Milton Keynes University Hospital NHS Foundation Trust

Patient Access Policy

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CQC Fundamental standards:
Regulation 09 – Person-centered 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 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

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Policy Statement

The NHS Constitution is the commitment of the NHS to patients in England on the provision of fair and equitable access to healthcare services and what patients have a right to expect under law. It establishes the principles and values of the NHS for delivering safe and effective patient care and provides the basis for how all healthcare in England is managed. Everyone who works for the NHS is required by law / has a statutory obligation to take account of the NHS Constitution in our decisions and actions.

The event of the Covid-19 pandemic has permanently influenced the forward direction in which the NHS drives better patient care with new clinical initiatives to better prioritise treatment and to evaluate where interventions may not be necessary. At the same time, Trusts are under pressure to restore elective care performance to pre-pandemic levels, resolve the elective waiting list backlog and to find increasing levels of clinic and bed capacity to accommodate this. This has had a major impact on the design and content of the Patient Access Policy.

This policy represents the commitment of Milton Keynes University Hospital NHS Foundation Trust (MKUH or 'the Trust') to the provision and delivery of both safe and effective patient care under the terms of the NHS Constitution. To bring this commitment closer to individual staff, the Trust values align as follows:

- **We Care** about our patients and how they are treated.
- **We Communicate** where there are delays on care pathways and account for the reason(s).
- **We Collaborate** to improve care pathways and eliminate unnecessary intervention.
- **We Contribute** ways in which as individuals we can improve processes.

Purpose and scope

1. To enable the safe, efficient, effective, and equitable treatment of patients with the minimum of clinical intervention and using best clinical practice.

2. To provide the best range of care options to patients, maximising their right to choice in the care and treatment they need.

3. To set out the rules on the management of clinical pathways aligned to the natural order of a patient journey, with clear timescales and without blanket bans.

4. To provide a transparent, consistent, and clear approach to the management of patients on elective 18-week Referral to Treatment (RTT) pathways and in the light of Covid-19 and elective care recovery.

5. To make clear both the collective and individual responsibilities required in support of the above.

This policy does not include support for mental health elective care pathways as this service is not provided by the Trust.

Implementation and dissemination of document

All staff and non-executive directors are obligated to adhere to this policy. Managers at all levels are responsible for ensuring that the staff for whom they are responsible are aware of and adhere to this policy. They are also responsible for ensuring staff members are updated in regard to any changes in this policy. This policy document will be made available through the standard Trust Documentation webpage, as well as via a dedicated Wiki page.

1.0 Roles and Responsibilities

It is a fundamental tenet of this policy that safe and effective patient care is the responsibility of every member of staff as an embedded part of Trust culture and values. However, there are key individuals and groups that have specific governance functions related to elective care and these are detailed below.

All individual staff – All staff are personally responsible for ensuring the highest standards of professional conduct are met. Adherence to this and all Trust Policies is enshrined in performance standards which form part of formal appraisal and pay progression. Individual staff are also responsible for raising any concerns they have about adherence to this policy via their line manager.

Information Asset Owners / Administrators – Information Asset Owners (IAOs) are responsible for providing assurance on the information assets (systems) they own, including completion of the System Data Quality Assurance Report (Appendix 1 of the Data Quality Policy) and thereby managing the quality of data entered into those systems. For large systems, e.g. the Trust Patient Administration System (eCARE), this responsibility may be delegated to one or more senior roles within the Trust - referred to as Information Asset Administrators (IAAs) - for day-to-day system management, although the IAO remains accountable.

1.1 Key Governance Groups

For the current published Organisational structure, please refer to the link in Appendix 10.

Trust Executive Committee – (TEC) – The TEC has oversight of the operational management of the Trust, ensuring that the Trust meets all its statutory obligations to patient care under the terms of the NHS Constitution. It achieves this by receiving reports on Trust performance, service delivery and risk management from all delegated areas of responsibility through upward reporting from the Divisional Performance Review Meetings and holds these areas to account for delivery.

Audit Committee – Responsible for providing assurance that internal controls for the whole of Trust operations are working effectively and enabling the Trust to continue in fulfilling its regulatory requirements. The Audit Committee achieves this by ensuring that the system for doing this (the Board Assurance Framework) is fully informed from the results of internal and external audit work and operational / performance reporting from the Trust's other committees. The Audit Committee is responsible for agreeing the Trust's annual audit plan which should include a regular review of waiting list management.

Divisional Performance Review Meeting – Responsible for providing assurance to the Trust Executive Committee that elective patient care is being effectively managed. It achieves this by holding the Divisions accountable for delivery against national standards and targets through measures including key performance indicators and audit reporting as well as overseeing the development and implementation of plans where performance requires improvement. The Divisional Performance Review Meeting also serves as a vital source of challenge to the business, ensuring that controls around elective care are effective and that the appropriate level of scrutiny is in place.

Data Quality Governance Group – Receives reports on areas of poor data quality specifically for data entered into the Trust Patient Administration System (referred to hereafter as eCARE) and is responsible for the delivery of action plans to improve them, providing data quality assurance to the Divisional Performance Review Meeting. This group is an important control in the management of elective care including admissions, appointment booking, clinic management and review of changes to associated processes and supporting documentation.

PTL Review Meeting – Reporting upwards to the Operational Board, the PTL Review Meeting functions as a control in the management of RTT performance at a patient and specialty level. It receives reports from internal, regional, and national teams on areas of poor RTT performance, including long waiting patients and RTT data quality issues, developing and monitoring action plans to improve them.

Divisional PTL Review Meetings – Reporting into the PTL Review Meeting, the Divisions meet weekly to review all patients on their waiting lists and identify any operational challenges in moving patients on to the next stage of their care, e.g. delays with diagnostics, bed availability, clinic capacity. These meetings are also used to track progress with any requirements established by the PTL Review Meeting, e.g. national target performance.

1.2 Key Executives

Chief Executive Officer (CEO) – Has overall accountability for the management of the Trust and its performance against all national statutory obligations internally to the Council of Governors and externally to its monitoring bodies, including the Care Quality Commission (CQC) and NHS England. The CEO receives direct assurance from both the Director of Operations and Deputy CEO on all aspects of elective care and associated risk, including the underpinning data quality of all relevant performance indicators, including those used in waiting list management.

Director of Operations – Has executive accountability to the CEO for the delivery of safe and effective patient care through the management of patient services and that all associated controls are in place and effective. They have overall management responsibility for all operational staff that record data onto the Trust's information systems and are therefore ultimately responsible for the ensuring accuracy of this data and information, i.e. data used in waiting list management.

Deputy Chief Executive Officer (Deputy CEO) – Has executive accountability to the CEO for the internal and external management of elective care performance reporting, including performance against national waiting time targets and that all associated controls are in place and effective. The Deputy CEO works closely with the Director of Operations to develop and maintain reporting controls on elective care, including development and use of the PTL and reporting strategies to support chronological booking.

Medical Director – Has executive accountability to the CEO for ensuring that clinicians and management work effectively to deliver safe and effective patient care. Through the Divisional Performance Review Meetings the Medical Director receives assurance from Clinical Directors and Heads of Service that internal controls for clinical services are effective and working, including theatre utilisation and clinical management of patient pathways, including use of clinical prioritisation and the Evidence Based Interventions Programme (EBI).

Divisional Directors – Are responsible for working with leadership in the Divisional Triumvirate (i.e. management lead, clinical lead, and nursing / allied health professional lead) to ensure the delivery of safe and effective patient care at an operational level and are accountable to the Medical Director. Divisional Directors are responsible for overseeing the management of clinical prioritisation, patient harm reviews and making the final clinical decision for all patients who are to be put on active monitoring following a decision to admit the patient for treatment. They will also work with individual clinicians in support of an understanding of their obligations under RTT management.

Associate Director of Performance – At a Trust lead level, the Associate Director of Performance has responsibility and accountability to the Deputy CEO for both monitoring and reporting of elective care performance. Where performance is below required standards, they drive improvement through both projects and independent review, working closely with all key stakeholders to ensure the timely delivery of any recommendations.

1.3 Heads of Department

Clinicians – Working closely with Divisional Triumvirate, clinicians are directly responsible and accountable for the safe and effective management of a patient's medical condition(s), including their diagnosis, treatment, and monitoring and where appropriate a patient's onward referral to another healthcare provider. Clinicians have a particularly important role to play in providing a clear, consistent, and timely account of clinical decision making and guidelines to booking teams on when to escalate delays in patient care. This supports RTT outcomes and enables effective RTT waiting list management.

Associate Directors and Heads of Service – Working with their Divisional Triumvirates, Associate Directors and Heads of Service are responsible for ensuring that their waiting lists are managed effectively, using a combination of the online PTL Tool, and supporting internal reports to treat the right patients, at the right time. Associate Directors and Heads of Service are also responsible for monitoring day to day waiting list performance, identifying, and resolving associated risks particularly to clinic capacity management and theatre utilisation and reporting on challenges to Operational Board and upwards to the Divisional Performance Review Meetings.

Associate Director of Patient Services – Specifically responsible and accountable for the safe and effective operational management of Patient Services, providing timely access to both outpatient and elective care and enabling treatment to be provided in compliance with national rules on Referral To Treatment (RTT) and booking priority order. They are also responsible for using all available reporting to ensure the controls around service provision are effective and working, including overall management of the E-Referral Service (ERS) Directory of Services (DOS) (including sign-off of any changes) and providing assurances and data quality issues to the Divisional Performance Review Meetings.

Head of Informatics – At a Trust lead level the Head of Informatics has both responsibility and accountability for the provision of data and information used in the reporting of Trust performance, both internally and externally, providing both quality assurance and effective controls on reporting. Working closely with the Associate Director of Performance, The Head of Informatics also ensures that data is processed correctly in accordance with national and local guidance, supporting audits and process improvement initiatives to drive continuous improvement in data quality and waiting list performance.

Data Warehouse Manager – Responsible for ensuring that all data recorded and stored in the data warehouse conforms to national code value standards and subject to robust internal control processes for security, modification, and updates. They are responsible for the management of controls for the business rules which create RTT patient pathways (referred to hereafter as the 'RTT Algorithm') which is the most fundamental aspect of patient pathway reporting.

Individual Line Managers – Supporting their Associate Directors and Heads of Service, 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. This includes ensuring that wherever possible, data entry is as close to real time as possible and particularly where this relates to waiting list activities outside of the Central Booking Office, e.g. adding patients to elective waiting lists following attendance to the Emergency Department (ED). Where relevant, lack of compliance with the Patient Access Policy should form part of staff appraisal under the subject of skills / training.

1.4 Teams

Performance Management Team – Supporting the Associate Director of Performance, the Performance Management Team will offer subject matter advice and guidance on the management of patient pathways. They will also support with independent review guided by Divisional need and by areas of poor operational performance, supporting with recommendations for service improvement where appropriate.

Information Team – Supporting the Head of Informatics**,** the Information Team are responsible for the submission of the Trust's national data returns on RTT and for implementing any changes to submission requirements, highlighting any challenges, and working with the Divisions and the Associate Director of Performance to ensure any new data collection requirements are met. Using tools developed both nationally and internally, the Information Team will highlight any areas of poor RTT data quality and work with the other teams in this section to deliver improvements.

Back Office Team –a centralised function that manages the information architecture in eCARE. This includes the maintenance and updating of stored reference code tables, planning and implementation of system upgrades, design and implementation of system testing and identification and resolution of eCARE system issues. The team also supports routine system changes where information on clinics and staff may need to be updated, for example changes to outpatient clinic templates and the maintenance of the ERS Directory of Services (DOS).

Central Booking Office –a centralised function that manages the booking of all elective and outpatient appointments, including cancellations / reschedules and Did Not Attend (DNAs) ensuring that all patients are booked in the correct priority order and in accordance with national guidelines, particularly around cancer waiting times and RTT.

PTL Validation Team –a centralised function under Patient Services that validates RTT pathways according to national guidance and supports the Divisions in the correction of these where errors have been identified. The PTL Validation Team will work closely with the Head of Informatics and the Data Warehouse Manager to ensure that RTT pathways are reported correctly and with the Systems Training Team and Performance Management Teams to feedback any process issues driving errors in RTT pathways so that support can be given to individual staff.

Systems Training Team - a centralised function under Patient Services that trains Trust staff in the use of patient information systems such as eCARE, other essential training in this policy, and for maintaining and providing access to relevant guidance documentation. As a key control process, the Systems Training Team will work closely with the teams in this section to continually review and develop training in response to any process or technical issues identified with data entry, so training remains relevant and up to date.

1.5 Community

General Practitioners (GPs) –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. GPs must use the E-Referral System (ERS) to book referrals and check that such referrals are directed to the most appropriate service, not duplicated with potentially existing referrals, and that referrals are made against the best clinical practice, particularly where Advice and Guidance requests may be more appropriate.

Patients –have a personal responsibility to ensure that they manage their appointments appropriately, either attending their hospital appointment or ensuring that they contact the hospital with as much notice as possible to cancel or reschedule if they are unable to attend. This allows the Trust to offer any available appointments to other patients where appropriate and manage clinics more effectively, reducing the levels of DNAs. Patients must ensure that the details held about them by their GP are accurate and up to date in order to prevent delays in receiving care.

Referral Management Services (RMS) – Also known as Interface Services, RMS are a service layer between GP practices and NHS Trusts, intended to triage or potentially manage a patient's condition and avoid onward referral. RMS services have a responsibility to ensure that there are no unnecessary delays which will impact a patient's waiting time should an onward referral to an NHS Trust be necessary.

2.0 The 18-week Pathway – General Principles

2.1 The NHS Constitution and Patient Waiting Times

Under the NHS Constitution, patients have the right to "start [their] consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions." This is a fundamental principle of the constitution and is the basis from which all RTT waiting list management stems. Trusts must ensure that as per the national performance standard, 92% of patients reported on incomplete pathways must be waiting less than 18 weeks for their treatment.

Patients who are referred to a consultant-led service start an RTT pathway with a clock start time on receipt of referral and a clock stop time on receipt of treatment (which may be admission), active monitoring (also known as 'watchful waiting') or patient discharge. There can be no pause (suspension) at any point in-between and the patient breaches their waiting time on day 127 (18 weeks plus 1 day). If diagnostics are requested as part of the RTT pathway these carry a separate waiting time (see Section 5.0).

Figure 1 – RTT pathway flow

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

Stage in Pathway	Maximum Waiting Time
First Outpatient Appointment	Six weeks from referral received date to date seen
Diagnostic Tests	Six weeks from date requested to date of appointment
Elective Admission	Twelve weeks from Decision to Admit to inpatient admission

Occasionally the Trust 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 that any delays are minimised.

The Trust has separate policies covering the following types of referrals, however the rules on RTT within this Policy still apply:

- Referrals for cancer Two Week Wait (2WW) patients.
- Referrals to the Rapid Access Chest Pain service.
- Referrals to the colposcopy service from cervical screening.

Please refer to Section 9.0 for links to these policies.

2.2 Covid-19 and the Elective Recovery Programme

The event of Covid-19 does not change any of the rules which govern how RTT pathways are recorded. However, its impact has resulted in an elective care backlog which has required a specific NHS England driven recovery programme (Elective Care Recovery Programme - ERP) and transformed how patients are managed both to effectively manage patient care in the community and avoid referral and to expedite care when on an RTT pathway. These initiatives are mentioned in greater detail within this policy where appropriate.

2.3 The Evidence Based Interventions Programme

Evidence Based Interventions (EBI) are a series of clinical procedure / diagnostic guidelines based on available evidence, designed to prevent medical or surgical interventions where these might be counterproductive or risk patient harm. This approach also provides a means to reduce the number of resources that are used unnecessarily and allow the saved time to be used in both the development of new and more effective interventions, as well as making existing resources more available to patients and reduce patient waiting times. These initiatives were established before the event of Covid-19 but remain an important tool in supporting the ERP.

2.4 National Referral to Treatment Rules and Definitions

So that all Trusts work to the same terms and definitions for RTT, there are some terms which are particularly important to provide below as these define the length of an RTT pathway. There are no blanket rules in RTT (e.g. patient discharge after two cancellations) as all decisions must be clinically guided and focus on patient safety.

2.4.1 Clock Starts

The RTT clock starts when a patient is referred to a consultant-led service, defined as:

"A service where a consultant retains overall clinical responsibility for the service, care professional team or treatment" and where a consultant is defined as *"A person contracted by a health care provider who has been appointed by a consultant's appointment committee and must be a member of a royal college or faculty."*

Note that referrals to therapy services, e.g. Physiotherapy, do not start a new waiting time clock as these services are not consultant led.

A clock will typically start in the following scenarios:

- a Unique Booking Reference Number (UBRN) is converted to an appointment (or an attempt made) in the E-Referral system (this includes where the referral is booked first to RMS - see Section 3.4);
- receipt of an internal referral must be date stamped on receipt.
- receipt of an inter-provider transfer form (i.e. between healthcare providers).
- adding a patient to the admitted waiting list following a period of active monitoring.
- a new and significantly different treatment plan is agreed between consultant and patient
- Straight To Test (STT) diagnostics (see Section 5.1).

If a decision is made to start a significantly new or different treatment plan, the RTT clock will start on 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.

2.4.2 Clock Stops

The RTT clock stops when:

- a definitive treatment is given (outpatient setting);
- the patient is admitted and is treated (surgery);
- a period of active monitoring is applied (see Section 4.0 Outpatients for main guidance);
- the patient is discharged (treatment not required); or
- the patient's care is transferred to another healthcare provider.

Definitive treatment is defined as "*A clinical intervention intended to manage a patient's disease, condition or injury and avoid further clinical interventions*."

What constitutes definitive treatment is decided by the clinician and where appropriate will take into consideration the view of the patient and other healthcare professionals.

2.4.3 Patient Choice to Delay

A patient has the right to delay their treatment for social or personal reasons even if such delays also result in patients breaching their 18-week waiting time (e.g. outside of school term for teachers or university term for students). When such delays occur, the patient is responsible for informing the Central Booking Office who will in turn notify the consultant responsible for the patient's care, so that a clinical review can take place and a clinical decision made as to the risk to the patient of delaying treatment. Such delays are accounted for in the 8% margin for RTT 18-week performance.

What constitutes a delay is subjective, however, for guidance, if the delay is greater than three months, this would be a reasonable trigger for clinical review. However, a delay of three months should not be seen as a blanket delay period to instigate the above process if an earlier review is appropriate, e.g. for children or vulnerable adults.

A clinical review will result in one of two outcomes:

1) The delay will **not cause** any clinical risk to the patient in which case 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.

2) The delay **will cause** a risk to the patient in which case these risks must be communicated to them by the consultant and should the patient accept the risks, a period of active monitoring may be agreed if that is clinically appropriate (see also 4.8 active monitoring). If it is clinically inappropriate to delay treatment, the consultant may discuss the matter with the patient's GP and decide on a course of action which is appropriate.

   If the patient does not want to accept the risks, they will need to decide whether they still wish to delay their treatment (see also 2.4.4 thinking time below). Should the outcome be that they do still wish to delay, they will be removed from the waiting list.

Either 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 F for the standard letter template).

In all cases of clinical review, the relevant clinical risk assessment will also be documented in the patient's clinical record.

2.4.4 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 an RTT clock. The patient should be asked to contact the Trust within an agreed period with their decision; the agreement and timescale 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 more 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 then be re-referred by the GP.

2.4.5 Reasonableness

Reasonableness is a term that is applicable to all offers of appointment, including outpatient appointments, diagnostic tests and To Come In (TCI) dates for admission. For the purposes of this policy and as defined under national rules, 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 potentially be discharged back to their GP. Note however that if a patient has stated unavailability for a specific period of time (see 2.4.3 above) then two offers within that same period of time would not be considered reasonable.

2.4.6 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. Otherwise, the patient will remain on the Trust waiting list until treated or otherwise discharged.

2.4.7 RTT Exclusions

Under the national rules, the following services and types of patients are excluded from RTT:

- Obstetrics and midwifery.
- Planned patients (please see also section 6.13)
- Referrals to a non-consultant led service.
- Referrals for patients from non-English commissioners.
- Genitourinary medicine (GUM) services.
- Emergency pathway non-elective follow-up clinic activity.

2.5 Special Patient Groups

2.5.1 Armed Forces Personnel

In line with the Armed Forces Covenant enshrined in the NHS Constitution, all veterans, reservists 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.

GPs 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.

Active serving military personnel must not be removed from NHS waiting lists as a result of re-deployment outside the area of service for MKUH unless this is clinically appropriate and / or their care has been transferred to another Healthcare Provider (see also sections 2.4.6 and 5.5).

2.5.2 Persons Detained under HM Prison Services

All RTT waiting time standards and rules apply to persons detained under HM Prison Services. 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, i.e., the clock continues.

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.

2.5.3 Private Patients

Patients may choose to transfer their care between private and NHS providers. There are two scenarios for this:

1) In the case of a patient transferring from private to NHS care, the RTT clock will start on receipt of the referral by the NHS provider. This is on the assumption that the referral is accepted.

2) In the case of a patient transferring from NHS to private care, the patient will be discharged from their NHS care and at this point will end any active RTT waiting time clock. Once a patient has been transferred to private care, they can only return to NHS care via their GP who will then issue a new referral.

In the event a patient is seen at the Trust in a private capacity, they do not start an RTT waiting time clock but are subject to the Trust's Private Patient Policy and cannot be seen within the time of a clinicians NHS clinic list / theatre list.

2.5.4 Overseas Patients

Overseas patients are entitled to access NHS emergency services free of charge but may be required to pay for ongoing care. It is important that wherever possible, patients who may have to pay are identified, typically through either a pseudo postcode (starting ZZ99) and/or no NHS number and their entitlement to services managed via the Overseas Visitors guidance and Private Patient Policy (see Section 9.0 for links).

3.0 Referrals

Referrals to consultant-led services must always be made with the intention to manage a patient's condition in the most clinically effective way by using the most appropriate services available. Referrals must be managed according to locally agreed timescales with line of sight to the national 18-week RTT waiting time and must not be delayed unnecessarily at any stage of the process, including where a referral cannot be booked at point of care.

3.1 Referral Action Timescales

Patients who are referred into consultant-led services must have their referrals actioned according to the following locally agreed timescales:

Action	Timescale	Organisation / Role Responsible
Booking referrals from the Appointment Slot Issue (ASI) list or Referral Assessment Service (RAS) list	Within 5 working days from the date referral appears on ASI or RAS list	Central Booking Office (CBO)
Date stamp incoming paper referrals and record these onto the eCARE system (e.g., Inter Provider Transfer - IPT)	On the day of receipt	Role responsible for processing internal mail for Central Booking Office or clinical area
Clinical review of referral with outcome, i.e., acceptance, re-direction, or rejection	Within 24 hours of receipt	Clinician to whom the patient is being referred

3.2 Receiving Referrals

3.2.1 Sources of Referral and Referral Standards

The Trust can receive referrals from the following sources:

- General Practitioners (GPs) through ERS.
- internal referrals from Allied Health Professionals (AHP) or Clinicians.
- Inter-Provider Transfer (IPT) from other NHS healthcare providers.
- community referrals, e.g. Opticians, Dentists.
- private to NHS transfer.

All referrals from GPs must be received via ERS 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 it is in the clinical best interest of the patient and any delay would compromise patient care. This is to allow the patient a choice of provider where appropriate, should they not wish to be treated at this Trust.

Referrals must also satisfy the following requirements:

- contain up to date demographic information (e.g. address and contact numbers);
- contain complete and relevant clinical information;
- be directed to the most appropriate clinical service (see Section 3.2.2 below).

3.2.2 Directory of Services (DOS)

The DOS is a list of the consultant-led services that the Trust provides through the ERS. In effect, it is the shop window of the services offered by the Trust to its patients and is what the GP will access when referring a patient to secondary care.

GPs must ensure where possible that referrals are made to the right service first time. There must be a consistent feedback loop between GPs and service providers where patients are directed to inappropriate services to ensure that patients are not delayed in receiving care.

The DOS must be maintained regularly to ensure that the available services are up to date and any changes to the DOS must be agreed between the Divisional Managers and Consultants in conjunction with the Associate Director of Patient Services. The Associate Director of Patient Services will then ensure that the services offered are correctly reflected on ERS, and action any changes in a timely manner.

Where clinically appropriate, referrals should always 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.

A DOS should include a range of services, designed to offer the most clinically appropriate options to patients, and which may involve expert clinical guidance offered to the referrer instead of asking the patient to be seen in clinic.

3.3 Directly Bookable Services

These services offer the patient the option to book directly into an appointment for a specific service from a given range of dates or if none are available at the time of booking, the patient will be placed onto a queue known as the Appointment Slot Issue (ASI) list for booking by the Trust (see Section 3.7). The RTT clock starts for these patients when an attempt is made to book the referral.

3.4 Referral Management Services (RMS)

RMS Services are designed to offer a range of clinical options to the referrer for the patient where it may not be appropriate to refer them into a directly bookable service. Where the RMS service is an assessment service, i.e., no treatment is provided, the RTT clock will continue until the patient is referred on to another service and subsequently treated or is referred back to the GP with advice and guidance.

3.4.1 Referral Assessment Services (RAS)

If it is unclear to the referrer which service is most appropriate, particularly for more complex care needs, they can refer into a Referral Assessment Service (RAS) from which a clinician can review the referral and decide on the next appropriate course of action (e.g. diagnostics, first appointment or Advice and Guidance).

Once referred, patients then appear in ERS on the Referrals for Review worklist with the RTT clock starting on the date that the referral appears on the RAS. This worklist must be managed on a daily basis with actions performed within locally agreed timescales (see Section 3.1).

3.4.2 Clinical / Telephone Assessment Services (CAS / TAS)

Where a multi professional approach to patient care might be more appropriate, a GP can refer into a CAS (face to face appointment) or TAS (virtual or telephone) service. These services may involve healthcare professionals from either the community, e.g. GPs with a Special Interest, or consultants from secondary care and are intended to direct a patient to further services where it is not entirely clear which service a patient may need on initial referral. They do not provide treatment.

As with Directly Bookable services, referrals to CAS/TAS will start an RTT clock when an attempt is made to book the appointment and if none are available, the patient will be placed onto the ASI list (see Section 3.7).

3.4.3 Interface Services

An Interface Service is a specific type of RMS which exists between GP care and Secondary (Hospital) care and may offer the patient the prospect of treatment without onward referral to secondary care. Patients referred to such services will start an RTT clock from the date the referral is booked to the interface service and if treatment is provided then the RTT clock will stop. However, if the patient is referred on to secondary care, the RTT clock will continue or if they had been treated, a new RTT clock will start on receipt of the referral by the Trust.

3.5 Advice and Guidance

Where a GP requires specialist advice or guidance to support patient care in the community, they may refer in to such a service within ERS where these referrals do not start an RTT clock. GPs should be encouraged to use such services wherever clinically appropriate to reduce the need for patients to be reviewed in clinic unnecessarily.

3.6 Referral Review

Clinicians must have the opportunity to review the appropriateness of referrals into their service which will result in one of the following outcomes:

1. Approving the referral into the service (and adjusting the clinical priority if required)
2. Re-direction of the referral to another service / clinician in the same service (Special Interest).
3. Rejection of the referral (e.g. if the service is inappropriate).
4. Provision of Advice and Guidance if this service was selected by the GP.

Referrals must be reviewed within the timescales set out in 3.1 above. If on reviewing a referral letter a clinician either re-directs or rejects the referral, it is good clinical practice to provide an explanation for this action to enable appropriate feedback to be given to the referrer.

If a referral is re-directed, the RTT clock will continue on to the new service. If it is rejected, the RTT clock will stop, and the patient will be discharged from the service.

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

3.7 Appointment Slot Issue (ASI) List

If no appointments are available for referrals sent through either a directly bookable or RMS route, they are placed into a queue known as the Appointment Slot Issue (ASI) list and are referred to as 'deferred' to the service provider in ERS. Deferred referrals remain with an active RTT clock and must be managed such that this worklist remains as close to zero patients as possible.

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

3.8 Referrals 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 three scenarios where this is possible:

1) The patient is referred to another specialty for Advice and Guidance as part of their ongoing care, e.g. a cardiac opinion prior to surgery. In this scenario, the RTT clock will continue with the referring specialty and will only start a new clock with the receiving specialty (from the date of referral) if the patient needs to be seen in clinic.

2) The patient is referred to another consultant within the same specialty for specialist care, e.g. from a hip specialist to a knee specialist. In this scenario, where the patient has not been treated (e.g. in the case of re-direction of referrals), the RTT clock will continue, otherwise a new clock will start from the date of referral.

3) The patient is referred to another consultant-led service in a different specialty, e.g. as a result of a finding on diagnostics requiring treatment under another specialty. In this scenario, a new RTT clock will start for the receiving specialty from the date of referral and may continue for the referring specialty depending on clinical outcome.

Where the referral is redirected to another consultant in the same specialty, it may be advisable to provide feedback to the GP if the initial referral was sent to a named consultant rather than being pooled within a specialty as recommended (see Section 3.2.2).

Requests for Advice and Guidance will not start a new RTT clock unless the receiving specialty decides the patient needs to be seen in clinic, in which case a new RTT clock will start from the date of receipt of the referral.

3.9 Inter-Provider Transfers (Tertiary Referrals)

During a patient's RTT pathway, it may be clinically necessary or more appropriate for their care to be continued at another healthcare provider. In such cases, a mandatory minimum data set (IPT proforma) must be completed using the clinic outcome system and transferred to the receiving provider.

The responsibility for the patient's RTT pathway is transferred with the clinical responsibility and as such, the originating provider must ensure that the patient's initial RTT clock start date forms part of the onward referral information.

If a patient is only being referred for a diagnostic test, the referring Trust retains responsibility for the RTT pathway.

4.0 Outpatients

Where it is clinically appropriate, GPs and clinicians should consider directing referrals to services that enable patients to be treated in the community, including increased use of Advice and Guidance. Where this is not appropriate, Trusts should offer services that allow patients to be seen virtually rather than face to face. Use of follow-ups must be based on Evidence Based Intervention (see Section 2.3) and where required and clinically appropriate, patients should be offered Patient Initiated Follow-Up (PIFU – see Section 4.7) rather than arbitrary review.

As with the management of referrals, there are no blanket rules and all decisions on patient care, including outcomes of multiple patient rescheduling / cancellation / Did Not Attend (DNA) must remain with the consultant in charge of that patient's care.

4.1 Booking of Outpatient Appointments

Following referral to a consultant-led service, where an appointment is required and needs to be booked, patients must be booked in order of clinical urgency and then length of wait with any specialty level priorities considered. To do this correctly, booking staff must ensure that they are sighted on patients from all waiting lists, including ASI and Referrals for Review.

In circumstances where patients are not able to be given reasonable notice as defined in Section 2.4.5, they must be telephoned to offer an appointment and the RTT clock will not be reset if they are unable to accept it. When contacting patients, reasonable effort must be made to arrange calls when patients are most likely to be available, including noting any patient availability comments in ERS.

4.2 Face to Face and Virtual (Telemedicine) Appointments

Where it is possible and clinically appropriate, a patient should be offered a virtual appointment, i.e., via telephone or video call. Every effort must be made by clinicians in collaboration within their Divisional triumvirates to provide such services where they are clinically appropriate. Virtual appointments are often more convenient for patients, making them less likely to cancel or not attend. They can also reduce patient wait times and increase the availability of clinic resources for patients who do require a face-to-face appointment.

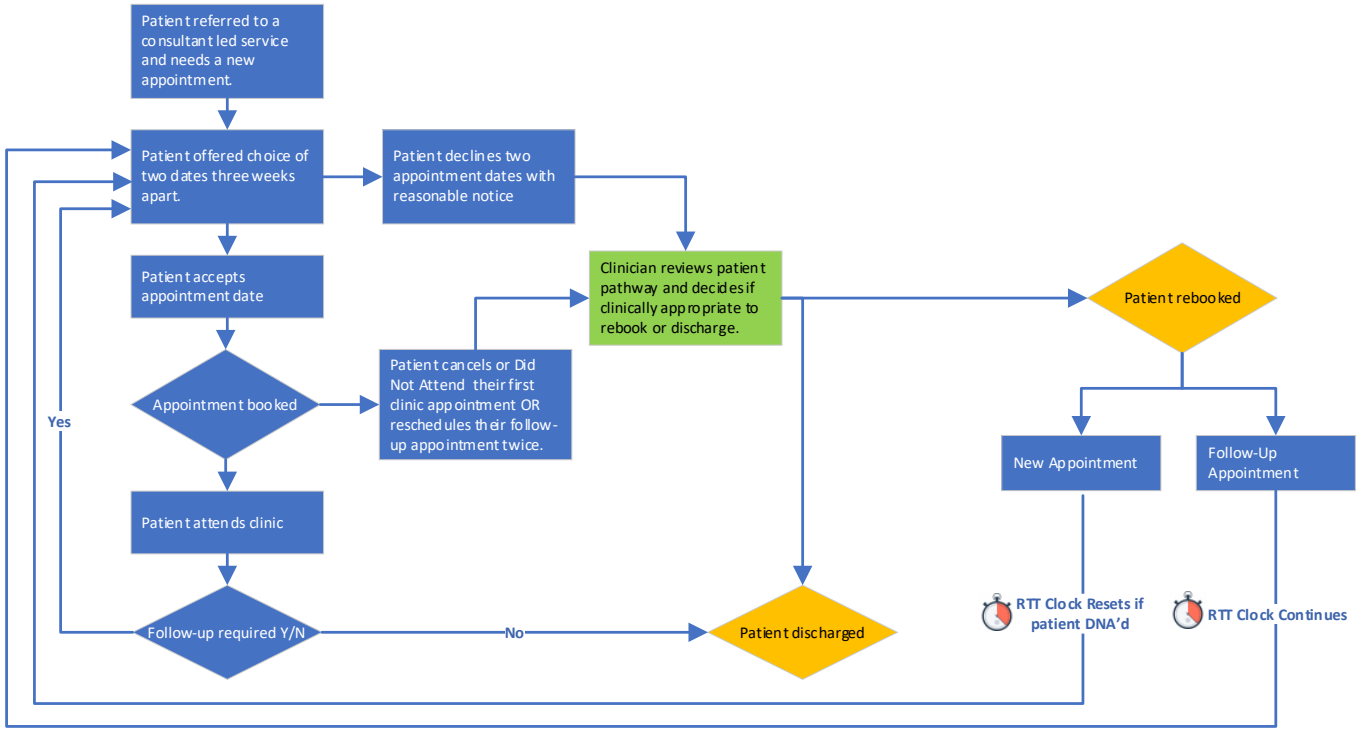
4.3 Cancelling / Rescheduling Appointment Dates

Patients are entitled to cancel or reschedule their appointment and be offered a further appointment if required within the reasonableness criteria (2.4.5). The workflow for cancellations / reschedule / DNA is in sections 4.3.1 and 4.3.2 below and applies to all patients. However, the Trust also has separate policies for safeguarding adults and children and a Was Not Brought Policy for paediatric patients which must be followed alongside this policy and workflow as appropriate.

4.3.1 Patient Cancellation, Reschedule or Did Not Attend (DNA)

The workflow diagram below should be used by booking staff to guide the management of patient cancellations, reschedules or Did Not Attend (DNA). No patient may be discharged from care as a result of this process unless the consultant in charge of the patient's care has reviewed the pathway and has decided that it is clinically appropriate to do so.

Diagram 1 – workflow for the management of cancellations / reschedule or DNA.



With reference to the above workflow, please note the following:

- If the patient is discharged following clinical review, the RTT clock will stop. In the case of a first appointment, this will also nullify the clock, i.e., as if the patient was never referred.

- If the patient is rebooked, the RTT clock will continue but in the case of a first appointment, it will be reset to the date the patient contacts the Trust to rebook their appointment.

- Cancellations up to the time of the appointment are classed as cancellations and not as a Did Not Attend (DNA).

If the patient is discharged, the clinician must communicate this decision to both the patient and the GP in writing. For patients who DNA, the Trust will need to be able to demonstrate that the appointment offer was agreed in principle and clearly communicated to the patient. If reasonableness cannot be adequately demonstrated, the patient's clock cannot be reset.

4.3.2 Hospital Cancellations / Reschedules

It is the Trust's policy to avoid hospital cancellations or reschedules wherever possible. The Trust's leave policy Annual/Study and Professional Leave Policy for Medical Staff states that a minimum of eight weeks' notice **must** be given by consultants (and a minimum of six weeks for SAS doctors) 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 Associate Director for the Division (or delegated authority), 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 patient appointments have to be cancelled and rescheduled by the Hospital, these must be rebooked in accordance with current clinical / administrative protocols and in priority order and no review of the patient record is required. If a patient cancels their hospital appointment, a clinician should review the patient's medical record to ensure that any risk of patient harm is identified and appropriately communicated to the patient. See also 4.3.1 Patient Cancellations.

4.4 Documentation Standards

In keeping with the Health Records Policy Section 3.5, all staff involved with providing patient care must ensure that patient records remain an up to date and accurate reflection of care provided to the patient. In particular, the following documentation must be completed comprehensively and as close to the time of the appointment as possible:

- Outpatient clinic letter(s)
- Addition To Waiting List proforma.
- Clinic outcome form.
- Inter Provider Transfer (IPT) proforma.

Clinic letters must document a patient management plan that allows staff tracking patient pathways to easily identify where a patient should be on that pathway. In accordance with national best practice, clinical letters must be available within 5 working days of the clinic appointment.

4.5 Clinic Outcome Forms

Clinic outcome forms are an essential part of the RTT pathway, containing a list of nationally defined RTT events from which the clinician must select in order to correctly reflect where a patient is on their RTT pathway. The form must be completed in clinic and the RTT events electronically transcribed on the Clinic Outcome portal for use in the RTT algorithm.

The list of available options on the clinic outcome form is determined by a set of national RTT status codes. Where the clinical decision on next steps in patient care does not instinctively translate to one or more RTT status codes, the clinician seeing the patient must seek advice from the Pathway Validation Team to ensure the closest options are selected.

The table below provides a list of the available RTT status options on the Clinic Outcome Portal and how the RTT clock is impacted by that selection. In the case of multiple options selected, an option which stops the RTT clock will always take priority.

Table 2: Clinic Outcomes with their RTT Clock Status

Clinic Outcome	RTT Clock Status
Sent For Diagnostics	Clock continues
Added To Inpatient Waiting List	Clock continues
Outpatient Minor OP Clinic	Clock stops
Referred To Another MK Clinician	Situational
Referred To Another MK Professional	Situational
Referred to Tertiary Provider	Situational
Definitive Treatment Starting Now	Clock stops this visit
Definitive Treatment Started Previously	Clock stopped previously
Definitive Treatment Not Required	Clock stops this visit
Definitive Treatment Declined by patient	Clock stops this visit
Active Monitoring Starting Now	Clock stops this visit
Active Monitoring Ongoing	Clock stopped previously
Discharged	Clock stops this visit

Whether an RTT clock stops for referrals to another MK clinician, professional or to a tertiary providers depends on the clinical intention (see 3.8).

When completing the RTT status on a clinic outcome form it must also be logical, and the following examples, whilst not exhaustive, illustrate where there may be issues with the recording of outcomes:

- Definitive Treatment Started Previously for a first appointment.
- Active Monitoring Ongoing for a first appointment.

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

4.6 Partial Booking (Non-RTT Request Queue)

If a patient requires a follow-up appointment but there is no clinic capacity within the required timeframe or the patient is on PIFU (see Section 4.7), the request is placed onto a queue, often referred to as partial booking (or non-RTT) request queue.

The partial booking request queue is a waiting list which must be managed in parallel with the other waiting list queues, e.g. ASI and RAS to ensure that patients are always booked in line with clinical urgency, waiting time and to specialty level agreements where relevant. On the partial booking queue, the Latest Due Date determines the booking order. Any cancellations / reschedules / DNA must also be managed as per Section 4.3.

4.7 Patient Initiated Follow-Up (PIFU)

PIFU is when a patient initiates an appointment when they need one, based on their symptoms and individual circumstances; giving them the flexibility to arrange their follow-up appointments as and when they need them,

At follow-up, a clinician may decide that it is clinically appropriate to offer the patient an opportunity to manage their follow-up appointments via a PIFU pathway. If the patient agrees the relevant booking team add them to a dedicated PIFU partial booking queue within the non-RTT request queue (see 4.6).

At the time of this decision, the patient must be offered appropriate guidance on the management of their condition and any triggers for needing to be seen earlier if clinically appropriate. Patients on PIFU pathways must be managed in line with all other patient waiting lists and any cancellations / reschedules / DNA managed as per Section 4.3 above).

4.8 Active Monitoring - Outpatients

Once a patient has attended their appointment, the clinician may decide to put the patient on a period of active monitoring. Active monitoring is intended to enable the continued care of the patient by the service in clinical circumstances where treatment is either not required or not possible but it is not clinically appropriate to return the patient to their GP. Active monitoring must be compatible with the patient's expectation of their wait, i.e. the patient is not expecting further intervention. Typical examples include:

- Reduction in a patient's weight before surgery can be considered.
- Long-term monitoring of a health condition, e.g. Glaucoma.

Patients may wish to delay their treatment and in such circumstances a period of active monitoring may be applied if this is clinically appropriate (see also 2.4.3 Patient Choice to Delay).

5.0 Diagnostics

5.1 Diagnostic Pathway and Standards

The diagnostics section of an RTT pathway starts at the point of request for a diagnostic test and ends when the diagnostic test is completed. Trusts must ensure that as per the national performance standard, 99% of patients have their diagnostic test no later than six weeks from the date of diagnostic request.

There are two situations in which a diagnostic test is part of an RTT pathway:

1) The request is made as part of an established RTT pathway; or
2) The request is made directly from the GP as a Straight to Test (STT) request.

Where there is an expectation that the patient will subsequently be reviewed by a consultant, these diagnostics are classed as STT requests and are measured under the RTT rules (see Section 2.4.1).

5.2 Direct Access Referrals

When a patient is referred into the Trust for only a diagnostic test, with no expectation of 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 on the date the request is made. These referrals are known as direct access referrals.

5.3 Screening Referrals (Planned Surveillance)

If a patient requires a diagnostic test as part of a program of monitoring, e.g. annual surveillance endoscopy for colorectal cancer, a diagnostic clock does not start on the clinical basis that the test cannot be performed any earlier if resources were available. However, if a patient passes their diagnostic due date, they must be added back to an active waiting list with a diagnostic clock start from the date of their planned appointment and continuing until their diagnostic test is completed.

5.4 Clinical Prioritisation and Booking of Diagnostic Appointments

On receipt of a diagnostic referral, the referral must be assigned a clinical priority. Clinical priorities are a series of national standard codes which are designed to support the effective booking order of patients on the basis of clinical need as well as waiting time.

Patients will then be booked in order of clinical priority followed by clinical urgency and then waiting time, with all patients 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.

In circumstances where patients are not able to be given reasonable notice as defined in Section 2.4.5, they must be telephoned to offer the appointment and the diagnostic clock will not be reset if they are unable to accept it.

Patients who are on the waiting list for planned diagnostic tests are not assigned a clinical priority unless they breach their due date.

5.5 Patient Cancellation, Reschedule or Did Not Attend (DNA)

If a patient cancels or fails to attend their diagnostic appointment and providing the criteria for reasonableness are satisfied (see section 2.4.5), the diagnostic clock is reset to zero and starts again from the date of the diagnostic appointment. If reasonableness cannot be demonstrated, e.g. offering a short notice appointment, the diagnostic clock cannot be reset.

If a patient cancels, reschedules or fails to attend their appointment on 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 clinician. If it is not clinically appropriate to do this, the patient should be offered a further appointment (for example 2WW or paediatric referrals). The clinician, patient and their GP should be informed in writing of any return to the referring clinician.

Failure to attend a diagnostic appointment does not reset the RTT waiting time clock.

5.6 Diagnostic procedures which require admission

There may be occasions where a diagnostic procedure as part of an RTT pathway must be performed as an inpatient, e.g., an MRI under sedation for paediatric patients. In such cases, the patient is added to an elective waiting list for the procedure and starts a diagnostic waiting time clock from the date of request with the patient's RTT clock continuing. Should the test remain diagnostic (i.e., no treatment performed), the diagnostic clock will stop, but the RTT clock will continue until the patient receives treatment or is discharged. If the diagnostic test is also a treatment, the RTT clock will also stop (see 5.7).

5.7 Diagnostics Which May Also Be Therapeutic

There may be occasions where a diagnostic procedure is or becomes therapeutic, i.e., a treatment of the condition for which the patient was originally referred. As with all forms of treatment, this is a clinical decision, but certain types of diagnostics are more likely to be considered treatment:

- biopsies which remove a lesion entirely (excision biopsy).
- colonoscopies with polypectomy.
- injection of anaesthetic into a joint / area to rule out a source of pain.

It is therefore important that the clinical intent is documented clearly to enable the RTT clock to be stopped if treatment has occurred.

6.0 The Inpatient Pathway

6.1 Decision to Admit (DTA)

A decision to add a patient to a waiting list for surgery (Inpatient or Day Case) is a clinical decision and will take place following one of the below:

- a first or follow-up outpatient attendance at the Trust
- attendance at an Interface Service (see Section 3.4.3).
- transfer from private care.
- an emergency attendance.

There should not be any circumstances where a DTA is made outside of an appointment on the basis that the patient's care plan should have been agreed with the patient at clinic, but accepting that these might be conditional on diagnostics or on other clinical opinion.

The DTA can only be made by a clinician appointed as a consultant as they are the only clinical role other than Midwives with admitting rights. This still acknowledges that a member of the consultant's team may have seen the patient in clinic and has had the clinical discussion with the consultant responsible for the patient's care.

When the Decision to Admit is made, the patient must be both available and clinically fit for the procedure or where the patient is not fit, the risks of not proceeding (as evaluated by the consultant) are outweighed by the benefits of having the surgery (see 6.9). Short periods of illness or unavailability (i.e., less than two weeks) should be accepted and the patient still considered as waiting, e.g. for coughs and colds.

The RTT clock will continue at this point unless the patient has been on a period of active monitoring / treatment previously, in which case a new RTT clock will start from the date of the DTA (i.e., the date of the clinic).

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 including details of any patient unavailability, whether the procedure is planned or elective and the clinical priority (see Section 6.2).

The agreed clinical plan for treatment must be clearly documented in the patient's clinical record, in the case of RTT, this is because if the treatment plan is changed outside what was originally agreed, this may start a new RTT clock (see Section 6.6).

Note that if a patient is admitted as an emergency (i.e., non-electively) and they receive treatment for the same condition they are on the waiting list for, the consultant in charge of the patient's care must be notified and, subject to clinical review, the patient removed from the elective waiting list. If this occurs, the RTT clock will stop.

6.2 Clinical Prioritisation

As part of the Addition to the Waiting List proforma, the clinical priority of the procedure must also be recorded. Clinical priorities are a series of national standard codes which are designed to support the effective booking order of patients on the basis of clinical need as well as waiting time.

6.3 Adding the patient to the elective admitted waiting list

Once the DTA has been made and the proforma completed, this must reach the Central Booking Office and be recorded onto eCARE within 24 hours. Before adding a patient to the waiting list in eCARE, it is good practice to check the following:

- that patients are not already listed for the same condition
- that the necessary information is recorded on the proforma, i.e., nothing is missing.
- if the patient was given a date for surgery at the time of DTA, that the admission method is 'Booked' not 'Waiting List.'

If the proforma is incomplete, the referring clinician must be contacted by the Central Booking Office to complete the missing information as soon as possible.

The patient must not be added to the waiting list under a generic consultant, e.g. CONMK003, they must always be added under a named consultant.

Once the patient has been added to eCARE, the clinical priority must be recorded directly onto the RTT PTL Tool using the edit function (see also Section 8.1).

6.4 Booking a To Come In (TCI) Date

Once the patient has been added to eCARE, they need to be given a TCI date which must be offered in line with the criteria for reasonableness (see Section 2.4.5) and booked in order of their clinical priority, clinical urgency and then their waiting time.

In certain circumstances, for example admissions for chemotherapy, a TCI date will have been identified and agreed at the time the DTA was made, in which case the criteria for reasonableness must have already been applied and the patient booked for that date.

Any relevant communication with the patient (including if dates have been declined and the reason) must be recorded on eCARE and also documented within the patient's clinical notes if the patient is being escalated for clinical review (see Section 6.5).

It is important that the patient has been given instructions on 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.

6.5 Patient Cancellation, Reschedule or Did Not Attend (DNA)

The flow diagram below should be used by booking staff to guide the management of patient cancellations, reschedules or Did Not Attend (DNA).

Patients cannot be removed from the elective waiting list without review and authorisation from the consultant in charge of the patient's care. A second TCI date is always necessary in the following circumstances:

- patients undergoing cancer treatment.
- urgent referrals based on clinical judgement.
- paediatric patients.
- maternity patients.

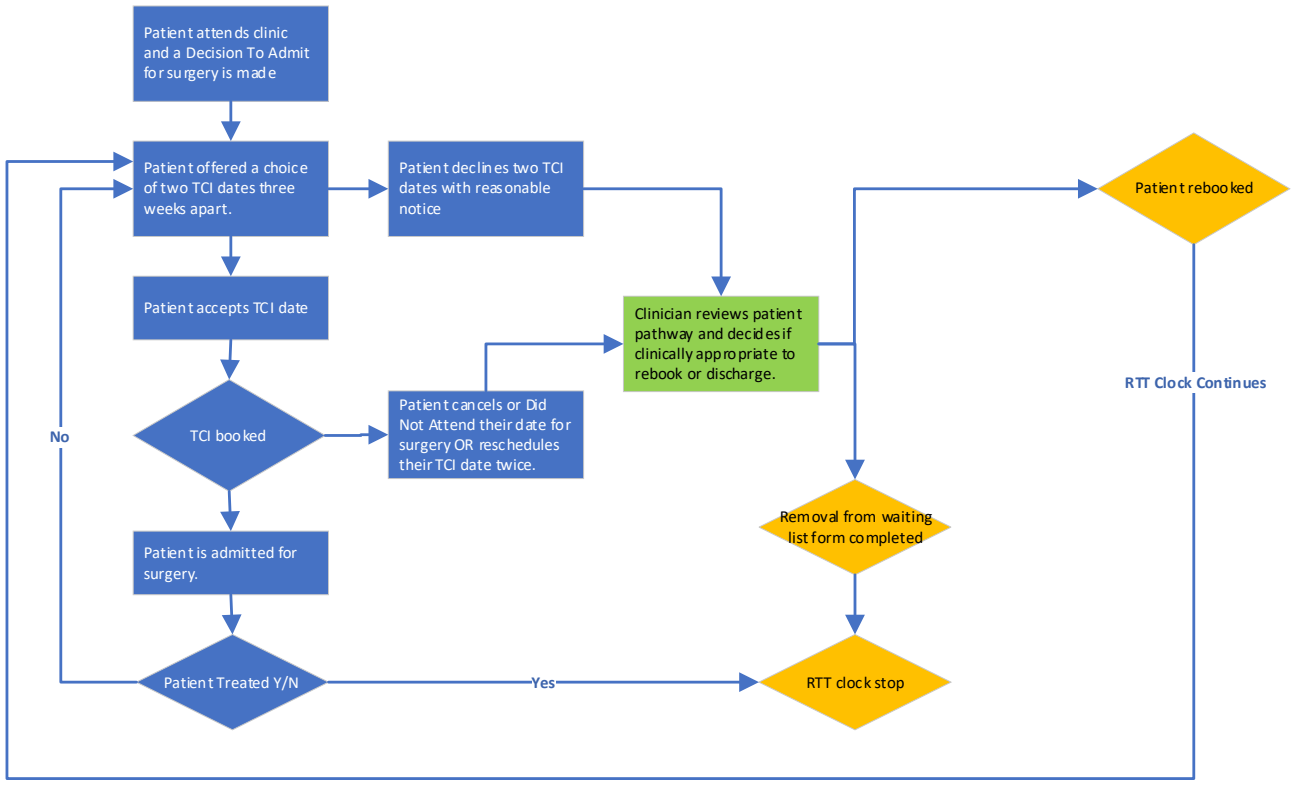
If as a result of the removal the patient is to be placed onto a period of active monitoring, this must be clearly indicated (see Section 6.10).

If on clinical review it is clinically appropriate to remove the patient from the waiting list, a Removal From the Waiting List Form (Appendix B) must be completed and signed by both the consultant and the Associate Director for the relevant Division. The completed form must also be scanned into the patients EDM record within 24 hours.

In the case of active monitoring or removal, the RTT clock will stop on the date the decision to remove was made.

Both the patient and GP must be contacted and informed of the outcome of any clinical review. Appendices D, E, F and G provide template letters to be sent in such events.

Diagram 2 – workflow for cancellation / reschedule / DNA of a TCI date.



6.6 Patients Listed for More Than One Procedure

At a clinic appointment, a consultant will agree a treatment plan with the patient. If the treatment plan involves multiple surgeries or specialties, there are three scenarios to consider:

1. Treatment plan involves bilateral (i.e. left and right sided) treatment, e.g. cataracts.
2. Treatment plan involves multiple stages, e.g. treatments in a chemotherapy cycle.
3. Treatment plan involves multiple procedures within the same surgery.

If the clinical plan agreed involves a two-part treatment, e.g. bilateral (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.

The RTT clock will stop when the patient is admitted for their first treatment and a new clock will start from the DTA of their second, i.e. when the patient is clinically ready and available to proceed.

If the clinical plan agreed involves multiple stages to treat a specific problem, e.g. chemotherapy treatments in a cycle, the first of these treatments will start an RTT clock from the DTA date, with subsequent treatments following a planned (non-RTT) pathway. This is because for such pathways, subsequent treatments cannot be completed any earlier if resources were available (see Section 6.12).

If the clinical plan agreed involves multiple procedures in the same surgery, i.e. several specialties supporting in the same operation, then the patient is only listed once under the consultant who is responsible for the patient's care.

6.7 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 must implement the guidance in section 6.9 below.

6.8 Swab Clinics

As a consequence of the Covid-19 pandemic, patients are required to be tested for Covid-19 prior to their admission for surgery if they are day case patients who are not fully vaccinated or if the intended management of the patient involves at least one overnight stay.

In the event that a patient refuses to test for Covid-19, their case must be escalated to the consultant for review which may result in the patient being deemed unable to complete their surgery (i.e. as a refusal). In this case, a Removal From the Waiting List Form (Appendix B) must be completed, and the RTT clock will stop on the date the decision to remove was made.

If a patient tests positive for Covid-19, their case must again be escalated to the consult for review and every effort made to reschedule the patient to another date, and in this scenario, the RTT clock will continue.

Should the patient be medically unfit as a result of Covid-19, the guidance in Section 6.9 (Medically Unfit Patients) may apply if the expected duration of illness is likely to be greater than two weeks, however this will be based on clinical review.

6.9 Medically Unfit Patients

As part of informing the DTA, a patient is assessed as to their fitness to undergo surgery through both an assessment in clinic and at a separate pre-operative assessment (which may also include an anaesthetic assessment). A clinical judgement is made from the assessment as to whether the benefits of surgery outweigh the risks, including if the patient has other conditions which may increase the likelihood of complications.

If the patient is unsuitable for surgery, then the clinician may decide to either put the patient onto active monitoring or discharge the patient until such a time as they are suitable for surgery. The appropriate outcome is always a matter for clinical judgement and in either case, the RTT clock will stop on the date the patient is deemed unsuitable for surgery.

If a patient is listed for surgery and becomes unfit three weeks after the DTA is made, and who will be medically unfit for longer than 14 days, they must be discussed with the consultant 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.

If the period of illness is expected to be short, i.e. less than two weeks, this should be accepted and the RTT clock continues until the patient is treated or otherwise under active monitoring or discharged.

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 B for the removal form). This must also be clearly communicated to the patient and their GP via a letter from the consultant (see Appendix C). In this eventuality, the 18-week clock will be stopped.

With the exception of long waiting patients who follow a different management approach (see Section 8.4) 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.

6.10 Active Monitoring Following a Decision to Admit

In the event that a patient becomes unfit for their surgical procedure after they have been added to the waiting list, it may be clinically appropriate to actively monitor the patient in secondary care, rather than discharge them to their GP. This type of situation is expected to be rare, on the basis that a patient should not need to be monitored by secondary care unless their clinical situation were particularly complex and hence would ordinarily be discharged to their GP until they were able to have their procedure.

As a result, where a patient does need to be put onto active monitoring following DTA, this must be reviewed and signed off by the relevant Divisional Director who must also countersign the Removal From Waiting List Form (Appendix B).

The steps for this process with the associated timescales and required evidence is in the table below. This process carries a level of expectation that the patient is aware of the intention to remove them from the waiting list prior to the steps below and that the discussion in an outpatient setting is with the intention of discussing next steps and potentially a new treatment plan.

If the patient is placed onto active monitoring, the RTT clock will stop from the date the patient was informed, i.e. the date of clinic. A new RTT clock will then start from when the next DTA is made.

Table 3 – Process for removing a patient from the waiting list (active monitoring)

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 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 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 (Appendix F)	Within seven days of outpatient appointment.	Completed GP letter

6.11 Patient Admission

On the day of surgery, the patient will attend the ward to which they will be admitted. The patient admission must be recorded on eCARE in real time, i.e. at the time of their arrival and using the elective waiting list episode created for the purpose.

If the procedure is unable to be carried out due to a hospital reason, e.g. lack of available equipment, another TCI date must be offered to the patient which is within 28 days of the current TCI date (see 6.12). In this case, the RTT clock continues.

If the procedure is unable to be carried out for a clinical reason, e.g. the patient is unwell, the guidance on medically unfit patients must be followed (see 6.9).

6.12 Trust Cancellations & 28 Day Returns

If the Trust cancels an operation/procedure on or after 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. Hospital cancellations do not stop or reset the RTT waiting time clock.

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

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 and their GP.

Patients who fit the above criteria will not be reported as a 28-day breach if either of the following statements are true:

- the patient becomes medically unfit during the 28-day period and is removed from the waiting list (subject to consultant review – see Section 6.9).

- the patient was offered two dates for admission which fall within the 28-day period which follow the criteria for reasonableness and that these dates were both declined.

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;
- 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.

6.13 Planned Pathways

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 (admitted or non-admitted). The decision to do this rests with the consultant in charge of the patient's care who will set an intended future date (due date) for the patient's procedure or review that cannot be arranged any earlier for clinical reasons, even if resources were not a constraint (a defining point of planned care).

Planned waiting lists must be monitored daily by the Divisions and given the same level of booking priority as RTT waiting lists as delays to intended procedures will share the same associated potential clinical risk if a procedure or intended review were to be delayed. Patients on such lists must also be checked to ensure that they fit the planned criteria.

If a patient's due date is exceeded by six weeks, they must be added back to the elective (RTT) waiting list from the date of their planned appointment. Patients who fulfil this criteria will start a new RTT waiting time clock from that date.

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

- surveillance procedures such as cystoscopies and colonoscopies.
- patients proceeding to the next stage of treatment i.e. patients undergoing the second treatment in a cycle of chemotherapy, or removal of metalwork.
- sterilisation following pregnancy when the procedure cannot be undertaken until after the pregnancy.

The above list is not exhaustive. A consultant or a member of their team 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.

7.0 Reporting, Monitoring and Performance

All healthcare organisations which provide consultant-led NHS services must have means by which they can provide assurance that the controls around satisfying their duty to patient care and the NHS Constitution are both effective and working. These means centre on three aspects of assurance – reporting correct pathway information, monitoring activity to identify problems and evaluating performance to determine if national and local targets on patient care will be met. All aspects of assurance form part of the Trust's Board Assurance Framework.

This section covers the key aspects of reporting, monitoring and performance for RTT but these are by no means exhaustive, and all staff have a duty to escalate all issues through the most appropriate channels as per this Policy.

7.1 Waiting List Reporting

The Trust provides internal reporting on all of the available waiting lists, most notably including patients on RTT pathways (which includes all e-referral lists, e.g. ASI) and also those on planned and non-RTT pathways as booking in order must consider all patients on waiting lists. This is through a structured PTL (see Section 7.2.1) which all operational teams must use to track their patients.

External reporting of patients on RTT pathways is a legal requirement for all healthcare providers who run consultant-led services. Reported data is used at both national and System level to hold healthcare providers accountable for their RTT performance and ensure that patients are seen and treated within the terms of the NHS Constitution. It also enables providers to monitor where performance is poor and to relate this information to other national initiatives such as the Getting It Right First Time (GIRFT) programme to better manage delays in patient care, e.g. theatre utilisation and outpatient clinic capacity.

7.1.1 RTT Business Rules

In order for RTT pathways to be reported, they first have to be created. The Trust achieves this using an RTT algorithm which is a series of business rules derived from national guidance that identifies the activity that starts and ends an RTT pathway, and for each new activity creates an RTT pathway. These business rules are fundamental to producing RTT waiting lists and as such, must have robust controls on changes as any erroneous data produced will adversely impact reporting (see Section 8.0).

7.1.2 National Returns

The most important submission of data the Trust makes nationally on RTT patients is a Waiting List Minimum Data Set (WLMDS) which is an extract taken from the data warehouse on a weekly basis (for the previous week ending) containing a list of all active RTT pathways, including patients on the ASI. The specification for the WLMDS a national standard, i.e. all Trusts must submit the same data items in the same way.

The submitted data is published nationally each month as an aggregated position from which a System level report is generated and provided to the Trust for benchmarking (see Section 7.3).

The Trust also submits a smaller subset of the waiting list for patients currently waiting over 52 weeks and containing specific information necessary to manage these potentially higher risk patients much more closely at both a Trust operational level and a regional level.

7.2 Monitoring

7.2.1 PTL Tool

The PTL Tool is a web-based platform which enables operational staff to track patient pathways and access key elements of this information, including specialty, waiting time and clinical priority and providing a means to book patients in the right order. The PTL Tool provides access across the following areas:

- active RTT Pathways (Admitted and Non-Admitted)
- active diagnostic pathways (those reportable on DM01).
- patients on the Non-RTT (partial booking) request queue.
- patients on the ASI list.
- patients on a planned waiting list (admitted).

7.2.2 Audit

Audit is a useful tool in checking that the control processes for RTT are working effectively and can be tailored to answer specific questions on a particular supporting process (for example in the process for setting up new services) or a particular aspect of the Access Policy, for example in ensuring no blanket rules are being applied to cancellations.

The Trust uses both internal auditors (i.e. appointed from an external third-party company) and the Performance Management Team to provide this type of assurance by virtue of their role, with the Divisional teams performing their own audits as part of due diligence that their internal processes are working effectively.

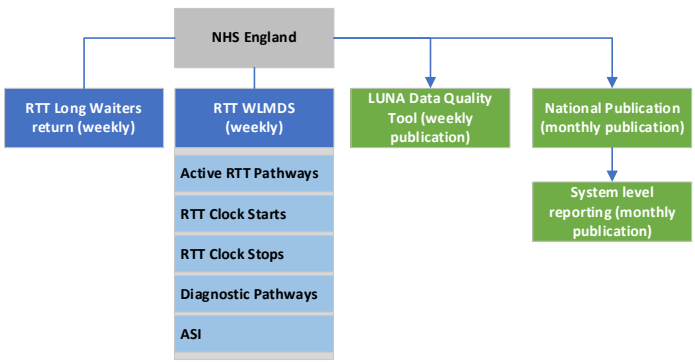
7.2.3 Operational Priority Reports

The Trust produces a refreshable suite of operational priority reports designed to support the monitoring of performance against the key elective care recovery plan targets. Divisions use these reports to inform their individual recovery plans and when reporting to both Operational Board and upward to the Divisional Performance Review Meetings.

7.2.4 LUNA Data Quality Tool

The LUNA Data Quality Tool is a national initiative to use Trust's submitted WLMDS data to identify and feedback on data quality issues which result in waiting lists holding inaccurate information. The Trust uses this information to inform targeted clean-up of incorrect data and feedback into programmes of refresher training for staff.

Diagram 3 – National RTT return reporting structure and publication.



7.3 Performance

Trusts must monitor their performance against the RTT national standards and benchmark these at both a national and System level to determine compliance with those standards. Comparison of performance to other Trusts is an important indicator of whether the Trust is a performance outlier, i.e. if the Trust is performing either significantly better or worse than its peers to inform decisions on for example, mutual aid.

7.3.1 Trust and Divisional Dashboards

The Information Team produce monthly dashboards of key performance measures which the Trust uses to provide assurance on its performance against both local and national targets, including 18-week RTT performance, diagnostic performance and cancer performance. The Trust dashboard is presented to TEC for review with the Associate Directors to provide insight into areas of poor performance and inform action plans to address them.

A divisional level version of the Trust dashboard is also produced to provide the same insight at a more operational level as the same measures may have very different performances depending on the Division. Other metrics are also reported at this level which are unique to individual Divisions.

7.3.2 Model Health System

The Model Health System uses a combination of nationally reported patient level data sources to benchmark performance between healthcare providers across a series of healthcare measures. It does this in order to provide Trusts with an opportunity to use the information to identify opportunities for improvement and support the elective care recovery programme through initiatives such as Theatre Utilisation and the national Getting It Right First Time (GIRFT) programme.

8.0 Controls

Controls are an essential part of any process. They are intended to prevent problems and enable a standardised approach to process management. In the context of RTT, controls are in place to prevent patient harm by ensuring that the right patients are booked in the right order, and that where there is a risk of patient harm, particularly in the longest waiting patients, that patient reviews are completed to assess that risk and take action where appropriate.

8.1 Training

8.1.1 Mandatory Training

The Trust has a mandatory training programme which must be completed by all staff both clinical and non-clinical at the start of their employment. This training includes data protection and provides the gateway to providing staff with their network user name and password which can then be used to access eCARE and other systems used in patient care.

8.1.2 IT Systems Training

The Trust have a Systems and Training Team who are responsible for the delivery of training and assessment for use of those systems essential in RTT management: eCARE, E-Referral and the Electronic Document Management (EDM) system. Staff must complete their training and assessment before they are able to use those systems.

The Systems and Training Team are also responsible for the delivery of training on the Access Policy and an assessment which staff also need to pass.

8.1.3 RTT Training

The Trust have a PTL Validation Team who provide training on RTT rules and use of the Clinic Outcome portal for recording RTT events. They are also responsible for investigating data quality issues in relation to RTT pathways and consulting with the other teams in this section in terms of training feedback, data clean up and pathway validation.

8.2 PTL Systems Management

8.2.1 PTL Tool

The Trust has a dedicated, central means of providing access to patient waiting lists referred to as a Patient Tracking List (PTL). This is a web-based tool which provides the necessary information to enable operational teams to track and manage these waiting lists and provide a means to record the patient's position on their RTT pathway and the next steps in their care. Staff are not able to edit this information.

8.2.2 RTT Business Rules

The RTT business rules which generate RTT pathways (see Section 7.1.1) are a set series of rules taken from national coding standards, updates to which are managed through a business change process. Any changes to these rules must be subject to the most stringent controls to avoid waiting lists containing incorrect or invalid pathway information, or valid pathways not being represented at all. All changes to the rules must be signed off by both the Associate Director of Performance and Director of Operations.

8.2.3 Clinic Outcome Tool

The Trust uses a web-based form to enable the recording of RTT events (e.g. active monitoring) against an RTT pathway, and only contains options which reflect the options available as part of the national standard RTT status codes. Any changes to this software are managed by the IT Team and are subject to the standard IT system change request process.

8.2.4 System Downtime

There may be periods of time when a system is unavailable for data entry, for example due to planned maintenance or systems failure. All departments must have processes in place to manually record information relevant to any activity which may impact waiting list management, e.g. clinic outcomes or appointment / admissions bookings. This information must be recorded onto the relevant IT systems, e.g. eCARE as soon as that system is available.

8.3 Pathway Validation

8.3.1 Validation Best Practice

It is essential in the management of RTT pathways for operational teams to assure themselves that a patient on an RTT pathway is correctly represented in terms of their waiting time, clinical priority and next steps in their care. The process for reviewing patient pathways is referred to as validation and whilst there is no definitive approach, below are a series of important checks which all staff should make throughout the pathway:

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

RTT pathway activity	What staff should check
Referral from GP	Clock start date (referral received date) is either: • date of receipt of paper referral • date patient books an appointment via ERS or TAL • date appointment deferred to ASI list
First outpatient appointment	First appointment is: • booked with a referral • not a planned appointment type (unless following admission) • checked in and out as close to real time as possible
Clinic Outcome	Clinic outcome has: • paper version completed and given to patient at checkout • patient's RTT status correctly recorded • any procedures recorded with copy for Clinical Coding
Decision To Admit	DTA requires: • a completed waiting list proforma including clinical priority • a copy of the proforma in patient notes • a copy of the proforma sent to the Central Booking Office
Addition to the Inpatient Waiting List	• patient is not already listed for the same condition • DTA date matches the date on the waiting list proforma • proforma is complete and signed • admission method is correct (waiting list / booked)
Removal from the inpatient waiting list	• decision has been agreed by clinician • removal proforma signed, dated with copy in patient notes
Diagnostics	Diagnostics have: • the request made date as clock start date • a diagnostic priority code assigned

Follow-up OP appointment	Follow-up appointment is: • correctly booked from previous appointment • booked from the non-RTT request queue if partial booking • checked in and out as close to real time as possible
Admission for procedure	Patient is: • admitted from correct elective inpatient waiting list entry • admitted as close to real time as possible • transferred to another ward as close to real time as possible • discharged as close to real time as possible

8.3.2 Management of Data Quality Issues

In the course of ongoing RTT pathway review, pathways with data quality issues may be identified. Whilst correction is always the right course of action, an assessment must be made of the impact of updating such pathways on waiting times. Should any updates result in a waiting time of 30 weeks or above the escalation process must be triggered (see Section 8.4).

8.3.3 Third Party Data Management

In the event that a third party is contracted to provide support in the management of patient waiting lists, a Data Protection Impact Assessment (DPIA) agreement must be completed as well as a third-party agreement with a stipulation that contractors must abide by the terms of this and all other relevant Trust Policies.

8.4 Escalation and management process for long waiters >30 weeks

All patients on waiting lists should be proactively managed by both operational and clinical teams as part of routine waiting list management. However, patients who have been waiting on RTT pathways for extended periods of time may carry a higher risk of potential clinical harm and consequently this group of patients requires monitoring more closely with a separate escalation process in place to support more intensive management and patient review.

For local purposes, this escalation process applies to all patients waiting >30 weeks for treatment, irrespective of whether this is one pathway or many.

8.4.1 Review mechanisms for >30-week patients

The following review mechanisms must be in place:

- 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 a patient review undertaken by the Divisional Director and/or clinical lead for the relevant service. 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.

8.4.2 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 patient 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 patient review undertaken by the Medical Director, with an assessment of any potential harm that may be caused for a prolonged continuous wait.

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

8.4.4 Removals from the Waiting List

If 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 B). Any removal from the waiting list must also be communicated in writing to both the patient and their GP, and this communication 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 C, Appendix D, Appendix E and Appendix F.

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*.'

9.0 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
- Cancer Waiting Times Policy
- Data Quality Policy
- Did Not Attend (DNA) or Was Not Brought (WNB) Paediatrics Policy
- Failsafe & Did Not Attend (DNA) for Colposcopy
- Incident Reporting Policy and Procedure
- Information Governance Policy
- Overseas visitors Trust guidance
- Private Patient Policy
- Rapid Access Chest Pain Clinic Operational Policy
- Safeguarding Children Policy and Procedures
- Health Records Policy.

10.0 Statement of Evidence/References

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11.0 Governance

11.1 Document review history

Version number	Review date	Reviewed by	Changes made
11.0	Oct 2023	Trust Executive Committee	See below
11.0	Sep 2023	Trust Executive Committee	See below
10.0	July 2023	Associate Director of Performance	See below
9.0	Feb 2019	Trust Documentation Committee	See below
9.0	Jan 2019	Management Board	See below
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

11.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Trust Executive Committee	Policy and Operations	Oct 2023	Oct 2023	Update to wording in escalation section 8.4	Yes
Trust Executive Committee	Policy and Operations	Sep 2023	Sep 2023	Update to Organisational chart and section on patient cancellations	Yes
Associate Divisional Directors, Director of Ops and Deputy Assoc. Dir of Ops (Outpatients).	Management and 18-weeks	July 2023	Aug 2023	Minor amendments to terminology and references	Yes
Associate Director of Performance	Performance	May 2023	July 2023	Major update in light of Covid-19 elective recovery	Yes
Trust Documentation Committee	Policy	Feb 2019	Feb 2019	Updates to reference section	Yes
Management Board	Policy	Jan 2019	Jan 2019	None received	Yes
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.	Yes
Chief Executive Officer	Management	Dec 2016	Dec 2016	Update to references to Board accountable and CEO as Accountable Officer	Yes
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	Yes
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	Yes

11.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Patient Pathway Integrity	LUNA DQ Tool	Information Team	Weekly	PTL Governance Meeting
	PTL Tool	Clinical Divisions	Daily	
	Internal reporting of long waiters	Information Team	Daily	
	Internal / External Audit	Performance Management Team	As required	Audit Committee
National policy rules and guidance	Internal / External Audit	Performance Management Team	As required	PTL Governance Meeting
	Training	PTL Validation Team / Systems and Training Team	As required	DQ Governance Board
RTT business rules	RTT algorithm	Data Warehouse Manager / Information Manager	As required	PTL Governance Meeting / IT Change Control Board
RTT Performance	PTL Tool	Performance Management Team	Daily / Weekly / Monthly	Operational Board
	Trust / Divisional Dashboards	Information Team	Monthly	Trust Executive Committee

11.4 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 Management
Person completing the EqIA	Hitesh Patel	**Contact No.**	Teams
Others involved:		**Date of assessment:**	July 2023
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

12.0 Appendices

12.1 Appendix A: 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.
Data Warehouse	A relational database of patient information used by the Trust to provide reporting on all aspects of Trust business and performance.
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 (ERS)	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, is 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 ERS.

2.2 Appendix B: 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

12.3 Appendix C: 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

12.4 Appendix D: 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>

Milton Keynes University Hospital
NHS Foundation Trust

12.5 Appendix E: 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 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

12.6 Appendix F: 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 be 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>