ELECTIVE PATIENT ACCESS (ADULT)

NGH-PO-263

Ratified By:	Procedural Documents Group
Date Ratified:	October 2014
Date(s) Reviewed:	October 2014
Next Review Date:	October 2017
Version No:	5.1
Superseded Document No:	NGH-PO-263 V2 (V2-Hospital Management Group-2nd March 10) (V3-PDG 20th Dec 2011)
Responsibility for Review:	Chief Operating Office
Contributors:	Performance Meeting

POLICY

CONTENTS

POLICY

POLICY

POLICY

SUMMARY

This Policy establishes a number of good practice procedures to ensure that staff effectively manages outpatient, inpatient, diagnostic waiting lists and cancer pathways.

.

1. INTRODUCTION

Northampton General Hospital NHS Trust aims to provide Access Policy that encompasses the collection, interpretation and definition of nationally agreed data standards for the NHS.

Hospital medical staff, managers, secretarial and administrative staff have an important role in managing waiting lists effectively. Treating patients, delivering a high quality, efficient and responsive service as well as ensuring prompt communication with patients are core responsibilities of the hospital and the wider local health community.

This policy will ensure consistency, equity and confidence in the process of managing patient care from outpatients through to admission and treatment for the people of Northamptonshire.

Patient access refers to how quickly and efficiently a patient can be treated. The treatment of patients is the core function of the NHS. This means that getting patients treated efficiently and reducing waiting times is everyone's business, from the GP who refers a patient to outpatients, through to the receptionist or ward staff who discharge them.

Service commissioners must ensure that service agreements are established, which secure capacity to ensure that no patients wait more than a guaranteed maximum time. Failure to commission and commit resources to fund adequate capacity will lead to longer waiting lists and times.

The healthcare community has a responsibility to review the patient pathway to ensure effectiveness for the patient and reduce length of wait. The role of the General Practitioners and Clinical Commissioning Groups is important. Changes in referral pattern will alter the balance between patients being added to the waiting list and the numbers being seen/treated. Any unpredicted increases in referrals could lead to longer waiting lists and time and therefore will need to be closely monitored and action taken if necessary.

Agreeing appointments or an admission is recognised as fundamental to a modern NHS – an NHS which is personalised, responsive and actively seeks to involve patients as equal partners in their own care. Whilst greater involvement is one benefit for patients, so too is the opportunity for patients to make the choices that reflect their own priorities. These might include being treated closer to home, or alternatively by a treatment centre focusing specifically on their condition, or indeed the private sector

The Trust is working to national rules for 18-weeks pathways and cancer standards as defined in: -

Department of Health's 18 Week Rules Suite (June 2010):

- waiting time clock rules
- definitions
- guidance on applying the rules locally

Review of Cancer Waiting Times Standards (Jan 2011)

Key Points:

- Patients will be treated within national waiting time standards
- Patients should only be added to a waiting list if there is a real expectation that they will be treated
- Patients should only be added to the waiting list if they are willing, fit and able to be admitted / appointed for their treatment or consultation
- Patients will be treated in order of their clinical need
- Patients with the same clinical need will be treated in chronological order
- Suspending a patient is not acceptable (see section 7.8.7)
- All non-urgent patients must be given reasonable notice of their appointment or admission date, this is currently set at three weeks

NHS patients can expect a certain level of service to be maintained at all times. These include the right to be seen by an appropriately qualified health professional, to have a clear explanation of their condition and treatment options, and to be treated fairly in accordance with this policy as laid out in this document.

2. PURPOSE

The purpose of this policy is to outline how we meet the values for all patients referred to Northampton General Hospital. The policy outlines the Trust and commissioner requirements for managing patient access to secondary and tertiary care services from referral to treatment and discharge back to primary care or to the patient's original referrer. The Trust will ensure that the management of patient access to services is transparent, fair, and equitable and managed according to clinical priority.

The policy covers the processes for all stages of cancer and referral to treatment pathways including diagnostics and audiology.

3. SCOPE

This policy is applicable to all members of staff responsible and or involved with the management of the patient pathway from referral to discharge. This policy specifically identifies the rules and regulations in place with regards to RTT, cancer waiting times and diagnostic access and as well as upholding the NHS Constitution.

4. COMPLIANCE STATEMENTS

Equality & Diversity

This policy has been designed to support the Trust's effort to promote Equality and Human Rights in the work place and has been assessed for any adverse impact using the Trust's Equality Impact assessment tool as required by the Trust's Equality and Human Rights Strategy. It is considered to be compliant with equality legislation and to uphold the implementation of Equality and Human Rights in practice.

NHS Constitution

The contents of this document incorporates the NHS Constitution and sets out the rights, to which, where applicable, patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with the responsibilities which, where applicable, public, patients and staff owe to one another. The foundation of this document is based on the Principals and Values of the NHS along with the Vision and Values of Northampton General Hospital NHS Trust.

5. DEFINITIONS

18 week target	Time from referral to start of first treatment
Cancer 2 Week Wait (2WW)	Time from GP referral to 1st outpatient appointment
Cancer 62 day target	Time from Urgent GP referral to start of first treatment
Cancer 31 day target	Time from referral to subsequent treatment or specialised treatment via a 2ww referral to start of first treatment i.e. testicular cancer
Reasonable notice	Refer to relevant pathway
Diagnostic waits	Time from request for diagnostic test to test
Day case (DC) procedure	The patient is not intended to occupy a hospital bed overnight, and does not actually occupy a bed overnight
Planned admission	A patient admitted, having been given a date or approximate date at the time that the decision to admit was made. This is usually part of a planned sequence of clinical care determined mainly on social or clinical criteria (e.g. check cystoscopy)
Waiting List admission	A patient admitted electively from a waiting list having been given no date of admission at a time a decision was made to admit

Booked Admission	A patient admitted having been given a date at the time the decision to admit was made, determined mainly on the grounds of resource availability
RTT	Referral To Treatment

Further definitions can be found in Appendix 4

6. ROLES & RESPONSIBILITIES

ROLE	RESPONSIBILITY
Chief Executive and the Trust Board	Responsible for ensuring there is a policy in place.
General Managers and Service Managers in conjunction with the individual clinicians, the appropriate waiting list/outpatient/booking team, medical secretaries, and waiting list co-ordinators	To effectively manage lists and conform to the said policy.
All Staff that Admit a Patient	Have a responsibility to confirm the patient's details as follows: • Postal address (including postcode) • Referring General Practitioner. It is essential that the correct name of the referring GP/GDP be recorded for that episode of care to ensure clinical letters are sent to the appropriate referrer. • Patient's home, work, mobile or a daytime telephone contact number.
All Trust Employees	Have a responsibility to: • Support the Trust to achieve its Vision • Act at all times in accordance with the Trust values • Follow duties and expectations of staff as detailed in the NHS Constitution – Staff Responsibilities

7. SUBSTANTIVE CONTENT

7.1. Core Principles

7.1.1. Over-riding Principles

This policy is based on the following over-riding principles: -

- Full patient demographics and GP details must be confirmed at each contact point
- Patients on the waiting list must be fit and available for surgery
- All additions to, changes to, or removals from waiting lists must be made in accordance with this policy
- A patient should only be added to a waiting list if there is an expectation of treating them
- The waiting list module on the iPM system must be used to administer all waiting lists and booked admissions. It is the responsibility of all those involved in waiting list management to ensure that the information held is accurate and updated in real time
- Dates offered must be recorded on iPM/ waiting list card

7.1.2. Patient Focus

- Patients to have choice and responsibility in organising their care within the 18-week journey
- Patients to have the opportunity to negotiate and choose the date and time of their treatment
- Patients can expect reasonable notice to prepare for their appointment / treatment of no less than three weeks unless otherwise agreed by the patient
- Equitable access to care via chronological management for patients of the same clinical priority
- A 'no cancellation/alteration policy' aside from exceptional circumstances e.g. staff sickness
- Patients will wait no longer than the National waiting time

7.1.3. Data Quality

- iPM must be up-to-date and used for all patient transactions in waiting time and waiting list management
- Accurate and timely record keeping

7.1.4. Clinical Priorities

- Clinical priorities are the basis for selecting when to see patients
- Clinical involvement in the development of standards
- Leaving patients on a waiting list is not an alternative to treatment

7.1.5. Risk Management

- In line with clinical governance requirements and recommendations
- Reduces clinical and corporate risk

- Links to and encapsulates existing policy frameworks
- Supports national waiting time standards

7.1.6. Staff

- Clarity of roles and responsibilities at each stage in the administrative processes supporting patient care
- Staff must be informed and trained to be able to fulfil their duties in line with this policy and operate within the policy framework

7.2. Referrals

7.2.1. External Referrals for a 1st Consultant Outpatient Appointment

An external referral could be a GP referral, Optometrists, Dentists, Education or Social Services

The quality of the initial referral is a crucial determinant in identifying the priority for attendance at outpatients. The following information must be included in the referral pro-forma as well as a concise description of the presenting problem and the initial diagnosis and results from tests already undertaken: -

- Surname
- First name(s)
- Sex
- Date of birth
- Address
- Postcode
- Daytime telephone number
- Evening telephone number
- Alternative telephone number (including mobile telephone numbers)
- NHS number

'Low Clinical Priority' (LCP) procedure referrals should not be accepted until evidence of funding is provided by the GP practice.

7.2.2. GP Referrals

All GP to consultant first outpatient appointments should be referred via Choose and Book. Paper referrals will only be accepted for those services not available on the system, or during system downtime. All other paper referrals are to be returned to the referring GP and the GP requested to make a referral on Choose and Book. GPs are to attach the referral letter to Choose and Book within 24 hours for urgent referrals and 3 days for non-urgent referrals.

The implementation of direct booking for the majority of services means that appointments may be booked directly into the hospital patient administrative system and patients will then have access to booking their appointments through the following: -

- Directly from the GP surgery
- Via the internet
- Through the national telephone appointments line (TAL)

The referral information will be printed from the Choose and Book system and sent to consultants for review. These must be reviewed and returned to the relevant booking team within 5 working days or the Booking Team will default to an 'accepted' referral position.

All consultants will have the ability to accept, reject, or divert the referral to a more appropriate service. Consultants will also be able to review the referrals on line and reject or accept them on line. The 18-week clock continues for onward referrals.

Unless there are exceptional circumstances or the need for the referral to be seen by a clinician with a sub-specialty interest, GPs will refer patients to the appropriate clinical specialty rather than a named consultant. Should a patient be referred to a named consultant, the referral may be passed on to another appropriate consultant who has a shorter waiting time if clinically acceptable to do so. With any referral, patient choice should be considered.

7.2.3. Internal Referrals

All of these referrals will continue to be part of the 18-week patient pathway until initial treatment has been commenced.

- Consultant to consultant referrals
- Non Consultant Clinics – examples include nurse and therapists led clinics
- Investigations – examples include radiology and clinical investigations unit

All internal outpatient referrals either from a consultant or non-consultant sources must meet the criteria as listed below in 7.2.4.

For national guidance on clock starts see appendix 3 and section 7.5.

7.2.4. Consultant to Consultant Referrals

The consultant or other healthcare professionals should forward any recommendations for further management of a secondary condition (i.e. one that is not directly related to the original GP referral) to the patient's GP. By doing this the responsibility for ongoing care of this secondary condition passes back to the GP.

The consultant or other healthcare professionals should **NOT** undertake any referral of a secondary condition unless:

- Referral to another consultant/other healthcare professional deemed clinically urgent or potentially limb or life threatening
- Referral to another consultant/other healthcare professional, within the same or even a different specialty, that is entirely consistent with the original care pathway
- Referral to another consultant/other healthcare professional for community services in order to avoid an admission.
- With the exemption of any 2ww cancer referrals or consultant upgraded cancer referral

Note: No payment will be received for consultant to consultant referrals unless in line with the points above.

7.3. Management of Outpatient Clinics/Waiting Lists

7.3.1. Outpatient Clinics Overview

All patient appointments, attendances and cancellations must be fully completed on the iPM outpatient module. If this is not done patients will be at risk of not receiving their next appointment details.

Aims

- All clinic activity should be completed according to standards at the end of each clinic session
- Outcomes MUST be recorded for every patient. It is the responsibility of the Clinician treating the patient to decide on, and complete the 'Clinic Outcome Form' for all patients

7.3.2. Management of Outpatient Clinics

In collaboration with clinical teams, outpatient clinic rules will be authorised by the Service Manager or representative and only changed with their approval.

The cancellation/reduction of all outpatient clinics requires a minimum of 6 weeks written/electronic notice. The only exception will be because of short notice sickness. Breaches of this standard must be escalated to the Service Manager and Clinical Director.

Any reduction in slots per outpatient clinic requires a minimum of 6 weeks written/electronic notice before the changes will become effective. All changes in clinic number slots must be agreed with the Clinical Lead/Service Manager.

It is the responsibility of Clinical Directors to manage medical staff absences to avoid significant numbers of medical staff being absent at the same time, potentially disrupting the management of the outpatient service. It is the responsibility of the Service Managers to ensure clinic productivity and to raise issues with consultants and Clinical Directors

Each Care Group should review clinic templates annually, to reflect contractual changes.

All clinics must be set up and completed on the iPM.

All appointments must be correctly recorded with the outcome recorded on iPM using the 18-week clinic outcome sheets. Outcomes will be audited quarterly with the results presented on the data quality dashboard.

7.3.3. Outpatient Attendances

On attendance at clinic the following patient information should be confirmed by the out-patient clinic staff: -

- Patient's name, date of birth, address including postcode and referring GP
- Patient's telephone number, home and work or a number through which he/she can be contacted
- Confirm the patient's entitlement to NHS treatment
- Patient Ethnicity

If the outcome of the attendance is an addition to the waiting list the following information must also be obtained: -

- Availability to come in at short notice i.e. less than 48 hours if an unexpected vacancy arises and if the patient has not been given an admission date
- If any special circumstances requiring longer notice than usual for an admission (caring for a relative, transport arrangements etc.)
- Any dates when the patient will not be available for admission e.g. booked holidays etc.

It is essential that when the clinic outcome is to 'add a patient to a waiting list' that this happens within 1 working day.

7.3.4. Recording Attendance Status

An attendance status must be recorded for every outpatient appointment by the end of the clinic. This is particularly pertinent for new patients as they remain on the outpatient waiting list until their attendance status is marked and are likely to become a breach of the waiting time targets.

7.3.5. Recording Outcomes

An outcome must be recorded on iPM for every patient who attends an outpatient appointment before the end of the clinic. This will be taken from the 18- week clinic outcome sheets. These are to be completed by the appropriate clinical staff for every outpatient attendance.

7.3.6. Managing Follow-Up Appointments

Patients should be given the opportunity to choose a convenient date and time for their follow-up appointment prior to leaving the outpatient department.

Patients who do not need to be seen in clinic but who, for medical reasons, may need the facility to come back and see the consultant at a later date, should be discharged and advised to see their GP for an urgent appointment. The GP will then need to re-refer a patient using Choose and Book. The referral will be added to iPM as a new referral. The exception to this will be for specialities that currently run an SOS system e.g. Dermatology and Rheumatology.

If a patient Did Not Attend (DNA) a follow-up appointment, the team responsible for booking the patient are to check the appointment was properly communicated. This will be by checking the patient contact details and checking that the appointments were not rescheduled and multiple appointments sent to the patient. If the DNA was the result of miscommunication by the hospital then the patient is to be rebooked as soon as possible and the 18 week clock continues.

7.4. Management of Elective Waiting Lists

7.4.1. Adding Patients to the Waiting List and Pre-Operative Assessment

The decision to add a patient to the waiting list can only be made by a consultant or under arrangement agreed with the consultant. Patients must only be added to the waiting list if they are clinically ready for admission at the time the decision is made. The waiting list must only contain patients who are fit, ready and able to come in for surgery/procedure.

All patients who are added to the waiting list must be given a clinical priority by the consultant. Patients should be classed as: -

- Urgent
- Routine

Within an urgent priority, consultants may also stipulate that the patient should be admitted within a specific time span. This should be taken into account when scheduling patients.

Patients will be able to agree their date of treatment at the time of decision to admit where possible.

Patients fitting a set criteria will then be referred to the one-stop pre-operative assessment service following their outpatient appointment where a decision to admit has been made. Patients will be assessed and if fit for surgery it will be confirmed they can be added to the waiting list.

Patients who require further tests and investigations prior to addition to the waiting list will undergo the tests and then be reviewed again by the pre-operative assessment service.

Patients are to be added to the waiting list within one working day of a decision to admit. The date the patient is entered as going onto the waiting list is the decision to admit date, not the date the details are entered onto iPM.

All requests for daycase (DC) and inpatient (IP) additions to the waiting list should contain the following information: -

- Management Intent (IP or DC)
- Procedure description
- OPCS procedure code
- Left / Right /Bilateral if applicable

- Estimated theatre time required
- Level of professional career required, e.g. Consultant / Registrar to do

7.5. 18-Week Journey

The 18-week patient pathway has been introduced to look at the whole of the patient journey from the patient's perspective and to join up previous targets and journey times. Previous targets have been focused on specific phases of the patient journey without joining these phases together into a single pathway.

95% of all non-admitted patients (outpatients), 90% of all admitted patients (elective/inpatients) and 92% of all patients on incomplete pathways should wait no longer than 18-weeks from referral into the system to first definitive treatment.

The NHS Constitution states that patients have the' rights to access certain services commissioned by NHS bodies within maximum waiting times or for the NHS to take all reasonable steps to offer you a range of suitable alternative provider if this is not possible'. With that in mind, providers should be expected to offer information on maximum waiting times to patients and there should be monitoring of compliance with these standards.

An 18 week clock starts when any health care professional or service refers where the intention is to asses and if appropriate treat. For choose and book referrals the clock start date will be the date when the patient books their appointment through choose and book. For paper referrals the 18 week clock starts from the date the referrals are received by the Trusts. For national rules on clock starts see appendix 4.

All internal referrals will continue to be part of the 18-week patient pathway until initial treatment has been commenced. If treatment has commenced a new 18 week clock may start with an internal referral, the referral should be added to iPM with the 'date received' as the date the internal referral letter was written.

Admitted pathways are those that end in an admission to hospital (either inpatient or day case) for treatment

Non admitted pathways are those that end in treatment that did not require admission to hospital or where no treatment is required.

Incomplete pathways are those where the 18 week clock is still running.

In 18 week terminology, we talk of clock starts (e.g. the date of receipt of the GP referral) and clock stops (e.g. the start of the first definitive treatment or decision not to treat).

What each 'RTT outcome Code' in iPM represents:

- 30, 33, 34 Stops a clock
- 20, 21 Clock still ticking
- 11 Start of a new clock
- 90, 98 No longer on an 18 week pathway or N/A to 18 weeks

See appendices 3 & 4 for national 18 week clock rules and definitions

7.6. Outpatient Access

7.6.1. Patient Access Management

Patient access to the acute Trust services should be managed according to clinical priority and the urgency streams should be limited to clinical priority of 'urgent' and 'routine'. Patients with a routine clinical priority should be treated in chronological order. Patients within the clinical priority category will be treated according to clinical need.

7.6.2. Outpatient Letters

Whenever a change is made to a patients' waiting management, as set out in the policy, the patient will be informed in writing of the action taken by the Trust.

All correspondence between patients, hospital and GP should quote the patients' Hospital Number, and 10 digit NHS number.

Following negotiation of an outpatient appointment, a confirmation letter will be sent to the patient with the following detail: -

- Appointment details
- Outline responsibilities of the hospital and the patient in relation to the provision of an appointment
- Contact details
- Information on the DNA policy
- Rights under the NHS Constitution
- Information on the telephone reminder system

7.6.3. Outpatient Waiting Management

Pooled referrals will ensure the waiting times between clinicians are equalised within each specialty and that the patient is seen in the next available clinic slot. The Trust will ensure clear clinical responsibility for pooled referrals and specialty waiting lists is maintained.

Where there is development of, or existence of a sub-specialty interest, the facility to refer to a named clinician will remain.

The Trust will have in place a robust administrative system ensuring that referral letters are processed in a timely and efficient way, enabling a clear audit trail to be followed.

All patients with a new unique booking reference number (UBRN) and wishing to receive their treatment under Northampton General Hospital will be accommodated. No patient will be suspended on the outpatient waiting list.

A choice of appointments will be offered where possible.

7.6.4. Follow ups – examples:

- Consultant appointment following first outpatient attendance is a follow- up within the same specialty
- Tertiary referrals returned to the Trust for follow up should be classed as 'follow-up outpatient appointments'
- If a consultant transfers a patient's care to another consultant within the same episode then this appointment should be classed as new.
- If a consultant forwards a referral to another consultant or clinician before seeing the patient, then the patient is booked as a new appointment for the accepting clinician
- Patients moving into the catchment area and requiring a review at a particular time i.e. 12 month diabetic follow up, can be considered as new referrals to the Trust and allocated a new appointment but with appropriate 'exception comments' being entered on iPM, so that the Trust is not penalised for clinically inappropriate waiting
- A&E referrals to the same specialty will be classed as follow-up appointments. A&E referrals to a different specialty will be classed as new referrals.

7.6.5. Reasonable Offer – First Outpatient Appointment

To constitute a reasonable offer, the Trust has to agree an appointment date with the patient with at least 3-weeks' notice, unless a patient chooses an earlier appointment.

In line with Access, Booking and Choice, a reasonable offer will include a choice of dates (a minimum of 2). If the patient declines both dates offered, they will be discharged back to the original referrer.

Patients can be offered an appointment at either NGH or Danetre Hospital (if services are provided at Danetre) with an appropriate consultant or member of the clinical team. If a patient declines an appointment at one location and expresses a wish to be seen at the other location, one of the reasonable offers should be at the location of their choice. An offer of another provider cannot be classed as reasonable unless the patient has first accepted the opportunity to be treated elsewhere.

For diagnostic tests a reasonable offer is a choice of at least 2 dates within the 4 week target.

7.6.6. Outpatient Did Not Attend (DNA)

Confirming Patient Details

All patients who DNA should have their demographic details rechecked. Should the patient details be incorrect a new appointment must be offered as soon as possible within 2 weeks of the DNA.

First Outpatient Appointment DNA:

Patients who DNA their first new outpatient appointment will be referred back to their GP provided we can demonstrate that the appointment was clearly communicated to the patient. Appointments will be confirmed by letter. The GP will receive the original referral letter and a copy of the removal from outpatient waiting list. The patient will receive a "removal from the waiting list" letter. If the patient is re-referred, this must be through Choose and Book. The appointment will be classed as new and will be dated within the maximum wait times following receipt of new referral.

If the original appointment was properly communicated and the consultant requests that a new appointment is to be re-booked then their 18-week clock can be nullified by using the RTT outcome on iPM of '33' (DNA 1st Act after initial referral) and a new ad hoc clock start added on the date the Trust re-books the patient.

See appendix 3 for national guidance on clock stops for non-treatment.

Follow up Appointments DNAs:

If a patient DNAs a follow-up appointment, the team responsible for booking the patient are to check the appointment was properly communicated. This will be by checking the patient contact details and checking that the appointments were not rescheduled and multiple appointments sent to the patient. If the DNA was as a result of miscommunication by the hospital then the patient is to be rebooked as soon as possible and the 18 week clock continues.

Patients who DNA a follow-up appointment will be discharged back to the GP providing discharging the patient is not contrary to their best clinical A letter will be sent to the patient stating that no further appointments will be made. A letter will notify the patients' G.P. If a clinical decision for a further appointment is made and the patient is still on an 18-week pathway, this appointment is to be made within 2 weeks of the DNA. If a patient DNA's the second appointment, they will be discharged back to their GP and notified of this.

In exceptional circumstances, patients may be given a further appointment following two DNAs. This would be if a consultant considers discharging a patient is contrary to the patient's clinical needs. In these circumstances, a further appointment is to be agreed with the patient.

7.6.7. Outpatient Self Deferral

A choice of appointment dates will be available to the patient (see reasonable notice to patients, 7.3.5). Should they decline these dates, they will be discharged back to their original referrer (up to a maximum wait of 11 weeks).

Patients who re-schedule their appointment will be offered an alternative date at the time of re-schedule and these patients will not have their 18-week clock stopped. If a patient re-

schedules more than once they will be removed from the waiting list and discharged back to their original referrer.

See appendix 4 for national guidance for clock stops for non-treatment

Under the directly bookable service patients are able to go on line and cancel their appointment up until the appointment time. All cancellations will be monitored using the Choose and Book 'Appointments Awaiting Booking' report. If a patient cancels, they will be contacted by the department and offered another appointment, if they decline an appointment the Unique Booking Reference Number (UBRN) will be cancelled and the patient referred back to the GP.

7.6.8. Clinic Cancellation

Clinic cancellations that affect patients must not occur with less than 6-weeks' notice, unless exceptional circumstances prevail.

When a clinic is cancelled the Trust will immediately re-arrange a date for the patient to be seen within the maximum waiting time (11 weeks), or earlier for clinical priority patients.

If it is not possible to rearrange the date within 11 weeks the patient must be added to the outpatient waiting list on iPM.

Individual new patients should only be re-scheduled by the Trust on one occasion, if required, due to exceptional circumstances; potential breaches of this requirement needs to be escalated (daily monitoring is undertaken)

7.6.9. Outpatient Validation

Patients wishing to be removed from the waiting list, or wishing to cancel an agreed appointment will be cancelled or removed by trained booking staff. A confirmation of removal letter will be sent to the patient and the GP.

7.6.10. Expediting Patients

Patients must see their GP, referrer or clinician in order to expedite an outpatient appointment. Patients will only be expedited if there is a clear clinical/social change in the patients' circumstances since the decision to refer. It must be a clinical decision to expedite a patients' appointment or investigation and, therefore, the outpatient waiting list holder must only expedite an appointment following receipt of this information. This can be faxed to the relevant department. Co-ordinators will then refer the request to the appropriate clinician. Outpatient administration staff must not expedite without agreement with the relevant consultant.

The clinical priority of the patient must be updated on the Trust's iPM and Choose and Book to reflect any agreement to expedite and to ensure continued chronological booking.

7.6.11. Private Patients Transfers to NHS Outpatient Clinics

Private patients to be seen as NHS patients will be classed as new consultant–to-consultant referral to the Trust and should be referred in accordance with the consultant-to-consultant referral guidelines. Private patients being added to elective lists should have their 18-week clock started on referral to the NHS.

7.7. Diagnostic Waiting Lists Access

7.7.1. Addition to Diagnostic Waiting Lists

This section refers to the diagnostic waiting lists that are not covered by inpatient and day-case waiting list management. Patients referred for diagnostic procedures e.g. Radiology investigations etc., should be given an opportunity to negotiate an appointment time. Each department will have a procedure for logging requests for diagnostic tests and for adding them to a diagnostic waiting list. Telephone numbers including mobile and home number, must be available on the request form. Where possible, departments will identify a process whereby a patient can come straight from their outpatient appointment when it was agreed to refer for a diagnostic test, to the relevant department to book a provisional appointment. If patients do not attend a department to book their test, they will be contacted by phone to arrange an appointment. If a patient is not available on the phone an appointment will be sent in the post.

All appointments will be booked within the target of 4-weeks from the date of request. Diagnostic tests covered by the day-case waiting list management section of the policy e.g. Endoscopy and Cystoscopy will need to be carried out within 4-weeks.

All requests for radiology test are to be made via ICE. ICE is a local requesting system that provides a web-based service that enables electronic requests to be made. This system can only be accessed via the NHS N3 network allowing full demographic and clinical information to be available to the radiology department.

Any test requested that is not on ICE will be required to include the following minimum dataset:

- Surname
- Date of Birth
- Address
- Post Code
- Telephone number
- Mobile number
- Referral source
- Clinical history
- Examination required
- Request date
- NHS number
- Urgency
- 2ww status if appropriate

7.7.2. Reasonable Offer

Patients will be given at least 2 reasonable offers within the 4-week target. If a patient is unable to accept they will be referred back to the referring clinician to be sent back to the referring GP.

7.7.3. Did Not Attend (DNA)

If a patient DNAs a diagnostic appointment, the diagnostic department will re-check and confirm they have the correct patient details. If the details were not correct a new appointment will be made within 2-weeks of the DNA.

If the details were correct the department will refer the patient back to the referring clinician and the patient will be referred back to the GP if this does not compromise clinical care. A letter will be sent to the patient by the referring clinician stating that no further appointments will be made. A letter will notify the patients' G.P.

If it is considered (by the treating consultant) as clinically important for the patient to be seen, appropriate action should be taken. This could include communication with the GP, other Primary Healthcare team professionals, and directly with the patient. Issuing a further appointment without taking this step is not sufficient to ensure that proper care is delivered. A further request for a diagnostic test should include details of the action taken.

If a further diagnostic appointment is to be made and the patient is still on an 18- week pathway, this is to be made within 2 weeks of the DNA. If a patient DNAs the second appointment, they will be discharged back to their GP by the referring clinician and notified of this.

Patients referred directly from GPs for direct access diagnostics. If a patient DNAs a direct access diagnostic appointment, the contact details will be re-checked as above. If the details are correct the patient will be discharged back to the GP and the GP asked to contact the patient to confirm the test is required and to re-refer if the diagnostic test is required.

7.7.4. Cancellation of Appointment

Where possible, appointments will not be cancelled by the Hospital. In exceptional circumstances where this does occur, a further appointment will be booked within the 4-weeks maximum wait.

7.7.5. Admission for Diagnostic Test

Once the patient has been sent for a diagnostic test the department requesting the test must actively monitor the patient. If the test results are normal and no further treatment is required this must be communicated to the patient and an 'ad hoc' RTT status of decision not to treat added to the pathway.

7.8. Inpatient & Day Case Waiting Lists Access

7.8.1. Active Waiting List

Patients will only be added to the active waiting lists that are fit, ready and able at the time of the decision to admit, and have agreed they need to undergo an Inpatient or Daycase procedure.

7.8.2. Planned Waiting List

Patients on the planned waiting list will normally have had previous treatment and are to receive further treatment as part of a planned sequence of care. Patients on the planned list are not included in National returns in relation to the waiting list size (except for endoscopy), because their procedure could not be done any sooner for clinical reasons, even if resources were not a constraint.

7.8.3. Bilateral Procedures

A new 18-week clock starts once a patient becomes fit for a second bilateral procedure. These patients should not be added to a planned list. They should be added to the active waiting list and a clinic outcome that starts a new 18-week clock selected at the clinic when a decision is made that the patient is fit for the bilateral procedure.

7.8.4. Suspended Waiting List

No patient will be suspended on the elective waiting list. See section 7.8.7 for 18- week 'pause' rules and how to include a 'pause' for patient choice. Also see Appendix 2 for specific questions on how to apply pauses.

7.8.5. Patients Requiring Thinking Time or Active Monitoring

An 18-week clock may be stopped where it is clinically appropriate to start a period of active monitoring in secondary care without clinical intervention or diagnostic procedures at that time.

If a long period of thinking time is agreed and a review date is also agreed then it is appropriate to place the patient on active monitoring .The 18-week clock would stop at the point the decision is made to commence active monitoring. The RTT status of 30 should be selected on discharge from iPM and a '' start added when the decision to treat is made after a period of active monitoring.

If the agreed thinking time is only a few days, for example, to consider if they would like to go ahead with the surgery then the 18-week clock should continue to tick.

See appendix 4 for national guidance on clock stops for 'non- treatment'.

7.8.6. Patients Unfit for Surgery

Patients who are not fit at the time of the decision to admit should not be added to the waiting list and returned to their GP for further management. In particular: -

- If they need to lose weight
- To manage hypertension
- Pregnant leading to an inability to undertake the procedure

Once a patient is referred back to the GP their 18-week clock stops. This should be recorded on iPM as RTT status 34 'Decision Not To Treat'. See appendix 4 for national guidance on clock stops for 'non- treatment'

Patients who require further specialist assessment and management should be referred to the relevant specialist.

Once fit and ready for surgery the patient can then be fast tracked to the pre-operative assessment service. Once deemed fit at pre-assessment the patient can then be added to the waiting list from that date. For GP fast tracked referrals, a new 18-week clock will start once a fast track referral is received. The pre-operative assessment will add an 18-week clock start outcome onto iPM.

7.8.7. Patients Not Available

The Department of Health 18-week clock rules state that an 18-week clock may be 'paused' only where a decision to admit for treatment has been made, and the patient has declined at least 2 documented reasonable offers for admission e.g. as they are not available due to holiday or other commitments. 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. The 18-week rules do not allow for a 'pause' for a diagnostic stage of a pathway.

A reasonable offer is giving at least 3 weeks' notice and 2 dates (except for diagnostics see 7.7.3). If a patient declines 2 reasonable offers the 'pause' is to be recorded on iPM using the suspended function with the reason recorded in the comments section. The dates of the reasonable offers declined will need to be recorded in the consultant diary if the date is agreed in clinic or by the waiting list office if the date is agreed with the waiting list staff. All reasonable offers must be logged in the waiting list comments field using the format RTCI DD/MM/YY

If a patient states they are unavailable for a set period of time before two reasonable dates for admission have been offered, the 18-week clock can be 'paused'. The clock should be paused from the earliest reasonable offer that the provider would have been able to offer the patient.

See Appendix 2 for specific questions on how to apply pauses.

7.8.8. Patients Awaiting Investigations

Patients may be fit and ready for the procedure but require an investigation to be completed in order to assist with the management of the patient whilst they are waiting. Such patients must be added to the waiting list as the investigation is not a deciding factor for surgery. When the investigation is required to determine whether a surgical procedure is necessary then the patient should not be added to the waiting list until the investigation has been completed.

7.8.9. Summary for Additions to Waiting List

- Only add patients to a waiting list when they have accepted Consultant advice for treatment
- Only add patients who are now ready to come in on the date the decision is made
- Ensure that all procedures and investigations are coded
- Do not add patients if they need to lose weight
- Do not add patients if they are unfit
- Do not add patients if they are not ready for the surgical phase of their treatment
- Do not add patients who require further investigation
- Do not add patients where there is no serious intention to admit them, for example, if they are not ready to be treated because they are pregnant at the time the decision to add to the list is made, because of procedural restrictions e.g. clinically prohibited procedures.
- If adding a patient to the waiting list for new or different treatment a new 18- week clock should start from the date the decision was made, for internal referrals the date will be the date the letter was typed.

- 'Low Clinical Priority' (LCP) procedure referrals should not be accepted until evidence of funding is provided by the GP practice. Where the Consultant is requesting the approval this should be done by email and a 4 day turnaround is expected.

7.8.10. Complex Waiting List Entries

Where the same surgeon will perform more than one procedure at one time, only one waiting list entry is required. Add the priority procedure code to the waiting list entry with additional procedures coded as secondary procedures.

Where different surgeons working together will perform more than one procedure at the same time only one waiting list entry is required. Add the patient to the waiting list of the consultant surgeon with a priority procedure with additional procedures noted. Where appropriate, shared care of responsibilities should be noted on iPM.

7.8.11. Offers of Admission

Where possible, patients should be offered a provisional date for treatment at the appointment where a decision to treat is made. The date of admission will be confirmed once a patient has been reviewed by the pre-operative assessment team and a letter of confirmation sent by the waiting list co-ordinator. If it is not possible to offer a date at the time of decision to treat, the elective co-ordinator will contact the patient by phone to offer a date and confirmation of the date will be sent by post.

The offers of admission should be confirmed in writing. All letters sent to the patient should be clear and informative. Each letter will include the job title and telephone number of a person who the patient can contact with any questions. The letter will explain clearly the consequences should the patient cancel the admission or fail to attend for pre-admission or admission at the designated time.

7.8.12. TCI (To Come In) - Letter to Patient

The admission or TCI letters sent to the patient must contain the following information:

- Patient name
- NHS number
- Date letter sent to patient
- Name of hospital for admission
- Date and time of admission
- Name of Consultant
- Where to report on arrival
- Response required from patient
- Named contact for queries relating to admission
- Reference to instructions for admission and/or booklet
- Request to check bed availability on day of admission
- Reasons for checking bed availability
- Information about the planned treatment
- Corporate information sheet must be sent with the patient information letter if patients are offered an appointment date immediately they are placed on the waiting list.

TCI letters should be sent out under the name of the Consultant/waiting list co-ordinators. Letters should be sent out using iPM or via PCS

Letters should clearly state what action the patient must take in order to confirm or decline their offer of admission. They should be requested to respond by telephone to a named department.

7.8.13. Patient Initiated Cancellations

This refers to patients who have agreed a reasonable offer of admission and subsequently cancel this admission date.

If a patient notifies the Trust that they cannot accept a previously agreed offer of admission, the admission date should be cancelled with the reason given as ‘cancelled by patient’. An RTT clock cannot be ‘paused’ because of a patient cancellation. However the rebooking process resulting from a cancellation may initiate the start of, or extension of a clock ‘pause’.

If at the rebooking stage the patient declines two or more reasonable offer then the RTT clock can be paused. The clock is paused from the earliest reasonable offer given. The offer must be recorded in the waiting list comments field using RTCI = DD/MM/YY

The patient should then be offered another date where possible within their 18- week target. If a patient subsequently cancels this date they are referred back to their GP.

7.8.14. Patients who Do Not Attend (DNA) for their Admission

If a patient DNA's either their pre-assessment appointment or admission, the waiting list co-ordinator is to check that the letter was sent to the correct address. If the contact details were incorrect, the patient should retain their place on the waiting list and another offer letter sent immediately to the correct address. The patient is to be given a date within their 18-week target date where possible.

The consultant should be made aware of patients who DNA a TCI by the waiting list co-ordinator. If the consultant decides that the patient should be removed from the waiting list, this should be done and the patient informed. A copy of the letter should be sent to the GP.

If the consultant decides that the patient should remain on the waiting list for medical reasons or complex social reasons (e.g. caring for a sick relative), the patient should be contacted by phone and a new TCI agreed this should be confirmed in writing and scheduled within their 18-week target where possible.

If it is not possible to contact the patients by telephone, a validation letter should be sent asking the patient to contact the Trust, if they fail to respond to the validation, they should be removed from the waiting list, informed by letter and a copy sent to their GP.

7.8.15. Hospital Initiated Cancellations

Whenever a hospital cancels an operation or procedure for non-medical reasons after the patient has been admitted or on the day of admission, the patient should be offered a re-arranged date within 28-days of their original TCI date or within their 18-week target if this is sooner. Every effort must be made not to cancel patients, particularly on the day of surgery. Should the hospital not be able to undertake this within its own facilities then an alternative admission should be arranged by the Trust with another NHS or private facility within the 28-day period, the cost of which will be borne by the Trust.

In the unfortunate event that a patient classed as urgent may have to be cancelled for any reason the Directorate Manager or On-Call Manager out of hours must be informed.

If the patient is cancelled for clinical reasons after they are admitted, the patient needs to be reviewed and either managed with corrective treatment or referred back to their GP for ongoing care.

Six weeks' notice must be given to Directorate Managers and Consultants of any changes or cancellation of theatre lists.

7.8.16. TCI Date Cancelled by Hospital in Advance

The patient will remain on the active waiting list and a new TCI date will be arranged as soon as possible within their 18-week target. The date will be agreed directly with the patient to avoid any further cancellation.

7.8.17. Re-instating a Patient onto a Waiting List

If the patient was removed from the list and the removal was later found to be a mistake, then the waiting list entry must be re-instated without prejudice. The patient must not breach the maximum waiting time.

If a patient has been referred back to their GP as they were unfit for surgery and are now deemed ready for surgery, they are to be fast tracked to pre-operative assessment and a new 18-week pathway will be started.

If a patient is removed for any other reason e.g., DNA and is re-referred direct to a waiting list, a new referral is to be created and a waiting list entry is to be added to this referral in order to start a new 18-week pathway.

7.8.18. Patients Who Relocate

A patient who physically relocates from one area to another will remain on a waiting list at the original hospital where the normal waiting time guarantee will apply. Alternatively the patient may be transferred to a new hospital and therefore removed from the waiting list. The original waiting time guarantee will no longer apply and the clock will therefore start again. The waiting time guarantee will apply from the date the patient is formally referred to NGH.

Patients who decide to pay their treatment to be carried out privately should be removed from the waiting list and a confirmation letter sent to the patient with a copy to the GP and a copy in the hospital notes.

7.8.19. Private Patients

No NHS patient should be cancelled, delayed or disadvantaged because of a private patient. The only exception is where there is a clinical priority for treatment and the private patient can only be treated at

7.8.20. Transfers between Waiting Lists Within The Trust

If transfer between consultants within the Trust takes place all existing waiting list entry details should be replicated in the new entry. If the transfer will result in treatment by a different consultant because of shorter waiting times, the patient has the right to refuse the

transfer. If the patient declines the transfer this will be considered a decline of a reasonable offer and a 'pause' can be recorded as per section 7.8.7. If the transfer is due to a Consultant leaving or retiring, the waiting list entry can be transferred without consulting the patient. All reasonable offers must be logged in the waiting list comments field using the format RTCI DD/MM/YY

7.8.21. Transfers between NHS Providers

Transfers from the host Trust to alternative providers for treatment must always be managed with the consent of the patient and the GP. If a patient does not wish to be transferred, the original provider must ensure that the patient is admitted for treatment within the maximum waiting time.

An offer of another provider cannot be classed as reasonable unless the patient has first accepted the opportunity to be treated elsewhere.

Once all have agreed the transfer, then the patient may be removed from the Trust's waiting list when confirmation has been received that the Consultant at the new provider has accepted the patient.

For all transfers to other Trusts an 18-week 'Inter Trust Transfer' form must be completed recording the 18-week start date and 18-week clock status.

Under the NHS constitution, patients have the right to request to be transferred to another organisation for their treatment if a Trust is unable to offer their treatment within 18 weeks. Any patients transferred as a result of this request will continue to be monitored on the 18 week pathway.

7.8.22. Transfers to Private Providers

Patients may be offered the opportunity for treatment at a private or independent hospital to shorten their waiting time.

The transfer must always be with the consent of the patient.

The patient has the right to refuse transfer, and remain on the Trust's waiting list with no change in status.

If the patient and GP agree to the transfer, the patient remains on the Trust's waiting list throughout the process. Once admitted and treated the transactions will be carried out in the normal way on iPM. The Trust remains responsible for ensuring treatment is delivered within the national waiting time.

7.9. Cancer

The cancer waiting times service standards are:

Maximum two weeks from:

Urgent GP (GMP or GDP) referral for suspected cancer to first outpatient attendance [***Operational Standard of 93%***];

Referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment [***Operational Standard of 93%***]**;**

Maximum one month (31 days) from:

Decision to treat to 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 recurrence where the subsequent treatment is:

Surgery [***Operational Standard of 94%***]

Drug treatment [***Operational Standard of 98%***]

Radiotherapy [***Operational Standard of 94%***]

Maximum two months (62 days) from:

Urgent GP (GMP or GDP) referral for suspected cancer to first treatment (62 day classic) [***Operational Standard of 85%***];

Urgent referral from NHS Cancer Screening Programmes (breast, cervical and bowel) for suspected cancer to first treatment [***Operational Standard of 90%***];

Consultant upgrade of urgency of a referral to first treatment

Maximum one month (31 days) from urgent GP referral to first treatment for children's cancer, testicular cancer, and acute leukaemia

7.10. Outpatient Access - Cancer

All suspected cancer referrals received on the two week wait referral forms will be seen within 14 days by an appropriate clinician with the shortest waiting list according to the agreed protocols.

To meet required NHS standards cancer referrals must be seen by a specialist within 14-days of the receipt of referral**.** To help ensure that we achieve this, referrals from General Practitioners will be by: -

- Referral protocol only
- They will be sent to the hospital via Choose and Book and actioned immediately
- Staff monitoring the fax/Choose and Book will ensure that a date within the next two-weeks is immediately offered to the patient
- All patients contacted by telephone will be asked to confirm their acceptance of the appointment offered
- A letter confirming the appointment will be sent to the patient. Confirmation of the appointment will also be sent to the GP

- If a patient declines the first appointment offered the next available appointment will be offered to the patient. The 14-day clock continues from the receipt of the original referral.

The 2ww staff will input the 2ww appointment details onto the Somerset Cancer Register.

The quality of suspected cancer referrals needs to be subject to regular audit with appropriate feedback to individual General Practitioners and the Clinical Commissioning Groups. If there is evidence of training needs in General Practice in relation to cancer symptoms or that this route is being abused to secure fast-track appointments for inappropriate referrals, the correct response must be agreed with the Clinical Commissioning Groups.

For two-week wait suspected Cancer referral, a reasonable offer is any appointment within two-weeks of receipt of the referral.

7.10.1. DNA - Waiting time adjustment reason (first seen)

Any 2-week wait suspected cancer referrals who DNA their first appointment will be offered a second appointment. The two-week wait clock starts again from the time the booking team is notified of the DNA. A patient will be offered an appointment following 2 DNAs. If a patient DNAs a third appointment they will be referred back to their GP. Patients who DNA will be contacted by telephone to agree a further appointment.

The waiting time adjustment is only available to patients that DNA.

7.11. Diagnostic Waiting Lists Access – Cancer

7.11.1. Addition to Diagnostic Waiting Lists

This section refers to the diagnostic waiting lists that are not covered by inpatient and day-case waiting list management. Patients referred for diagnostic procedures e.g. Radiology investigations etc., should be given an opportunity to negotiate an appointment time.

Each department will have a procedure for logging requests for diagnostic tests and for adding them to a diagnostic waiting list. Telephone numbers including mobile and home number, must be available on the request form. Where possible, departments will identify a process whereby a patient can come straight from their outpatient appointment when it was agreed to refer for a diagnostic test, to the relevant department to book a provisional appointment.

If patients do not attend a department to book their test, they will be contacted by phone to arrange an appointment. If a patient is not available on the phone an appointment will be sent in the post.

All appointments will be booked within the target of 4-weeks from the date of request. Diagnostic tests covered by the day-case waiting list management section of the policy e.g. Endoscopy and Cystoscopy will need to be carried out within 4-weeks.

All requests for radiology test are to be made via ICE. ICE is a local requesting system that provides a web-based service that enables electronic requests to be made. This system can only be accessed via the NHS N3 network allowing full demographic and clinical information to be available to the radiology department.

Any test requested that is not on ICE will be required to include the following minimum dataset:

- Surname
- Date of Birth
- Address
- Post Code
- Telephone number
- Mobile number
- Referral source
- Clinical history
- Examination required
- Request date
- NHS number
- Urgency
- 2ww status if appropriate

7.11.2. Reasonable Offer

Patients will be given at least 2 reasonable offers within the 4-week target. If a patient is unable to accept they will be referred back to the referring clinician to be sent back to the referring GP.

7.11.3. Did Not Attend (DNA)

If a patient DNAs a diagnostic appointment, the diagnostic department will re-check and confirm they have the correct patient details. If the details were not correct a new appointment will be made within 2-weeks of the DNA.

If the details were correct the department will refer the patient back to the referring clinician and the patient will be referred back to the GP if this does not compromise clinical care. A letter will be sent to the patient by the referring clinician stating that no further appointments will be made. A letter will notify the patients' G.P.

If it is considered (by the treating consultant) as clinically important for the patient to be seen, appropriate action should be taken. This could include communication with the GP, other Primary Healthcare team professionals, and directly with the patient. Issuing a further appointment without taking this step is not sufficient to ensure that proper care is delivered. A further request for a diagnostic test should include details of the action taken.

If a further diagnostic appointment is to be made and the patient is still on an 18- week pathway, this is to be made within 2 weeks of the DNA. If a patient DNAs the second appointment, they will be discharged back to their GP by the referring clinician and notified of this.

Patients referred directly from GPs for direct access diagnostics. If a patient DNAs a direct access diagnostic appointment, the contact details will be re-checked as above. If the details are correct the patient will be discharged back to the GP and the GP asked to contact the patient to confirm the test is required and to re-refer if the diagnostic test is required.

7.11.4. Cancellation of Appointment

Where possible, appointments will not be cancelled by the Hospital. In exceptional circumstances where this does occur, a further appointment will be booked within the 4-weeks maximum wait.

7.11.5. Admission for Diagnostic Test

Once the patient has been sent for a diagnostic test the department requesting the test must actively monitor the patient. If the test results are normal and no further treatment is required this must be communicated to the patient and the pathway updated appropriately.

7.12. Inpatient & Day Case Waiting Lists Access – Cancer

7.12.1. Active Waiting List

Patients will only be added to the active waiting lists that are fit, ready and able at the time of the decision to admit, and have agreed they need to undergo an Inpatient or Daycase procedure.

7.12.2. What is classed as a 'reasonable' offer?

It is any offer for an appointment between the start and end point of the 31 or 62 day period. This would effectively mean offering the patient the next available date of admission or an offer of admission consistent with their clinical need - the full definition of a reasonable offer can be found at the following web address:

http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/r/reasonable_offer_de.asp?shownav=1.

7.12.3. Summary for Additions to Waiting List

- Only add patients to a waiting list when they have accepted Consultant advice for treatment
- Only add patients who are now ready to come in on the date the decision is made
- Ensure that all procedures and investigations are coded
- Do not add patients if they need to lose weight

- Do not add patients if they are unfit
- Do not add patients if they are not ready for the surgical phase of their treatment
- Do not add patients who require further investigation
- Do not add patients where there is no serious intention to admit them, for example, if they are not ready to be treated because they are pregnant at the time the decision to add to the list is made, because of procedural restrictions e.g. clinically prohibited procedures.

7.12.4. Complex Waiting List Entries

Where the same surgeon will perform more than one procedure at one time, only one waiting list entry is required. Add the priority procedure code to the waiting list entry with additional procedures coded as secondary procedures.

Where different surgeons working together will perform more than one procedure at the same time only one waiting list entry is required. Add the patient to the waiting list of the consultant surgeon with a priority procedure with additional procedures noted. Where appropriate, shared care of responsibilities should be noted on iPM.

7.12.5. Offers of Admission

Where possible, patients should be offered a provisional date for treatment at the appointment where a decision to treat is made. The date of admission will be confirmed once a patient has been reviewed by the pre-operative assessment team and a letter of confirmation sent by the waiting list co-ordinator. If it is not possible to offer a date at the time of decision to treat, the elective co-ordinator will contact the patient by phone to offer a date and confirmation of the date will be sent by post.

The offers of admission should be confirmed in writing. All letters sent to the patient should be clear and informative. Each letter will include the job title and telephone number of a person who the patient can contact with any questions. The letter will explain clearly the consequences should the patient cancel the admission or fail to attend for pre-admission or admission at the designated time.

7.12.6. TCI (To Come In) - Letter to Patient

The admission or TCI letters sent to the patient must contain the following information: -

- Patient name
- NHS number
- Date letter sent to patient
- Name of hospital for admission
- Date and time of admission
- Name of Consultant
- Where to report on arrival
- Response required from patient
- Named contact for queries relating to admission
- Reference to instructions for admission and/or booklet

- Request to check bed availability on day of admission
- Reasons for checking bed availability
- Information about the planned treatment
- Corporate information sheet must be sent with the patient information letter if patients are offered an appointment date immediately they are placed on the waiting list.

TCI letters should be sent out under the name of the Consultant/waiting list co-ordinators. Letters should be sent out using iPM or via PCS

Letters should clearly state what action the patient must take in order to confirm or decline their offer of admission. They should be requested to respond by telephone to a named department.

7.12.7. Patient Initiated Cancellations

The patient should then be offered another date where possible within their target treatment date. If a patient subsequently cancels this date they are referred back to their GP.

7.12.8. Patients who Do Not Attend (DNA) for their Admission

If a patient DNA's either their pre-assessment appointment or admission, the waiting list co-ordinator is to check that the letter was sent to the correct address. If the contact details were incorrect, the patient should retain their place on the waiting list and another offer letter sent immediately to the correct address. The patient is to be given a date within their 18-week target date where possible.

The consultant should be made aware of patients who DNA a TCI by the waiting list co-ordinator. If the consultant decides that the patient should be removed from the waiting list, this should be done and the patient informed. A copy of the letter should be sent to the GP.

If the consultant decides that the patient should remain on the waiting list for medical reasons or complex social reasons (i.e. caring for a sick relative), the patient should be contacted by phone and a new TCI agreed this should be confirmed in writing and scheduled within their target date where possible.

If it is not possible to contact the patients by telephone, a validation letter should be sent asking the patient to contact the Trust, if they fail to respond to the validation, they should be removed from the waiting list, informed by letter and a copy sent to their GP.

7.12.9. Hospital Initiated Cancellations

Whenever a hospital cancels an operation or procedure for non-medical reasons after the patient has been admitted or on the day of admission, the patient should be offered a re-arranged date within 28-days of their original TCI date or within their target date if this is sooner. Every effort must be made not to cancel patients, particularly on the day of surgery.

Should the hospital not be able to undertake this within its own facilities then an alternative admission should be arranged by the Trust with another NHS or private facility within the 28-day period, the cost of which will be borne by the Trust.

In the unfortunate event that a patient classed as urgent may have to be cancelled for any reason the Directorate Manager or On-Call Manager out of hours must be informed.

If the patient is cancelled for clinical reasons after they are admitted, the patient needs to be reviewed and either managed with corrective treatment or referred back to their GP for ongoing care.

Six weeks' notice must be given to Directorate Managers and Consultants of any changes or cancellation of theatre lists.

7.12.10. TCI Date Cancelled by Hospital in Advance

The patient will remain on the active waiting list and a new TCI date will be arranged as soon as possible. The date will be agreed directly with the patient to avoid any further cancellation.

7.12.11. Re-instating a Patient onto a Waiting List

If the patient was removed from the list and the removal was later found to be a mistake, then the waiting list entry must be re-instated without prejudice. The patient must not breach the maximum waiting time.

7.12.12. Patients Who Relocate

A patient who physically relocates from one area to another will remain on a waiting list at the original hospital where the normal waiting time guarantee will apply. Alternatively the patient may be transferred to a new hospital; the original waiting time guarantee will still apply and any breach will be shared with the treating hospital.

7.12.13. Transfers to Private Providers

Patients may be offered the opportunity for treatment at a private or independent hospital to shorten their waiting time.

The transfer must always be with the consent of the patient.

The patient has the right to refuse transfer, and remain on the Trust's waiting list with no change in status.

If the patient and GP agree to the transfer, the patient remains on the Trust's waiting list throughout the process. Once admitted and treated the transactions will be carried out in the normal way on iPM. The Trust remains responsible for ensuring treatment is delivered within the national waiting time.

7.12.14. Waiting Time Adjustment (Treatment)

There is only one. A patient has to be offered a reasonable To Come In (TCI) date for admitted treatment (ordinary admission or day case) within the 31 or 62 day period. If the reasonable offer is declined the clock can be stopped from the date of the declined appointment (TCI date) to the point when the patient could make themselves available for admission again as shown

7.13. Access to Health Services for Military Veterans

Where secondary care clinicians agree that a veteran's condition is likely to be service-related, they are asked to prioritise veterans over other patients with the same level of clinical need. But veterans should not be given priority over other patients with more urgent clinical needs.

It is for clinicians to determine whether it is likely that a condition is related to service

Veterans are encouraged to tell their GP about their veteran status in order to benefit from priority treatment.

8. IMPLEMENTATION

The policy will be ratified by the Procedural Document Group and circulated to all areas of the Trust. Additionally the policy will also be available on the intranet and as a summary version.

It is the responsibility of the General/Department Managers and Clinical Directors to remove previous policy versions and to ensure all relevant staff receive the policy and are adhering to the latest ratified version.

Training on any aspects of the details within the policy is provided on request via the Information Department. There is also a suite of iPM reference documents available on the intranet (http://thestreet/ClinicalSystems/ClinicalSystems.aspx) [accessed 28 August 2014].

9. MONITORING & REVIEW

Minimum policy requirement to be monitored	Process for monitoring	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/ group/ committee for monitoring of action plan
Application of Policy & pauses	18 week walk through audits	Information Department	Monthly	Data Quality Steering Group	Relevant Specialty Lead	Data Quality Steering Group
	18 week standards Outside threshold trigger an audit/ training	Information Department	Weekly	Performance Meeting	Relevant Specialty Lead	Performance Meeting
	RTT Status Audit	Service teams	Monthly	Data Quality Steering Group	Relevant Specialty Lead	Data Quality Steering Group
	Clinic Outcome Sheet Audit	Information Department	Quarterly	Data Quality Steering Group	Relevant Lead	Data Quality Steering Group
	Internal Audit	Internal Audit	Annual	Chief Operating Officer	Chief Operating Officer	
	External Audit of	External Audit	Minimum every 3 years	Chief Operating Officer	Chief Operating Officer	
Application of Policy for Cancer	Internal Audit	Cancer Services	Quarterly	Cancer Steering Group	Head of Cancer	Cancer Steering Group

10. REFERENCES & ASSOCIATED DOCUMENTATION

Department of Health (2013) *The NHS Constitution: the NHS belongs to us all.* [online] London, DH Available from: http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf

Department of Health (2014) Referral to treatment consultant-led waiting tomes: rules suite. [online]. London, DH. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255582/RTT_Rules_Suite_April_2014.pdf [Accessed 17.6.14]

Department of Health (2011) *Review of cancer waiting times standards.* [online] London, DH. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213787/dh_123395.pdf [Accessed 17.6.14]

Health & Social Care Information Centre (n.d.) *Reasonable offer.* [online] Leeds, HSCIC. Available from: http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/r/reasonable_offer_de.asp?shownav=1. [Accessed 17.6.14]

National Cancer Intelligence Network (2012) *Cancer Waiting Times (CWTs): a guide.* [online] London, NCIN. Available from: http://www.nwlcn.nhs.uk/Downloads/Cancer+Intelligence/Going+Forward+on+Cancer+Waits+A+Guide+Version+7.0.pdf [Accessed 17.6.14]

National Health Service Reform and Health Care Professions Act 2002. (c.17) London, HMSO.

NHS Choices (2013) *Your rights in the NHS: guide to NHS waiting times.* [online] Available from: http://www.nhs.uk/choiceintheNHS/Rightsandpledges/Waitingtimes/Pages/Guide%20to%20waiting%20times.aspx [Accessed 17.6.14]

APPENDICES

Appendix 1 Access Policy Summary of Key Points

Appendix 2 18 week - RTT clock pauses - guidance 19.06.13

Appendix 3 18 week Clock Rules

Appendix 4 18 week Definitions

Appendix 1 Access Policy Summary of Key Points

1 How is the 18 weeks pathway measured?	
The 18-week pathway starts when a patient is referred to NGH and books their appointment through Choose and Book	
• For patients referred onto NGH from another Trust for their first treatment, the start date is the referral date to the original Trust.	
• The pathway stops when treatment starts in an outpatient clinic and is recorded on the 18-week clinic outcome sheets and on iPM or when a patient is admitted for their elective treatment or they are discharged from clinic without the need for further treatment.	
2 Booking a new outpatient appointment (Section 7.2 Access Policy)	
• GP referrals will be referred via Choose and Book except in areas where paper referrals are still being received e.g. dentists and optometrists.	
• All new referrals must have a **new** referral created. The 18-week clock starts from the referral date entered onto iPM.	Booking Team
• All referrals from other hospitals should have an Inter Trust Referral Form/Minimum Data Set (ITRF/MDS) attached. The start date logged onto iPM will be the start date on the ITRF. When the referral is received the clinic coordinator must log MDSYES or MDSNO in the referral comment. If MDSYES and the patient is on an active pathway they need to use the start date indicated on the form as referral received date with an added comment in the referral to record the date we actually received the referral.	Booking Team
• The referral information will be printed off the Choose and Book system and sent to consultants for review. These must be reviewed and returned to the relevant booking team within 5 working days.	Booking Team Clinician
• If the referral has not been returned within 5 working days the referral will default to an 'accepted' referral position.	Booking Team
• GP referrals will be pooled and booked onto the shortest list unless the referral needs to be seen by a sub specialist.	Booking Team
• All patients will be offered a choice of appointments where possible.	Booking Team
3 What is a reasonable offer? (Section 7.6.5 Access Policy)	
• A reasonable offer is an offer of an appointment with <u>at least</u> 3 weeks' notice up to a maximum of an 11 week wait. However patients can choose to accept an appointment earlier than 3 weeks	Booking Team
A reasonable offer can be Danetre or Northampton, however if a patient expresses a preference for one of the locations, the reasonable offer	Booking Team

POLICY

Appendix 1 Access Policy Summary of Key Points

must include this location.	Booking Team
• An offer of another provider cannot be classed as reasonable unless the patient has first accepted the opportunity to be treated elsewhere.	Booking Team
• Patients should be given a choice of 2 dates with at least 3 weeks' notice.	Booking Team
4 What if a patient declines or cancels an appointment? (Section 7.6.7 Access Policy)	
• If a patient declines a reasonable offer for a new appointment (up to an 11 week wait) and is therefore unavailable for 11 weeks or more, they will be referred back to their GP. A reasonable offer must include at least 2 offers with 3 weeks' notice.	Booking Team
• If a patient reschedules their appointment, they will be offered another date. The 18 week clock will continue from the original referral. At the time of rescheduling the patient will be informed they will not be able to reschedule their appointment again. Comment date declined must be added in either 'Dependant Resources' or 'Notes' on iPM using the comment DD (date declined) e.g. DD30.4.	Booking Team
• If a patient requests to reschedule a new appointment a second time, they will be referred back to their GP.	Booking Team Clinic Reception Clinician Medical Secretary
• All appointments that are booked using Direct Booking (DB) will be monitored by each booking team. If a patient cancels their DB appointment, they will be contacted by the booking team of that department and offered another appointment and informed if they cancel a second time they will be referred back to their GP. If patients request to reschedule their follow-up for a second time, they will be discharged back to the GP providing discharging the patient is not contrary to their best clinical interest.	
5 What if a patient does not attend their appointment? (Section 7.6.6 Access Policy)	Booking Team
5.1 First outpatient appointment DNA (7.6.6 Access Policy)	
• It is the responsibility of the booking team/ clinic staff to check the patient details of any patient who DNAs. If the details are incorrect (i.e. wrong address or patient was sent different appointments due to rescheduled or cancelled clinics) a new appointment must be offered as soon as possible within 2 weeks of the DNA by the booking team.	Booking Team Consultant
• If the details are correct and a consultant requests to see the patient, then a second appointment is to be sent to the patient by the booking team. The 18 week clock can be nullified by using the RTT outcome	Booking Team

Appendix 1 Access Policy Summary of Key Points

on iPM of 33 (DNA after 1st Act after initial referral) and a new adhoc clock start added to their referral on the date the Trust re-books the patient.	Clinic Reception Booking Team
• If the patient DNAs a second time, they are to be referred back to the GP.	
5.2 Follow-up appointment DNA (7.6.6 Access Policy)	Clinic Reception Booking Team
• If a patient DNAs a follow-up appointment, the team responsible for booking the follow-up appointment are responsible for checking the appointment was properly communicated, checking the contact details and checking the patient was not sent multiple appointment requests due to rescheduling.	Clinician Medical Secretary
• If the DNA was as a result of miscommunication-a new appointment will be sent and the 18 week clock continues	
• If an appointment was properly communicated a patient will be discharged back to the GP providing discharging the patient is not contrary to their best clinical interest. In order to check if it is not contrary to best clinical interest, the clinician must review the medical notes to decide if a further appointment is required.	Clinic Reception Booking Team Clinic Reception Booking Team Medical Secretary
• If a further appointment is to be made and the patient is still on an 18-week pathway, this is to be made within 2 weeks of the DNA.	Clinician
• If a patient DNAs the second appointment, they will be discharged back to their GP and notified of this.	
6 Clinic Management	Clinic Reception
• An outcome must be recorded for every patient who attends an outpatient appointment before the end of the clinic. This will be taken from the 18-week clinic outcome sheets. These are to be completed by the appropriate clinical staff for every outpatient attendance.	Clinician
• All patient appointments, attendances and cancellations must be fully completed on the iPM outpatient module by the clinic reception team.	W/L Coordinator Medical Secretary
7 Inpatient and Day Case Waiting Lists (Section 7.4-Access Policy)	
• Patients will only be added to the active waiting list if they are fit, ready and able at the time of the decision to admit. This decision is to be made by the clinician responsible for the patient.	W/L Coordinator
• Patients are to be offered reasonable notice, at least 2 dates with at least 3 weeks' notice.	W/L Coordinator Medical Secretary

Appendix 1 Access Policy Summary of Key Points

• No patient will be suspended on the waiting list for medical reasons. Long term unfit patients should be removed from the waiting list and returned to their GP with the proviso that they can be fast tracked back to the service via pre-op assessment once fit.	Clinic Reception Clinician W/L Coordinator
• Patients on the planned waiting list will normally have had previous treatment and are to receive further treatment as part of a planned sequence of care and are no longer on the 18-week journey for this particular pathway.	
• A new 18-week clock starts once a patient becomes fit for a second bilateral procedure. They should be added to the active waiting list and a clinic outcome that starts a new 18-week clock selected on the clinic outcome sheet at the clinic when a decision is made that the patient is fit for the bilateral procedure. These patients should not be added to a planned list.	Diagnostic Booking Clerk
• Dates must be given within the 18-week target (18 weeks from the referral date).	Diagnostic Booking Clerk
8 Diagnostics (Section 7.7-Access Policy)	
• All diagnostic tests are to be carried out within 4 weeks of request	
• Once a referral is received within a diagnostic department, the booking team are to book the patient within 4 weeks of the request being made, i.e. the date on the request card.	Diagnostic Booking Clerk
• A reasonable offer is a choice of at least 2 dates within the 4 week target.	
• Diagnostic tests admitted as a day case e.g. cystoscopies and endoscopies do not end an 18-week pathway. The 18-week pathway ends when the first treatment is started.	Diagnostic Booking Clerk
• If a patient declines a reasonable offer for diagnostic test the 4 week diagnostic wait can be paused and the suspend function can be used. The clock will be 'paused' from the earliest reasonable offer to the date the patient is available. This will be entered onto iPM using the suspended function by the waiting list coordinators. The 18 week clock however continues. There is no facility in the 18 week pathway guidance to pause a clock for a date declined for a diagnostic test.	Diagnostic Booking Clerk Clinician
• For patients attending a diagnostic test as an outpatient, not a day case, use the date declined comment. Date declined must be added in either 'Dependant Resources' or 'Notes' on iPM using the comment DD (date declined) e.g. DD30.4 to record if a patient has declined a reasonable offer. The 4 week clock restarts at this date.	Clinician
• If a patient DNAs, the team booking the diagnostic are to check the correct appointment was sent to the correct patient details. If not the appointment is to be rebooked within 2 weeks.	Clinician

Appendix 1 Access Policy Summary of Key Points

• If the details were correct, the diagnostic department are to send the request back to the original referrer to check if a further appointment is to be made. It is the responsibility of the referring clinician to decide if a further appointment is to be made. The 18-week clock is still ongoing.	Clinician
• If a further appointment is to be booked, the referrer must re-send the request card.	Clinician
• If a patient DNAs a second appointment they will be referred back to the requesting clinician.	Pre-op Clinic
9 Patients who are unfit for surgery (Section 7.8.6 Access policy)	Clinician
• If a patient is not fit for surgery they should not be added to the waiting list.	Pre-op Clinic
• For certain procedures, patients will be referred to one stop pre-op assessment from the outpatient appointment when a decision is made to admit and a provisional date for surgery is given.	W/L Coordinator Medical Secretary
• If a patient is medically unfit for surgery they will be referred back to their clinician and an 18-week clock stop outcome recorded on iPM at the pre-op clinic.	W/L Coordinator
• If a patient is medically unfit and needs specialist assessment and management they will be referred to the relevant specialist, the 18-week clock is still ongoing.	Medical Secretary
• Once a patient referred back to their GP is medically fit, they are to be fast tracked back to pre-op assessment. If fit, Pre-op assessment will inform the waiting list team who add the patient to the waiting list. The pre-op assessment team will record an 18-week clock start outcome to start a new 18-week clock.	W/L Coordinator
10 Reasonable notice for elective admissions (Section 7.8.7 Access Policy)	Clinician
• Patients are to be given at least 3 weeks' notice.	
• A reasonable offer is 2 appointments with at least 3 weeks' notice.	W/L Coordinator
11 What if a patient declines an offer of an admission date? Section 7.8.7 Access Policy)	W/L Coordinator Medical Secretary
• The 18-week clock can be 'paused' if a patient declines an offer of a reasonable date for admission. An offer of another provider cannot be classed as reasonable unless the patient has first accepted the opportunity to be treated elsewhere.	
• The dates of the reasonable offer must be recorded in the consultant diary or on the admission card, if used, for all dates offered and	

Appendix 1 Access Policy Summary of Key Points

declined in clinic. • The clock will be 'paused' from the earliest reasonable offer to the date the patient is available. This will be entered onto iPM using the suspended function by the waiting list coordinators. • If a patient states they are unavailable for a set time before two reasonable offers can be made, they pathway is to be paused from the date of the earliest reasonable offer to the date they are available again. All reasonable offer must be logged in the waiting list comments field using the format RTCI DD/MM/YY	W/L Coordinator Medical Secretary
12 What if a patient phones in to cancel a date of admission (Section 7.9.13Access Policy) • • If a patient notifies the Trust that they cannot accept a previously agreed offer of admission; the admission date should be cancelled with the reason given as 'cancelled by patient'. • An RTT clock cannot be 'paused' because of a patient cancellation • The patient should then be offered another date where possible within their 18- week target. If a patient subsequently cancels this date they are referred back to their GP.	W/L Coordinator Medical Secretary W/L Coordinator Medical Secretary
13 What if a patient becomes unfit for admission at short notice? (Section 7.8.6 Access Policy) • If the patient is unfit for surgery at short notice, e.g. with sickness or a cold then the admission will be cancelled and a new admission booked for when the patient is better and where possible within their 18 week target date. • If the patient becomes unfit for surgery for anything other than a short notice illness such as a cold or sickness then they are to be referred back to their GP and can be fast tracked to pre-op assessment when they are fit for their treatment as in point 9 above. The 18-week clock will be stopped once a patient is referred to their GP and a new clock started once they are referred back to pre-operative assessment.	W/L Coordinator Medical Secretary Clinician Medical Secretary Clinician
14 What if a patient DNAs their admission (Section 7.8.14- Access Policy) • The booking clerk is to check the letter was sent to the correct address. If the letter was sent to the incorrect address send a new TCI date within their 18-week target date. • If the consultant decides that the patient should remain on the waiting list, this should be done and the patient informed of a new TCI date within their 18 week target where possible. • If the consultant decides the patient is to be discharged. A letter should be sent to the patient and the GP.	W/L Coordinator W/L Coordinator

Appendix 1 Access Policy Summary of Key Points

	Booking Team
15 What if the Hospital cancels an admission? (Section 7.9.14 Access Policy) • If the hospital cancels an admission on the day of admission the patient should be given a new TCI within 28 days or within their 18 week target if this is sooner. • If the hospital cancels an admission prior to the patient being admitted the patient should be rescheduled prior to their 18-week target date.	Medical Secretary Clinician
16 What if a patient is referred from another provider? (Section 7.8.21 Access Policy) • If a patient is referred from another provider to NGH for their first treatment, the 18-week clock is ongoing from their referral to their original provider. It is the responsibility of the referring provider to inform NGH of the original 18-week referral date by completing an Inter Trust Transfer Form. All referrals from other hospitals should have an Inter Trust Referral Form/Minimum Data Set Form (ITRF/MDS) attached. When the referral is received the clinic coordinator must log MDSYES or MDSNO in the referral comment. If MDSYES and the patient are on an active pathway they need to use the start date indicated on the form as referral received date with an added comment in the referral to record the date we actually received the referral. This will be added to iPM as the referral date in order to calculate the clock from the original referral date.	Medical Secretary Clinician
17 What if a patient is referred to another provider? (Section 7.8.21 Access policy) • If a patient is referred to another provider from NGH for their first treatment, the 18-week clock is ongoing from their referral to NGH. It is the responsibility of the referring clinician to complete an Inter Trust Referral Form detailing the start of the 18 week pathway and if first treatment has commenced or not. This is to be sent with the referring letter.	

Appendix 2 18 week - RTT Clock Pauses

Patients will only be added to the active waiting lists that are **fit, ready and able** at the time of the decision to admit, and have **agreed** they need to undergo an Inpatient or Daycase procedure.

No patient will be 'paused' on the waiting list for medical reasons.
Long term unfit patients should be removed from the waiting list and returned to their GP with the proviso that they can be fast tracked back to the service via Pre-op once fit.
Outpatient appointments cannot be 'paused'.

The Department of Health 18-week clock rules state that an 18-week clock may be 'paused' only where a decision to admit for treatment has been made, and the patient has declined at least 2 documented reasonable 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 is available again for admission.

A reasonable offer of admission is defined as "an offer of a time and date three or more weeks from the time that the offer was made". Two or more reasonable offers should be made before a clock is 'paused'. The offers should be on different days rather than two slots offered on the same day. It is not appropriate to use a 'pause' for a patient who cannot commit to short notice. Patients can be offered an appointment at either NGH or Danetre Hospital (if services are provided at Danetre) with an appropriate consultant or member of the clinical team. If a patient declines an appointment at one location and expresses a wish to be seen at the other location, one of the reasonable offers should be at the location of their choice.

A reasonable offer for a diagnostic test is a choice of at least 2 dates within the 4 week target. If a patient declines a reasonable offer for diagnostic test the 4 week diagnostic wait can be 'paused' and the suspend function can be used. The clock will be 'paused' from the **earliest reasonable** offer to the date the patient is available.
The 18 week clock however continues. There is no facility in the 18 week pathway guidance to 'pause' a clock for a date declined for a diagnostic test.

A reasonable offer for cancer waits is an appointment within the target time.

If a patient states they are unavailable for a set period of time before two reasonable dates for admission have been offered, the 18-week clock can be 'paused'. The clock should be 'paused' from the **earliest reasonable** offer that the provider **would have** been able to offer the patient, i.e. 3 or more weeks.

RTT CLOCK PAUSE Q & A

- **Do we have to review current 'pauses' in line with the RTT 'pause' policy?**

Yes: All patients that are 'paused' on the current PTL must be validated to confirm compliance with current RTT policy.

- **What does the earliest reasonable offer mean?**

A reasonable offer of admission is defined as "an offer of a time and date three or more weeks from the time that the offer was made". Two or more reasonable offers should be made before a clock is 'paused'. The offers should be on different days rather than two slots offered on the same day. It is not appropriate to use a 'pause' for a patient who cannot commit to short notice. Patients can be offered an appointment at either NGH or Danetre Hospital (if services are provided at Danetre) with an appropriate consultant or member of the clinical team. If a patient declines an appointment at one location and expresses a wish to be seen at the other location, one of the reasonable offers should be at the location of their choice.

For example:

Patients seen in clinic on the 1st and added to the waiting list, the first reasonable offer would be the 22nd onwards. It is not appropriate to use a 'pause' for a patient who cannot commit to short notice.

- **What if we are unable to give 3 weeks' notice?**

No 'pause' is to be used and the patient needs to be escalated to your line manager or an agreed individual responsible.

- **What if we are unable to give 2 dates?**

No 'pause' is to be used and the patient needs to be escalated to your line manager or an agreed individual responsible.

- **How do we log declined TCI dates?**

These must be recorded in the waiting list comments field using:
RTCI DD/MM = (First Reasonable TCI offer)

- **Can we 'pause' from date of clinic?**

No: All 'pauses' should start from the date of the first reasonable offer. If no reasonable offer available you need to escalate to your line manager or an agreed individual responsible.

.

- **If a patient states they are unavailable for a set period of time (for example a patient who is a teacher who wishes to delay their admission until the summer holidays) before two reasonable dates for admission have been offered to the patient, is it still legitimate to 'pause' the clock?**

Yes. Where a patient makes themselves unavailable for admission for a longer period of time, then this may mean that offering actual dates which meet reasonableness criteria would be inappropriate (as the patient would be being offered dates that the provider already knew they couldn't make). In these circumstances, the clock should be 'paused' from the date of the **earliest reasonable** offer that the provider **would have** been able to offer the patient. Reasonable offers must be recorded in the waiting list comments field using: **RTCI DD/MM** = (First Reasonable TCI offer)

For example:

Patients holiday dates are 1st to 10th and the first reasonable offer would be the 11th, no 'pause' can be used. If the 1st reasonable offer date would have been the 5th a 'pause' can be used from the 5th to the 10th.

RTT CLOCK PAUSE Q & A continued

- **Should patients be added to the waiting list and 'paused' whilst waiting for a diagnostics test/scan?**

No: Patients should not be added to the W/L and then 'paused' for diagnostic tests. Patients should only be added to the active waiting lists that are fit, ready and able at the time of the decision to admit.

- **What if a patient phones in to cancel a date of admission?**

NB: Our current Access policy section 7.8.13 will be updated to reflect the National RTT policy below.

An RTT clock cannot be 'paused' because of a patient cancellation. However the rebooking process resulting from a patient cancellation may initiate the start of, or extension of, a clock 'pause'. If a patient has previously agreed to a reasonable offer date for admission for treatment which they subsequently cancel (prior to the admission date), the patient cancellation in its self **does not stop or 'pause'** the RTT clock. However as part of the rebooking process, the patient should be offered alternative dates for admission. If at the rebooking stage the patient declines two or more reasonable offers, then the RTT clock can be 'paused'. The clock is 'paused' on the date of the **earliest reasonable** offer given as part of the rebooking process. These must be recorded in the waiting list comments field using: **RTCI DD/MM** = (First Reasonable TCI offer)

- **What do we do if a patient cancels a previously 'paused' admission?**

If a patient's clock is already 'paused' (because they have previously declined two or more reasonable offers of admission for treatment) and the patient wishes to cancel their previously agreed admission date, then the patient's clock should still be 'paused' and the start of the 'pause' will remain unchanged (it will still be the **earliest reasonable** offer given as part of the original booking process). The end of the 'pause' will be the new date that the patient states they are now available from. This must be recorded in the TCI outcome comments field.

- **What if a patient phones in to cancel a date of admission and we have no dates to offer, where would the 'pause' start?**

The 'pause' can only be started from the date of the first reasonable offer**.** If no reasonable offer available you need to escalate to your line manager or an agreed individual responsible.

.

PLEASE REFER TO THE ADULT ELECTIVE ACCESS POLICY NGH - PO-263
The Street/Procedural documents/Type/Policy/Trustwide

18 WEEKS NATIONAL CLOCK RULES

Clock Starts

1. An 18 week clock starts when any health care professional or service permitted by the Primary Care Trust to make such referrals, refers to:

   - a *medical or surgical 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;

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

2. An 18 week clock also starts upon self referral by a patient, where these *pathways* have been agreed locally by commissioners and providers.

3. Upon completion of an 18 week *pathway*, a new 18 week clock only starts:

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

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

   - upon a patient being re-referred in to a *medical or surgical consultant-led; interface; or referral management service* as a new referral;

   - when a *decision to treat* is made following a period of *watchful waiting*.

Clock Pauses

4. A clock may be *paused* only where *a decision to admit* 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 first *reasonable offer* and the date from which the patient says that they are available.

Clock Stops

<u>Clock stops for treatment</u>

5. A clock stops when:

   - *First definitive treatment* provided by *an interface service* begins;

   - *Consultant-led first definitive treatment* begins;

   - 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;

   - *Therapy or healthcare science intervention* provided in secondary care or at an *interface service* begins, if this is what the *consultant-led* or *interface service*

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

Clock stops for 'non-treatment'

6. An 18 Week clock stops when it is communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay that:

It is clinically appropriate to return the patient to primary care for any *non-medical/surgical consultant-led* treatment in primary care;

- A clinical *decision* is made to embark on a period of *watchful waiting*;
- A patient declines treatment having been offered it;
- A clinical *decision* is made not to treat;
- A patient does not attend (DNAs) 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 and received by the patient[1];
- A patient *DNAs* any other appointment and is subsequently discharged back to the care of their GP, provided that:
    - the provider can demonstrate that the appointment was clearly communicated to and received by the patient;
    - discharging the patient is in their best clinical interests;
    - discharging the patient is carried out according to local, publicly available, policies on DNAs.

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.

[1] *DNAs* for a first appointment following the initial referral that started an 18 week clock nullify the patient's clock (i.e. it is removed from the numerator and denominator for Referral to Treatment time measurement purposes).

Appendix 4

18 WEEK DEFINITIONS

The aim of this document is to provide clear and unambiguous definitions of terms used where they have a particular meaning within the context of 18 Weeks.

18 Week pathway	The part of a patients' care following initial referral, which initiates a clock start, leading up to start of definitive treatment or other 18 Week clock stop point. It is recognised that a patient's care may start before and often extends beyond the 18 Week pathway
A	
Admission	The act of admitting a patient for a day case or inpatient procedure
Admitted pathway	A pathway which ends in a clock stop for admission
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	
Clinical decision	A decision taken by a clinician or other qualified health care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements
Consultant	A medical or surgical consultant is 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. 18 weeks applies to medical, surgical and dental consultants, but excludes non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.
Consultant-led	A medical or surgical 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	Unique Booking Reference Number. The act of a patient making a booking through Choose and Book
D	
DNA – Did Not Attend	DNA (sometimes known as an FTA – Failed to attend). In the context of 18 Weeks, this is defined as where a patient fails to attend an appointment/admission or gives less than 24 hours notice that they will not be able to attend
Decision to admit	Where a clinical decision is taken to admit the patient for either a daycase or inpatient procedure

Decision to treat	Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or daycase, but also includes treatments performed in other settings e.g. as an outpatient
F	
First definitive treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further invention. What constitutes First Definitive Treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient. Symptom specific suggestions for first definitive treatments can be found in the 18 Week commissioning pathways available from www.18Weeks.nhs.uk
Fit (and ready)	A new 18 Week 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	
Health 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.
I	
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 18 Week pathway target relates to hospital/consultant-led care. Therefore, the definition of the term 'interface service' within the context of 18 Weeks does not apply to similar 'interface' arrangements established to deliver traditionally primary care or community provided services, outside of their traditional (practice or community based) setting. 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 arrangements as described above.
M	
Medical Consultant	A consultant who treats diseases, illnesses or injuries through medication(s) as opposed to surgery. See also *Surgical Consultant*
N	
Non-admitted pathway	A pathway which results in a clock stop for 'non-

	treatment', or for treatment that does not require an admission eg: out-patient treatment or therapy.
Non consultant-led	Where a medical or surgical consultant does not take clinical responsibility for the patient.
P	
Pause/ clock pause	The act of pausing a patients' 18 Week clock. Clocks may only be paused where a patient chooses to wait longer for admission than 2 '*reasonable offers'* made by the provider
R	
Reasonable offer	Where a decision to admit, as either a daycase 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 when a patient has turned down 2 or more 'reasonable offers' of admission dates. *A reasonable offer* is an offer of a time and date 3 or more Weeks from the time that the offer was made. If the patient declines these offers and decides 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 the patient says they are available to come in.
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 having clinical discussions with general practitioner practices about good referral practice. In the context of 18 Weeks, a 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.
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	It is recognised that a patient's care often extends

treatment	beyond the 18 weeks 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 was not already planned a new 18 weeks clock should start at the point the 'decision to treat is made'. An example of this would be: "Patients attending regular follow-up out-patient appointments where a decision is made to try a substantively new of different treatment. In this context a change to the dosage of existing treatment may not count as substantively new of different treatment whereas a change to medication combined with a decision to refer for therapy would." The decision about whether the treatment is substantively new or different from the patients agreed care plan is one that must be made by the treating clinician in consultation with the patient.
Surgical consultant	A *consultant* who treats diseases, illnesses or injuries by operative manual and instrumental treatment and non operative methods. See also *Medical consultant*
T	
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 (e.g. hearing aid fitting) is the best way to manage the patient's disease, condition or injury and avoid further interventions;
Tolerance	We will define success by what our patients tell us, but patients' views need to be underpinned by measures of delivery that organisations can report and monitor progress on operationally. The measure of delivery for organisations that we will continue to judge progress against will be the monthly Referral to Treatment data for admitted and non-admitted patients. The tolerances for December 2008, to take into account other patient initiated delays and clinical exceptions, are 10% for admitted patients and 5% for non-admitted patients, making the operational standards 90% and 95% respectively.
W	
Watchful waiting/active monitoring	An 18 Week clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures. A new 18 Week clock would start when a decision to treat is made following a period of watchful waiting/active monitoring.

Where a clinical decision is made that 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 an 18 Week clock.

If a patient is subsequently referred back to a consultant-led service, then this referral starts a new 18 Week clock.

Northampton General Hospital NHS
NHS Trust

FORM 1a- RATIFICATION FORM - FOR COMPLETION BY DOCUMENT LEAD Note: Delegated ratification groups may use alternative ratification documents approved by the procedural document groups.	
DOCUMENT DETAILS	
Document Name:	Adult Elective Patient Access
Is the document new?	No
If yes a new number will be allocated by Governance	NGH-PO-263
If No - quote old Document Reference Number	N/A
This Version Number:	**Version: 4**
Date originally ratified:	February 2010
Date reviewed:	October 2014
Date of next review: a 3 year date will be given unless you specify different	**October 2017 (3 Years)**
If a Policy has the document been Equality & Diversity Impact Assessed? (please attach the electronic copy)	Yes
DETAILS OF NOMINATED LEAD	
Full Name:	Sean McGarvey
Job Title:	Head of Information and Data Quality
Directorate:	Corporate
Email Address:	sean.mcgarvey@ngh.nhs.uk
Ext No:	4670
DOCUMENT IDENTIFICATION	
Keywords: **please give up to 10** – to assist a search on intranet	18 weeks, RTT, cancer, access, waiting list, outpatient, diagnostic, pauses, DNA, inpatient

GROUPS WHO THIS DOCUMENT WILL AFFECT?
(please highlight the Directorates below who will need to take note of this updated / new policy)

Anaesthetics & Critical Care	Gynaecology	Medicine
Child Health	Haematology	Nursing & Patient Services
Corporate Affairs	Head & Neck - inc Ophthalmology	Obstetrics
Diagnostics	Human Resources	Oncology
Facilities	Infection Control	Planning & Development
Finance	Information Governance	Trauma & Orthopaedics
General Surgery		Trust wide

TO BE DISSEMINATED TO: NB – if Trust wide document it should be electronically disseminated to Head Nurses/ Dm's and CD's .List below all additional ways you as document lead intend to implement this policy such as; as presentations at groups, forums, meetings, workshops, The Point, Insight, newsletters, training etc below:

Where	When	Who
N/A		

Northampton General Hospital NHS
NHS Trust

FORM 2 - RATIFICATION FORM to be completed by the document lead

Please Note: Document will not be uploaded onto the intranet without completion of this form

CONSULTATION PROCESS

NB: You MUST request and record a response from those you consult, even if their response requires no changes. Consider Relevant staff groups that the document affects/ will be used by, Directorate Managers, Head of Department ,CDs, Head Nurses , NGH library regarding References made, Staff Side (Unions), HR Others please specify

Name, Committee or Group Consulted	Date Policy Sent for Consultation	Amendments requested?	Amendments Made - Comments
Julie Mason	12/5/2014	More explicit on Cons to Cons referrals.	Included a paragraph about none payment and put 'NOT' in bold.
Sue McLeod	12/5/2014	Make reference to LCP & section 7.1.1 state local and national waiting times.	LCP already in section 7.8.9 but also added to section 7.2.1.
Lorraine Warden	12/5/2014	Examples/clarify in the policy 2ww, 31 and 62 day breach targets.	Provided up to date link within document to CWT guidance document; explained complexity of CWT & specialist admin support only will input on this area. Overview was considered adequate.
Gillian Baxter	12/5/2014	Follow-up phone calls with letter, they do not use request cards ICE requests are protocol.	Added in that outpatient appts need to be confirmed in writing.
Mary Burt	12/5/2014	Typographical suggestions	Included majority of the suggestions
David White	12/5/2014	ICE protocol	Added in statement provided on ICE protocol

Existing document only - FOR COMPLETION BY DOCUMENT LEAD

Have there been any significant changes to this document? *if no you do not need to complete a consultation process*		YES / NO
Sections Amended:	YES / NO	**Specific area amended within this section**
Re-formatted into current Trust format	YES / NO	**Everything – re-written and restructured**
Summary/ Introduction/Purpose	YES / NO	
Scope	YES / NO	
Definitions	YES / NO	
Roles and responsibilities	YES / NO	
Substantive content	YES / NO	
Monitoring	YES / NO	
Refs & Assoc Docs	YES / NO	
Appendices	YES / NO	

Elective Patient Access Adult 2015
#NGh-PO-263

Area of Work
Operations

Person Responsible
Sarah Kinsella

Created
23rd February, 2015

Last Review
23rd February, 2015

Status
Complete

Next Review
28th February, 2018

Screening Data

What is the name, job title and department of the lead for this procedural document?

Debbie Needham, COO, Chief Operating Office

What are the main aims, objectives or purpose of this procedural document?

The purpose of this policy is to outline how we meet the values for all patients referred to Northampton General Hospital. The policy outlines the Trust and commissioner requirements for managing patient access to secondary and tertiary care services from referral to treatment and discharge back to primary care or to the patient's original referrer. The Trust will ensure that the management of patient access to services is transparent, fair, and equitable and managed according to clinical priority.Â The policy covers the processes for all stages of cancer and referral to treatment pathways including diagnostics and audiology.

Who is intended to benefit from this procedural document?

This policy is applicable to all members of staff responsible and or involved withÂ the management of the patient pathway from referral to discharge. This policy specifically identifies the rules and regulations in place with regards to RTT, cancer waiting times and diagnostic access and as well as upholding the NHS Constitution.

Is this a Trustwide, Directorate only or Department only procedural document?

Trustwide

Is there potential for, or evidence that, this procedural document will not promote equality of opportunity for all or promote good relations between different groups?

No

Is there potential for, or evidence that, this proposed procedural document will affect different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics - see below)?

Age

Disability

Gender Reassignment

Marriage & Civil Partnership

Pregnancy & Maternity

Race

Religion or Belief

Sex

Sexual Orientation

No

Recommend this EA for Full Analysis?

Yes

Rate this EA

Low

Impact Assessment Data

What impact does, or could, this procedural document have on the protected characteristic of AGE:

A negative adverse impact (i.e. could it disadvantage)
A positive impact (i.e. contribute to promoting equality and diverstity)
No impact (neither positive nor negative impact)

- Positive impact

  All patients will be treated in order of their clinical need regardless of age.

What impact does, or could, this procedural document have on the protected characteristic of DISABILITY:

A negative adverse impact (i.e. could it disadvantage)
A positive impact (i.e. contribute to promoting equality and diverstity)
No impact (neither positive nor negative impact)

- Positive impact

  All patients will be treated in order of their clinical need regardless of disability.

What impact does, or could, this procedural document have on the protected characteristic of GENDER REASSIGNMENT:

A negative adverse impact (i.e. could it disadvantage)
A positive impact (i.e. contribute to promoting equality and diverstity)
No impact (neither positive nor negative impact)

- Positive impact

  All patients will be treated in order of their clinical need regardless of gender reassignment.

What impact does, or could, this procedural document have on the protected characteristic of RACE:

A negative adverse impact (i.e. could it disadvantage)
A positive impact (i.e. contribute to promoting equality and diverstity)
No impact (neither positive nor negative impact)

- Positive impact

  All patients will be treated in order of their clinical need regardless of race.

What impact does, or could, this procedural document have on the protected characteristic of RELIGION OR BELIEF:

A negative adverse impact (i.e. could it disadvantage)
A positive impact (i.e. contribute to promoting equality and diverstity)
No impact (neither positive nor negative impact)

- Positive impact

  All patients will be treated in order of their clinical need regardless of religion or belief.

What impact does, or could, this procedural document have on the protected characteristic of SEX:

A negative adverse impact (i.e. could it disadvantage)
A positive impact (i.e. contribute to promoting equality and diverstity)
No impact (neither positive nor negative impact)

- Positive impact

  All patients will be treated in order of their clinical need regardless of sex.

What impact does, or could, this procedural document have on the protected characteristic of SEXUAL ORIENTATION:

A negative adverse impact (i.e. could it disadvantage)
A positive impact (i.e. contribute to promoting equality and diverstity)
No impact (neither positive nor negative impact)

- Posititve impact

  All patients will be treated in order of their clinical need regardless of sexual orientation.

What impact does, or could, this procedural document have on the protected characteristic of PREGNANCY AND MATERNITY:

A negative adverse impact (i.e. could it disadvantage)
A positive impact (i.e. contribute to promoting equality and diverstity)
No impact (neither positive nor negative impact)

- Positive impact

  All patients will be treated in order of their clinical need regardless of pregnancy or maternity, unless the pegnancy leads to an inability to undertake the procedure.

What impact does, or could, this procedural document have on the protected characteristic of MARRIAGE AND CIVIL PARTNERSHIP:

A negative adverse impact (i.e. could it disadvantage)
A positive impact (i.e. contribute to promoting equality and diverstity)
No impact (neither positive nor negative impact)

- Positive impact

  All patients will be treated in order of their clinical need regardless of marriage or civil partnership.

What consultation has taken place in relation to this procedural document?

Trustwide

Organisation Sign-off Data

Do you have any recommended actions?

Consideration should be given to ensuring that this document is made available in alternative formats to enable access for staff who may be not be able to access it in its current format.

If you have made any recommended actions have you advised the procedural document lead of these?

No

Next Review Date

2018-02-28

Outstanding Actions

No outstanding actions

FORM 3- RATIFICATION FORM (FOR PROCEDURAL DOCUMENTS GROUP USE ONLY) **Read in conjunction with FORM 2**			
Document Name:	**Adult Elective Patient Access**	**Document No:**	**NGH-PO-263**
Overall Comments from PDG re the Policy	**Why does this document only have one year on it?** **Changed to 2 years** SC met with SM and made amendments on 28th October 2014		
	YES / NO / NA	**Recommendations**	**Recommendations completed**
Consultation Do you feel that a reasonable attempt has been made to ensure relevant expertise has been used?	**YES**		
Title -Is the title clear and unambiguous?	**YES**		
Is it clear whether the document is a strategy, policy, protocol, guideline or standard?	**YES**		
Summary Is it brief and to the point?	**NO**	Add flowcharts refer to appendix 1 key summary	Not appropriate – OK/Accepted
Introduction Is it brief and to the point?	**NO**	Review the intro, purpose and scope use the scope information in the introduction	Track changes accepted and suggestion on combining scope and introduction. – small amendments had been made
Purpose Is the purpose for the development of the document clearly stated?	**NO**	Review the intro, purpose and scope use the scope information in the introduction	Suggested line included and the rest deleted as suggested. – No changes could be seen (SC to meet and amend together) SC met with SM and made amendments
Scope -Is the target audience clear and unambiguous?	**NO**	Review the intro, purpose and scope use the scope information in the introduction	Done – No changes could be seen (SC to meet and amend together) SC met with SM and made amendments
Compliance statements – is it the latest version	**YES**		
Definitions –is it clear what definitions have been used in the	**YES**		
Roles & Responsibilities Do the individuals listed understand about their role in managing and implementing the policy?	**YES / NO / NA**	All Staff - Is this all staff? Who checks this information? Please clarify	Is All Staff, so no changes made – Further clarification required regarding 'ALL' staff (SC to meet and amend together) SC met with SM and made amendments
Substantive Content is the Information presented clear/concise and sufficient ?	**YES / NO / NA**	7.1.2 Clarify this point add	Line deleted – OK/Accepted
Implementation & Training – is it clear how this will procedural document will be implemented and what training is required?	**YES**	Does informal training taking place?	Line added in implementation and training section. – OK/Accepted
Monitoring & Review (policy only) -Are you satisfied that the information given will in fact monitor compliance with the policy?	**YES**		
References & Associated	**YES**	Review library references	Reviewed and adjusted –

Documentation / **Appendices**- are these up to date and in Harvard Does the information provided provide a clear evidence base? Are the reference provided using Harvard Referencing format?		comments and insertions in red and adjust as appropriate	OK/Accepted
Are the keywords relevant	**Yes/No/**		

Name of Ratification Group	Ratified Yes: Ratified No:	Date of Meeting: **16/10/2014**
PDG	**To Return to PDG**	
Name of Ratification Group	Ratified Yes: Ratified No:	Date of Meeting: