHS Constitution. In the context of this policy, this is achieved by providing a transparent, consistent and clear approach to the management of patients on elective (i.e. non-emergency) care pathways.

Purpose and scope

Aimed at all staff who work with elective pathways, the Patient Access Policy (Access Policy) provides a transparent, consistent and clear approach to the management of patients on elective 18-week Referral To Treatment (RTT) pathways. In Appendix A and Appendix B, a list of acronyms and definitions have been provided to support the contents in this Access Policy.

Implementation and dissemination of document

The clinical divisions are responsible for identifying the relevant staff members applicable under this policy and ensuring that a copy of policy is included as part of their induction. A copy of the Access Policy can be found on both the Trust Intranet and patient facing Trust website.

1.0 Roles and Responsibilities

Maintaining the data which contributes to waiting lists is the responsibility of all Trust staff involved with elective patient care. However, it is clear that specific groups and individuals have greater day to day responsibility and these are outlined below.

Trust Board – Has overall responsibility for assuring the Trust's obligation to meeting the objectives set out in the NHS Constitution concerning waiting list management and performance and will be kept informed via a programme of internal and external audit.

Management Board – The Management Board will receive reports from both the Deputy Chief Executive Officer and the Director of Clinical Services on matters relevant to waiting list performance, including performance against national waiting time targets and related operational issues.

Data Quality Compliance Board (DQCB) – The DQCB was established to coordinate efforts to improve data quality; identifying areas for improvement through information asset assurance, compliance audits and key performance indicators and then using the results to develop action plans for the clinical divisions to implement. RTT data quality has a significant impact upon waiting times with incorrect data potentially affecting the care delivered to patients.

Chief Executive Officer (CEO) – Has overall responsibility for the management of the Trust and its performance, including statutory returns regarding patient waiting times and ensuring Trust compliance with the objectives set out in the NHS Constitution.

Deputy Chief Executive Officer (Deputy CEO) – Has executive accountability for reporting matters pertaining to waiting list performance to the CEO, including performance against national waiting time targets.

Director of Clinical Services – Has executive accountability for waiting list management from an operational perspective. The Director of Clinical Services has overall management responsibility for all operational staff that record data onto the Trust's information systems and is therefore ultimately responsible for the accuracy of this information.

Divisional Clinical Director – The Divisional Clinical Director is responsible for making the final decision for all patients who are to be put on active monitoring following a decision to admit the patient for treatment. This decision can only be made in exceptional circumstances, as described in section 5.4 of this policy.

Associate Director of Performance & Information – At a Trust lead level, the Associate Director of Performance & Information has responsibility for monitoring and reporting of waiting list performance.

CSU Management Teams (including General / Service Managers, Chiefs of Service, Heads of Nursing and Clinical Directors) – Members of the CSU management teams have responsibility for the quality of waiting list data recorded within their CSU. CSU managers must ensure that staff within their team, who have any involvement with the management of patient waiting lists, including the capture, recording and management of relevant patient data, are made aware of and fully understand the content of the Patient Access Policy and that the principles within the policy apply to all information systems that are covered within the scope of this document. A representative of each CSU is required to report to DQCB on an annual basis,

providing assurance on the data quality performance of their CSU and that any data quality risks are being appropriately managed.

Performance & Information Department – Is responsible for reporting the Trust's position nationally in regards to patient waiting times for 18-week RTT, diagnostics and cancer.

Information Asset Owners – Are ultimately accountable for the quality of data held in the information asset that they 'own' and provide assurance that risk to the quality of waiting list data is being managed effectively. Accurate waiting list data is dependent on these assets being appropriately managed and risks controlled.

Information Asset Administrators – Are responsible for ensuring that procedures, standards and checks are developed and implemented for their assets and that their systems which support accurate waiting list information are configured to optimise data quality. They are responsible for recognising actual or potential waiting list data quality issues, escalating to Information Asset Owners, and putting plans in place to resolve them. Specifically:

- Reviewing the Patient Access Policy, ensuring they are kept up to date with any national changes;
- Ensuring compliance with the Patient Access Policy and associated policies (e.g. Data Quality Policy) – via spot checks, and rolling programmes of audit;
- Ensuring staff receive adequate training in the use of systems related to the processing of patient waiting list data, e.g. PAS and the waiting list management tool; and
- Providing assurance to the DQCB, via an annual report, of the data quality performance of their system and of the checks and procedures in place.

Team/Ward Managers and Administrative Managers – It is the responsibility of line managers to ensure their staff comply with the Patient Access Policy and are trained to competently use the appropriate information systems, including how to raise waiting list concerns.

All Staff – All staff are personally responsible for the quality of data used to support waiting lists entered by themselves, or on their behalf, on the Trust's computerised systems. This responsibility will be clarified in their job description and monitored via ongoing supervision/appraisal. It is essential that any alterations or updated information is amended as soon as possible on the Trust PAS (Patient administration system) and other systems to provide up-to-date information to support the delivery of care and reduce any associated risk to patient safety.

Community Responsibilities - Meeting the 18-week RTT target is the responsibility of the entire healthcare community. Each section of the community has responsibilities it needs to follow to ensure that the 18-week target can be met.

General Practitioners (GP's) – GP's play a pivotal role in ensuring that patients are fully informed of the likely waiting times of a new outpatient appointment and of the need to be both contactable and available for an appointment when they are referred. Wherever possible, GP's should use the e-Referral system to refer all patients who are on an 18-week pathway, and should refer according to the established protocol and best practice.

Clinical Commissioning Groups (CCGs) – The CCGs are responsible for ensuring good lines of communication between GP's and the Trust. Additionally, CCGs must ensure that there is no more than a one week (five working days) delay (from the date of GP referral) in referral from a Referral Management Service. The CCGs are also responsible for managing tertiary providers and ensuring that they are sent in a timely manner.

Patients – Patients should be aware of the following responsibilities:

- attending their hospital appointment or ensuring that they contact the hospital to cancel it, giving as much notice as possible if they are unable to attend;
- managing their own health where possible;
- use the part of the service appropriate for their needs;
- be involved in the management of their treatment pathway;
- telling their consultant/doctor or nurse when they feel they have not been treated promptly and are unhappy with their care; and
- ensuring that they inform their healthcare provider of any changes to personal circumstances, particularly contact details and registered GP.

2.0 The 18-week Pathway – Key Principles

2.1 Waiting Times

18-week waiting times are calculated from the pathway start (referred to as a 'clock start') to the pathway end (referred to as a 'clock stop') and there can be no pause (suspension) at any point in-between. The patient breaches their waiting time on day 127.

Any breaches of 18-week wait are to be avoided wherever possible. In support of this, the Trust works to maximum waiting times for first outpatient appointments, diagnostic tests and elective admissions as detailed below:

First outpatient attendance:	Six weeks from referral received to date seen.
Diagnostic Tests Inc. Audiology:	Six weeks from date requested to date of appointment.
Elective Admission:	Twelve weeks from Decision to Admit to inpatient admission and within the total 18-week timeframe.

Occasionally MKUH may use patient services from alternative providers, particularly diagnostic investigations. For all patients, but particularly those who are on 18-week pathways, Divisions must continue to monitor the patient pathway and ensure where practical any delays are minimised.

2.2 National Performance

As a means of overseeing the delivery of 18-week RTT nationally, Trusts are required to submit information regarding the proportion of patients seen and treated within 18-weeks and of diagnostics within six weeks. Nationally, targets have been set which Trusts must not fall below; this is to ensure that patient care is not unduly compromised by pressures on Trust services. These standards are:

- 92% of all patients must be treated within 18-weeks.
- 99% of diagnostics tests must be completed within six weeks.

The Trust is subject to financial penalties for any performance which falls below these standards.

The reason the target is not 100% is because an 8% allowance is made for patients who through no fault of their own are unable to been seen and treated within 18-weeks (including social reasons). The 8% tolerance considers the following scenarios:

- patients for whom it is not clinically appropriate to be treated within 18-weeks;
- patients who choose to wait longer for one or more elements of their care; or
- patients who do not attend appointments.

2.3 Overview of the National Referral to Treatment Rules

2.3.1 Clock Starts

The RTT clock starts when:

1) The patient or GP books (or attempts to book) an appointment from an E-Referral;
2) An internal (consultant to consultant) referral is received (must be date stamped);
3) A 'Decision to Treat' is made following a period of active monitoring; or
4) New and significantly different treatment plan is agreed between consultant and patient.

If a decision is made to start a significantly new or different treatment plan, the RTT clock will start at the date the decision is made. To support the correct start of an RTT pathway in this regard, treatment plans must be clearly documented in clinic consultations. If the treatment was part of the original plan (just not preferred by the patient) then this does not constitute a new clock start.

2.3.2 Clock Stops

The RTT clock stops when:

1) Definitive Treatment is given (outpatient setting);
2) The patient is admitted and is treated;
3) A period of active monitoring is applied (see section 5.4 & 5.5 for main guidance);
4) The patient is discharged (treatment not required); or
5) The patient's care is transferred to another healthcare provider.

2.3.3 Patient Choice to Delay

A patient may wish to delay their appointment or treatment for greater than two months for social reasons (e.g. outside of school term for teachers or university term for students). Such delays do not have any impact on recorded RTT waiting times. However, the patient should inform the Trust of these delays when they occur. Upon being notified, the relevant booking team will inform the consultant responsible for the patient's care and a clinical decision will be made as to the risk to the patient of delaying treatment. Where possible, consultants should review every patients' case individually to determine whether there is potential for any delay to cause clinical harm to the patient.

Should the delay not cause any clinical risk to the patient, it may be appropriate to discharge the patient back to their GP on the basis that the patient should only have been referred if they are available for their appointments or treatment. This decision can only be made by the consultant in charge of the patient's care, and should be clearly communicated to both the patient and their GP (see Appendix I).

Should the delay cause clinical risk to the patient, the risks must be communicated to the patient. Should the patient accept the risks, the patient will remain on an active RTT pathway. If the patient does not want to accept the clinical risk, they will need to decide whether they wish to delay their appointment or treatment. Irrespective of the patient decision, the relevant clinical risk assessment will be documented in the patient clinical record.

The delay of two months should not be seen as a blanket delay period to instigate the above process. An individual judgement by the consultant should be made on an individual case by case basis, with the initial assessment being whether the request for a delay in treatment is reasonable.

2.3.3 Patients Requiring Thinking Time

On some occasions, patients may wish to spend time thinking about the recommended treatment options before they proceed. If the patient requires thinking time of up to two weeks, it would not be appropriate to stop the RTT clock. The patient should be asked to contact the Trust within an agreed period with their decision. The agreement and timescale should be recorded in the clinic letter as part of the patient consultation.

Should a patient require thinking time of greater than two weeks, it may be appropriate to discharge the patient back to the GP. This decision can only be made by a consultant and only made on an individual case by case basis. The patient's best clinical interests must always be considered before a decision to discharge the patient back can be made. When the patient feels that they are ready for treatment, they may be re-referred by the GP.

2.3.4 Reasonableness

Reasonableness is a term that is applicable to all stages of the 18-week pathway and refers to certain criteria that should be met when offering patients outpatient appointments or inpatient admission dates. For the purposes of this policy, a reasonable offer is the choice of two appointment dates with at least three weeks' notice. Patients who refuse two reasonable offers will be subject to clinical review and may be potentially discharged back to their GP.

2.4 Special Patient Groups

2.4.1 Military Veterans

In line with the Armed Forces Covenant enshrined in the NHS Constitution, all veterans and war pensioners should receive priority access to NHS care for any conditions related to their service, subject to the clinical need of all patients. Military veterans should not need to have applied and become eligible for a war pension before receiving priority treatment.

GP's will notify the Trust of the patient's condition and its relation to military service when the patient is referred. This is so that the Trust can ensure that it meets the current guidance for priority access to NHS care over other patients of the same level of clinical need. Patients with more urgent clinical needs will continue to receive priority.

2.4.2 Persons Detained under HM Prison Services

All elective waiting time standards and rules apply to prisoners. Any delays to treatment that are incurred as a result of difficulties in prison staff being able to escort patients to clinic does not affect the 18-week waiting time for the patient.

Trust staff will work with the staff in the prison service in an attempt to minimise delays through clear and regular communication channels and by offering reasonable choices for appointments or admission dates.

2.4.3 Private and Overseas Patients

Patients referred to and seen at the Trust in a private, i.e. fee paying capacity do not start an RTT waiting time clock and are subject to the Trust's Private Patient Policy. Please refer to this policy for detailed information.

3.0 The Outpatient Pathway

3.1 Referrals

3.1.1 Receiving Referrals

As of the 1st October 2018, all referrals from GP's must be received via e-Referral (the e-Referral system) and any paper referrals from GP practices returned to the GP. Paper referrals from other sources (e.g. consultant to consultant referrals) will still be accepted but are only encouraged if in the clinical best interest of the patient and any delay would compromise patient care.

Where clinically appropriate, referrals should be made to a service rather than a named consultant to avoid any unnecessary delay in patient care. To facilitate this, all GP referrals will be treated as open and pooled within the specialty. The only exceptions to this process will be for referrals to specific sub-specialties, special interest, research, patients with previous treatment history under the care of a specific consultant and requests for second opinions.

It is the responsibility of the referrer to ensure that the referral letter contains accurate and up to date demographic information regarding the patient, including NHS number and both daytime and evening contact telephone numbers. The National Spine will be updated when required by the referrer. The details provided will be updated on the Trust PAS if necessary and then used when arranging appointments.

3.1.2 E-Referral – Referral and Booking of New Outpatient Appointments

Once the patient has chosen to be seen at this Trust and the referral is made on the e-Referral system, they are then required to book their appointment either directly with the hospital or via a national call centre (Telephone Assessment Line) if that facility exists for the service they have chosen. Patients may choose to reschedule their appointments but are then subject to this Policy's rules on rescheduling (see 3.2.4).

Consultants must have the opportunity to review the appropriateness of referrals into their service and to expedite any routine referrals they consider clinically urgent. As per the Data Quality Policy, referrals should be reviewed within five days to prevent any unnecessary delays in patient care.

If a consultant, on reviewing a referral letter, deems the referral to be inappropriate it must be rejected with an explanation as to why it is inappropriate and advice on the most appropriate management may be provided. The patient will be discharged back to the GP.

If a referral has been made and the special interest of the consultant does not match the needs of the patient, the consultant will redirect the patient to an appropriate colleague (within their specialty only) who is able to provide such a service, and the referral details amended on the PAS.

Any patient who attends an agreed outpatient appointment when the referral has not yet been approved or rejected must be seen.

3.1.3 Appointment Slot Issue (ASI) List

If the patient chooses to attend the Trust and attempts to book an appointment but there are no appointment slots available, then the referral is deferred to the provider to book and the patient is placed into a queue. This queue is referred to as the Appointment Slot Issue (ASI) list.

Referrals deferred to the provider are immediately visible in the ASI work list. The referral date will display in red after a number of working days dependent upon the priority of the referral:

- **2WW 3 days**
- **Urgent 6 days**
- **Routine 11 days**

It is important to note that when a referral enters the ASI process, the patient will be informed that the provider will contact them within these timescales. This list must be monitored frequently to avoid any unnecessary delays to patient care.

3.1.4 Directory of Services

The Directory of Services is the list of services that the Trust provides through the e-Referral system. In effect, it is the shop window of the services offered by the Trust to its patients. As such, it is an important virtual document that needs authorisation by both Divisional Managers and Consultants. Any changes to the Directory of Services must be agreed between the Divisional Managers and Consultants in conjunction with the Patient Services Manager. The Patient Services Manager will ensure that the services offered are correctly reflected on the e-Referral system and any changes will be actioned in a timely manner.

3.1.5 Transfer between Consultant Teams

During a patient pathway, it may be necessary for the patient to be referred to another consultant (in the same or different specialty). There are two scenarios where this is possible:

1) If the referral is directly related to the condition for which the patient was originally referred, e.g. a cardiac opinion prior to surgery.

2) If the referral is for a newly diagnosed condition not related to the patient's original condition, e.g. a finding on diagnostics requiring treatment under another specialty.

If, on review of a patient, a consultant decides that another consultant within the same specialty is better placed to manage the condition for which the patient was initially referred, the patient can be referred on, but this does not start a new waiting time clock.

If the patient's condition is identified as clinically urgent, for example, suspected cancer or a cardiology condition, or is directly related to the condition for which the patient was originally referred/admitted, then a referral to another consultant in the same Trust (where possible) should be made immediately. This referral will then follow the same pathway as external referrals, with equal priority and waiting times. As noted above, referrals more appropriate for a specific consultant within the specialty should be re-directed prior to the first outpatient appointment.

3.1.6 Transfers between Providers (Tertiary Referrals)

Patients may be transferred to or from the Trust in relation to their 18-week RTT pathway. The responsibility for achieving the 18-week deadline is transferred with the clinical responsibility and as such, the originating provider should ensure that the patient's initial RTT clock start date forms part of the onward referral information. However, if the patient is only transferred for a diagnostic test, the referring Trust retains responsibility for the RTT pathway.

A mandatory minimum data set (inter provider transfer proforma) must be completed using the clinic outcome system and transferred to the receiving provider.

3.1.7 Rapid Access Chest Pain Clinics

To meet the required NHS Standard National Service Framework for Coronary Heart Disease, patients who present to their GP with newly diagnosed chest pain must be seen in secondary care by a specialist within 14 days of the receipt of an NHS e-Referral proforma.

- Rapid Access Chest Pain Clinic referrals are made either by a proforma which is faxed or mailed to the Cardiology Department, or referred via the e-Referral service. Suitable appointments are then made and the patient informed.
- Standard rules apply regarding patient cancellations and failure to attend.

For specific guidance please see the Rapid Access Chest Pain Clinic Operational Policy.

3.1.8 Colposcopy Clinics

To meet the required British Cervical Screening Programme standards, issued by the Department of Health, targets exist to ensure patients are seen promptly depending on the clinical need outlined on referral.

- The patient pathway begins with their GP taking a smear test and sending it away for testing. If the results are positive then the testing Organisation (currently High Wycombe Hospital) will send them to the Colposcopy Department at Milton Keynes University Hospital (as well as informing the GP).
- Colposcopy appointments are currently booked by the Women's Health Department, following referral by the Colposcopy Department.
- Standard rules apply regarding patient cancellations and failure to attend.

For specific guidance please see the Cervical Screening Programme Operational Policy.

3.2 Outpatient Appointments

3.2.1 Documentation from Clinic Visits

In keeping with both local and national record keeping guidance and policy, all staff involved with providing patient care must ensure that patient records remain both an up to date and accurate reflection of care provided to the patient. Letters documenting discussions at clinic visits (clinic letters) are of particular importance; providing both an appropriate audit trail and clarity in where a patient is on their RTT pathway.

3.2.2 General Principles

- All patients are to be seen in order of referral (and where appropriate, clinical priority).
- Referral dates and waiting times are to be correctly recorded and measured.
- Patients are to be able to choose/negotiate their appointment time and date (recognising that clinics are held on specific dates during set time periods).

3.2.3 Declining Appointment Dates

Patients will be offered a choice of at least two appointment dates with reasonable notice (see 2.3.4). Should they decline the dates offered and if it is not clinically detrimental to the patient in the opinion of the consultant, the patient may be discharged back to their GP.

3.2.4 Hospital Reschedules of Outpatient Appointments

It is the Trust's policy to avoid hospital reschedules wherever possible. The Trust has an agreed leave policy Annual/Study and Professional Leave Policy for Medical Staff which states that a minimum of six weeks' notice **must** be given by all medical staff in order to minimise disruption to clinics and patient cancellations.

Approval for any appointment reschedules as a result of the above must be obtained from the Divisional Manager, and a contingency plan outlined for accommodating the rescheduled patients if there are patients who may potentially breach waiting time targets or who have been rescheduled previously.

Where patients have to be rescheduled at short notice, the patient's record on EDM must be reviewed by medical staff. Waiting times are not reset in the event of Trust reschedules for outpatient appointments.

3.2.5 Non-Attendance of an Outpatient Appointment

Any patient who fails to attend their first appointment must have their referral reviewed by a consultant, who will decide if a further appointment is clinically appropriate. In the event that the consultant decides a further appointment is not required, the consultant must communicate this to both the patient and GP in writing. It is expected that such a review will take place whilst the consultant is in clinic and the letter dictated at this time.

In the event that the consultant decides that a further new appointment is not required, the patient's RTT waiting time clock will be nullified (as if never referred). The Trust will need to be able to demonstrate that the appointment offer was agreed in principle and clearly communicated to the patient. It may be considered clinically inappropriate to return the referral and in these cases the patient will be given a new appointment, but the patient will have a new clock start from the date that the patient contacts the hospital to rebook their appointment.

If a patient fails to attend a follow-up appointment, the RTT clock will continue if the consultant indicates that a further appointment should be offered. If a patient waits for longer than 18-weeks due to this delay, they will become part of the 8% tolerance as discussed in the National Performance section above. The RTT clock will stop if the consultant decides that it is in the patient's best clinical interests to be discharged back to their GP. Any decision to discharge the patient back to their GP will be communicated to both the patient and their GP in writing.

A paediatric patient DNA should be managed with reference to the Trust's Paediatric 'Did Not Attend or Was Not Brought Policy', as well as the Trusts Safeguarding Policies.

3.2.6 Cancellations and Reschedules of Outpatient Appointments

Patients are entitled to cancel and/or reschedule their outpatient appointments without any effect on their RTT waiting time clock. Such actions can be made at any point that is prior to the time of the appointment and this includes on the day of the appointment itself.

If however, the appointment is cancelled and/or rescheduled a second time, the patient pathway will be reviewed by the clinical team to determine if it is in the patient's best clinical interest to be referred back to the GP or other referrer. Should this be the outcome, the consultant must communicate this in writing to both patient and GP.

Paediatric cancellations of an appointment where a further appointment date is not agreed should be managed with reference to the Trust's Paediatric 'Did Not Attend or Was Not Brought Policy', as well as the Trusts Safeguarding Policies.

3.2.7 Clinic Outcomes

Every outpatient clinic attendance must have a clinic outcome recorded by the clinical team as part of the clinical decision making process and whilst the patient is in clinic. This is an essential part of the RTT pathway, ensuring that the Trust is able to accurately monitor patient waiting times and follow-up on any decision making required to progress the patient journey.

Where a patient has received treatment in an outpatient setting, it is the responsibility of the consultant who performed the treatment to record the necessary procedure on the outcome form and for the CSU to ensure the outcome form is available to the clinical coding team for clinical coding.

4.0 Diagnostics

The diagnostics section of the RTT pathway starts at the point of a decision to refer (request) for a diagnostic test and ends when the diagnostic test is completed. There are two situations in which a diagnostic is part of an RTT pathway:

1) Request as part of an established RTT pathway; and
2) Request directly from GP as 'Straight to Test' where there is an expectation that the patient will go on to be reviewed afterward by a consultant.

The diagnostic clock is separate with its own waiting time; starting at the same time as the referral (i.e. Straight to Test) or somewhere along an established RTT pathway (i.e. when diagnostics are required).

If a patient fails to attend for their diagnostic test, the diagnostic waiting time is reset to the date of the last appointment for that test (providing that the Trust can prove reasonable notice of the appointment was given to the patient). Failure to attend does not reset the RTT waiting time clock.

4.1 Direct Access Referrals

When a patient is referred into the Trust for only a diagnostic test, with no consultant led treatment, the RTT clock does not start as the clinical responsibility for the patient remains with the GP. However, a six week diagnostic clock does start at the receipt of this referral. These referrals are known as direct access referrals.

4.2 Booking Imaging Appointments

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

- With the significant reduction in waiting times for imaging investigations, there is no longer a need to make a distinction between referral priorities. For the most part, booked appointments will be made in order of length of wait and resource availability; however we will aim to see urgent patients within 14 days.
- Patients are sent a letter with a specified appointment date and time and asked to contact the imaging department by phone to change the appointment if it is not convenient.
- In circumstances where patients are given less than seven days' notice, they will be telephoned to be offered the appointment and will not be penalised if they are unable to accept it.

4.3 Non-attendance of Imaging Appointments

Patients who do not attend for their diagnostic investigations without notification for plain X-Ray and CT will be sent letters to call asking the patient to contact the Trust within 14 days if they wish to rebook. The diagnostic clock will be reset to zero with the new waiting time starting from the date of the missed appointment providing that the reasonable criteria has been met. All other DNAs will be returned to the referrer and will not be given another appointment unless there are clear clinical indications following review of EDM by the consultant responsible for the session or a superintendent radiographer. The only exception to this rule is for both paediatric and 2WW patients, who will be automatically rebooked following a DNA.

If it is assessed (by the treating consultant) as clinically important for the patient to be seen, appropriate action should be taken. This could include communication with the GP, other Primary Healthcare Team professional, or directly with the patient. Issuing a further appointment without taking this step is not sufficient to ensure that proper care is delivered. However, only one re-appointment will be given in these circumstances. If, following the second offer of appointment, the patient fails to attend, this should be escalated for a clinical review and, if appropriate, the patient can be returned to the referring consultant. The RTT clock will continue throughout this process, as only the referring consultant can make the clinical decision to stop the clock.

If the patient contacts the Trust within 14 days of the missed appointment with an acceptable reason for their failed attendance and the consultant responsible agrees to see them, the original referral will be reinstated, but the waiting time will be reset to start from the date of the missed appointment. An acceptable reason predominantly refers to circumstances beyond the patient's control that had prevented them from attending and informing the Trust in advance.

4.4 Patient Cancellations of Imaging Appointments

Patients who cancel their appointment should be given an alternative date at the time of the cancellation. If a patient cancels their appointments on more than two occasions and reasonable notice has been provided on each occasion, this should be escalated for a clinical review. Following this review, if it is clinically appropriate, the patient can be returned to the referring consultant. If it is not clinically appropriate to do this, the patient should be offered a further appointment. The patient and their GP should be informed of any return to the referring consultant in writing by the Imaging Department. For any patient cancellations, the waiting time will be set to zero with the new start date set to the date of the cancelled appointment.

Cancelled appointment slots should be offered to another patient and not left vacant wherever possible.

5.0 The Inpatient Pathway

5.1 Decision to Admit (DTA)

The decision to add a patient to a schedule for surgery (Inpatient or Day Case) must be made by a consultant or a member of their clinical team in the name of the consultant (as only consultants have admitting rights). When the Decision to Admit is made, the patient must be both available and clinically fit for the procedure. Short periods of illness/unavailability (i.e. less than two weeks) should be tolerated and the patient still considered as waiting.

At the time of Decision to Admit the consultant must complete an 'Addition to the Waiting List' proforma. It is the consultant's responsibility to ensure that the proforma is completed clearly and correctly with details of any patient unavailability and whether the procedure is planned or elective. The proforma must reach and be logged on EDM by the appropriate scheduling team within 24 hours.

When logging a patient on the waiting list within PAS the patient pathway scheduler must ensure that:

- patients are not already listed for the same condition;
- the entry is recorded correctly as either Elective or Planned;
- that the patient is not already scheduled for surgery for another procedure; and
- patients will be scheduled in clinical priority and length of wait order.

Any communication with the patient must be recorded on PAS in the free text section of the system and documented within the patient's clinical notes.

5.2 Pre-operative Assessment before Admission

Pre-operative assessment (POA) will be used in elective surgical cases to determine the patient's fitness for surgery at the proposed time. A patient may be assessed by questionnaire/telephone or they may attend either on the day of the decision to admit or at a later date prior to surgery. If the patient is found to be medically unfit, Trust personnel should implement the guidance in the medically unfit patients section below.

5.3 Medically Unfit Patients

This excludes those patients for whom the risk of not having surgery outweighs the risk of proceeding when unfit. The decision to proceed with these types of patients lies entirely with the consultant anesthetist/consultant surgeon who, following a review, will make a decision whether to proceed.

Patients awaiting admission who become medically unfit for surgery three weeks after a Decision to Admit is made, and who will be medically unfit for longer than 14 days, must be discussed with the clinical teams and may be discharged back to the care of their GP. If this situation occurs as a result of nurse led Pre-Op Assessment (POA), then the POA nurse must communicate the outcome back to the consultant for review. Removal of the patient from the waiting list cannot be decided at this point.

For patients identified as not fit to proceed with surgery, a waiting list removal form must be signed and dated by the lead consultant, confirming that the patient can be removed from the waiting list (see Appendix E for the removal form). This must also be clearly communicated to the patient and

their GP via a letter from the consultant (see Appendix F). In this eventuality, the 18-week clock will be stopped.

With the exception of long waiting patients (see section 7.0) a GP may reinstate a patient on the waiting list within four months of the discharge by writing to the relevant consultant who will review the request either from the letter/notes or see the patient in an outpatient clinic. If more than four months have elapsed since discharge, the patient must be referred to the appropriate consultant via a new referral. In both these cases a new 18-week clock begins from the date of receipt of a new referral.

In the event a patient is deemed medically unfit for 14 days or less the clock does not stop.

5.4 Active Monitoring Following a Decision to Admit

For clarity the definition for active monitoring is where a decision is made that the patient does not require any form of treatment currently, but 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 in exceptional circumstances after a Decision to Admit has been made. Active monitoring is more commonly used in a non-admitted pathway setting, where options for treatments are being considered and therefore a period of active monitoring might be appropriate.

If a patient is on an admitted pathway and cannot be treated, for example where they have become medically unfit and will not be medically fit within six weeks, the patient cannot be put onto active monitoring for such situations. In such a situation, the patient should, in most cases, be discharged back to their GP and the patient can be re-referred back when they are medically fit. Patients with minor illnesses, e.g. coughs and colds, should not be removed from the waiting list or put on a period of active monitoring as it is typically expected such conditions should resolve within a few weeks.

There will also be exceptional circumstances where, based on a clinical decision, it may be appropriate to have a patient on the admitted pathway put on active monitoring. Such situations would be rare and infrequent. However, if such an exceptional circumstance does arise, this must be discussed and agreed with the Divisional Clinical Director. If the outcome of the discussion and agreement is that the patient should be put onto active monitoring, this should be communicated to the patient in an outpatient setting, with the outcome of the outpatient appointment recorded as active monitoring. Subsequent to the recording of the outcome of the outpatient appointment, the patient needs to be removed from the elective waiting list. It is important that the RTT pathway is appropriately updated to reflect the decisions made and evidence is documented. A removal form should also be prepared and signed by the consultant, including a note of the agreement with the Divisional Clinical Director.

Any decisions will also need to be documented and communicated to both the patient and the patient's GP (see Appendix F). Where the patient is discharged back to their GP as they are medically unfit (as an example), they may be re-referred back to the Trust.

As per the Medically Unfit section of this Patient Access Policy (section 5.3), if a patient subsequently becomes ready for surgery within four months after they were discharged back to the care of their GP, they can be reinstated onto the schedule at the GP's request in writing to the consultant. The consultant will review the patient (EDM notes or physical consultation in outpatients) before placing them on the waiting list. The new clock start date is the date of referral back to the hospital.

Patients who are referred for surgery more than four months after they were discharged back to their GP will need to be re-referred to the appropriate consultant and cannot be entered onto a waiting list without clinical consultation.

5.5 Active Monitoring and Discharge back to GP – Procedure & Process

The removal of patients from the elective waiting list under these circumstances must follow a process which allows for both a complete and accurate audit trail of events. This is in line with ensuring both patient safety and that the clinical decision made is transparent and consistent with any harm review undertaken. For the process that must be followed for removing patients from the waiting list due to exceptional circumstances active monitoring, see Appendix D.

If it is decided that there is no exceptional circumstances for the patient to be put on active monitoring, the patient should be discharged back to the GP. If possible, it may be appropriate to communicate this to the patient in an outpatient setting.

5.6 Non-Attendance of an Elective Admission

It is important that the patient has been given instructions of who to notify and how if they subsequently cannot come in for their operation/procedure and that the letter clearly states the consequences of not attending for their appointment date. Should a patient fail to attend for their admission, the consultant must review the patient's record and consider whether a further date is in the patient's best clinical interest. A second TCI date is always necessary in the following circumstances:

- patients undergoing cancer treatment;
- urgent referrals based on clinical judgement;
- paediatrics; and
- maternity patients.

See Appendix H for a template letter to send to the patient and GP when there is a non-attendance of an elective admission.

5.7 Trust Cancellations & 28 Day Returns

If the Trust cancels an operation/procedure after admission or on the day of admission for non-clinical reasons, the patient must be offered a new date which is within 28 days of their original date.

Patients that are cancelled at any point in time prior to surgery will always be notified by telephone and offered a new date (reasonableness criteria remain applicable). A notification of cancellation letter will be sent to the patient's GP.

All operations cancelled on the day should be reported via the Trust's current incident reporting process and all reasons for cancellation will be added to the PAS by the ward clerk/patient pathway coordinator.

Patients who become medically unfit within the 28 day period are subject to clinical review under section 5.3 (Medically Unfit Patients).

If the consultant has reviewed the patient and has decided they are medically unfit and to be removed from the waiting list as per the Access Policy; then they can also be excluded from the 28 day guarantee breach reporting, provided that they are removed as unfit within the 28 day

guarantee period and after the date the operation was cancelled. If however they have not been removed or have become unfit after the 28 day guarantee period, they will remain reportable as 28 day breaches."

Whatever the reason for the removal, if a patient is to be removed from the list of reportable 28 day breaches, the following information will be required in the comments field (and ideally confirmation of such in EDM):

- The patient was offered an admission date (or two dates if the offer was verbal) with at least 3 weeks' notice between the date the offer was made and the admission date offered; and
- the date offered was within 28 days of the cancellation date, and
- that the patient refused the dates offered.

Should the patient be deemed fit for surgery following review, then the 28 day rule remains in effect and the patient must be offered a date within this time.

5.8 Patients who move Out of Area

Should a patient move out of the Trust's catchment area while they are waiting treatment on an elective waiting list, they may choose to transfer their care to a hospital nearer to their new location. In this case, a tertiary provider proforma should be completed with all of the relevant information (including RTT clock start date), and the patients care and 18-week pathway will be transferred to the new provider.

5.9 Patients Listed for More Than One Procedure

Patients will only be added to the elective inpatient waiting list for one procedure at a time. The 18-week clock will stop when the first definitive treatment begins (i.e. when the procedure is undertaken). A second new clock starts once the patient is ready to proceed with the second procedure.

If the decision to treat involves two-part treatment, e.g. right and left knee replacements, then the patient will (before being discharged from part one of their treatment) be offered:

- either a date for the second part; or
- an early outpatient appointment for review of their condition.

If the decision to treat involves two procedures as part of a single pathway of treatment, e.g. T&O insertion of metal work and planned removal, the clock stops when the first treatment begins. The subsequent procedure is undertaken based on clinical need as part of the same pathway but the clock has already stopped (see 5.10 planned procedures).

5.10 Planned Procedures

Patients who have completed their 18-week RTT pathway but still require a further planned course of treatment or surveillance of a diagnosed condition are added to a planned waiting list.

Patients who are on the planned list are not included in any calculation of the size of the waiting list because their procedures would not be done sooner if resources were not a constraint. These patients are monitored via the PTL (patient tracking list) for planned patients; the planned PTL being given the same level of priority as the RTT PTL.

Each Speciality Operational Lead is responsible for reviewing the planned PTL list regularly. This review will include checking that patients are being seen in accordance with their planned review dates and have been listed appropriately to the planned PTL list data definition.

Examples of procedures which should be on a planned list are:

- patients waiting for more than one procedure where the procedures need, for clinical reasons, to be undertaken in a certain order, i.e. Drug Treatments, Injections and Infusions;
- follow up check procedures such as cystoscopies, colonoscopies;
- patients proceeding to the next stage of treatment i.e. patients undergoing chemotherapy, or removal of metalwork; and
- sterilisation following pregnancy, when the procedure cannot be undertaken until after the pregnancy.

The above list is not exhaustive. A consultant or consultant's representative will decide whether a patient should be added to, or remain on, the planned waiting list and in conjunction with the patient decide a date by which the next stage of treatment will commence.

When a patient on a planned list does not have their consultant–led procedure/treatment within six weeks of the planned date, they must be transferred to an active RTT list and an RTT clock should start. Usual RTT monitoring should be followed from this point; with the clock start being six weeks after the planned admission date.

6.0 Validation of Patients on RTT Pathways

6.1 Best Practice for RTT Validation

The management of RTT patient pathways requires CSUs to be active in understanding where a patient is on their pathway and for how long they are currently waiting. The process for reviewing RTT patient pathways is referred to as 'validation' and involves checking the pathway data against the patient's clinical record to confirm whether the data is reflective of the clinical decisions made. For the particular benefit of Trust staff involved with managing RTT pathways, below is an outline of best validation practice.

A complete list of patients currently on an 18 week pathway can be found on the Trust's PTL tool (patient tracking list).

Table 2: Data checks advised at key points in the RTT pathway activity

RTT pathway activity	What staff should check and where
Referral from GP	**What:** Clock start date (referral received date) is either: • Date of receipt of paper referral; • Date patient books an appointment via e-Referral or TAL; or • Date appointment deferred to ASI list **Where:** Paper referral should be in the patient's notes; e-Referrals can be accessed via the e-Referral application and the booking history checked for any deferral.
First outpatient appointment	**What:** First appointment is booked with a referral; First appointment is not planned; and Appointment has a completed and correct clinical outcome recorded. **Where:** Appointments can be checked from within the PAS system; clinic outcomes must be checked against the hard copy forms and the clinic letter for accuracy.
Diagnostics	**What:** Elective inpatient diagnostics are admitted and discharged; and/or Outpatient diagnostics are checked in and out of clinic. **Where:** PAS – appointments view (Outpatient diagnostics) or PM Office (for Inpatient diagnostics).
Follow-up OP appointment	**What:** Follow-up appointment has correct link to new appointment. **Where:** PAS system – appointments view
Addition to Inpatient Waiting List	**What:** Patient not already listed for the same condition DTA date matches the date on the waiting list proforma Proforma is complete and signed

	Where: The proforma can be found in the patients' notes and can be checked against the inpatient waiting list entry in the PAS system.
Admission for surgical procedure	**What:** Patient admitted from correct elective inpatient waiting list entry Patient treated **Where:** The inpatient admission will have the same identifier (FIN) as the waiting list entry and the waiting list entry will no longer exist (it has been used to admit the patient). Evidence for treatment can be from the theatre record in Powerchart or the operation notes if they have been scanned into the patients' notes.

7.0 Long Waiting Patients (>30 weeks) – Escalation Guidance

All long waiting patients should be proactively managed by the operational and clinical teams responsible for the patients' pathways. This is to ensure that a timely solution and plan are put into place. For the reference of long waiters, this document will refer to all patients that are on an active waiting list with a waiting time over 30 weeks.

7.1 Processes for Monitoring and Validation of Long Waiting Patients

The following processes should be followed when looking at patients waiting over 30 weeks:

- All patients over 30 weeks on the PTL should be reviewed at the respective divisional weekly waiting list management meetings to identify the number of patients that are yet to be treated and do not have a plan.
- All patients who have waited 30 weeks or more should have their pathway validated by the relevant operational manager to ensure that the current status recorded on the PTL is correct and that any relevant information or action is updated on the PTL.
- Between 30 weeks and 40 weeks, on a weekly basis, every patient will be reviewed to assess if there are any changes in circumstances from the initial review at 30 weeks.
- All patients who have waited over 40 weeks should be reviewed in detail at the divisional weekly waiting list meetings to ensure that they have a defined and agreed management plan that will ensure they will not exceed the maximum waiting time of 52 weeks.
- All patients that exceed a waiting time of 40 weeks on the PTL should have clinical harm review undertaken by the Divisional Director and/or Clinical lead for the relevant service in which the long waiter is attributed to. A proforma should be completed to indicate whether clinical harm has been identified or not, including whether the patient may yet come to harm. This list of patients will be provided by the General Manager and feedback will be provided at the weekly Executive PTL meeting.
- All patients that exceed 52 weeks wait for their treatment will have their pathway reviewed by the Medical Director to determine if any clinical harm has been attributed to the wait. This will be reported at the weekly Executive Director's meeting.

7.2 Trigger Points

- All patients waiting over 30 weeks should have their pathway validated.
- All patients waiting over 40 weeks should have an admission or appointment plan.
- No patients should breach over 52 weeks.
- Any patients that do wait beyond 40 weeks for treatment should have a clinical harm review undertaken by the Divisional Director and Clinical Lead for the service in which the breach is occurring.
- Any patients that do wait beyond 52 weeks for treatment should have a clinical harm review undertaken by the Medical Director, with an assessment of any potential harm that may be caused for a prolonged continuous wait.

7.3 Escalation

Any concern highlighted by the Divisional Teams that any of the trigger points are not going to be delivered should be escalated immediately to the Director of Clinical Services and/or Deputy Director of Clinical Services.

Any concerns in relation to capacity that may impact on the length of RTT wait for long waiting patients should be escalated to the Director of Clinical Services and/or Deputy Director of Clinical Services and subsequently discussed at the Executive PTL meeting.

Any risk that the Trust may have to cancel or defer a patient's treatment in the 40+ week category should be discussed immediately with the Director of Clinical Services and/or Deputy Director of Clinical Services before any decision is made to do so (in the absence of either, then this should be escalated to the Executive Director on-call).

Any risk of not being able to agree a management plan for a patient should be escalated with details to the Director of Clinical Services and/or the Deputy Director of Clinical Services and also be discussed at the weekly Executive PTL meeting.

Any issues that are preventing or delaying a definitive plan being made for a patient that is exceeding a waiting time of 40 weeks should be escalated to the Divisional Director for support and resolution. If after escalation to the Divisional Director, the matter is not resolved, then this should be escalated through the Executive PTL meeting and/or Medical Director if it relates to clinical delay with decision making.

The Performance and Information team will provide the month end position of any 52 week breaches to the Medical Director for a clinical harm review. Where appropriate, the Medical Director will meet and challenge the relevant teams if it is concluded that due process has not been followed.

7.4 Removals from the Waiting List

In the event that it has been decided upon clinical review that a patient should be removed from the waiting list, a waiting list removal form must be completed and scanned into the patient's clinical record. The removal form has been appended to this document (see Appendix E). Any removal from the waiting list must also be communicated in writing to both the patient and their GP and this communication be recorded in the patient's clinical records as a supporting audit trail. Letter templates for a number of reasons for removals from the waiting list can be found in the Appendices, specifically in Appendix F, Appendix G, Appendix H and Appendix I.

As per the sections above on unfit patients and active monitoring, patients with more significant illnesses must be discharged back to the GP for management, which may include re-Referral to other specialist services. In the case of long waiting patients, in recognition of the length of time these patients have been waiting, the decision must be communicated with the patient in writing with a commitment using the following standard text:

> *'Your patient had been waiting for elective surgery at MKUHFT for a long period (34 weeks or more). Your patient is not currently deemed to be fit for surgery, and it is not envisaged that he/she will become fit within the next six weeks. Your patient is therefore being discharged back to your care. Should your patient become fit for this procedure within four months of the date of this letter, please re-refer including the text '**PRIOR LONG WAIT – NOT OPERATED**'. We will endeavour to expedite the patient's operative care (within 18-weeks of re-Referral) in these circumstances with rapid discussion with their surgeon and early pre-operative assessment*.'

8.0 Other Associated Documents

Associated documents to the Access Policy:

Milton Keynes University Hospital NHS Foundation Trust Policies

- Annual/Study and Professional Leave Policy for Medical Staff.
- Data Quality Policy.
- Failsafe & Did Not Attend (DNA) for Colposcopy.
- Incident Reporting Policy and Procedure.
- Information Governance Policy.
- Private Patient Policy.
- Rapid Access Chest Pain Clinic Operational Policy.
- Safeguarding Children Policy and Procedures.
- Did Not Attend (DNA) or Was Not Brought (WNB) Paediatrics Policy

Other local policies

Milton Keynes Safeguarding Children Board Inter Agency Policy and Procedures.
Available at: http://www.mkscb.org/policy-procedures/

9.0 Statement of Evidence/References

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10.0 Governance

10.1 Document review history

Version number	Review date	Reviewed by	Changes made
9.0	Dec 2018	Associate Director of Performance and Information	See below
8.0	Dec 2016	CEO	See below
7.0	Nov 2016	Trust Documentation Committee	See below

10.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Associate Director of Performance and Information	Performance	Dec 2018	Dec 2018	Major revisions; including position on active monitoring following DTA and management of long waiters.	
Chief Executive Officer	Management	Dec 2016	Dec 2016	Update to references to Board accountable and CEO as Accountable Officer	
Trust Documentation Committee	Policy review	Nov 2016	Nov 2016	Minor revisions	Yes
Associate Director of Performance and Information	18-weeks	Nov 2016	Nov 2016	Layout changes made to allow policy to flow more effectively in line with patient pathways	
Performance and Information Manager Information analyst 18ww validators	18-weeks	Feb 2016	Feb 2016	Layout changes made to allow policy to flow more effectively in line with patient pathways	

10.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Access Policy Compliance	Patient Tracking List/ Monthly returns	Data Quality Compliance Board	Weekly	Management Board
18-week Wait performance			Monthly	
RTT data compliance	DQ dashboard	Data Quality Compliance Board	Monthly	Management Board
	Compliance audits	Data Quality Compliance Board	Monthly	
Auditors (Internal/External)	PTL Tool	Audit Committee	Annual	Management Board

10.4 Equality Impact Assessment

As part of its development, this policy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified.

Equality Impact Assessment			
Division	Corporate	**Department**	Performance & Information
Person completing the EqIA	Hitesh Patel	**Contact No.**	86244
Others involved:		**Date of assessment:**	December 2018
Existing policy/service	Patient Access Policy	**New policy/service**	Patient Access Policy

Will patients, carers, the public or staff be affected by the policy/service?	Staff
If staff, how many/which groups will be effected?	All staff

Protected characteristic	Any impact?	Comments
Age	NO	
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?	Refer to consultation history
How are the changes/amendments to the policies/services communicated?	N/A

11.0 Appendices

11.1 Appendix A: Acronyms

Term	Definition
ASI	Appointment slot issue (list): a list of patient referrals where an attempt has been made to book an appointment through the national e-Referral Service but has failed, e.g. no clinic slots available.
CCGs	Clinical Commissioning Groups: Clinical Commissioning Groups are groups of GP Practices that are responsible for buying health and care services for patients, taking over the role from Primary Care Trusts.
CSU	Clinical Support Unit; divisions of Trust business responsible for ensuring delivery of patient care.
DNA	Did not attend: Patients who have been informed of their admission date or appointment date, and who, without notifying the hospital in advance, did not attend that admission/outpatient appointment.
EDM	Electronic Document Management System; records a patient's clinical notes.
GP	General Practitioner: GPs account for a significant proportion of the patients referred to the Trust for assessment and treatment.
PAS	Patient administration system: This is the Trust's current PAS, introduced as part of a national scheme to improve access to patient information aiming for a complete Electronic Patient Record (EPR).
PTL	Patient Tracking List: A list of all patients on an active RTT pathway; used to support the safe and effective management of patients on RTT pathways.
POA	Pre-operative assessment: A system that assesses patients' health before they are admitted to hospital to ensure that they are fit to undergo their elective procedure.
RTT	Referral to treatment: The period from referral into a consultant led service to the start of first definitive treatment, active monitoring or discharge.
UBRN	Unique booking reference number assigned when requesting a referral through the NHS e-Referral service.

11.2 Appendix B: Definitions

Term	Definition
Active Monitoring	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures, sometimes referred to as "watch and wait".
Active Waiting List	Patients awaiting elective admission and are currently available i.e. fit, able and ready to be called for admission.
Admission	A patient attending a hospital ward for either a day case or inpatient procedure.
Admitted pathway	The part of an RTT pathway which starts with a Decision To Admit and ends with the patient being admitted for treatment.
Consultant-led service	A service where the consultant retains overall responsibility for the care of the patient.
Day Case	A patient who is admitted to hospital for treatment but is not intended to stay in hospital overnight.
Decision to Admit	A clinical decision indicating the intention to admit a patient, either as part of an elective care pathway or as an emergency.
First Attendance	The first time a patient is seen in an outpatient setting following referral to a consultant led service (from any source, including A&E). This is also sometimes referred to as a 'new' appointment.
First definitive treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgement in consultation with the patient.
Follow-Up Attendance	Following a first attendance, any subsequent attendance in an outpatient setting which is part of the same patient pathway is referred to as a follow-up attendance.
Fully Booked	Patients who have the opportunity to agree a date at the time of, or within one working day of, the referral or decision to treat.
Inpatient	Patient who is admitted to the hospital for treatment and is expected to remain in hospital for at least one night.
NHS e-Referral system	An electronic booking software application designed to enable patients needing an outpatient appointment to choose which hospital they are referred to by their GP, and to book a convenient date and time for their appointment.
Non-admitted pathway	The part of an RTT pathway which starts with an outpatient referral and ends either when the patient is seen and treated / placed onto active monitoring or is added to the elective inpatient waiting list.
Outpatient	Patient referred to the Trust for clinical advice or treatment. An outpatient attendance usually takes place in a clinic setting, but occasionally will take place on a ward.
Planned Admission	Patients who are to be admitted as part of a planned sequence of treatment or investigations, e.g. long-term monitoring of conditions. Planned admissions do not count as RTT pathways.
Reasonable notice/offer	A choice of two appointments or admission dates within three weeks' notice.
Referral Received	The date an outpatient referral is received by the relevant consultant led service. This is indicated with a date stamp for paper referrals or the date an appointment is booked or attempted to be booked in the e-Referral service.

11.3 Appendix C: The Two Week Wait pathway

The Trust has a dedicated cancer services policy which details both the national rules and local Trust agreements in respect of the management of patients referred on a two week wait (2WW) pathway. Patients and staff are directed to that policy for detailed guidance. Staff are also reminded that two week wait patients are also subject to the national rules for 18-week wait and that the general principles of this policy still apply.

For clarity the waiting time standards for patients on a two week wait pathway are:

- The patient must be seen in an outpatient appointment within two weeks (14 days) of the date that the referral is received into the Trust.
- When a Decision to Treat (DTT) is made for a cancer patient, the patient must then be treated within 31 days.
- The entire cancer pathway, from receipt of referral to definitive treatment, must be completed within 62 days.
- Both the 31 and 62 day waiting time clocks can only be stopped following the delivery of first definitive treatment, placing a patient with a confirmed cancer diagnosis on active monitoring or the confirmation of a non-malignant diagnosis.

11.4 Appendix D: Process to be undertaken for active monitoring/discharge to GP

Table 1: The process to be undertaken for active monitoring/discharge to GP:

Decision	Action	Timescale	Evidence required
Consultant responsible for the patient's care decides that a period of active monitoring **under the exceptional circumstances category** is required following a decision to admit	Decision escalated to the Divisional Clinical Director for review and authorisation.	Within 24 hours from decision taken	Documented discussion in clinical record.
Consultant responsible for the patient's care notifies the relevant staff within the Division that patient can be put on active monitoring based on the **exceptional circumstances category**.	Removal form to be completed with the decision clearly identified; form both signed and dated and a copy sent to the Admissions Office	Within 24 hours from notification by the Consultant to the Division	Signed and dated removal form scanned into EDM
Elective RTT waiting time clock to be stopped	Waiting list encounter removed by Admissions Office using a suitable removal reason	Within 24 hours of receiving the form	Removed waiting list entry and confirmation on RTT PTL tool
Book outpatient appointment to review decision with the patient	Outpatient appointment to be booked	Within four weeks of decision made to actively monitor	Completed clinical outcome form with active monitoring form ticked.
Decision communicated to GP	Letter confirming decision of patient on active monitoring to GP	Within seven days of outpatient appointment.	Completed GP Letter

11.5 Appendix E: Removal from the Waiting List Form

Removal from the Waiting List Form

Consultant Name:	**MRN:**
Patients Name:	**D.O.B.:**
Date:	

Procedure listed for:

Admissions comments: (insert reason why the patient is to be removed from the waiting list)

Please attach form with all relevant information i.e. proforma / last clinic letter etc.

Section 1 – Patient to be removed

Remove from W/L: ☐ → **Discharge back to GP**: ☐

OR

Place on a period of active monitoring: ☐

Timescale of active monitoring: _____

Please note: A patient can only be placed on active monitoring following the agreement of exceptional circumstances. See the Patient Access Policy for further information.

Section 2 – Patient not to be removed

Do not remove from W/L: ☐ → **Review back in clinic:** ☐

Clinical review / Consultant comments: (Insert comments – if clinically appropriate to remove / do not remove)

Clinical Signature: _____ **Date:** _____

General Manage Name: _____ **Date:** _____

General Manager Signature: _____

Milton Keynes University Hospital NHS Foundation Trust

11.6 Appendix F: Letter to Patient and GP - Medically Unfit

Standing Way
Eaglestone
Milton Keynes
MK6 5LD

01908 660033
www.mkhospital.nhs.uk

Hospital No:
NHS No:

<DATE>

<GP Address>

Dear <GP Name>

[Patient name] is currently on our waiting list for [insert procedure].

[Patient name] is currently not fit for surgery due to [insert problem] and it is anticipated that this will be the case for a period greater than two weeks.

As part of our commitment to patient safety and in accordance with Trust policy, the patient's medical records have been clinically reviewed and further to this;

A. [Patient name] has been discharged back to your care and their name removed from our elective waiting list.

[Include B if patient waiting 34 weeks plus]

B. At the time of this decision being made, your patient has been waiting for elective surgery for greater than 34 weeks. Should your patient become fit for this procedure within four months of the date of this letter, please re-refer including the text ***'PRIOR LONG WAIT – NOT OPERATED'***. We will endeavour to expedite the patient's operative care (within 18-weeks of re-Referral) in these circumstances with rapid discussion with their surgeon and early pre-operative assessment.'

Yours sincerely

[Consultant or member of the clinical team]

Copy
<Patient Name>
<Patient Address>

Milton Keynes University Hospital NHS Foundation Trust

11.7 Appendix G: Letter to Patient and GP – Patient Declined Treatment

Standing Way
Eaglestone
Milton Keynes
MK6 5LD

01908 660033
www.mkhospital.nhs.uk

Hospital No:
NHS No:

<DATE>

<Patient Name>
<Patient Address>

Dear <Patient Name>

I understand that following your recent contact with our admissions office, you have indicated that you no longer wish to have [insert procedure].

As part of our commitment to patient safety and in accordance with Trust policy, your medical records have been clinically reviewed and further to this, I am happy to discharge you back to your GP. Your name will be removed from the elective waiting list.

Should you change your mind in the future, please return to your GP in order to be re-referred.

Yours sincerely

[Consultant or member of the clinical team]

Copy

<GP Name>
<GP Address>

11.8 Appendix H: Letter to Patient and GP – Patient DNA

Standing Way
Eaglestone
Milton Keynes
MK6 5LD

01908 660033
www.mkhospital.nhs.uk

Hospital No:
NHS No:

<DATE>

<Patient Name>
<Patient Address>

Dear <Patient Name>

I am writing to you to inform you that you did not attend on <Date> for [insert procedure].

As part of our commitment to patient safety and in accordance with Trust policy, your medical records have been clinically reviewed and further to this;

(Delete A or B as appropriate)

A. A further date for surgery will be offered to you in due course.

B. You have been discharged you back to your GP. Should you decide you still require treatment, please contact your GP for a re-referral.

Yours sincerely

[Consultant or member of the clinical team]

Copy

<GP Name>
<GP Address>

Milton Keynes University Hospital
NHS Foundation Trust

11.9 Appendix I: Letter to Patient and GP – Patient Unavailability

Standing Way
Eaglestone
Milton Keynes
MK6 5LD

01908 660033
www.mkhospital.nhs.uk

Hospital No:
NHS No:

<DATE>

<Patient Name>
<Patient Address>

Dear <Patient Name>

I understand that you have been in touch to advise us that you are not able to accept a date for [insert procedure] within the next two months due to personal circumstances.

As part of our commitment to patient safety and in accordance with Trust policy, your medical records have been clinically reviewed and further to this;

(Delete A or B as appropriate)

A. We have discussed that whilst it may not in your best clinical interest to be removed from the waiting list, you are happy to return to your GP for re-referral when you are available for surgery. Your name will be removed from the elective waiting list.

B. We have discussed that it is best you remain on the elective waiting list and you are aware that any delay (whilst unavoidable) may increase the risk of complications from your condition. You are happy to accept this and your name will remain on the elective waiting list.

Yours sincerely

[Consultant or member of the clinical team]

Copy

<GP Name>
<GP Address>