Derby Hospitals NHS
NHS Foundation Trust

TRUST POLICY FOR WAITING LIST AND PATIENT ACCESS MANAGEMENT

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Training and Dissemination: All Staff associated with Waiting List and Patient Access Management must undergo training on this policy, see **Section 8** of the Trust Procedures for Waiting List and Patient Access Management. This will be delivered to all new staff as part of their induction as applicable and through an **essential** annual E-learning assessment. General Managers will be responsible for ensuring medical staff are compliant with their training. Policy published on hospital Intranet/website

To be read in conjunction with: Trust Procedures for Waiting List and Patient Access Management.

Trust Policies for Safeguarding Children and Adults, Draft Trust Policy Children, Young People and Neonates who DO Not Attend (DNA) their Appointments, Procedures of Limited Clinical Value, Access to Health Services for Military Veterans: priority treatment Gateway 13406, A Code of Conduct for Private Patients, The National Cancer Action Team Cancer Waiting Times guide version 8.0, Overarching Leave Policy (Trust Leave Policy for Consultant & SAS Doctors) version 3.4

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Trust Policy and Procedures Waiting List and Patient Access Management

1. Introduction

This policy outlines relevant rules, responsibilities and actions by which the Trust will manage patients through their pathways:

- National 18 week Referral to Treat (RTT) – Outpatient/Inpatient/Daycase Waiting list management.
- National Cancer Waiting Times for all suspected cancers
- Patient Access – National and Local Targets
- Associated local targets

2. Purpose and Outcomes

This policy and procedures set out the rules and definitions for how we will manage 18 week pathway and cancer/suspect cancer referrals. Application of the policy principles will ensure that each patient's RTT clock starts and stops fairly and consistently in accordance with an agreed structured methodology. Treatment decisions will be fair and transparent. At an operational level this translates into the adoption of the following key principles:

- The management of our patients will be consistent with the NHS 18 Week Target / Cancer 14, 31 and 62 day targets and the guidelines which apply to these targets.
- The management of patients will be fair, consistent and transparent and communication with patients will be clear and informative.
- The management of our patients will be consistent with the Human Rights Act 1998 and the Equality Act 2010.
- Patients seen in outpatients, diagnostics or admitted as inpatients/day cases will be seen according to clinical priority and in chronological order on the 18RTT and cancer pathway.
- We will acknowledge the rights of individuals to agree a date to suit their personal circumstances.
- Internal consultant to consultant referrals criteria is:
    - Direct referrals will be appropriate for:
        - Suspected cancer
        - Urgent problems for which delay would be detrimental to the patient's health. The expectation here would be that the patient needs to be seen within 2 weeks.
        - Referral as part of the same clinical problem
        - Part of the recognised pathway of care for the condition or as part of a pre-operative assessment
        - Transfer of responsibility of care for an ongoing condition when it would be more convenient for the patient to be seen in a different location.
    - Referral back to General Practitioner (GP) will be appropriate for:

        - Conditions that are unrelated to the presenting problems and do not require urgent referral
        - Incidental findings
        - Conditions that can be dealt with by the Clinical Commissioning Group
    - Referral Queries
        - If there is any doubt as to whether a patient needs to be managed by the hospital or whether a patient should be offered a choice it would be advisable for the consultant to contact the GP to discuss the case.

- Patients will only be added to a waiting list if there is an expectation of treating them and they are clinically fit and ready to undertake the treatment. Except cancer cases.

3. Definitions Used

"Staff" refers to **ALL** staff who are involved in a patient's care and treatment and in particular to those with responsibility for patient access and choice.

'Patient' refers to NHS patients unless explicitly stated otherwise.

4. Key Responsibilities/Duties

The following are required to instigate appropriate actions to ensure the successful implementation of the policy within their area(s) of control:

Management Executive (ME) - Approval of the policy.

Medical Advisory Committee (MAC) - Consultation and clinical input.

Chief Operating Officer – Responsible for Waiting List and Patient Access Management.

Director of Strategy and Partnership - Participate with the Executive Directors in monitoring the Trust and Directorate performance against commissioning, contract and service agreements, national and local standards and strategies, undertaking benchmarking, reporting and review work as necessary.

Divisional Directors and Divisional Medical Directors – Responsible for the overall application and adherence to this policy and procedures within their area of responsibility.

Approval of leave with less than 6 weeks notice must be authorised by the Divisional Director and Divisional Medical Director.

Consultants – Consistent application and adherence of policy and principles.

- Consideration will be given by teams of consultants for cross cover arrangements during periods of annual leave. In some circumstances, it may be appropriate to agree protocols for grading and accepting or rejecting referrals.

- A minimum of 6 weeks notice is necessary for consultant and medical staff planned leave (in accordance with section 3.1 in the Overarching Leave Policy) to ensure patient appointment dates are honoured to reduce the need for changes and cancellations. All leave requests must be authorised by the Lead clinician and General Manager/Assistant General Manager.

- All referrals (electronic and paper) will be reviewed and prioritised within 2 working days of receipt except for visiting consultants (alternative arrangements will be agreed locally) and cancer (separate rules will apply for 2 week wait (2WW) and screening.

    - Administrative staff must be allowed to accept the booking on behalf of the service if the 2 day target cannot be achieved to ensure no delays are built into the 18 week target.

Specialist Nurses - Consistent application and adherence of policy and principles

General Manager – Responsible for the application of the policy at Business Unit level and the delivery of national and local targets and training specific to staff roles within their area of responsibility.

Assistant General Managers or equivalent – Responsible for the implementation of policy and procedures and training for relevant staff groups in their areas of responsibility.

Assistant Director of Strategy and Partnership – Responsible for performance monitoring waiting list to ensure external targets are delivered.

Associate Director of Information Management & Technology (IM&T) – Responsible for the provision and accuracy of information and data quality reports. Responsible for the content and delivery of training.

Head of Information – Responsible for providing information and analysis support to monitor targets and adherence to policy. Responsible for the training and education of data quality officers and information analysts. Responsible for the content of training programmes.

Head of Records Management - Responsible for ensuring all admin staff working in outpatients or day case, including those staff that are not directly responsible to them, are fully trained and comply with mandatory training.

Managers, Administrators, Secretaries and relevant Health Professionals – Responsible for day to day management and application and escalation **as appropriate to area of work.**

Divisional Medical Staffing Officers –Responsible for escalating, to the appropriate General Manager, occasions when they cannot achieve the minimum 6

weeks notice required for changes to doctors rota's to Outpatient / Day case Team Leaders. This notice period is necessary to allow changes to booking rules to take place.

Cancer Centre Manager/Audit - Responsible for ensuring that staff adhere to the cancer waiting times through the audit programme. Responsible for the content of training material relevant to cancer pathways management.

5. Managing the Policy and Procedures for Waiting List and Patient Access Management

The Trust recognises the complexity of waiting list and patient access management. National rules are often complex and on occasion have competing requirements. The procedures contained within this policy give staff a clear direction and expectation for the implementation. The Trust will use this policy to demonstrate how to apply rules fairly and with equity in provision of planned care.

5.1 Governance structure

In order to ensure that robust governance process are in place key staff groups have been identified detailing their RTT role and their training requirements. Please refer to sections 4 and 5 of the Waiting List and Patient Access Management Procedures. The three levels of training are:

- Generic – Trust wide for all staff involved in a patients pathway
- PAS – in depth explanation of codes uses and effect on reporting of pathways
- Infoflex – in depth tracking and data capture for cancer pathways
- Service specific – specific pathway rules for that patient area.

Areas where training issues are not being resolved will be raised at Patient Access Group (PAG) and escalated if required.

5.2 Data Quality

Information Services, Data Quality Support Officers (3) and Cancer Centre Audit staff will support and monitor data quality issues within the Clinical Divisions. They will co-ordinate validation of patients waiting and monitor key indicator such as:

- Number and length of suspension periods
- System Did Not Attend (DNA)
- Adherence to policy e.g. patients being discharged following DNA.

5.3 Divisional Waiting List, Validation Staff and Cancer Centre Audit Team staff

These staff groups are responsible for ongoing validation and feeding back to staff on repeated problems to improve data quality. This feedback may be via key contacts in the service areas.

Managers should ensure that:

Validation and feedback to staff is ongoing

Appropriate resources are available

Where this policy is not being followed escalation is taken as detailed.

5.4 Reporting and Escalation

The Information and Cancer Centre Audit Team staff are responsible for reporting and monitoring waiting list targets and data quality issues. Concerns with data quality will be raised initially through the key contacts and then escalated to the General Manager and Assistant Director of Strategy and Partnership if necessary.

General data quality or process anomalies will be taken to PAG for discussion and, where specific to particular areas, be brought to the relevant General Managers attention. Issues that are sufficiently concerning or cannot be managed / resolved by the membership of PAG will be escalated to the Chief Operating Officer and Divisional Directors meeting.

Where there is a concern about achievement of targets this will be directly escalated to the General Manager and Divisional Director as well as the Assistant Director of Strategy and Partnership to liaise with Clinical Commissioning Groups.

There is a detailed Key Responsibilities for Adherence to Waiting List Policy in the Trust Procedures for Waiting List and Patient Access Management Appendix D.

6. Monitoring Compliance and Effectiveness

Monitoring compliance and effectiveness will be through the Trust Patient Access Group.

Monitoring Requirement :	1. The Trust can demonstrate compliance in relation to the standards which must be used by all healthcare professionals for the implementation of national policy. 2. The Trust can demonstrate compliance with training and education. 3. Cancer waiting times are monitored by Divisions with the Chief Operating Officer on a weekly basis
Monitoring Method:	1. Corporate audits and reporting through the patient access group using an agreed set of key performance indicators. 2. Reports from Divisions and IM&T.
Report Prepared by:	1.Associate Director of IM&T 2.Divisional General Managers and Associate Director of IM&T

Monitoring Report presented to:	Patient Access Group
Frequency of Report	1.Monthly 2.Training Reports – Twice a year

7. References

Trust Policy for Safeguarding Children2010 Trust Intranet

Commissioning Policy for Procedures of Limited Clinical Value.2010 (External policy written by Derby City PCT, circulated to patient access group members in March 2011)

Individual Funding Request Policy (External policy written by Derby City PCT circulated to patient access group members in March 2011)

Patient Transport Policy (as at May 2012 in development)

Access to health services for military veterans: priority treatment Gateway Reference 13406

A Code of Conduct for Private Practice Recommended Standards of Practice for NHS Consultants January 2004.

8. Appendix A

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WAITING LIST AND PATIENT ACCESS MANAGEMENT PROCEDURES

1. Consultants Responsibilities

Consultants clinically manage the needs of individual patients accessing Trust services consistently.

1.1 Leave and Clinic Cover

A minimum of 6 weeks notice for consultant and medical staff planned leave must be given to ensure patient appointment dates are honoured. All leave requests must be authorised by the Lead clinician or General Manager/Deputy General Manager.

1.2 Priority Treatment for Military Veterans (Outpatient/Daycase/Inpatient)

If it is agreed that the condition is service related they must be prioritised over other patients with the same level of clinical need. However, they must not be given priority over other patients with more urgent clinical needs.

1.3 Trust responsibilities regarding patients with learning disability

Where a person is recognised as having a learning disability the Consultant should ensure that the Learning Disability Liaison Nurse is contacted via the Safeguarding Team to support the team, the patient and their carers / family with access to the appointment and any reasonable adjustments that may be required during subsequent appointments / treatment episodes.

1.4 Outpatient Referrals

14.1 With the exception of cancer 2WW and screening, all referrals (electronic and paper**)** will be reviewed and prioritised within 2 working days of receipt except for visiting consultants (alternative arrangements will be agreed locally).

1.4.2 Cancer 2WW and cancer screening referrals must be reviewed and prioritised within 24 hours of receipt.

1.4.3 If these standards are not adhered to, administrative staff will accept the booking on behalf of the service to ensure no delays are built into the 18 week target.

1.4.4 Advice and Guidance requests (Choose and Book) must be responded to within 3 working days (urgent) or 5 working days (routine) of the request being made.

1.4.5 If a 2WW referral is deemed inappropriate, from the information provided, consultants must contact the GP by telephone to discuss the referral. If, after the discussion, the GP agrees to downgrade the referral, the GP must re-refer the patient using a standard urgent or routine letter. The consultant must note the date, time and outcome of the discussion on the 2WW form, which must be filed in the casenotes. The patient must be reclassified and the cancer audit team informed.

1.4.6 3 weeks (21 days) notice must be given to the patient when agreeing an appointment date. The only exceptions to this are:-

- Where it is clinically urgent (e.g. cancer 2WW referrals)
- Screening appointments i.e. bowel, breast and ovarian cancer screening
- Where a patient makes themselves available at short notice

1.4.7 Internal consultant to consultant referrals (Outpatients and Inpatients) will only be made if:

- Suspected cancer
- Urgent problems for which delay would be detrimental to the patients' health the expectation here would be that the patient needs to be seen within 2 weeks.
- Referral as part of the same clinical problem
- Part of the recognised pathway of care for the condition or as part of a pre operative assessment.
- Transfer of responsibility of care for an ongoing condition when it would be more convenient for the patient to be seen in a different location.

1.4.8 Referral back to a GP would be appropriate for:

- Conditions that are unrelated to the presenting problems and do not require urgent referral.
- Incidental findings
- Conditions that can be dealt with by the primary care team.

1.4.9 Referral Queries

If there is any doubt as to whether a patient needs to be managed by the hospital or whether a patient should be offered a choice it will be advisable for the consultant to contact the GP to discuss the case.

1.5 Inpatients / Day cases

1.5.1 Patients must only be added to a treatment waiting list or booked for surgery when they are ready and able To Come In (TCI) for their appointment/treatment.

1.5.2 Cancer patients must be given the earliest possible TCI date (within their 31 or 62 day target) whichever is the earliest. Please refer to the cancer centre team for the cancer target date information.

1.5.3 No pauses can be applied to patients on a suspected cancer or diagnosed cancer pathway.

1.5.4 A TCI form must be used by ALL consultants and completed for each patient,

including those who have been seen at peripheral and private hospitals.

1.5.5 An 18 week clock pause will be applied where a patient exceptionally needs to delay their inpatient treatment e.g. people in the teaching profession.

1.5.6 A decision to treat letter must be sent to the GP.

1.5.7 Patients with the same priority will be treated in chronological order, unless the patient has specifically chosen a later TCI date themselves.

1.5.8 When selecting patients for listing, it is essential to select patients on clinical grounds and length of wait.

1.5.9 DNAs where safeguarding issues (Adults and Children) are a factor must be alerted to the GP, the Health Visitor Liaison Nurse (based in CED), family and children's social care as necessary and in accordance with the Trust policy on Safeguarding: Management of DNA's.

1.5.10 3 weeks (21 days) notice must be given to the patient when agreeing a TCI date. The only exceptions to this are:-

- Where it is clinically urgent (e.g. cancer 2WW referrals). Patients must be given the earliest possible TCI date
    - Different rules apply to patients with suspected or diagnosed cancer.
- Where a patient makes themselves available at short notice
- Where the patient negotiates a date with the consultant during their consultation.

2 Divisional Management Responsibilities

2.1 Patients with a learning disability and their families / carers must be supported with reasonable adjustments to ensure access to treatment

2.2 Patients must be offered a minimum of 2 dates. One must give 21 days notice of appointment to demonstrate reasonableness and support to patient choice and fair and equitable access for all groups of patients.

2.3 All cancer patients must be listed once a decision to treat or undertake a diagnostic procedure has been made.

2.4 Ensure patients are seen within their maximum waiting time.

2.5 Use information reports to actively help plan capacity to ensure achievement of waiting time targets with no breaches.

2.6 Actively monitor referrals and booking rules to respond flexibly to demand and deliver flexible capacity.

2.7 Changes to booking rules must be authorised by a General Manager/Deputy and agreed with the Outpatient Services Manager/Deputy. The exceptions are:

- Adhoc requests with no reduction to patient booking numbers
- Changes to medical staff rota's
- Additions of target 2WW's or urgent slots for patients about to breach.

2.8 Responsible for having systems in place to ensure patients do not breach the 14, 31 and 62 days cancer waiting time and the 18 week referral-to-treatment targets. Cancer Centre staff will monitor pathways and escalate patients to the appropriate Divisional Medical Director or Divisional Director.

2.9 Ensure staff comply with PAS data quality standards.

2.10 Ensure systems allow, where appropriate and with the agreement of the clinician for new patients to be offered the opportunity of an appointment with a consultant who has a shorter waiting time.

2.11 Monitor and manage the reasons for DNAs, patient and hospital cancellations, removals (particularly removals without treatment) and additions to the waiting list.

- Review these cases as necessary to ensure that the best service possible is provided to patients as some of these may be indicative of other underlying problems, for example delays in sending out appointments, language needs, patient learning disabilities, etc.

- Review the trends in data e.g. ethnicity, age and gender.

- DNAs resulting from issues relating to protected characteristics (e.g. disability, language needs) need to be taken into account.

2.12 For planned patients staff must enter a date on to PAS in the 'Urgency/Date' field indicating when a patient will be seen.

2.13 Advise the PAS Support Team of any new waiting list requirements at least 6 weeks before the start date is needed.

2.14 Take ultimate responsibility for the content of the Directory of Services making sure regular updates are applied.

2.15 Managing flexible capacity to ensure slots are always available.

2.16 Ensure application of clinical leave as stated in the policy.

2.17 Following discussions and agreement with the relevant clinic admin lead and Data Quality Support Officer (DQSO) complete and submit a clinic template form (change form for booking rules new and existing) to the PAS Support Team. 2 weeks notice must be given.

2.18 Ensure booking rules reflect appropriate levels of capacity for new and follow-up consultations and monitor variances in new to follow up ratios.

2.19 Annually review booking rules with clinicians to ensure performance management and Key Performance Indicator's (KPIs) are considered.

2.20 Ensure that suspected cancer two-week wait referral patients are seen within 14 days of the clock start/date request received. Potential breaches must be escalated well in advance.

2.21 Ensure planned/outpatient patients are treated by their due date/cancer waiting time.

2.22 Ensure patients are listed in chronological order and discuss cases of non compliance with the consultant.

2.23 Ensure staff include the minimum data set information i.e. date of original referral and clock status when referring to another provider.

2.24 Ensure only patients who are fit and ready to be treated are added to the active waiting list.

2.24.1 All cancer patients must be listed once a decision to treat or undertake diagnostic procedure has been made.

2.25 Ensure ward staff record real time admissions, discharges and transfers on PAS.

3 Data Quality Team (Information Services)

3.1 The Data Quality Team – work closely with the Divisional Analyst, costing, and front line staff and are responsible for identifying, training and maintaining data quality excellence across all areas of delivery. The Data Quality Support Officers (DQSO) are responsible for raising the profile of data quality across each division and assist staff with any queries.

3.2 What is Data Quality? **–** Quality data is vital to the decision making processes of our organisation. It forms the basis for meaningful planning and alerts services to deviation from expected trends. It will ensure the nature of care provided is accurately and fully captured and that proper reimbursement for services provided takes place.

3.3 The Cancer Centre Team – will be responsible for cancer data quality and will work in conjunction with the Trust's Data Quality Team regarding any requests for data.

3.4 Examples of good quality data are:

- Ensuring referrals or TCI forms are entered onto PAS in a timely manner.
- Recording all offers of appointments / TCI dates on PAS.
- Ensuring patient's details (address, phone number, GP etc.) are up to date at every appointment / admission.
- Ensuring the correct dates are recorded for the start of a patient's pathway / referral and request received date / date on waiting list and any suspension period.
- Documenting any periods in which the patient is not available.

- Ensuring that correct pathways are picked up.
- Ongoing validation of missing clock starts and long waiters to ensure patients are treated within the appropriate timescales.

3.5 Standards – All staff have a responsibility to ensure that high quality data is captured across a wide range of systems and processes. The quality of information produced impacts on:

- Patient management
- Generating income through Payment by Results (PbR)
- Monitoring and reporting on national and local targets
- Service management, planning and development.

3.6 Core elements of high quality data are to ensure that processes allow for accurate, consistent, timely and complete recording of information. For support and advice about compliance contact the relevant Data Quality Support Officers (DQSO) for your area.

4. Outpatient and Daycase Admin/Reception Staff, Consultant Secretaries and other health professionals (specialist nurses, physiotherapists etc)

4.1 Ensure all referrals (electronic and paper) are accepted, rejected or changed within the following trust timescales from receipt to ensure that the patient is booked into an appropriate clinic.

Priority	Primary Care Turnaround Time (working days)	Trust Turnaround Time (working days)
2WW	24 hours	24 hours
Screening	24 hours	24 hours
Urgent	24 hours	3 days
Routine	3 days	3 days
Advice and Guidance	None	Urgent – 3 days Routine- 5 days

4.2 If the standard for 2WW's is not adhered to administrative staff will accept the booking to ensure the patient is not unduly disadvantaged and delays not incurred.

4.3 Support the achievement of national targets (90% admitted, 95% none admitted, 92% in complete pathways) plus cancer waiting time targets.

4.4 Escalate issues such as potential breaches, insufficient capacity or untypical removal from the waiting list to their line manager.

4.5 Changes to booking rules being required outside the 2 weeks notice period will not be actioned without the authorisation in email from the relevant General/Deputy Manager.

4.6 Requests for new clinics to be set up on PAS must be authorised by the appropriate General/Deputy Manager at least 2 weeks before the expected start date.

4.7 Subsequent clinic changes must be authorised and processed in line with these procedures.

4.8 Where consultant initiated clinic cancellations are requested with less than 6 weeks notice, team leaders must contact the relevant General/Deputy Manager as soon as possible for investigation and action.

4.9 Ensure patients are offered the opportunity to choose and agree a date within the maximum waiting time using either partial or full booking.

4.10 Where operationally possible the appointment needs of the patient will be taken into account such as religious festivals, statutory bank holidays, times of appointments (e.g. patients requiring carers and patients who are carers).

4.11 Ensure the special needs of the patient are taken into account such as font size for appointment letter or booking an interpreter for the appointment.

4.12 Ensure the 21 day guarantee is maintained when we cancel a patient on day of treatment for a non clinical reason.

4.13 If a patient with a suspected cancer or a diagnosis of cancer is cancelled on the day of procedure for a non clinical reason, a patient must be booked in to the next earliest possible slot to ensure that they meet target dates. Refer to the Cancer Centre Team for target date information.

4.14 Monitor the follow up review and planned lists to ensure patients are not waiting longer than their due return date. If this is the case this must be escalated.

4.15 Ensure suspected Cancer 2 WW's are seen within 14 days of receipt of referral (paper)/date of Unique Booking Reference Number (UBRN) conversion date or attempted conversion date (electronic). If this timescale cannot be met the escalation procedures must be followed.

4.16 When agreeing a TCI date, ensure patients are offered at least 2 dates. One date must give 21 days' notice to demonstrate reasonableness. The only exceptions to this are:-

- When it is clinically urgent (e.g. cancer 2WW referrals plus cancer screening)
- When a patient makes themselves available at short notice.
- When the patient negotiates a date with the consultant during their consultation.

4.17 Ensure all offer dates are recorded on PAS to provide an audit trail.

4.18 A waiting list pause will automatically be created by PAS for patients who decline 2 or more 'reasonable offers' for admission i.e. the date of offer is more than 3 weeks (21 Days) before the TCI date offered and a further TCI date has been accepted.

- Care must be taken if the patient is on a cancer pathway – no pauses can be applied to patients on a suspected cancer or diagnosed cancer pathway.

4.19 Short notice TCI dates offered to patients but not accepted will not compromise the patient's position in terms of their waiting time.

4.20 A patient cannot be a private and NHS for the treatment of one condition during a single visit to a NHS organisation.

4.21 Any patient changing their status from Private to NHS is entitled to NHS services on exactly the same basis of clinical need as any other NHS patient.

- Private to NHS for 18 week RTT clock – see 30.9

4.22 Ensure the minimum data set i.e. date of referral and clock status set is added to referrals from outside the Trust.

4.23 Inter provider transfers - In the event that this will cause an immediate waiting list breach, the patient must not be added to a waiting list without agreement with the appropriate General/Deputy Manager.

4.23.1 All patients with suspected or diagnosed cancer must be immediately added to a waiting list upon receipt of request/referral.

4.24 Patients who move out of the area have the option to remain on our waiting list. For those transferring to another hospitals' waiting list it is essential to send the 18 week details with the referral. See 30.12.

4.25 Transfer of care - In the event of a patient being transferred from one consultant's waiting list to another the original date on list must be retained.

5. Training – All Staff

Training arrangements

5.1 Four levels of training are required:

- Generic – Trust wide for all involved in a patients pathway
- PAS Training – in depth explanation of codes used in PAS and effect on reporting of pathways
- Service specific – Specific pathway rules for that patient area
- Infoflex – in depth tracking and data capture for cancer pathways

5.2 **Generic training** - will be developed by Data Quality staff in conjunction with e-Learning department. An on-line training and assessment package will be commissioned and approved by the Patient Access Group. This will cover the 'general understanding of RTT clocks and targets etc.' in the table below and

explain key responsibilities under the patient access policy. This will be mandatory as part of induction and thereafter every 2 years.

5.3 **PAS Training** - will be delivered by PAS Trainers with support on training material from Data Quality and PAG sub-group selected to advise on this. This will be delivered in an interactive training session with separate courses for new users and refresher courses for existing users. Once all staff have undertaken an initial training course future refresher courses could be delivered on-line, with an opportunity to book a face to face course if required. Detailed worked examples will be used to demonstrate which codes should be entered and the effect on the patient's pathway.

5.4 **Service specific** - training will be delivered in the Division by nominated key contacts (previously referred to as Super Users). These staff will be on hand to resolve queries as they arise and to explain local pathways that may not fit generic models. These staff can contact Data Quality for further advice and support. It is the responsibility of each division to reflect changes in their nominated key contacts.

5.5 **Infoflex -** will be delivered by IT Trainers with support on training material from Cancer Centre Audit staff.

5.6 See table below.

Staff Group	**RTT Role**	**Training Outcome**
Out Patient Admin staff – new patients	• Record referrals • Capture correct start dates and treatment status • Follow up on missing information from intra-provider transfers	Understand inter provider transfers and clock rules General understanding of RTT clocks and targets etc.
Out Patient Admin staff – follow up	• Record clinic outcomes based on information provided from clinic • Add patient to a review list or booking future appointments and record treatments status	Understand how outcome treatment status affects clocks and how to enter codes on PAS General understanding of RTT clocks and targets etc. Understand the patient access policy and their responsibilities.
Medical Secretaries and Waiting List Clerks	• List patients for treatment or investigations and record RTT status	Understand how WL and admin contact treatment status affects clocks and how to enter codes on PAS

	• Capture correct start dates and treatment status for patients going straight to test – follow up missing information from intra-provider transfers and stop clocks for those referred onto another provider for treatment. • Enter admin contacts for patients who have had a diagnostic test and no further treatment (or appts) required.	Understand inter provider transfers and clock rules. General understanding of RTT clocks and targets etc. Understand the patient access policy and their responsibilities.
Ward Receptionists	• Enter treatment status on admission and if patients are cancelled and / or re-listed	General understanding of RTT clocks and targets etc.
Medical Staff	• Indicate treatment status on outpatient outcome forms, TCI forms and letters referring patients on to other Clinicians / Providers	Understand inter provider transfers and clock rules. General understanding of RTT clocks and targets etc.
Nursing staff	• Enter treatment status on admission and if patients are cancelled and / or re-listed. • Support Medical Staff in outpatient clinics in completing outcome treatment status codes.	General understanding of RTT clocks and targets etc.
Information and Data Quality Staff	• Report on performance and support validation process.	Ability to provide comprehensive guidance and support on RTT clocks and targets etc.

	• Monitor compliance with the patient access policy.	Understand the patient access policy and their responsibilities.
Managers	• Ensure staff are trained to understand RTT rules and how to enter data. • Ensure appropriate validation is undertaken and that patient access policy is adhered to. • Escalation point for performance issues. • Authority to schedule additional clinical capacity where needed to avoid breaches.	General understanding of RTT clocks and targets etc. Understand the patient access policy and their responsibilities.
IT Training	• Deliver training to PAS users and support the Trust e-Learning tools to ensure key staff groups understand RTT rules and how to enter data on PAS.	Understand how treatment status affects clocks and how to enter codes on PAS General understanding of RTT clocks and targets etc.
Staff identified as being a 'specialist'' for RTT pathways within Divisions and Records Management	• Provide expert advice and support in pathway management within their speciality area. • Identify and escalate training and education issues arising from validation to relevant	Comprehensive understanding of all elements of the 3 training levels.

	General Manager/Head of Service	
All staff	• Ensure staff are trained to understand Cancer rules/pathways	General understanding of Cancer rules/pathways.

6 Outpatient Booking and Referral Management

6.1 Admin operational staff must ensure that the standards of practice for waiting list and patient access management are followed.

7. Current Methods of Referral to Access Services

7.1 Electronic Booking System (EBS) referral via the Choose and Book system is the expected method for **all** new patient referrals. This is where the patient has booked into a specific clinic slot and a referral letter/ proforma has been attached to the booking.

7.2 Paper Referrals are still accepted.

8. General Principles

8.1 If the patient was discharged more than 6 months ago GPs will have to re-refer for the same condition

8.2 Open appointments across all specialties are valid for 6 months from the last appointment

8.3 Review of referrals must be completed within 2 working days the exception being for visiting consultants

8.4 Rejected Referrals – referrals are not expected to be routinely rejected see 8.5.

8.5 The Choose and Book Directory of Service will be regularly updated and refined to ensure that information is accurate, current and reflects the services offered. In the event that a rejection is the only appropriate action, a brief explanation must be provided to the GP.

8.6 Choose and Book Operational Manager will audit rejected referrals on a regular basis and provide solutions for the issues.

8.7 Redirected Referrals – outpatient clinic staff will redirect as instructed to the correct service/clinic.

8.8 The 'Date Request Received' in PAS constitutes a clock start. This is the date an attempt was made to convert a UBRN into a booking for Choose and Book patients and the date the referral letter was received into the Trust for paper referrals.

8.9 Internal consultant to consultant referrals criteria is:

- Direct referrals will be appropriate for:
  - Suspected cancer
  - Urgent problems for which delay would be detrimental to the patient's health. The expectation here would be that the patient needs to be seen within 2 weeks.
  - Referral as part of the same clinical problem
  - Part of the recognised pathway of care for the condition or as part of a pre-operative assessment
  - Transfer of responsibility of care for an ongoing condition when it would be more convenient for the patient to be seen in a different location.
- Referral back to GP will be appropriate for:
  - Conditions that are unrelated to the presenting problems and do not require urgent referral
  - Incidental findings
  - Conditions that can be dealt with by the Clinical Commissioning Group
- Referral Queries
  - If there is any doubt as to whether a patient needs to be managed by the hospital or whether a patient should be offered a choice it would be advisable for the consultant to contact the GP to discuss the case.

8.10 Patients will only be added to a waiting list if there is an expectation of treating them and they are clinically fit and ready to undertake the treatment. Except cancer cases.

8.11 Where operationally possible the appointment needs of the patient will be taken into account such as religious festivals, statutory bank holidays, times of appointments (e.g. patients requiring carers and patients who are carers).

8.12 All demographics must be checked before 'arriving' the patient on PAS to ensure that data quality and contract/payment standards are achieved.

8.13 Admin staff/secretaries who work Choose and Book must view and action all work lists daily in accordance with the 'Daily Checks' guidance issued by the PAS Team.

8.14 The EBS spool (for choose and book patients) must be checked throughout the day to highlight any cancellations and prevent patients from being recorded as a DNA.

8.15 When booking patient appointments *outside* Choose and Book (in PAS) staff must select the correct EBS line entry from the 'Book New Appointment' screen to ensure the continuation of the 18 week RTT clock or cancer pathway.

9. Summary of Guidelines for Managing New Referrals

9.1 A New Referral will be required for:

a) Same specialty new condition

b) Previously discharged new condition

c) Previously discharged same condition - where new request is 6 months after discharge of the original referral.

10. 2WW Referrals - Receiving, Processing and Booking

10.1 Choose and Book is the expected method for all 2WW referrals with the exception of tertiary referrals.

10.2 The 14 and 62 day clock starts on either:
- the date the UBRN is converted to a booking OR
- the date the patient chose to 'defer to provider' due to no appointments being available

10.3 Patients must be seen within 14 days of the date request received.

10.4 Symptomatic Breast (non 2ww - not suspected cancer) referrals will be sent on a standard referral letter but must be seen within 14 days of the date request received.

10.5 For Faxed and Clinical Assessment Services (CAS) booked outside Choose and Book (in PAS) three attempts must be made to contact the patient, one of which must be in the evening.
- If a booking is made within 24hours of receipt of the referral the appointment in PAS will be recorded as 'fully booked'.
- If no contact is made an appointment letter will be sent. These appointments will be recorded in PAS as 'partially booked'.

10.6 If no appointments are available within 14 days local escalation procedures must be followed.

10.7 Once diagnosis has been confirmed patients will receive first treatment within 62 days of the date request received and within 31 days of the decision to treat, whichever is soonest.

11. Exceptions to the 2WW rule

11.1 **Inappropriate 2WW referral** - If, from the information provided by the GP, a clinician deems a 2WW referral inappropriate, they must contact the GP by telephone to discuss the referral. If after discussion, the GP agrees to downgrade the referral, the GP must re-refer the patient using a standard urgent or routine letter. The clinician must note the date, time and outcome of the discussion on the 2WW form, which must be filed in the notes. The clinician must then ensure that the relevant member of the cancer audit team is informed of this decision.

11.2 If a referral letter has been upgraded to a 2WW by the consultant, the priority must be recorded as urgent (not Target) in PAS and the target wait group left blank

12 New Paper Referrals - Receiving, Processing and Booking

12.1 All referrals processed through the Referral Process Office in Records Management.

12.2 Demographic and special needs information checked and amended as necessary on PAS. Referrals will be date stamped and registered within 24 hours of receipt and forwarded to the appropriate clinic area to be added to the Registered Referrals list.

12.3 Out-patient clinics will ensure all patients are added to the appropriate clinicians Registered Referrals List. Open/unnamed referrals will be allocated by the Team Leader relevant to their area of work.

12.4 With the exception of cancer 2WW and screening all referrals must be reviewed within 2 working days of receipt by an appropriate individual for prioritisation. Local agreements must be followed for visiting consultants. Arrangement must be in place for when consultants are on leave or when they do not attend on a regular basis.

12.5 Cancer 2WW and cancer screening referrals must be reviewed and prioritised within 24 hours of receipt.

12.6 The 18 week clock starts on the day the referral is received and date stamped into the Trust.

12.7 On receipt of referrals back from the clinician the following will be initiated:

- Admin staff must enter the clinical grading priority on PAS
- Urgent requests will be booked immediately
- Routine requests will be booked in accordance with the Partial Booking Process.
- Patients failing to respond will result in them being discharged and the referral returned to the GP with a covering letter generated from PAS
- Referrals marked as Straight To Test (STT) will be discharged from the registered referral list and forward to appropriate department.
- Inappropriate referrals will be discharged from the registered referrals list and the clinician will notify the referring clinician. This excludes 14 day cancer referrals (see 11.1).
- When an appointment is booked the patient will be sent a confirmation letter
- It is the responsibility of each Team leader/Supervisor to housekeep the Registered Referrals list.

13. Obstetric Referrals

13.1 Referrals and dating scans are managed directly by Ante-natal services to locally agreed procedures.

14. Choose and Book Referrals - Receiving, Processing and Booking

14.1 The first indication that an appointment booking has been made is the receipt of an auto-generated notification on the local EBS spool.

14.2 Referrals are only visible on the 'Referrals for Review' work list once both the appointment booking has been made and the referral attached.

14.3 All referrals are printed off and processed by the Referral Process Office in Records Management with the exception of the following which are managed by the relevant clinic areas:

- 2ww referrals (including Symptomatic Breast)
- Pain Management
- Palliative
- Rehabilitation
- Oncology (Established Diagnosis)
- Haematology
- Diagnostic Physiological Measurement
- Rapid Access Chest Pain

14.4 With the exception of cancer 2WW and screening all referrals must be reviewed within 2 working days of receipt by an appropriate individual for prioritisation. Local agreements must be followed for visiting consultants. Arrangement must be in place for when consultants are on leave or when they do not attend on a regular basis.

- If these standards are not adhered to, administrative staff will accept the booking on behalf of the service to ensure no delays are built into the 18 week target.

14.5 Cancer 2WW and cancer screening referrals must be reviewed and prioritised within 24 hours of receipt.

14.6 The cancer clock starts on either:

- the date the UBRN is converted to a booking OR
- the date the patient chose to 'defer to provider' due to no appointments being available

14.7 Referrals on the Referrals for Review work list must be actioned (accepted, rejected, changed) by the admin staff within 3 days working days of receipt or as a minimum daily for 2WW.

- When an appointment is booked the patient will be sent a confirmation letter.
- It is the responsibility of each Team leader/Supervisor to housekeep the 'Referrals for Review' work list.

15. Follow-up Appointments

15.1 Patients will only be followed up where there is a specific clinical need following the specialty protocol.

15.2 Fully Booked will only be recorded when booking a further appointment at the time of leaving clinic.

15.3 Partially Booked will be recorded at all other times e.g. when booking from a review list.

15.4 Patients who fail to respond to the partial booking process (including patients with a suspected or diagnosed cancer) within 3 weeks will be discharged from the review list and referred back to the Consultant for a clinical decision to be made regarding ongoing clinical care. The GP will be advised accordingly.

16. X- Inpatient Patient (XIP) Appointments

16.1 An XIP appointment is booked for a patient requiring a follow up appointment, within the same specialty as the inpatient stay, after an elective, planned or emergency admission.

16.2 It is the ward staff responsibility to provide clinic admin staff with the correct method of admission for the clinic booking on PAS.

17. Changing/Cancelling Appointments at Patient's Request – New and Follow-up

17.1 Patients have an additional option to cancel and change their Outpatient appointment on line, via the Derby Hospitals website. These requests will be actioned by the Referrals Processing Office. Choose and Book appointments cancel and change using the Choose and Book telephone appointments line or website.

17.2 In the event a patient cancels a 2ww wait appointment a further appointment must be given within 14 days of the original date request received/UBRN conversion. If this is not possible and the new appointment is over 14 days escalate to General/Deputy Manager.

17.3 If patient requests a rearrangement or cancellation within 24 hours of the appointment time it must be recorded as a patient cancellation.

17.4 If a patient is unable to attend due to being a current Inpatient, this must be recorded on PAS as a change/cancellation by patient.

17.5 With the exception of Antenatal and 2WW, if a patient cancels the same appointment twice they must be:

- New Patient - removed from the registered referral list and referred back to their GP.
- Follow-up – referred to the consultant for discharge to GP.

17.6 Patients can change Choose & Book appointments at any time - this is out of Trust control.

17.7 The EBS spool must be checked throughout the day for patient cancellations to ensure they are not recorded as a DNA.

17.8 If a patient has to leave a clinic prior to being seen (clinic over running or other circumstances) their appointment must be changed to ensure that they are not penalised in the 18 week cycle. The clock will continue ticking.

17.9 If a child's appointment is cancelled twice the issues/concerns associated with this must be reviewed and assessed by the Consultant. Refer to Trust policy for Safeguarding Children.

18. Hospital Cancellations – New and Follow-up

18.1 New appointments can be changed by clinic admin staff providing there is no breach to the waiting time targets.

- Potential breaches must be brought to the attention of the appropriate General/Deputy Manager for advice and resolution.

18.2 Appointments will be re-booked with the patient's agreement as close to their original appointment date as possible. Only in exceptional circumstances will a patient be cancelled twice.

18.3 A cancer 2ww appointment cannot be cancelled without the authority of a General/Deputy Manager.

19 Patients who do not attend (DNA) – New and Follow-up

19.1 Any qualified provider (AQP) states it is in the patient's interest to ensure that mechanisms are in place to minimise the number of patients who fail to attend pre arranged appointments. If a patient DNAs an appointment they should be offered one further appointment. Should they fail to attend this appointment the following will occur:

19.1.1 Adults - Where there are potential safeguarding issues the safeguarding team should be informed. Where there are no safeguarding issues they will be discharged back to their GP

- Cancer patients can be referred back to their GP after multiple (two or more) DNAs if this is agreed with the consultant.

19.1.2 Children - will automatically be offered another appointment. In DNA cases all consultants must identify whether safeguarding issues are a factor and whether the DNA constitutes potential neglect of medical needs. The Trust policy for Safeguarding: Management of DNA should be referred to. Where safeguarding issues are identified the safeguarding team should be contacted.

- Children who fail to attend a second outpatient appointment will be discharged back to their GP and the Health Visitor Liaison Nurse (based in CED) should be informed.

- Cancer patients can be referred back to their GP after multiple (two or more) DNAs if this is agreed with the consultant.

19.2 For patients with a series of planned appointments DNA's will need to be considered on a case by case basis.

20 Communication

Under the Human Rights Act and the Equal Opportunities Acts and anti-discrimination legislation the trust has a duty to provide interpreters for follow up appointments where deemed clinically relevant and to ensure reasonable adjustments are made for patients and their families.

20.1 Independent interpreters should be used when English is not a first language particularly where there are safeguarding concerns or concerns regarding domestic abuse.

20.2 Some patients may have limited verbal communication either due to learning disability or other issues. In these cases it is vital to have someone who does understand the communication favoured by the patient e.g. BSL interpreters / SALT.

20.3 Where the patient has a learning disability the Consultant should contact the Learning Disability Liaison Nurse to support the team and the patient with reasonable adjustments or other requirements

21. Ambulance Transport

21.1 A patient is only eligible for provision of transport (including escort) if considered necessary by a Health Care Professional.

21.2 For further information refer to Trust policy Patient Transport.

22. Diagnostics; Imaging

22.1 In accordance with national maximum waiting times guidance imaging appointments will be booked within 6 weeks. The exception to this is interventional radiology procedures which follow the RTT 18 week pathway (see Appendix E). Separate rules apply if 2WW straight to test/screening.

22.2 Patients must not be referred back to their GP after the first DNA of their first appointment. Patients can be referred back to their GP after multiple (two or more) DNAs if this is agreed with the consultant.

23. Referrals

23.1 The Imaging Service receives internal requests, referrals from GP's, and other external sources. The department starts the 2 or 6 week diagnostic wait time for each referral source as follows;

- Paper – date received in department
- Electronic – date referral is made

23.2 Referrals will be accepted in Imaging according to internal protocols and IRMER (Ionising Radiation Medical Exposure Regulations).

23.3 Rejected referrals will be returned to the referring clinician and the diagnostic wait time stopped.

23.4 Resubmitted referrals will start a new diagnostic wait time.

23.5 Where such patients require non-specialist care to improve fitness they will be discharged back to their GP to be re-referred into the service when they are ready for treatment

24 Inpatient /Day case Waiting List

24.1 Adding a non cancer patient to a Waiting List

24.1.1 A patient cannot be added to a waiting list unless they are medically fit and ready and able to be admitted.

24.1.2 Only a consultant, SPR, Associate Specialist or Clinical nurse specialist can authorise adding a patient to a waiting list indicating an appropriate grade (urgent, routine, Cancer target).

24.1.3 A TCI form must be completed for each patient, including those who have been seen at peripheral and private hospitals.

24.1.4 Patients must be added on PAS within 2 working days of the decision to treat.

24.1.5 Patients must not be added where residential criteria are unconfirmed (overseas visitor). Checks and confirmation must be completed by the Overseas Private Patients and Overseas Visitors Office (x 86330)

24.2 **Active Waiting List -** for patients who are medically fit and available to come in at the time of listing.

24.2.1 When a patient has a suspected cancer or a diagnosis of cancer, and the decision is to admit for a procedure, the following rules apply:

- Patients must be given the earliest possible TCI date (within their 31 or 62 day target) whichever is the earliest. Refer to the cancer centre team for target date information.
- No pauses can be applied to patients on a suspected cancer or diagnosed cancer pathway.
- All cancer patients must be listed once the decision to treat or undertake a diagnostic procedure has been made.

24.3 **Planned Waiting List -** for procedures which are part of an agreed programme of care required, for clinical reasons, to be carried out at a specific time or repeated at a specific frequency.

24.4 **Multiple Waiting List** - when a patient is listed for different procedures at the same time.

- If the patient has **conflicting conditions** which **cannot** be treated simultaneously i.e. the secondary condition needs to be treated after the primary condition is resolved. The patient will be removed from the waiting list, to be re-listed once they are fit and ready for treatment.

- If the patient has **non-conflicting conditions** which **can** be treated simultaneously suspension(s) will be added to all other waiting list entries whilst the patient is receiving/recovering from another procedure.

- Suspected or Diagnosed Cancer If the patient has **conflicting conditions** with suspected or diagnosed cancer which **cannot** be treated simultaneously consultant authorisation is required as to what condition is treated first.

24.5 **Staged bilateral procedures -** Where commissioned by the Clinical Commissioning Group staged bilateral procedures will be listed for the second side once the patient is fit and ready. The patient will be prioritised for urgency as with any other listing.

24.6 **Missed Listing**
If a missed listing is identified it must always be escalated to the appropriate general/deputy manager prior to adding them to the waiting list.

24.7 **Not Medically Fit -** Refer to section 24 Suspensions

- No pauses can be applied to patients on a suspected or a diagnosed cancer pathway.

24.8 **Preoperative Assessment –** Medical and Anaesthetic check prior to admission

- If a patient cancels their initial preoperative assessment appointment, a further choice of appointment and provisional admission date will be offered, based on their clinical priority.

- A second cancellation - the patient will be referred back to the consultant for removal from the waiting list. (A letter confirming their removal must be sent to the patient and their GP).

- Cancer patients – A patient cannot be removed from the waiting list if a second or further cancellation occurs unless agreed with the consultant.

- DNA – will be offered 1 further appointment before being referred back to the consultant for removal from waiting list (A letter confirming their removal must be sent to the patient and their GP).

- Cancer patient DNA – will be offered 2 appointments before being referred back to the consultant.

25. Suspensions - Maximum length/number of suspensions

25.1 A suspension will be used for patients on an active waiting list who have either declared that they are unavailable for treatment or where a clinical decision is made that the patient is not fit for the procedure.

25.2 Total suspension period for a patient will not exceed 8 weeks. (Also see Section 25.4 and 25.5). A patient will not be suspended more than twice on the waiting list. If a greater suspension period is required the patient will be removed from the waiting list and depending on clinical appropriateness either:

a) discharged back to their GP to be re-referred into the service when they are fit, ready and available for treatment

or

b) reviewed in outpatients until they are fit and ready to be re-listed

25.3 No pauses/suspensions can be applied to patients on a suspected cancer or diagnosed cancer pathway.

25.4 **Planned Waiting List Suspension -** a patient on a planned waiting list will not be suspended as their procedure is time specific.

- No pauses/suspensions can be applied to patients on a suspected cancer or diagnosed cancer pathway.

25.5 **Long term patient-initiated suspensions –** (example a farmer or school teacher with specific availability) If the patient declares long-term unavailability at the time of listing a TCI date will be agreed with the patient, within 6 months from the date on list and the suspension period extended accordingly. If the patient cannot agree a date within this period they will be discharged back to their GP to be re-referred into the service when they are ready and available for treatment.

- No pauses/suspensions can be applied to patients on a suspected cancer or diagnosed cancer pathway.

26. Cancellations and DNAs

26.1 **Cancelling an Agreed Operation Date -** If a patient cancels their first admission date, one further date will be agreed. If the patient cancels for a second time they will be removed from the waiting list and discharged back to their GP/referrer unless clinical priority dictates otherwise.

- If a patient cancels an agreed operation date they must be rebooked at the earliest possible date. Please check with the cancer centre team re cancer

waiting time targets.

26.2 **TCI Cancellation by Hospital**

26.2.1 Urgent operations can only be cancelled on the direction of the consultant and General/Deputy Manager.

26.2.2 Non clinical cancellations (e.g. lack of beds) can only take place following instruction from the General/Deputy Manager.

26.3 **Patients who DNA admission**

The Safeguarding: Management of DNAs policy must always be referred to

26.3.1 The DNA will be recorded on PAS by the Medical Secretary/Waiting list clerk who holds the respective Consultants waiting list.

26.3.2 Attempt to make verbal contact with the patient.

26.3.3 Patient will be removed from the waiting list unless clinical priority dictates otherwise (cancer patients).

26.3.3 If contact cannot be made contact details must be checked with the Referrer/GP.

26.3.4 The patient will be discharged and copied into the discharge letter.

26.3.5 Patients not removed from the waiting list on clinical grounds must have a risk assessment recorded in the case notes, the GP notified and a management plan agreed.

26.3.6 Further non-compliance by the patient will result in them being discharged back to their GP.

26.3.7 Cancer patients who DNA admission must be given the next earliest possible TCI date (within their 31 or 62 day target whichever is the earliest). Please refer to the cancer centre team for target dates.

26.4 **Cancelled by Hospital after Admission**

26.4.1 Cancer patients – if the hospital cancels an agreed operation date they must be rebooked at the earliest possible date. Please check with the cancer centre team re cancer waiting time targets.

26.4.2 For all non clinical cancellations a further admission date will be agreed with the patient within 28 days of the cancelled date.

26.4.3 The original date of decision to admit is retained i.e. date on waiting list.

26.4.4 In the event that re-appointment within 28 days is not achievable, the patient will be offered treatment at a hospital of their choice.

26.4.5 The offer will be made prior to the 28-day deadline and escalated to the appropriate Divisional Director.

27 Admission to Hospital

27.1 All patients must be admitted, transferred and discharged via the BedWeb and eDischarge system, ensuring the correct pathway ID and treatment status are used.

27.2 BedWeb and eDischarge

27.2.1 BedWeb and eDischarge are part of the same system.

27.2.2 BedWeb provides real-time bed management allowing the best use of inpatient beds

27.2.3 eDischarge ensures GPs receive an electronic copy of the discharge summary within 24 hours of the patient discharge. Further information/guidance can be found on the intranet.

28 Cancer Referral to Treatment – What are the Cancer Waiting Times Service Standards the NHS Needs to Deliver?

28.1 The cancer waiting times service standards are:

- Maximum 2 weeks from:
    - Urgent GP (GMP or GDP) referral for a suspected cancer to first outpatient attendance-operational standard of 93%.
    - Referral of any patient with breast symptoms (where cancer is not suspected) to first hospital assessment-operational standard of 93%.
- Maximum one month (31 days) from:
    - Decision to treat first definitive treatment-operational standard of 96%.
    - Decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrent where the subsequent treatment is:
        - Surgery – operational standard 94%.
        - Drug treatment – operational standard 98%.
        - Radiotherapy – operational standard 94%.
- Maximum two months (62 days) from:
    - Urgent GP (GMP or GDP) referral for suspected cancer to first treatment (62 day classic) – operational standard 85%.
    - Urgent referral from NHS cancer screening programmes (breast, cervical and bowel) for suspected cancer to first treatment – operational standard 90%.

- Consultant upgrade of urgency of a referral to first treatment – no operational standard as yet.

- Maximum one month (31 days) from urgent referral to first treatment for

  Children's cancer

  Testicular cancer

  Acute Leukaemia

  No operational standard – monitored within 62 day classic.

29 18 Week Referral to Treatment - What is 18 Week Referral to Treatment?

29.1 The Department of Health Rules state that patients must receive their first definitive treatment within 18 weeks of the date the referral is received by the Trust. The time a patient is waiting is called Referral to Treatment.

29.2 Definitive treatment can be defined in various terms for example the patient:-

- Is admitted for surgery or other intervention as an inpatient or Daycase (admitted clock stop – see below 29.3)

- Is seen in Outpatients and an opinion is given with the patient being referred back to the GP (non admitted clock stop – see below 29.3)

- A procedure of some description being performed in an Outpatient setting that means the patient can be discharged from our care (non admitted clock stop – see below 29.3)

- A definitive diagnosis being made following tests or x-rays with a referral back to the GP or where the patients begins a course of follow up appointments (non admitted clock stop – see below 29.3)

29.3 **Compliance**

Our compliance with this is monitored on a monthly basis and submitted to the Department of Health.

Admitted Clock Stops - 90% of patients admitted must have been waiting less than 18 weeks.

Non admitted clock stops - 95% of patients must have been waiting less than 18 weeks.

Incomplete patients (patients who have not completed their care with an admitted or non admitted clock stop are classed as incomplete) - 92% of our patients awaiting their first definitive treatment must have waited less than 18 weeks.

29.4 **18 Week Pathways**

Patients are assigned an 18 week pathway ID for their condition and every stage of their care is monitored in this pathway on PAS. This is done through inputting treatment status codes (see appendix E) against appointments, waiting lists, admissions etc, to reflect the current status of the patient's pathway.

Pathways may go cross specialty e.g. a patient may be referred into physiotherapy but then be referred onto orthopaedics for the same condition which will mean using the existing pathway information. Pathways may also go cross Provider / Trust e.g. a patient sees a consultant at Ripley who then refers them here for monitoring, tests and / or treatment.

18 week pathways will consist of a start and a stop and at times may have an ongoing status. Pathways can also re-start for a condition, for example, if it is decided a patient needs more aggressive treatment.

Care must be taken to pick up the correct pathway IDs, and not auto generating unnecessarily.

29.5 **Clock Starts**

A clock will start at the date the referral is received into a consultant led, interface (See Glossary – Appendix F) or assessment service.

For Choose and Book referrals the clock start is brought through from the Choose and Book system as is the pathway ID.

29.6 **Clock Continues**

- The clock continues while tests and investigations are taking place.
- A clock does not automatically stop when a patient DNA's a follow up appointment (see 29.7.2).
- The clock does not stop when a patient gives more than 24 hours notice that they are unable to attend an appointment. Patient changes of less than 24 hours notice are classed as a patient cancellation.
- An in-patient or daycase admission for a diagnostic procedure only will not stop an 18 week clock.

29.7 **Clock Stops**

29.7.1 The 18 week clock stops when first definitive treatment is given i.e. treatment given surgically or none surgically.

OR

29.7.2 When it is communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay that:

a. It is clinically appropriate to return the patient to primary care for any non consultant-led treatment in primary care;

b. A clinical decision is made to start a period of active monitoring;

c. A patient declines treatment having been offered it

d. A clinical decision is made not to treat

e. A patient DNA's their first appointment following the initial referral that started their 18 week clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient.

f. A patient DNAs any other appointment and is subsequently discharged back to the care of their GP provided that:

1. The provider can demonstrate that the appointment was clearly communicated to the patient

2. Discharging the patient is not contrary to their best clinical interests
3. Discharging the patient is carried out according to local, publicly available, policies on DNA's.

g. If there is a delay in booking a further follow up appointment because the patient preference makes it "impossible or unreasonable" for 18 weeks to be achieved for that patient, they will be discharged back to their GP. The Trust measures 4 weeks from the original offer as unreasonable.

29.8 **Clock Pause**

29.8.1 The clock will be paused only where a decision to admit has been made and the patient has declined at least 2 reasonable offers of admission. This includes patients who are not socially ready on the date the decision to admit is made.

29.8.2 The clock is paused for the duration of the time between the date of the earliest reasonable offer and the date at which the patient becomes available for admission. A clock may also be paused by the patient and / or the hospital once the patient is on a waiting list. However only patient initiated pauses will be counted, the hospital pause is not applicable to the 18week RTT. We can't pause the 18 week clock for non-admitted patients.

NB: The rules around clock pauses are very strict so for further guidance contact your Data Quality Support Officer.

29.9 **Patients Not Applicable to the 18 week RTT**

Emergency patients
Patients on a planned waiting list
Private Patient
Obstetrics

30. **Inter Provider Referrals**

30.1 A transfer of clinical care to an alternative provider using an Inter Provider Transfer Administrative Minimum Dataset/form (IPT/AMDS)

Receiving IPT/AMDS

30.2 There are three methods that an IPT/AMDS form will come into the Trust

- Community Hospitals (Ripley, Ilkeston, St.Oswalds, Heanor, Long Eaton, Babington) - Safe Haven Fax
- All other hospitals (including private providers treating NHS patients) - NHS net email account: dhft.interprovidertranfers@nhs.net .
    - IPT/AMDS received by any other method - contact must be made with the sender to inform them of the correct NHS net address. This is managed by the Referral Process Office in Records Management.
- Phoned referrals - Pathway ID, 18 week clock start date and status are required in order to record on PAS. The referring Trust must confirm this referral with an IPT/AMDS form within 48 hours.

Missing Data on IPT/AMPS

30.3 If the pathway ID, 18 week clock start date or 18 week clock status are missing the following action must be taken:

- Email the referrer's secretary insisting the information be sent within 48 hours. cc Referral to Treatment Co-ordinator, Information Services sarah.morgan6@nhs,net
- If the information has not been received within 48 hours, escalate to the Referral to Treatment Co-ordinator.

Entering Inter Provider Transfers on PAS – Same Condition

30.4 Process the referral in the normal way entering the referring provider's pathway ID, the clock start date if applicable and the appropriate clock/treatment status.

30.5 For details of which treatment status to use see Appendix B.

30.6 It is essential that the correct treatment status is used so that the RTT period can be accurately measured and ensure the patient is on the appropriate pathway. Contact the Referral to Treatment Co-ordinator or your Data Quality Support Officer if you are unsure about which treatment status to use.

Entering Inter Provider Transfers on PAS – New condition

30.7 Transfers from another provider for a new condition will need an auto generated pathway ID. The clock will start on the date we receive the referral.

Transfers from Private Providers

30.8 Many Private hospitals see both Private and NHS patients. Therefore, either of these patient groups may be transferred/referred to us. These transfers will be either:

30.9 **Private to NHS –** this will constitute a new clock start with an auto allocated pathway ID

- If the referral is for follow up, a clock start must still be recorded on PAS. The clock will then be stopped at the outcome of the appointment with either treatment not required or active monitoring.

30.10 **NHS (from a private provider) to NHS (NHS provider) –** 18 week details must be used when entering the patient activity on PAS. If no 18 week details are sent with the referral the referring provider must be contacted.

30.11 **Private to Private -** These patients are excluded from the 18 week RTT. A Pathway ID must still be auto allocated with a treatment status of 98 for as long as they remain a private patient

Sending IPT/AMDS to other Trusts – Appendix C

30.12 An IPT/AMDS form must be sent to the receiving provider within 48 hours of the date of decision to refer – new or existing conditions

31 **Cancer patients** – Tertiary referrals with a suspicion or diagnosis of cancer must be reviewed and prioritised within 24 hours of receipt, with liaison with the Cancer Centre.

Appendix B

Inter provider transfers – Treatment Status Required For Same Condition Referrals Status upon transfer from other provider

Referral to	Ongoing Pathway	Stopped/Not applicable pathway - continuing care
Outpatients	Enter clock start date given by the referring provider into RTTP start date in outpatients referrals screen Treatment status of 15 (referral same condition other provider) Use the referring provider's pathway ID CHECK PATHWAY SCREEN TO ENSURE THERE'S A CLOCK START	Use the referring provider's pathway ID Clock start date to be left blank Treatment status of 98 (not applicable) * ** If you have enough information to be more specific, e.g. that the patient has had treatment or is on active monitoring, you can use 1 or 24.*
Waiting list	Use the referring provider's pathway ID Add patient to waiting list with 15 (referral same condition oth. prov.) Enter an admin contact for the date of the clock start from the referring provider and use 8 Active monitoring end/Start of new RTT period as the treatment status in the admin contact. An admin contact is not needed if the start date is the same as the date on list. Can list with a TS of 8. CHECK PATHWAY SCREEN TO ENSURE THERE'S A CLOCK START	Use the referring provider's pathway ID Treatment status of 98 (not applicable) * ** If you have enough information to be more specific, eg that the patient has had treatment or is on active monitoring, you can use 1 or 24.* No admin contact needed.
Admissions	Admit with treatment status of 2 (treatment given surgical or 9 (treatment plan to be agreed) depending on whether the admission is for treatment or diagnosis. Enter an admin contact for the date of the clock start from the referring provider and use 8–Active monitoring end/Start of new RTT period as the treatment status in the admin contact	Use the referring provider's pathway ID Admit with a treatment status of 98 (not applicable) * ** If you have enough information to be more specific, e.g. that the patient has had treatment or is on active monitoring, you can use 1 or 24. NO ADMIN CONTACT NEEDED.*

	CHECK PATHWAY SCREEN TO ENSURE THERE'S A CLOCK START	

Appendix C

Inter Provider Transfer Form (Minimum Data Set)

NHS No: D.O.B Surname

Referral From: Contact Tel (Secretary)

Clinician / Cons

Is this referral for a NEW or EXISTING condition?

New Condition (No further information from the referring hospital is required)

(RECEIVING TRUST – PLEASE GENERATE A NEW PATHWAY)

Existing Condition (Complete further steps)

Patient's Pathway ID Number (20 Digits)

1. Treatment Stage / Clock Status. The patient is:

a) Waiting for treatment / investigation / opinion (Clock Ongoing)

Clock Start Date

(Date of original referral received or most recent clock re-start)

b) On Active Monitoring/Treatment Previously Given (Clock Stopped)

(Clock start not needed)

c) Is currently exempt from 18w. E.g. where the original referral was made as an emergency or from birth if a baby (No clock has been started and the current T/S code is 98)

Appendix D

KEY RESPONSIBILITIES FOR ADHERENCE TO WAITING LIST POLICY

Patient Access Policy Key Area	Report	Supplied by	Frequency of Reports	Lead Recipient	Escalation Point
Patients should only be listed once for each procedure	Duplicate entries on waiting list	Information Services	Monthly	Data Quality Support Officer	Key Contact for individual Waiting List
Patients must not be suspended for more than 6 weeks in total. However, where there may be an exception this must be documented and in the interest of the patient.	Patients suspended over 1 month	Information Services	Monthly	Data Quality Support Officer	Deputy General Manager or equivalent
Correct procedure codes should be used	Missing / unknown procedure codes	Information Services	Monthly	Data Quality Support Officer	Waiting List Key Contact
TCI dates must be confirmed on PAS	System DNA's	Information Services	Monthly	Data Quality Support Officer	Waiting List Key Contact
Maximum 2 patient cancellations then removal from waiting list	Patients who have had two or more cancellations for the same episode	Information Services	Monthly	Data Quality Support Officer	Asst General Manager or equivalent
Maximum 1 DNA then removal from the inpatient and/or outpatient waiting list, subject to clinical exceptions and agreement by consultant.	Patients who have had two or more DNA's for the same episode.	Information Services	Monthly	Data Quality Support Officer	Asst General Manager or equivalent
Consultants must give at least 6 weeks notice of planned leave to their clinical lead and General Manager	Instances to be flagged by Outpatient Staff	Information Services	As required	Records Management Clinic Staff	General Manager
Patients should be offered choice of their appointments. Patients must be given at least 21 days notice of TCI dates or appointments	Weekly checks to ensure that patients for the next four weeks have TCI/appointment dates with appropriate notice.	Information Services	Weekly	Waiting List Key Contact	Asst General Manager or equivalent
Ensuring all patients are seen by the maximum waiting time target – currently 18 weeks from referral to treatment as an inpatient (admitted) or an outpatient (non-admitted)	Weekly checks to ensure that patients for the next four weeks have TCI / appointment dates within target timescales	Information Services	Weekly	General Managers	Divisional Director

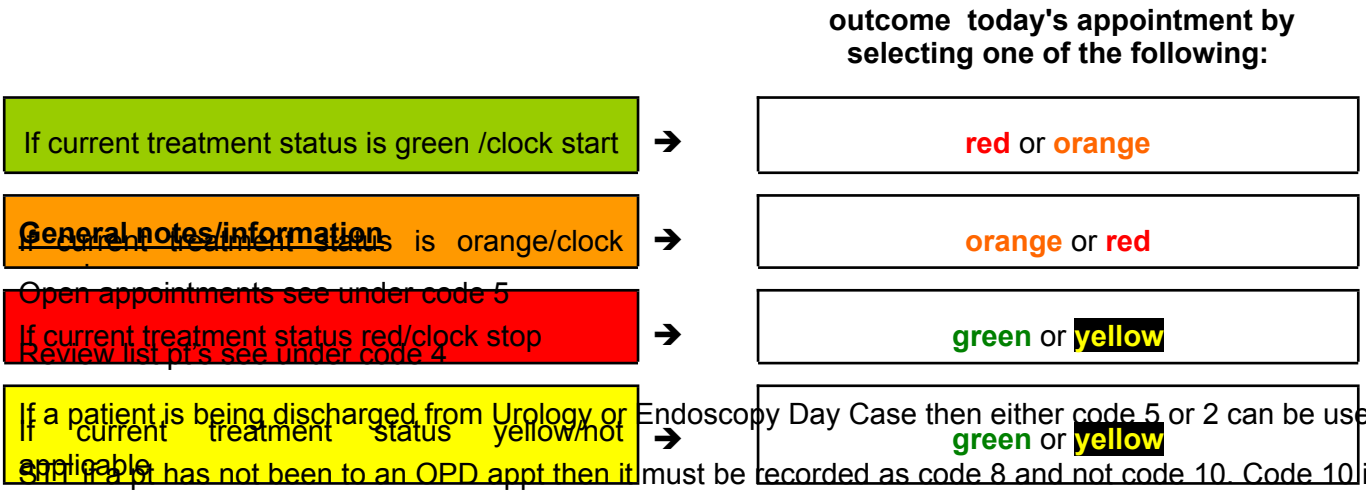
Patients referred to the hospital must be discharged or receive their first definitive treatment within 18 weeks of referral	Incomplete (patients still waiting for treatment) - Compliance with 18 week target (Admitted/Non Admitted)	Information Services	Weekly	General Manager	Divisional Director
Patients with suspected cancer must be seen within 14 days of seeing their GP	Compliance with 14-day requirement	Cancer Centre	Weekly	General Manager/ Cancer Centre Manager	Divisional Director/Chief Operating Officer
Patients referred for and diagnosed with cancer must begin their first definitive treatment (if appropriate) within 31 days	Compliance with 31-day requirement	Cancer Centre	Weekly	General Manager/ Cancer Centre Manager	Divisional Director/Chief Operating Officer
Patients referred for and diagnosed with cancer must receive their first treatment (if appropriate) within 62 days	Compliance with 62-day requirement	Cancer Centre	Weekly	General Manager/ Cancer Centre Manager	Divisional Director/Chief Operating Officer
Patients whose procedures are cancelled on the arranged date must have their procedure rescheduled within 28 days.	Compliance with standard	Information Services	Monthly	General Manager	Divisional Director
New Outpatients	Patients seen within 6 weeks	Information Services	Weekly	General Manager	Divisional Director
Planned Waiting list and Outpatient (Review lists).	Patients seen within required time	Information Services	Weekly	General Manager	Divisional Director
Appointment Slot Issues – Choose and Book	Compliance with Appointment Slot issue rate of 0.03.	Choose and Book Manager	Weekly	General Manager	Divisional Director

It is expected that the lead recipient, on receipt, will review and act on these reports and take required actions or escalate promptly.

	18 WEEK FLOWCHART Appendix E
PAS CODE	**DESCRIPTION**
Clock start codes – These are to be used for new referrals and patients restarting their clock.	
19	**Referral (new condition) NOT consultant to consultant -**This code is used for new GP referrals electronic and paper
20	**Referral (new condition) consultant to consultant –** This code is for all consultant to consultant referrals including inter-provider referrals and internal ones
8	**Active monitoring end start of new RTT period -**This is used when patients are on a clock stop but are going to begin a new or more aggressive treatment for the same condition on the same pathway. **Straight to test (STT) - This is to used for STT pt's who have not been seen in an OP clinic first. Including a private pt referral or a direct referral onto the waiting list.**
Ongoing clock – these are to be used only on a ticking clock (these codes will not work on a stopped clock) and should not be used on a stopped clock	
9	**Treatment plan to be agreed -**Use for - Undecided treatment plan, awaiting test results etc
10	**Add to waiting list/admission date agreed -**Use this for adding patients to a waiting list providing there is a previous clock start **Do not use this code for STT pt's use code 8**
11	**Treat at future outpatient appointment -**Use this when you have not treated but plan on treating at next appointment, however this would depend on time scales – seek advice
12	**Referral same condition consultant -**Use this only when referring for the same condition for that area to pick up the same pathway – new conditions should be referred back to GP
13	**Referral same condition therapist -**Use this only when referring for the same condition for that area to pick up the same pathway – new conditions should be referred back to GP
14	**Referral same condition nurse specialist -**Use this only when referring for the same condition for that area to pick up the same pathway – new conditions should be referred back to GP
15	**Referral same condition other provider -**Use this when referring someone to another provider for the same condition and when another provider refers here with the same condition.
17	**Treatment delayed patient choice -**Use this when a patient is delaying their treatment but still wishes to go ahead with treatment depending on time scales – seek advice
26	**Referral Discharged – ongoing** A situation where the referral is discharged but the clock is to be kept ticking from the original referral date due to the appt being booked into a more specialised service within the same speciality
18	**Treatment delayed clinical decision** Use this when a clinician has decided to delay treatment but the patient still definitely requires it in the future, depending on time scales – seek advice
7	**Admit patient direct** Use this when admitting a patient straight as an inpatient

Clock stop – activity that ends RTT period. These codes end a RTT clock and should only be used on an active pathway.	
2	**Treatment given – Surgical** Use this when a patient has been admitted for a surgical procedure that is their definitive treatment
3	**Treatment given – Non surgical** Use this when giving a patient non surgical treatment as a definitive treatment (drugs, lifestyle advice etc)
4	**Start active monitoring – Consultant initiated** Use this when a consultant decides it is clinically appropriate to start monitoring a patient. **(Sometimes uses when adding a patient to a review list but only when the decision has been made to monitor them and not whist the clock is still ticking as they are still waiting for tests. Then when booking the appointment from a review list record as a 24)**
22	**Start active monitoring – Patient initiated** Use this when it is the patients decision to monitor the condition
5	**Treatment not required** Use this when treatment is not required and no further treatment is to take place. **(To be used when an open appointment option is chosen)**
6	**Treatment declined by patient** Use this when a patient decline to have treatment.
16	**DNA – Adults and Peads** Did not attend – this can only be used on new appointments not follow ups. If making a further new patient appt after DNA then use this code as the clock will re-set in the background
25	**Referral discharge clock stop** Use this when the referral is not deemed appropriate and is referred back to the provider
27	**Clock stop other provider** Use this when you have had conformation from another provider that the clock has been stopped
Activity that is not part of on an active clock – this is for use on stopped clocks only	
1	**First treatment previously given** Use this when treatment has commenced and is now ongoing
23	**Patient died before treatment** Use this on an active pathway where a patient has died before treatment.
24	**Care during active monitoring** Use this when a patient has commenced active monitoring
Emergency admissions	
98	**Not applicable to referral to treatment period** This is for use for emergency admissions and follow up care after admissions For planned care – where the pathway is already planned out but is requiring a course of ongoing treatment. For Obstetrics patients. Private activity- not where the referral is from private but the treatment/appt is being done as private in the Trust and not NHS

99	**Not yet known** This option should not be chosen without seeking advice from a Senior Manager or a Data Quality Officer. However, should a patient have a date to have their operation carried out but the future OPD must be arranged prior to the operation do not choose option 1 treatment previously in this case you would pick 99. and record in comment/remarks booked in advance of admission. **Note: If having to use 99 for an admission, contact Data Quality to get this amended**



General notes/information

Open appointments see under code 5

Review list pt's see under code 4

If a patient is being discharged from Urology or Endoscopy Day Case then either code 5 or 2 can be used

SHT if a pt has not been to an OPD appt then it must be recorded as code 8 and not code 10. Code 10 is used when a pt has been seen in OPD then requires adding to a waiting list

Bowel Screening

If a patient is to return to the bowel screen programme then use code 4 or if the patient is being referred on for the same condition then use code 12

Key Points

1. It would be helpful if consultants and clinical staff indicated on their referrals whether it is for a *new* or *existing condition*. This will determine whether a new RTT pathway starts or an existing pathway is carried forward.

2. Providers sending referrals for continuing pathways must provide the RTT start date, pathway id and current treatment status. These can then be recorded on PAS. This rule also applies for any referrals we send to other providers. You should transfer this information on the Inter provider form.

3. Outpatient outcome forms will continue to be important in determining a patient's 18 week pathway treatment status. An appropriate treatment status must be recorded for each outpatient appointment.

4. Selecting the wrong treatment status and ending a RTT clock incorrectly will generate problems on PAS which are difficult to resolve.

5. Clinic lists from PAS will now display the patient's current treatment status and their RTT wait. It maybe useful to obtain copies of clinic lists to refer to in the consulting rooms.

6. Active monitoring can now be either Consultant or Patient initiated. Any subsequent activity during Active monitoring should be recorded as treatment status 24 - Care Activity During Active Monitoring.

7. A new RTT pathway should be started when:
   - a decision to treat is made following a period of active monitoring
   - a patients existing condition requires a substantively different treatment
   - a new condition is diagnosed and will be treated by the current medical team

8. Select treatment status 8 – Active Monitoring End/Start of New RTT Period to start a new 18 week pathway.

   - The 18 week clock is nullified and restarts when a patient DNAs their first appointment and is given a subsequent appointment. Only select treatment status 16 – DNA (new appointments only) for patients DNAing new appointments.

9. If a patient DNAs any further appointments the 18 week clock continues unless they are discharged.

Inpatients Key Points

1. Admissions for diagnostic procedures do not stop the 18 week clock. Select 9 – Treatment plan to be agreed when admitting patients for diagnostic procedures.

2. If a patient is admitted for treatment but the procedure is not carried out, the treatment status must be amended, on the admission screen, to ensure that the RTT pathway continues. And placed back on the waiting list if future treatment is intended.

3. A new RTT period must be started for patients receiving the second bi-lateral treatment.

Other Key Points

1. Where a decision is made that will stop a RTT pathway outside of a normal hospital event an administration contact must be recorded on PAS to flag that the RTT period has ended. For example, results of a diagnostic test are negative and no treatment is required.

2. Activity excluded from 18 week wait pathway:
   - Emergency admissions
   - Outpatient appointments following emergency admissions
   - Planned admissions
   - Obstetrics

Select treatment status 98 – Not Applicable to Referral to Treatment Period to flag that the activity is excluded from the 18 week pathway.

Appendix F

Glossary of Terms

2WW - 2 week wait is the timeframe a new suspected cancer referral has to be seen within, in line with the National Cancer Guidelines.

18 Week Referral to Treatment - The part of a patient/child's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other 18 week clock stop point .

Active Monitoring - A waiting time clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage.

A new waiting time clock would start when a decision to treat is made following a period of active monitoring (also known as watchful waiting).

Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to refer the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such and also stops a waiting time clock.

If a patient is subsequently referred back to a consultant-led service, then this referral starts a new waiting time clock.

Admission - The act of admitting a patient/child for a day case or Inpatient procedure.

Bedweb - An electronic system that provides the trust with real-time bed management

Bilateral Procedure - A procedure that is performed on both sides of the body, at matching anatomical sites.

Booking Rules
Booking rules reflect the appropriate levels of capacity for new and follow- up clinics

Breaches - Patient/child episode which would over-run the maximum wait time for 18 weeks from referral to first treatment

Choose and Book - A national electronic referral system that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic.

Clinic Template - Clinic templates define the number of each type of patients that can be seen in a clinic based on grade of clinician in the clinic.

Clinical Decision - A decision taken by a clinician or qualified care professional, in consultation with the patient.

Clock Pause - A clock may be paused only where a decision to admit for treatment has been made, and the patient has declined at least 2 reasonable appointment offers for admission. The clock is paused for the duration of the time between the earliest reasonable offer and the date from which the patient makes themselves available again for admission for treatment

Day case - Patient /child who requires admission for treatment but who is not intended to stay overnight

DNA –Did Not Attend - Where the patient fails to attend their appointment/admission and no contact is made by the patient.

Directory of services - The Choose and Book Directory of Services (DoS) is the national database of elective care services that can be booked via Choose and Book. It provides GPs with a shop window into the specialist services provided by hospitals and clinics.

EBS - Choose and Book is an electronic booking system (EBS) which allows patients to choose their initial hospital or clinic appointment and book on the spot in the GP surgery or later on the phone or internet

Full Booking - Full booking requires that the patient is given the opportunity to agree a date at the time of, or within one working day of, the referral being received. The patient may choose to agree the date when initially offered, or defer their decision until later. All patients will be offered a choice of appointment date within the nationally guaranteed waiting time.
This also applies to a follow up booking when either the patient is face to face or on the telephone and the appointment is booked within 24 hours of the request

Grading - Indicates the level of clinical priority i.e. 2ww, Urgent, Routine

In patient - Patient/child who requires admission to hospital for treatment and will remain for at least one night.

Outpatient - Patients referred by a General Practitioner (GP) or another clinician/referrer for clinical advice or treatment that does not require a hospital bed

Partial Booking - After prioritisation of the referral the patient is contacted by telephone and an appointment is agreed or a letter is sent to the patient requesting the patient telephones the hospital to agree a mutually convenient date. All patients will be offered a choice of appointment date within the nationally guaranteed waiting time.
If 3 attempts have been made (one call must be after 6pm) an appointment will be made and sent directly to the patient and recorded as Partially Booked.

This also applies to a follow up booking when either the patient is face to face or on the telephone and the appointment is booked outside 24 hours of the request. E.g. review list

Pathway ID - Unique pathway identifier generated each time a patient is referred to the Trust with a new condition.

Pause – see clock pause

Reasonable Offer - Where a decision to admit, as either a day case or inpatient has been made, many patients will choose to be admitted at the earliest opportunity. However, not all will, and it would not be appropriate to *pause* a clock for patients who cannot commit to come in at short notice.
A clock may only be paused therefore when a patient has turned down two or more 'reasonable offers' of admission dates.

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

If patients decline these offers and decide to wait longer for their treatment, then their clock may be paused from the date of the first reasonable offer and
should restart from the date that patients say they are available to come in.

Referrals - Letters/Performa's which contain the patient's demographics and the reason they are being referred

Registered Referrals - All new outpatient patient *paper* referrals received into the trust are registered onto the PAS system using specialty code only.

Straight to test - A specific type of direct access diagnostic service whereby a patient will be assessed and might, if appropriate, be treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional.

TCI - A TCI (to come in date) is a booking for a patient who will be coming into the hospital to have their waiting list procedure.

UBRN (Unique Booking Reference Number) - The reference number that a patient receives on their appointment request letter when generated by the referrer through Choose and Book. The UBRN is used in conjunction with the patient password to make or change an appointment.

UTA (unable to attend) - Term used when a patient re-arranges their appointment.

Work list - A work list on choose and book lists patients UBRNs that require actioning.

XIP (Ex In patient) **-** A patient who has been admitted for a day case or Inpatient procedure and discharged