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Title:	**Devon Health Community Elective Care Access Policy**	
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- **Northern Devon Healthcare NHS Trust**
- **Royal Devon & Exeter NHS Foundation Trust**
- **University Hospitals Plymouth NHS Trust**
- **Torbay and South Devon NHS Foundation Trust**
- **Northern, Eastern and Western Devon Clinical Commissioning Group**

APPROVALS

ORGANISATION	DATE	NAME	DESIGNATION	SIGNATURE
Northern Devon Healthcare NHS Trust				
Royal Devon & Exeter NHS Foundation Trust				
University Hospital Plymouth NHS Trust				
Torbay and South Devon NHS Foundation Trust				
Northern Eastern and Western CCG				

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Section One
General Principles

1) STATEMENT OF INTENT

All organisations within this Devon Health Community Access Policy are united in their commitment as a Local Health Economy to ensure patients receive treatment in accordance with national standards and objectives. The purpose of this policy is to outline the Devon Health Community's expectations and requirements in terms of managing patients referred into elective care pathways.

2) SCOPE OF POLICY

This policy applies to the principles and procedures for the management of the different groups of patients encompassing elective pathways. These are categorised as follows:

- Patients on a Referral to Treatment (RTT) pathway awaiting treatment
- Patients not on a RTT pathway but still under review by clinicians
- Patients who have been referred for a diagnostic investigation either by their GP or by a clinician

3) STRUCTURE OF POLICY

The policy is structured in such a way which makes it easy to navigate in both hard copy and electronically. Where a separate Standard Operating Procedure (SOP) or document is referenced, a hyperlink will be shown allowing the reader to be taken directly to it if desired. The principles within the policy are applicable across all organisations comprising the Pan Devon area, as detailed on the covering page. SOPs are generally specific to each organisation so there may be a number of different versions. The policy is split into the following four sections:

1. **General Principles**

2. **Pathway Specific Principles –** following a logical chronological patient journey. Where there is a Standard Operating Procedure (SOP) providing a detailed process to be followed at a given stage, this is referenced at the relevant point. Readers can either click on the link taking them to the SOP or turn to the back of the Access Policy where they are listed as appendices.

3. **Reference Information**

4. **Standard Operating Procedures (SOP)** These are only available to NHS staff and are not published or available outside the NHS.

4) KEY POLICY PRINCIPLES

a) This policy covers the way in which Devon Health Community will collectively manage administration for patients who are waiting for or undergoing treatment on an elective pathway.

b) As set out in the NHS Constitution 2015 and the National Referral to Treatment Consultant-led waiting times October 2015, patients have the right to start consultant-led treatment within maximum waiting times. The policies and procedures comprising this policy adhere to national best practice and provide a framework to ensure that patients are treated transparently, fairly and reasonably.

c) Trusts will give priority to clinically urgent patients and treat everyone else in turn.
Trusts will work to meet the maximum waiting times set by NHS England for all groups of patients.
Trusts will negotiate appointment and admission dates and times with patients.
Trusts will work to ensure fair and equal access to services for all patients.

d) Cancer patients are expected to be managed in accordance to the RTT guidance in the document but also in accordance to the cancer waiting times guidance as laid out in a separate document.

e) Where a patient cannot be treated within the maximum waiting time and wishes to exercise their right under the NHS constitution to seek a suitable alternative provider, the organisation that commissions and funds the treatment (CCGs or NHS England) must investigate and offer the patient a range of suitable alternatives. Once the alternative has been identified the original hospital will generate an IPT. The local CCG or NHS England must take all reasonable steps to meet the patient's request.

5) ROLES & RESPONSIBILITIES

Devon Health Community

The Local Health Economy is collectively responsible for the production, review and revision of this policy on at least a biennial (2 yearly) basis. All organisations will have a designated lead in this respect.

a) **Clinical Commissioning Groups**
   i) Promote the rights and pledges enshrined in The NHS Constitution (2015)
   ii) Develop and manage the local health market to provide plurality and patient choice;
   iii) Ensure that all patients needing planned elective care are offered clinically appropriate choices of provider;
   iv) Ensure that patients are treated within clinically appropriate, commissioned pathways and maximum treatment times.

b) **Primary Care Referrers Responsibilities**
   i) Ensure that the patient is clinically suitable for their referral and intended pathway of care
   ii) Ensure that the patient is prepared to be treated within the maximum Referral to Treatment times

iii) Initiate the referral through the use of the NHS e-Referral Service, where service is available
iv) Identify clinically appropriate speciality services for the patients, to include priority and clinic type. Provide the minimum core data set when making a referral
v) Ensure that where appropriate, funding for interventions not normally funded has been obtained prior to referral Commissioning Policies.
vi) Where available ensure adherence to Clinical Referral Guidelines:- http://northeast.devonformularyguidance.nhs.uk/ http://southwest.devonformularyguidance.nhs.uk/

c) **Trusts**

i) **Chief Executives / Chief Operating Officers**
Chief Executive Officers (CEOs) and Chief Operating Officers (COOs/Director of Operations) have overall responsibility for the implementation of this policy and board level accountability for the delivery of elective access standards.

ii) **Clinicians**
Clinicians have a responsibility for adhering to key internal procedures in the proactive management of patients along their RTT journey. Key examples are the timely and accurate completion of the clinic outcome and swift review of referrals/diagnostic results.

iii) **General Managers / Operational Managers**
General Managers and Operational Managers are responsible for ensuring that staff are fully trained / competent in and performance managed against the principles and associated SOPs relevant to their role.

iv) **Administration Staff**
All administration staff must abide by the principles in this policy and the supporting standard operating procedures.

d) **Patients**

- Attend agreed appointments and give sufficient notice in the event of the need to change agreed date and time
- Make every effort to accept an available appointment
- Respond to hospital communications in a timely manner
- Communicate immediately to the hospital or general practitioner if treatment and/or appointments are no longer required
- Consider the choice options that are available to them
- Immediately communicate to the hospital and general practitioner any changes in personal contact details

6) STAFF COMPENTENCY AND COMPLIANCE

- All staff including new starters to the trust will undergo elective care training applicable to their role.

- Staff will be monitored against Key Performance Indicators (KPIs) applicable to their role. Role specific KPIs are based on the principles in this policy and specific aspects of the trusts Standard Operating Procedure (SOPs).
- Non-compliance will be managed in accordance with the Trusts HR policies.

7) SERVICE STANDARDS

All service standards should be managed in accordance with individual trusts SOPs /APNs.

8) CHRONOLOGICAL BOOKING

Patients should be selected for booking in accordance with their clinical priority and then in chronological order in terms of their RTT wait (as capacity and case mix restrictions allow), unless it is for reasons of patient safety or improved list efficiency.

9) NATIONAL ELECTIVE CARE STANDARDS

Link to National Elective Care Standards
See Appendix 4

10) PLANNED PATIENTS

Patients on a planned waiting list are outside the scope of RTT rules. Planned procedures are part of an agreed programme of care, which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Patients should not be added to the planned waiting list for any other reason.

11) INTERVENTIONS NOT NORMALLY FUNDED – Low Value Procedures and Low Priority Treatments (LVP/LPP)

LVP/LPP Policies must be adhered to – any procedures undertaken without prior funding authorisation will not be authorised by the Commissioners. In these circumstances the 18 week clock will begin when the GP proceeds to make a formal referral, either with or without funding approval having been secured at the outset.

The majority of treatments or conditions require funding approval to be secured prior to referral to secondary care for assessment and treatment. There are however a small number of specialist treatments where funding approval can only be sought by a secondary care Consultant. In these cases, the 18 week clock will not stop whilst funding approval is sought from the Commissioner.

The current list of LVP/LPP Procedures can be found here. DRSS will be asked to ensure this policy is followed. However any referral being received in secondary care without approval that is clearly covered by the Prior Approval Policy should be rejected (and the 18 week clock nullified) and returned to the referrer with advice for them to follow the Prior Approval Policy.

12) ACCESS TO HEALTH SERVICES FOR

Military Veterans

a) In line with the Armed Forces Covenant, the Trust will ensure that members of the Armed Forces Community (including those serving, reservists, their families and veterans) are supported, treated equally and receive the same standard of and access to healthcare as any other UK citizen in the area they live.

b) Referrers should make it clear that the patient is a member of the Armed Forces Community.

c) Armed Forces Community should retain their relative position on any NHS waiting list, if moved around the UK due to the Service person being posted, however they should not be given priority over other patients with more urgent clinical needs. Inter Provider Transfer (IPT) forms should be used in these cases.

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

Prisoners

All elective standards and rules are applicable to prisoners.

13) PRIVATE PATIENTS

Patients can choose to move between NHS and private status at any point during their treatment without prejudice. Where it has been agreed, for example, that a surgical procedure is necessary the patient can be added directly to the elective waiting list if in line with the commissioned service and clinically appropriate. The RTT clock starts at the point the GP or referrer's letter arrives in to NHS care. The RTT pathways of patients who notify the trust of their decision to seek private care will be closed with a clock stop applied on the date of this being disclosed by the patient.

14) OVERSEAS VISITORS AND PATIENTS NOT ENTITLED TO NHS CARE FUNDING

All trusts have an obligation to identify patients who are not eligible for free NHS treatment and specifically to assess liability for charges in accordance with Department of Health guidance /rules.
The trust will check every patient's eligibility for treatment. Therefore, at the first point of entry, patients will be asked questions that will help the trust assess 'ordinarily resident status'. Some visitors from abroad, who are not ordinarily resident, may receive free healthcare, including those who:

- have paid the immigration health surcharge
- have come to work or study in the UK
- have been granted or made an application for asylum

Citizens of the European Union (EU) who hold a European Health Insurance Card (EHIC) are also entitled to free healthcare, although the trust may recover the cost of treatment from the country of origin.
All staff have a responsibility to identify patients who are overseas visitors and refer them to the overseas visitors' office for clarification of status regarding entitlement to NHS treatment before their first appointment is booked or date to come in (TCI) agreed.

Trusts will ensure they assess patients' eligibility for NHS care in line with the Guidance on implementing the overseas visitors hospital charging regulations

15) VULNERABLE PATIENTS

It is essential that patients who are vulnerable for whatever reason have their needs identified at the point of referral. This group of patients might include but is not restricted to:

a) Patients with learning difficulties or psychiatric problems;
b) Patients with physical disabilities or mobility problems;
c) Elderly patients who require community care;
d) Children (as defined in The Children Act (2004)[1] – see Footnote1 below.

16) COMMUNICATION WITH PATIENTS

The rules and principles, within which the Devon Health Community will operate to deliver elective care to all patients, must be made clear and transparent to patients at each stage of their pathway. All communications with patients whether verbal or written must be informative, clear and concise.

A key principle for RTT is that patients are explicitly made aware of the implications on their RTT wait should they choose to delay their treatment, either through cancellation of appointments, declining TCI offers or non-attendance.

Commissioners and providers will need to be able to demonstrate (to an auditor, the CQC or in the event of a patient complaint) that cases that take longer than 18 weeks to reach the start of first definitive treatment are legitimate exceptions.

Providers will ensure that patients receive information in formats that they can understand and receive appropriate support to help them to communicate (Accessible Information Standard 2015)

17) ELECTIVE CARE GOVERNANCE STRUCTURE

Providers and commissioning organisations will ensure they have robust Board level reporting and suitable organisational structures beneath to support management, delivery and escalation reporting and action as required.

18) INFORMATION, MONITORING & REPORTING

a) Monitoring and reporting will be managed through the information schedule of provider's acute contract. In addition, other statutory returns to NHS England and Monitor will be provided as required.
b) Providers will ensure robust systemic governance of data quality is in place with clear work plans, reporting and escalation.

[1] 1 The Children's Act defines children as any person under the age of 18 and in addition a person 18, 19, or 20 who; (a) has been looked after by a local authority at any time after attaining an age of 16; or (b) has a learning disability. A person is "looked after by a local authority" if: (a) for the purpose of the Children Act 1989 (c.41), they are looked after by a local authority in England and Wales; "learning disability" means a state of arrested or incomplete development of mind, which induces significant impairment of intelligence and social functioning.

Section Two
Pathway Specific Principles

19) OVERVIEW OF NATIONAL RTT RULES

The full national RTT rules suite can be accessed by clicking here. Detailed local application of the rules is provided in the standard operating procedures within section four at the end of this policy.

a) Clock Starts – appendix 3

The RTT clock starts when:

- A referral is received into a consultant-led service, regardless of setting, with the intention that the patient will be assessed and if appropriate, treated before clinical responsibility is transferred back to the referrer.
- A referral is received into an interface or referral management assessment centre which may result in an onward referral to a consultant-led service before clinical responsibility is transferred back to the referrer.
- A patient self refers into a consultant-led service for pre-agreed services agreed by providers and commissioners.
- Following active monitoring
- Following a decision to start a substantively new treatment plan
- For second of a bilateral procedure
- A rebooking is made after a Did Not Attend (DNA) of a first outpatient appointment

Exclusions:

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

- Obstetrics and midwifery
- Planned patients - Where a patient requiring a planned procedure goes beyond their due date, they will be transferred to an active pathway and a new RTT clock started.
- Referrals to a non-consultant-led service
- Referrals for patients from non-English commissioners
- Genitourinary medicine (GUM) services
- Emergency pathway non-elective follow-up clinic activity.

b) Clock Stops

The RTT clock stops upon either First Definitive Treatment (FDT), a decision is made that treatment is not required or if the patient declines treatment.

FDT is defined as:-

An intervention normally designed to manage the patient's condition, disease or injury to avoid further intervention.

If a patient requires a procedure or surgery as a day case or inpatient, the clock stops upon admission. If the patient's treatment is medication prescribed in outpatients or if a decision not to treat is made in outpatients, this information is captured on clinic outcomes or directly in the

Trust's relevant Patient Administration System (PAS). There may also be occasions where a decision not to treat is made in an 'ad hoc' setting, for example following review of diagnostic results by a clinician in the office.

Clock stops such as these must also be captured in the Provider's PAS. A full list of clock starts and stops is documented in appendix 3

c) **Patients Who Do Not Attend (DNA)**
These rules are applicable only if the patient has had a reasonable offer of an appointment or admission date.

i) **First Appointment Following Initial Referral**
If a patient DNAs their first appointment following the initial referral which started their RTT clock, their RTT clock should be nullified (i.e. not stopped and not reported). This includes any subsequent DNA for their first outpatient appointment on this pathway. Should the patient be offered another date, a new RTT clock will start on the date that the appointment is re-arranged.
If a patient DNAs a subsequent (follow up) appointment their RTT clock should not be nullified. Should the patient be offered another date the RTT clock continues.

ii) **Any Other Outpatient Appointment, Diagnostic Appointment or Admission Along the Patient's Pathway**

a) If the patient is offered another appointment / admission date – the RTT clock continues
b) If the patient is discharged back to GP – the RTT clock stops (following confirmation that it is not contrary to the patient's clinical interests)

d) **Patient Reschedules of Outpatient & Diagnostic Appointments**
If a patient chooses to reschedule any outpatient or diagnostic appointment, their RTT clock should continue to tick.

e) **Patient Reschedules of Admission Dates**
If a patient chooses to reschedule an admission date, their RTT clock should continue to tick.

f) **Active Monitoring**
Active monitoring is where a decision is made that the patient does not require any form of treatment currently but is to be monitored in secondary care. When a decision to commence a period of active monitoring is made and communicated with the patient, the RTT clock stops. Stopping a patient's clock for a period of active monitoring requires careful consideration on a case by case basis and its use needs to be consistent with the patient's perception of their wait.

20) PATHWAY MILESTONES

The agreement and measurement of performance against pathway specific milestones is an important aspect of successful RTT sustainability. Pathway specific milestones should be

agreed for each specialty (in line with robust demand and capacity analysis) in terms of the point of the pathway by which the following should occur:

- First outpatient appointment
- Treatment decision
- Treatment

Trusts will aim to identify and work to set timescales for each 'stage of treatment' by speciality as best practice identifies. If urgent, timescales will be clinically appropriate.

21) CANCELLING, DECLINING OR DELAYING APPOINTMENT AND ADMISSION OFFERS

Patients can choose to postpone or amend their appointment or treatment if they wish, regardless of the resulting waiting time. Such cancellations or delays have no impact on reported RTT waiting times. However, clinicians will be informed of patient-initiated delays to ensure that no harm is likely to result from the patient waiting longer for treatment (clinicians may indicate in advance, for each specialty or pathway, how long it is clinically safe for patients to delay their treatment before their case should be reviewed). Where necessary, clinicians will review every patient's case individually to determine whether:

- The requested delay is clinically acceptable (clock continues)
- The patient should be contacted to review their options – this may result in agreement to the delay (clock continues) or to begin a period of active monitoring (clock stops)
- The patient's best clinical interest would be served by discharging them to the care of their GP (clock stops)
- The requested delay is clinically acceptable but the clinician believes the delay will have a consequential impact (where the treatment may fundamentally change during the period of delay) on the patient's treatment plan-active monitoring (clock stops).

The general principle of acting in the patient's best clinical interest at all times is paramount.

22) REFERRAL MANAGEMENT

a) **Pre Requisites Prior to Referral**

i) **Primary Care**

In line with national RTT rules, before patients are referred, GPs and other referrers should ensure that patients are ready, willing and able to attend for any necessary outpatient appointments and/or treatment and that they fully understand the implications of any surgery or other treatment which may be necessary.

ii) **Secondary Care**

It is the responsibility of the management teams in conjunction with clinicians to ensure that the e-Referral Service Directory of Services (DoS) is up to date in terms of the service specific criteria and that clinics are mapped to the relevant services. This gives the best chance of the patient being booked into the correct clinic at the first visit and reduces the rejection rate.

b) **Referral Sources**

i) **General Practitioners and Health and Social Care Professionals**

Referrals should only be made from primary to secondary care if it is thought that the input of the secondary care specialist will contribute to the management of the patient.

ii) **Internal Provider Referrals**
When a clinician or member of their team decides that the opinion of another Clinician /service should be sought, for all elective patients he/she can refer when:

- The referral is for the same presentation/symptom as the originating referral
- The referral is clinically urgent or a suspected cancer
- The referral prevents an urgent admission

Internal referrals for an unrelated non-urgent condition should only be made when the referrer is certain that a consultant appointment is required and the referral complies with national and local commissioning policies and clinical referral guidelines/pathways. If there is uncertainty as to the management of the patient, patient should be referred back to the GP for their input and decision on further management without raising expectation of an onward referral.

iii) **External Consultant to Consultant Referrals / Inter Provider Transfers**
Referrals to other providers must be accompanied by the national Inter-Provider Transfer Administrative Minimum Dataset (IPTAMDS). All fields must be completed.

Patient referrals from other providers (including Primary Care Interface Services) should be accompanied by a completed IPTAMDS (Appendix 1). Where the IPTAMDS does not accompany the referral it must follow within 48 hours. In the event of the relevant information not being received then local escalation will apply. Providers should not transfer patients with the sole intention of achieving an access target without the prior agreement of the receiving trust. E.g. outsourcing arrangements

iv) **Devon Referral Support Services (DRSS)**
DRSS is in place in Devon Health Community to review referrals, offer choice and book patients to the most appropriate services. To ensure DRSS can successfully support the referral process referrers must ensure a full data set is provided when referring.

c) **Referral Methods**
The Devon Health Community jointly supports and is working towards all referrals being made directly via NHS e-Referral Service. Referrals on the appropriate pro-forma will be accepted where this is an agreed process for a provider.

There are currently two recognised methods of referral for non-cancer referrals as described below:

i) **e-Referrals**
Trusts will endeavour to give patients their choice of site within the Trust but as a single provider, patient appointments may be offered at a different site if appropriate treatment is available. If patients choose to wait for a particular site or consultant, the implications on their overall RTT wait for treatment should be clearly explained to them. If this subsequently causes the patient to wait more than 18 weeks for treatment, this will be accounted for within the operational tolerances.

- **Directly Bookable Services**
Within Devon Health Community when DRSS book a directly bookable appointment on

NHS e-Referral Service, an appointment is automatically registered in the provider's PAS and the RTT clock start is triggered (i.e. this is the date the patient contacts DRSS)

Where an appointment slot issue is experienced DRSS defer to Provider at which point the clock starts.

Referrals made to a Directly Bookable Services (DBS) from outside of the area are processed in e-RS and booked either while the patient is in the surgery, or the patient can phone the Appointment Line (TAL) or go online using their Unique Booking Reference Number (UBRN) as a reference to book a slot at the hospital of their choice.

Trusts will ensure that sufficient capacity is available for patients to directly book their first appointment. Patients who have been directly booked will have a referral automatically created on the provider's PAS by the e-Referrals software and the RTT clock start will be automatically triggered from the referral received date on PAS i.e. when the patient first attempts to book their appointment.

- **Indirectly Bookable Services including Clinical Assessment Services and any referrals made using e-RS that require manual entry into the Trust's PAS.**
  Referrals that have been booked under the Indirect Booking rules will need to have a referral added to PAS, including the unique patient identifier generated(UBRN) as a result of the e-RS referral. The referral received date (i.e. the RTT clock start date) must be the date at which DRSS notify the provider via NHS e-Referral Service, or when the patient has contacted the hospital.

ii) **Primary Care Paper Based Referrals**

- Where Providers have a centralised location all paper based referrals should be sent to the designated centralised location within each provider.
- Upon receipt of paper based referrals, the date of receipt should be clearly and permanently marked. This date is the RTT clock start date.

Non-e-Referral patients
Primary Care will not send paper referrals if the service is available on NHS e-Referral.

Failure of e-Referral Service
Refer to Business Continuity Plan

d) **Referral Criteria / Minimum Data Sets**

i) The referrer is responsible for ensuring that the referral letter contains the essential minimum data set (Appendix 2). This includes but is not limited to the patient's NHS number, full patient demographics and including a day, evening and mobile telephone number that the patient would like to be contacted on as well as sufficient clinical data to enable the appropriate appointment to be made. The letter should also state the patient's current drug regime, clinical question to be answered and significant past medical history.

ii) Referrals should be addressed to a speciality rather than a named consultant and the patient will be offered an appointment with the consultant with the shortest waiting time. Named referrals will be allocated to the relevant consultant but if they do not have sufficient capacity to accept the referral then a decision will be made in conjunction with the consultant and the speciality operational / service manager to allocate the referral to an appropriate alternative consultant. Exceptions to this would be where denying access to a sub-speciality opinion would compromise clinical care or patients choose to wait to see the consultant they had requested.

e) **Clinical Triage / Review of Referrals**

i) All referrals should be triaged to ensure clinical suitability, unless there are clear guidelines and evidence that demonstrates patients are all typically referred correctly first time.

f) **Rejected Referrals**

i) If a referral has been made through eRS and the service selected does not meet the needs of the patient, the referral should be rejected via eRS to return to Primary Care. For these rejections DRSS/GP will receive an electronic notification to inform the patient of the rejected referral. In this circumstance, DRSS/GP redirects the referral and books an appointment to the appropriate service without delay or if non eRS service then GP will re-refer as required.

23) FIRST APPOINTMENT

2 Week Wait, Urgent and Routine GP to Consultant-led first outpatient referrals

All 2 Week Wait, Urgent & Routine referrals from a GP to a Consultant-led service must be submitted using the electronic Referral Service (e-RS). Trusts should ensure that appropriate services are available on the e-Referral system.

Referrals for a same day/next day service should be referred by the most appropriate means to ensure the receiving Trust has access to relevant clinical information in a timely manner (email, telephone). Such referrals are not able to be processed using e-Referral.

Should a GP practice submit a paper 2 Week Wait referral, the receiving specialty will ring the GP and request that they submit the referral electronically within 24 hours. Should the GP fail to submit the 2ww referral within this time frame then the Acute Trust will process the paper referral and email the GP practice informing them of their actions and re-iterate the process that should be followed for all future referrals.

Any urgent or routine paper referrals received by the acute trust will be returned to DRSS to process via the e-Referral system. The paper referral will be treated as a rejection and the clock start date for RTT purposes will be the date the Trust receives the referral electronically. A reasonable offer for outpatients and diagnostics is an offer of at least two dates and times three or more weeks from the time that the offer was made at any of the Trust's sites. Should a patient accept an appointment less than three weeks into the future, this becomes a reasonable offer.

Patients should be appointed firstly by their clinical priority (i.e. urgent patients first) and then within chronological order.

a) **Booking appointments via the NHS e-Referral Service**

Patients who do not book their appointment while with their GP can telephone the Appointments Line/DRSS to make their appointment using their Unique Booking Reference Number and password.

It is essential that sufficient appointment capacity is available to book patients within their clinical priorities and specialty specific milestones for first appointments.

b) **Appointment Slot Issues (ASIs)**

If booking via NHS e-Referral Service is not possible due to lack of capacity, the UBRN will be directed to the Trust via the 'Defer to Provider' function on the e-Referral Service for local management to resolve. This is referred to as an ASI. The RTT clock is ticking from the point at which the patient attempted to book their appointment even though they will not be visible on the Trust's patient administration system at this point. Appointment staff will then call the patient to offer an appointment.

ASIs result in a poor patient experience and time consuming administrative workarounds. Sufficient capacity must therefore be made available via e-RS to ensure patients can book directly into services. This is the responsibility of the operational / service management team responsible for the speciality.

c) **Paper Based Referrals**

Referrals received from non-GP referrers or to non-consultant led services should be sent using the e-RS system where available but can still be processed on paper. Patients that are referred via the paper referral process will be placed on the outpatient waiting list and will either be sent an invitation to call letter in order to book their appointment within pathway specific milestones, or appointments staff will contact the patient.

Patients should be offered a choice of reasonable dates and an appointment made which is mutually convenient. The patient's details including daytime contact number must be checked and corrected at this time and all appointment offers must be recorded on PAS where functionality is available. A letter should be sent to confirm the appointment, which must also include details of how to cancel and reschedule appointments.

If the patient fails to respond and all reasonable attempts have been made to contact the patient to agree an appointment, the outpatient waiting list entry is removed. A letter is sent to the patient's GP and the referral is closed. The reason for removal will be 'patient declined treatment'. **This should only happen, if in the clinical best interests of the patient, as determined by the clinical lead responsible for patient's care.**

Where a patient is referred to a pooled service, they are to be offered an appointment with the consultant with the shortest waiting time.

24) HOSPITAL INITIATED APPOINTMENT CHANGES

- In the event of a hospital initiated cancellation, the patient's RTT clock continues to tick from the original referred received date.

- The patient will be contacted to arrange an alternative appointment date and time. Both an apology and a reason for cancellation will be given. The Trust will make every effort to ensure that they do not cancel patient's appointments.
- If the cancellation is within two weeks of the appointment date, the patient will be informed of the cancellation by telephone.

25) PATIENT INITIATED APPOINTMENT CANCELLATIONS

Patients who wish to cancel their appointment and do not require a further appointment or treatment at any stage of a pathway should be removed from the waiting list, their RTT clock stopped, clinician informed and a letter should be sent to the patient and their GP confirming their decision.

26) PATIENT INITIATED APPOINTMENT CHANGES

Patients will have the opportunity to cancel or rearrange appointments during their pathway. The RTT clock continues to tick during the appointment reschedule but will be stopped if the patient is being discharged back to their GP. This should only happen if in the clinical best interests of the patient as determined by the clinical lead responsible for patient's care.

27) CLINIC ATTENDANCE

a) **Arrival of Patients**

i) Patient demographic details should be checked at every clinic attendance and amended as necessary on the Trust's PAS. The status of overseas visitors will be checked at this time. The relevant manager must be notified where it is suspected that there is an overseas visitor.

ii) All patients must have an attendance / arrival status recorded, i.e. Attended or Did Not Attend.

b) **Clinic Outcomes**

i) All patients must have an outcome (e.g. follow up, discharge or add to elective waiting list) and an updated RTT status recorded on the clinic on PAS. Clinics will be fully outcomed or 'cashed up' within one working day of the clinic taking place. This includes patients who have already started treatment and have had a previous clock stop as they may need to start a new clock due to a new treatment plan or continue being monitored.

ii) The vast majority of non-admitted RTT performance is derived from the data transferred to PAS from the clinic outcomes so it is critical that the data is recorded in an accurate and timely manner.

c) **Follow Up Appointments**

Patients who require an appointment within six weeks should be fully booked as they leave the Department or Ward; if this cannot be accommodated then they should be added to the appropriate follow up waiting/pending list

Patients who require an outpatient follow up appointment in more than six weeks' time, will not be appointed and will be added to a pending list/Partial booking waiting list. With a relevant 'see by date'. Please refer to local SOP/APN
In all cases the appropriate partial or fully booked process will apply. Please refer to local SOP/APN.

28) DID NOT ATTENDS (DNAS)

a) Any patient who does not attend their agreed appointment (new or follow up) will be clinically reviewed and discharged if appropriate back to the care of their GP. Both patient and GP will be notified of this in writing to ensure the referring GP is aware and can action further management of the patient if necessary. The patient's RTT clock will be stopped. Exceptions to this are:

   i) when a clinical decision is taken that discharging the patient is contrary to the patient's clinical interests;

   ii) clinically very urgent referrals including cancer, or active surveillance for cancer, rapid access chest pain, and other critical illnesses;

   iii) Children of 18 years and under or vulnerable adults (See Footnote2 below[2]).

   iv) When one of the following can be confirmed:-
      a. The appointment was sent to the incorrect patient address
      b. The appointment was not offered with reasonable notice

b) Where circumstances were beyond the patient's control, the Trust will endeavour to be as flexible as possible. The patient must first be contacted to ascertain the reasons for DNA and ensure compliance to attend a rescheduled appointment.

c) For paediatric patients after the reason for a DNA has been established, this should be documented in the health records. A further appointment needs to be offered to the patient and the importance of attendance needs to be reiterated to the parent / carer. If there are any safeguarding concerns about a child or young person under the age of 18 years further guidance should be sought from the relevant Trust policy or safeguarding lead.

d) If a patient DNAs their first appointment following the initial referral which started their RTT clock, their RTT clock should be nullified (i.e. not stopped and not reported). This includes any subsequent DNA for their first outpatient appointment on this pathway.
Should the patient be offered another date, a new RTT clock will start on the date that the appointment is re-arranged.
If a patient DNAs a subsequent (follow up) appointment their RTT clock should <u>not</u> be nullified (i.e. not stopped and reported). Should the patient be offered another date the RTT clock continues.

[2] The Children's Act defines children as any person under the age of 18 and in addition a person 18, 19, or 20 who; (a) has been looked after by a local authority at any time after attaining an age of 16; or (b) has a learning disability. A person is "looked after by a local authority" if: (a) for the purpose of the Children Act 1989 (c.41), they are looked after by a local authority in England and Wales; "learning disability" means a state of arrested or incomplete development of mind, which induces significant impairment of intelligence and social functioning.

29) PATIENTS WHO ATTEND BUT DO NOT WAIT

If a patient does not wait to be seen, the Clinician will review the clinical information and arrange a further appointment as indicated. The patient should be contacted to determine whether another appointment is necessary or desired by the patient.
If a decision is made to not rebook, the referrer and patient will be informed in writing.

30) CLINIC MANAGEMENT

a) **Clinic Cancellation, Reductions & scheduling**

i) Consultants, medical staff and other health professional staff must give the agreed notice of annual leave, please refer to local policy. Where this is not given, the Consultants team or alternative health professional should provide cover for the clinic. Leave requests should be submitted as early as possible to minimise the effect on clinics.

ii) Devon Health Community is committed to offering certainty to patients as well as choice in arranging care. As such, every effort will be made to avoid cancelling patient's appointments. Every effort will be made to backfill absent clinicians by the speciality.

iii) Clinics should not be cancelled, reduced or re-scheduled with less than the agreed notice for any purpose unless there are exceptional circumstances.

b) **Outpatient Clinic Capacity**

Providers should systematically undertake a review of clinic templates and room capacity to ensure they are aligned to demand (contracted activity).

31) DIAGNOSTIC PATHWAYS

The diagnostic stage of the pathway can be:

- the start of an RTT clock, e.g. straight to test
- continuation on an RTT pathway,
- or not be on a RTT pathway should the GP retain responsibility for the patients care (e.g direct access diagnostics)

The following pages detail the agreed diagnostic policies and principles.

32) DIAGNOSTIC PATIENTS ON RTT PATHWAYS

a) Where a patient is referred for a diagnostic test to take place, the principles and policies within sections 19 and 23 should be adhered to in terms of booking, cancellation and DNAs.
b) Some diagnostic tests will be undertaken on an admitted basis.
c) Patients who are referred for diagnostics as part of an RTT pathways need also to be seen within the current diagnostic waiting time.

d) Providers will work to establish one-stop appointments with outpatient and diagnostic elements occurring concurrently wherever clinically appropriate.

33) SUBSEQUENT DIAGNOSTICS

Where the patient has received first definitive treatment for a condition they were referred for and subsequent new treatment plan is agreed following the result of a 'check' diagnostic, a new RTT clock should commence.

34) STRAIGHT TO TEST

An RTT pathway starts when a referral is triaged straight to test as the first step in a commissioned pathway. For example, where a consultant-led outpatient or pre-op appointment is the next commissioned step. This ensures by the time the patient attends their first OP appointment, they will have already had the test and the results can then be discussed at the OP appointment. In such instances, the RTT clock starts on the date that the provider receives the referral.

35) DIRECT ACCESS DIAGNOSTICS

Where a GP refers a patient for a diagnostic test but retains clinical responsibility for the patient and makes a decision regarding referral on the basis of the results; this does NOT constitute an RTT pathway. An RTT clock only commences if the GP subsequently makes a referral to a consultant-led service.

36) DIAGNOSTIC TARGETS AND VALIDATION

All diagnostic tests must be completed or carried out within 6 weeks of a decision to refer. The clock starts from the date that the request was made and ends on the date that the test was carried out. The one exception to this is direct access referrals where the clock starts on the date that the request was received.
Where there is the intention of a purely therapeutic intervention then the 6 week diagnostic timeframe does not apply. In instances where there is both a diagnostic and a therapeutic intention then both the 6 weeks target and the RTT target apply.
Achievement against the 6 week diagnostic is measured by applying the below validation rules:

- DNA = new 6 week clock to be adjusted and start again from the point of the DNA
- Patient cancellations = new 6 week clock to be adjusted and start again from the date of the cancelled appointment.
- Patient choice = new 6 week clock to be adjusted and start again from the point of the first declined "reasonable" appointment/TCI

37) DECISION TO ADMIT

The decision to admit a patient for surgery (as a day case or inpatient) must be made by a consultant or another clinician who has been given delegated authority.

i) A patient should only be added to an active waiting list for surgery if:
   a) There is a sound clinical indication for surgery
   b) The patient is clinically fit, ready and available to undergo surgery

Patients who are added must be clinically and socially ready for admission on the day the decision to admit is made, i.e. if there was a bed available tomorrow in which to admit a patient, they are fit, ready and able to come in.

ii) A number of procedures have been deemed low priority or have thresholds agreed by the CCGs these include LVP/LPP and commissioned pathways. For these procedures there must be evidence that the correct pathway has been followed or prior approval form must have been received. It is the responsibility of the clinician in the specialty where the surgeon works to gain prior approval for the procedure. Turnaround times for prior approval decisions are guaranteed and detailed in the IFR Policy. All patients must be added to the waiting list at the time a Decision to Treat is made however approval must be sought thereafter (please note that the RTT clock continues during the time approval is sought). If approval is rejected, the patient must be removed from the waiting list and referred back to the GP with a letter documenting that approval was rejected. A copy of the letter must also be sent to the patient.

38) WAITING LIST TO COME IN (TCI) INFORMATION

A waiting list TCI/elective admission form will be completed at the time that the decision to admit is made by the clinician. This information must then be entered into the PAS system by adding the patient to the waiting list.

39) PRE-ANAESTHETIC & PRE-OPERATIVE ASSESSMENT

a) Patients should be pre-anaesthetically and pre-operatively assessed as soon as possible following the decision to admit, preferably immediately following the decision to admit.

This is an assessment required to ensure the patient is fit to undergo the anaesthetic and that they are listed for the appropriate type of admission (day case, or inpatient care). It is typically a conversation with the operating surgeon, pre-operative nurse and/or anaesthetist regarding the nature of the surgery. In some instances this will happen at the point of being listed and in other scenarios at a time closer to the surgery.

b) Patients who are medically not fit for treatment should be managed dependent on the nature of their condition as below :-

i) **Short term conditions** – less than 2 weeks until medically fit. Where the patient's optimisation is resolvable via an individual management plan agreed with the acute clinician, the RTT pathway clock continues and the patient will be listed for their procedure.
ii) **Long term conditions (clinically routine)** – greater than 2 weeks, trigger for clinical discussion

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

- If the patient requires optimisation in secondary care active monitoring will be applied (NB: if the patient is already on the elective waiting list then this must be removed). Once the patient is optimised a new RTT clock will start.
- If the patient requires referral back to the GP for optimisation, the RTT pathway clock will be stopped and they will not be listed for their procedure. Once optimised the patient should be re-referred and start a new RTT pathway at the clinically appropriate point, i.e. pre-op assessment.

iii) **Long Term conditions (Urgent and Cancer).** The decision to proceed with these types of patients lies entirely with the consultant anaesthetist / consultant surgeon who following a review will make a decision whether to proceed.

iv) For patients who have previously been added to a waiting list and subsequently become unfit the above rules will apply.

40) ADDING PATIENTS TO THE ADMITTED WAITING LIST

Patients must be added to the admitted waiting list within locally agreed timescales. The date on list should be the date the patient has confirmed their wish to undergo treatment, e.g. date of clinic attendance, or after a period of the patient considering their treatment options.

When adding a patient onto the waiting list in the PAS, staff must ensure all information is gathered and recorded in line with the Trust Standard Operating Policy (SOP).

41) LISTING PATIENTS/OFFERING TCI DATES

a) If the patient fails to respond and all reasonable attempts have been made to contact the patient to agree an appointment, the waiting list entry is removed as the patient has declined treatment. A letter is sent to the patient and the GP and the patient's RTT pathway will be closed. This should only happen if in the clinical best interests of the patient as determined by the clinical lead responsible for patient's care.

b) Where patients are not fully booked the Trust's Patient Tracking List (PTL) must be used as the data source for scheduling admitted patients.

c) Listing must be undertaken by selecting patients firstly by their clinical priority and then within chronological order of RTT wait time.

d) Patients must be contacted to have the opportunity to verbally agree their TCI date.

e) Patients should be offered two separate dates with at least three weeks' notice for routine day case or inpatient admissions.

Where available, patients can be offered dates with less than three weeks' notice and if they accept, this then becomes a 'reasonable' offer.

42) CANCELLING, DECLINING OR DELAYING APPOINTMENT AND ADMISSION OFFERS

Patients can choose to postpone or amend their appointment or treatment if they wish, regardless of the resulting waiting time. Such cancellations or delays have no impact on reported RTT waiting times. However, clinicians will be informed of patient-initiated delays to

ensure that no harm is likely to result from the patient waiting longer for treatment (clinicians may indicate in advance, for each specialty or pathway, how long it is clinically safe for patients to delay their treatment before their case should be reviewed). Where necessary, clinicians will review every patient's case individually to determine whether:

- The requested delay is clinically acceptable (clock continues)
- The patient should be contacted to review their options – this may result in agreement to the delay (clock continues) or to begin a period of active monitoring (clock stops)
- The patient's best clinical interest would be served by discharging them to the care of their GP (clock stops)
- The requested delay is clinically acceptable but the clinician believes the delay will have a consequential impact (where the treatment may fundamentally change during the period of delay) on the patient's treatment plan-active monitoring (clock stops).

The general principle of acting in the patient's best clinical interest at all times is paramount.

43) THE TO COME IN (TCI) LETTER

A letter must be generated immediately following the agreement of a TCI date. The TCI letter must contain all the relevant information associated to the attendance, as listed in the Trusts Standard Operating Policy (SOP).

44) CONSIDERING TREATMENT OPTIONS

Where a patient would like time to decide on their treatment options then they should generally be given two weeks. Anything above two weeks should act as a trigger to have conversations with the patient's clinician in order to agree the future treatment plan. Please refer to local guidelines.

If in the event it is considered that patients will require longer than two weeks then a case by case discussion must be had with the relevant management team to ensure that the patient's best interests are taken into account.

45) HOSPITAL CANCELLATION OF TCI

a) **Cancellation by the Trust for Clinical Reasons**

If the operation is cancelled because the patient is unfit for surgery the patient will either remain under the hospitals care for optimisation or be discharged back to their GP (please refer to section 29c). If the operation is no longer required the clock stops and the patient should be referred back to their GP.

b) **Cancellation by the Trust for Non Clinical Reasons**

The Trust will only cancel a patient's admission when it is not possible to carry out the procedure (e.g. bed capacity, unplanned leave, emergency cases). Before any cancellation

is made, this must be discussed with the senior manager for that speciality. Everything must be done to try to avoid a hospital cancellation as it causes distress to the patient and an operational problem to the hospital.

If it is absolutely necessary for the hospital to cancel a patient's surgery, the patient will normally be given a new admission date at the time of cancellation.

In the event of a cancellation by the trust for non-clinical reasons on the same day or after admission (28 day rule) then it is best practice to agree a new date of admission at the point of the cancellation. This new date of admission must be within 28 days if the original admission date and the patient must be given reasonable notice of the rearranged date.

The patient may choose not to accept a date within 28 days. If it is not possible to offer the patient a date within 28 days of the cancellation, the trust will offer to fund the patient's treatment at the time and provider of the patient's choice where appropriate.

If this is not possible it is the responsibility of the specialty manager to ensure that the patient has a new date of admission within 28 days. If the patient is cancelled for a second time then the original 28 day target date applies.

Should it be necessary to cancel elective admissions, priority will be given to clinically urgent cases and long waiters.

46) PLANNED WAITING LIST

a) Patients who are waiting to be recalled to hospital for a further stage in their course of treatment or diagnostics are classed as planned admissions. This is an admission where the date of admission is determined by the clinical needs of the treatment. Examples of these would be follow up chemotherapy sessions, a removal of internal fixation, check cystoscopy or repeat colonoscopies. These patients will be held on a 'planned waiting list', separate from the other waiting list, however will be subject to the same monitoring and validation process.

b) Operational managers are responsible for reviewing the planned list to ensure compliance. This review will include checking that patients are being brought in, in accordance with their planned review dates and have been listed appropriately to the planned list definition.

c) Patients on planned waiting lists are outside the scope of RTT rules.

d) Patients who wait beyond their clinically defined interval between appointments or 'planned by date' should be transferred to the active RTT or diagnostic waiting list with a new clock start date. i.e. a planned second procedure or diagnostic.

The planned waiting list must not be used where there are delays as a result of administrative or resource problems assessments are being sought e.g. anaesthetic or renal opinion prior to surgery.

47) PATIENTS WHO DO NOT ATTEND (DNA) ADMISSION

a) It is important that the patient has been given instructions of who to notify and how if they subsequently cannot come in for their operation / procedures. The letter should clearly state the consequences of not attending for their procedure date.

b) Any patient who does not attend their agreed procedure date will be clinically reviewed and if appropriate discharged back to the care of their GP. Both patient and GP will be notified of this in writing to ensure the referring GP is aware and can action further management of the patient if necessary. The patient's RTT clock will be stopped. Exceptions to this are:

i) when a clinical decision is taken that discharging the patient is contrary to the patient's clinical interests
ii) clinically very urgent patients including cancer, or active surveillance for cancer
iii) children of 18 years (See Footnote3 below[3]) and under or vulnerable adults
iv) When one of the following can be confirmed:
- The operation date was sent to the incorrect patient address
- The operation was not offered with reasonable notice

c) Where circumstances were beyond the patient's control, the Trust will endeavour to be as flexible as possible. The patient must first be contacted to ascertain the reasons for DNA and ensure compliance to attend a rescheduled operation. The rescheduled appointment must be made from the original referral and the RTT clock will continue.

d) For paediatric patients after the reason for a DNA has been established, this should be documented in the health records. A further operation needs to be offered to the patient and the importance of attendance needs to be reiterated to the parent / carer. If the patient DNA's further operation dates, providers will refer to their SOP.

e) If there are any safeguarding concerns about a child or young person under the age of 18 years further guidance should be sought from then relevant Trust policy or safeguarding lead.

48) BILATERAL PROCEDURES

Unless it is clinically appropriate to do so and in line with commissioning policy patients will only be put onto the admitted waiting list for one procedure at a time.
The RTT clock will stop when first definitive treatment for the first side begins. A second new clock starts once the patient is fit and ready to proceed with the second procedure.

[3] The Children's Act defines children as any person under the age of 18 and in addition a person 18, 19, or 20 who; (a) has been looked after by a local authority at any time after attaining an age of 16; or (b) has a learning disability. A person is "looked after by a local authority" if: (a) for the purpose of the Children Act 1989 (c.41), they are looked after by a local authority in England and Wales; "learning disability" means a state of arrested or incomplete development of mind, which induces significant impairment of intelligence and social functioning.

49) ADMITTING PATIENTS

Where a patient's admission is for a procedure or operation constituting first definitive treatment as part of an RTT pathway, the admission on PAS will stop the patient's clock.

50) EMERGENCY ADMISSIONS FOR AN ELECTIVE PROCEDURE

Where patients are admitted as an emergency for a procedure the patient is currently waiting for as part of a RTT pathway, the patient will be removed from the waiting list and their RTT clock stopped.

51) REMOVALS OTHER THAN TREATMENT

Patients who state that they do not wish to receive treatment will have their waiting list entry removed and their clock stopped and the clinician informed.

Section Three

Reference Information

Definitions

A

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 for a day case or inpatient procedure

Admitted pathway

A pathway that ends in a clock stop for admission (day case or inpatient)

APN

Administration Process Note

ASI – Appointment Slot Issues

This occurs when there are no appointments available on the E-Referral System. In these instances the ERS system informs the provider that the patient requires an appointment

B

Bilateral (procedure)

A procedure that is performed on both sides of the body, at matching anatomical sites. For example, removal of cataracts from both eyes.

C

Care Professional

A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

Clinical decision

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

Consultant

A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. Consultant-led waiting times exclude non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.

Consultant-led

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

Convert(s) their UBRN

When an appointment has been booked via the NHS e-Referral Service (Choose and Book), the UBRN is converted. (Please see definition of UBRN).

D

DNA – Did Not Attend

DNA (sometimes known as an FTA – Failed to attend). In the context of consultant-led waiting times, this is defined as where a patient fails to attend an appointment/ admission without prior notice.

Decision to admit

Where a clinical decision is taken to admit the patient for either day case or inpatient treatment.

Decision to treat

Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatments performed in other settings, for example, as an outpatient.

DRSS – Devon Referral Support Services

DRSS works on behalf of all practices in Devon and East Cornwall as a referrals contact centre; supporting individuals in getting the right advice, care or treatment in a timely manner.

E

e-RS – e-Referrals

The NHS e-Referral Service (e-RS) combines electronic booking with a choice of place, date and time for first hospital or clinic appointments.

F

First definitive treatment

An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.

Fit and ready (in the context of bilateral procedures)

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

H

Healthcare science intervention

See Therapy or Healthcare science intervention.

I

IFR Policy

Individual Funding Request Policy- this document sets out how the process for how NEW Devon CCG and South Devon and Torbay CCG manage these requests.

Interface service (non-consultant led interface service)

All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care.

The definition of the term does not also apply to:

- non consultant-led mental health services run by mental health trusts.
- referrals to 'practitioners with a special interest' for triage, assessment and possible treatment, except where they are working as part of a wider interface service type.

K

KPI

Key Performance Indicator

N

NHS e-Referral Service (formerly Choose and Book)

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

Non-admitted pathway

A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment'.

Non consultant-led

Where a consultant does not take overall clinical responsibility for the patient.

Non consultant-led interface service

See interface service.

P

Patient pathway

A patient pathway is usually considered to be their journey from first contact with the NHS for an individual condition, through referral, diagnosis and treatment for that condition. For chronic or recurrent conditions, a patient pathway will continue beyond the point at which first definitive treatment starts, as it will include further treatment for the same condition. A person may therefore have multiple RTT periods (see Referral to treatment period) along one patient pathway. NHS England often uses the term 'RTT pathway' in published reports and in this document and this is the same as an 'RTT period'.

Planned care

An appointment /procedure or series of appointments/ procedures as part of an agreed programme of care which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.

R

Reasonable offer

An offer is reasonable where the offer for an outpatient appointment or an offer of admission is for a time and date three or more weeks from the time that the offer was made.

Referral Management or assessment service

Referral management or assessment services are those that do not provide treatment, but accept GP (or other) referrals and provide advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient.

Referral Management and Assessment Services should only be in place where they carry clinical support and abide by clear protocols that provide benefits to patients. They must not be devices either to delay treatment or to avoid local clinical discussions about good referral practice.

A waiting time clock only starts on referral to a referral management and assessment service where that service may onward-refer the patient to a surgical or medical consultant led service before responsibility is transferred back to the referring health professional.

Referral to treatment period

An RTT period is the time between a person's referral to a consultant-led service, which initiates a clock start, and the point at which the clock stops for any of the reasons set out in the RTT national clock rules, for example the start of first definitive treatment or a decision that treatment is not appropriate.

S

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.

Substantively new or different treatment

Upon completion of a consultant-led referral to treatment period, a new waiting time clock starts upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.

It is recognised that a patient's care often extends beyond the consultant-led referral to treatment period, and that there may be a number of planned treatments beyond first definitive treatment.

However, where further treatment is required that did not form part of the patient's original treatment plan, a new waiting time clock should start at the point the decision to treat is made.

Scenarios where this might apply include:

- where less 'invasive/intensive' forms of treatment have been unsuccessful and more 'aggressive/intensive' treatment is required (for example, where Intra Uterine Insemination (IUI) has been unsuccessful and a decision is made to refer for IVF treatment);
- patients attending regular follow up outpatient appointments, where a decision is made to try a substantively new or different treatment. In this context, a change to the dosage of existing medication may not count as substantively new or different treatment, whereas a change to medication combined with a decision to refer the patient for therapy might.

Ultimately, the decision about whether the treatment is substantively new or different from the patient's agreed care plan is one that must be made locally by a care professional in consultation with the patient.

T

TCI

To come in date or the date offered for admission to hospital.

Therapy or Healthcare science intervention

Where a consultant led or interface service decides that therapy (for example physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science (for example, hearing

aid fitting) is the best way to manage the patient's disease, condition or injury and avoid further interventions.

U

UBRN (Unique Booking Reference Number)

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

Appendix 1

INTER-PROVIDER ADMINISTRATIVE DATA TRANSFER DATA COLLECTION TEMPLATE

Referring organisation name:	Referring organisation code:
Referring clinician:	Referring clinician registration code:
Referring treatment function code:	Contact name:
Contact phone:	Contact e-mail:
Patient Details:	
Patient's family name:	Patient's forename:
Title:	Date of birth:
NHS number:	Local patient identifier:
Correspondence address: Post code:	Contact details: Patient is lead contact ☐ Lead contact if not the patient: ☐ Lead contact name: Contact home tel no: Contact work tel no: Contact mobile: Contact e-mail:
GP Details:	
GP Name:	GP practice code:
Referral To Treatment Information:	
Patient Pathway Identifier:	Allocated by (organisational code):
Is the patient on an 18 Weeks RTT pathway: Yes ☐ No ☐ (98)	
Is this referral the: Start of a new pathway – (New condition or change of treatment) ☐ (12) Continuation of an active pathway – (1st definitive treatment not given) ☐ (20) Continuing treatment for a stopped pathway (1st definitive treatment given) ☐ (90)	
Is this referral for: Diagnostic test only ☐ Opinion only ☐	
Date of decision to refer to receiving organisation:	Clock start:
List all organisations involved in the 18 Weeks pathway	
Receiving Organisation Details:	
Receiving organisation name:	Receiving organisation code:
Receiving clinician:	Receiving treatment function code:
Date IPTAMDS sent:	
For Receiving Organisation:	
Date received:	

Appendix 2

Referral Letter Information Requirements

Minimum Data Set (MDS) – in bold

- **Referring clinician**
- **Practice Address including postcode**
- **Telephone number**
- **Practice code**
- **Practice Generic Email Address**
- **NHS Number**
- **Eligibility for NHS Treatment**
- **Patient Surname**
- **Forename(s)**
- **Date of Birth and Age**
- **Sex**
- **Ethnicity**
- **Address**
- **Postcode**
- **House telephone**
- **Mobile telephone**
- **Any accessible information requirements**
- **Specialty/Department**
- **Date**
- **Presenting complaint**
- **Reason for referral**
- **Expected outcome**
- **Treatments tried and outcomes**
- **Significant PMH**
- **Relevant investigations**
- **Current medication**
- **Allergy history**
- **Interpreter required? If so which language?**
- **Does this patient have a learning disability? Yes/No**
    - If yes, note to providers: *please ensure that reasonable adjustments are made to effectively meet the needs of this individual*

Optional Data items

- BMI (to assess suitability for offering providers with BMI referral criteria)
- Smoking status

Appendix 3

Referral to treatment consultant-led waiting times rules suite

Clock Starts

1) A waiting time clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to:

a) a consultant-led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner;

b) an interface or referral management or assessment service, which may result in an onward referral to a consultant-led service before responsibility is transferred back to the referring health professional or general practitioner.

2) A waiting time clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional permitted to do so.

3) Upon completion of a consultant-led referral to treatment period, a new waiting time clock only starts:

a) when a patient becomes fit and ready for the second of a consultant-led bilateral procedure;

b) upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan;

c) upon a patient being re-referred in to a consultant-led; interface; or referral management or assessment service as a new referral;

d) when a decision to treat is made following a period of active monitoring;

e) when a patient rebooks their appointment following a first appointment Did Not Attend (DNA) that stopped and nullified their earlier clock.

Clock Stops

Clock stops for treatment

1) A clock stops when:

a) First definitive treatment starts. This could be:

i) Treatment provided by an interface service;

ii) Treatment provided by a consultant-led service;

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

b) A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

Clock stops for 'non-treatment'

1) A waiting time clock stops when it is communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay that:

   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 DNAs their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient9;

2) DNAs for a first appointment following the initial referral that started a waiting time clock nullify the patient's clock (in other words, it is removed from the numerator and denominator for Referral to Treatment time measurement purposes).

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

      i) The provider can demonstrate that the appointment was clearly communicated to the patient;

      ii) discharging the patient is not contrary to their best clinical interests;

      iii) discharging the patient is carried out according to local, publicly available/published, policies on DNAs;

      iv) These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g. children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders.

Appendix 4: National Elective Care Standards

Referral to Treatment	
Incomplete Pathways	92% of patients on an incomplete pathway (ie still waiting for treatment) to be waiting no more than 18 weeks (or 126 days)
Diagnostics	
Applicable to the following diagnostic investigations	99% of patients to undergo the relevant diagnostic investigation within 6 weeks (or 41 days) from the date of decision to refer to appointment date
Cancer	
Two Week Wait Urgent Suspected Cancer Referral	• 93% of patients to be seen within two weeks of an urgent GP referral for suspected cancer • 93% of patients to be seen within two weeks of a GP referral with breast symptoms (where cancer is not suspected)
Decision to Treat to Treatment (31 Day Wait)	• 96% of patients to receive their first definitive treatment for cancer within 31 days of the decision to treat • 94% of patients to receive subsequent treatment for cancer within 31 days of the decision to treat/earliest clinically appropriate date to start a second or subsequent treatment where that treatment is surgery • 98% of patients to receive subsequent treatment for cancer within 31 days of the decision to treat/earliest clinically appropriate date to start a second or subsequent treatment where that treatment is an anti-cancer drug regime • 94% of patients to receive subsequent treatment for cancer within 31 days of the decision to treat/earliest clinically appropriate date to start a second or subsequent treatment where that treatment is a course of radiotherapy • Maximum wait of 31 days from urgent GP referral to first treatment for children's cancer, testicular cancer and acute leukaemia - no performance measure set for this – monitoring as a part of the 62 day wait for first treatment
62 day cancer (referral to treatment)	• 85% of patients to receive their first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer • 90% of patients to receive their first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service (breast, bowel and cervical) • Maximum wait of 62 days for patients to receive their first definitive treatment for cancer where their consultant has upgraded their referral to urgent – no national performance measure set for this at present but a local performance measure of 85% has been set
All the standards within the table above are set at less than 100% to allow for tolerances which apply in the following scenarios;	
Exceptions	• Applicable to RTT pathways where it is in the patient's best clinical interest to receive treatment past 18 weeks.
Choice	• Applicable where patients choose to extend their pathways via rescheduling previously agreed appointment dates or admission offers or making themselves unavailable for a period of time.
Co-operation	• Applicable where patients do not attend previously agreed appointment or admission date

Torbay and South Devon NHS
NHS Foundation Trust

Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

This guidance has been registered with the Trust. The interpretation and application of guidance will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using clinical guidance after the review date, or outside of the Trust.

Ref No:	2164		
Document title:	Devon Health Community Elective Care Access Policy		
Purpose of document:	To outline the Devon Health Community's expectations and requirements in terms of managing patients referred into elective care pathways.		
Date of issue:	18 January 2019	**Next review date:**	18 January 2022
Version:	4	**Last review date:**	November 2018
Author:	Performance Manager		
Directorate:	Organisation Wide		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Senior Business Management Team Meeting Performance Risk and Assurance Group – Elective Care		
Date approved:	15 November 2018		
Links or overlaps with other policies:			

Have you identified any issues on the Rapid (E)quality Impact Assessment. If so please detail on Rapid (E)QIA form.	Yes ☐	
	Please select *Yes*	*No*
Does this document have implications regarding the Care Act? *If yes please state:*	☐	☐
Does this document have training implications? *If yes please state:*	☐	☐
Does this document have financial implications? *If yes please state:*	☐	☐
Is this document a direct replacement for another? *If yes please state which documents are being replaced:*	☐	☐

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
2 July 2015	1	First draft circulated for feedback and comment	
6 August 2015	2	Second draft circulated for feedback and comment	
20 October 2015	3	Third draft circulated for feedback and comment	
5 November 2015	1	Final draft agreed by steering group	
11 April 2016	2	Final version ratified by SBMT	COO
28 July 2016	3	Feedback from IST review	COO
8 September 2017	3	Re-formatted only and republished on ICON	
19 February 2018	3	Review date extended from 2 years to 3 years	
18 January 2019	4	Revised	Senior Business Management Team Meeting Performance Risk and Assurance Group – Elective Care

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Rapid (E)quality Impact Assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)		**Version and Date**	
Policy Author			

An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.

Who may be affected by this document?

Patients/ Service Users ☐	Staff ☐	Other, please state… ☐

Could the policy treat people from protected groups less favourably than the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Age	Yes ☐ No☐	Gender Reassignment	Yes ☐ No☐	Sexual Orientation	Yes ☐ No☐
Race	Yes ☐ No☐	Disability	Yes ☐ No☐	Religion/Belief (non)	Yes ☐ No☐
Gender	Yes ☐ No☐	Pregnancy/Maternity	Yes ☐ No☐	Marriage/ Civil Partnership	Yes ☐ No☐

Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☐

Please provide details for each protected group where you have indicated 'Yes'.

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☐ No☐ NA ☐
Are the services outlined in the policy fully accessible[6]?	Yes ☐ No☐ NA ☐
Does the policy encourage individualised and person-centred care?	Yes ☐ No☐ NA ☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☐ NA ☐

EXTERNAL FACTORS

Is the policy a result of national legislation which cannot be modified in any way?	Yes ☐ No☐

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

Who was consulted when drafting this policy?

Patients/ Service Users ☐	Trade Unions ☐	Protected Groups (including Trust Equality Groups) ☐
Staff ☐	General Public ☐	Other, please state… ☐

What were the recommendations/suggestions?

Does this document require a service redesign or substantial amendments to an existing process? ***PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below***	Yes ☐ No☐

ACTION PLAN: Please list all actions identified to address any impacts

Action	Person responsible	Completion date

AUTHORISATION: By signing below, I confirm that the named person responsible above is aware of the actions assigned to them			
Name of person completing the form		**Signature**	
Validated by (line manager)		**Signature**	

Please contact the Equalities team for guidance:

For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net

For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net

This form should be published with the policy and a signed copy sent to your relevant organisation.

[1] Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user
[2] Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them
[3] Consider any provisions for those with no fixed abode, particularly relating to impact on discharge
[4] Consider how someone will be aware of (or access) a service if socially or geographically isolated
[5] Language must be relevant and appropriate, for example referring to partners, not husbands or wives
[6] Consider both physical access to services and how information/ communication in available in an accessible format
[7] Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

Clinical and Non-Clinical Policies – Data Protection

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 18) in mind, and therefore provides the reader with assurance of effective information governance practice.

The UK data protection regime intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy. Furthermore, data protection legislation requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data.

Does this policy impact on how personal data is used, stored, shared or processed in your department? Yes ☐ No ☐

If yes has been ticked above it is assured that you must complete a data mapping exercise and possibly a Data Protection Impact Assessment (DPIA). You can find more information on our GDPR page on ICON (intranet)

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdft@nhs.net,
- See TSDFT's Data Protection & Access Policy,
- Visit our Data Protection site on the public internet.