Nottingham NHS Treatment Centre

# Access Policy

## Management of patients accessing secondary care services

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|---|---|
| Name of Author | Administration Lead |
| Ratified By | Executive Board |
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### Revision History

| Version | Revision Date | Summary of Changes |
|---|---|---|
| V.4 | 25/06/2010 | Reviewed and amended to incorporate changes in access criteria and new legislation |
| Version 5 | 24/09/2010 | Reviewed and amended to incorporate changes in access criteria and new legislation |
| Version 6 | 30/04/2012 | Reviewed and amended to incorporate changes in access criteria and new legislation |
| Version 6.1 | 13/02/2013 | Removed last paragraph of 4.14.1 (24 hour or less process for DNA patients. Page 18 in line with Department of Health Referral to treatment consultant -led waiting times, Rules suite January 2012. |
| Version 7.0 | 01/06/2014 | Review of whole document to incorporate Standard Acute Contract |
| Version 8.0 | | Reviewed and amended to incorporate new guidance Independent Healthcare Advisory Service to ensure compliance for the treatment of Paediatric patients. |
| Version 9.0 | 30/11/2015 | Reviewed to ensure compliance with new RTT guidelines published on 1st October 2015 |

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|---|---|---|
| Version 10.0 | 20/03/2017 | Reviewed with the new CQUINS and accessible information |
| Version 11.0 | 01/10/2018 | Reviewed with PLCV,GDPR Overseas Visitor and Appointment Times |

**In developing this policy the following legislation has been duly considered:**

### Data Protection Act 2018

Data Protection issues have been considered with regards to this policy. Adherence to this policy will therefore ensure compliance with the Data Protection Act 2018 and internal Data Protection Policies Including General Data Protection Regulation (GDPR) GDPR is Europe's new framework for data protection laws – it replaces the previous 1995 data protection directive. Previous UK law was based upon this directive. It aims to give greater protection and rights to individuals

### Accessible Information 2017/2018

Accessible Information Standard has been considered with regards to this policy and our aims are to make sure that people who have a disability, impairment or sensory loss receive that they can access and understand, and any communication support that they need from our services is supplied.

### Diversity & Equality Policies

Equality issues have been considered with regards to this policy. Adherence to this policy will therefore ensure compliance with Equal Opportunity legislation and internal Equal Opportunity policies.

### Freedom of Information Act 2000

Freedom of Information issues have been considered with regards to this policy. Adherence to this policy will therefore ensure compliance with the Freedom of Information Act 2000 legislation and internal Freedom of Information policies.

### Health and Safety Act 1974

Health and Safety issues have been considered with regards to this policy. Adherence to this policy will therefore ensure compliance with Health and Safety legislation and internal Health and Safety policies.

### Human Rights Act 1998

The Human Rights Act 1998 has been considered with regards to this policy. Proportionality has been identified as the key to Human Rights compliance. This means striking a fair balance between the rights of the individuals and those of the rest of the community. There must be a reasonable relationship between the aim to be achieved and the means used.

### Race Relations Amendment Act 2000

The Race Relations Amendment Act 2000 has been considered with regards to this policy. Adherence to this policy means that the company will eliminate discrimination on the grounds of race and will promote race equality and good race relations.

### The Employment Equality (Age) Regulations 2006

Circle Healthcare acknowledges that the age profile of the United Kingdom and therefore the local community is changing. The company is committed to equality of opportunity both in service delivery and employment and we have made a commitment to promoting age diversity. Adherence to this policy means that the company will challenge the general acceptance of "ageism" in order to eliminate age stereotyping.

### The Mental Capacity Act 2005

Has been considered when developing this policy to ensure the guiding principles of the act are adhered to with reference to testing and assessment of capacity, consulting others and protecting the best interests of the patient. The Mental Capacity Act provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes it clear who can take decisions, in which situations, and how they should go about this. It enables people to plan ahead for a time when they may lose capacity.

## Table of contents

## Definitions overview

| Full Name | Abbreviation | Description |
|---|---|---|
| Clinical Commissioning Group | CCG | Group is made up of local GP consortiums |
| Business Day | | Business day constitutes 24 hours from when received, weekend days are not included. |
| Minimum Data Set | MDS | Required minimum data required to process requests |
| Did Not Attend | DNA | Patients who fail to attend an appointment |

# Section 1

# General introduction

The successful management of patients waiting for outpatient and Two Week Wait (2WW) Suspected Cancer appointments and elective treatment is the responsibility of the Sponsor to which the patient belongs. Commissioners must ensure that service agreements are established with sufficient activity to ensure that no patient waits more than the guaranteed maximum time. The Nottingham NHS Treatment Centre (NTC) recognises it has a responsibility to deliver this requirement on behalf of the Sponsors and a role in contributing to effective patient care. This is a comprehensive responsibility from receipt of a patient referral or Inter Provider Transfer (IPT) to the discharge of the patient to primary care or onwards to another provider.

In agreement with Commissioners this policy covers the management of patients 16 years old and over in an outpatient setting and over 18 years old for daycase. General Practitioners are aware to refer patients under 16 years of age to local providers of these commissioned services.

Treating patients and delivering a high quality, efficient and responsive service, as well as ensuring prompt communications with patients is a core responsibility of the (NTC) and the wider local health community.

The accuracy of data is paramount and as such, all transactions made in the Proxima Patient Administration System (PAS) will be performed by staff in accordance with this Access Policy (AP) and the supporting Standard Operating Procedures (SOPs). The most up to date versions of the AP will be accessible to staff and the general public.

The SOPs define the processes and procedures that the NTC will undertake to support the functions and achieve the desired outcomes of the AP. In essence, the AP sets the standards for referral management and the SOPs detail how they are achieved.

There is a detailed SOP document designed to support the NTC AP. This will be referenced within this document.

## 1.1. Executive summary

The length of time a patient needs to wait for investigation and treatment of a medical/surgical condition is an important quality issue. Waiting times are a visible and public indicator of the efficiency of NTC, its partners and Sponsors. Efficiency and quality are often the basis on which certain patients make the decision on their choice of care.

## 1.2. Policy statement

This policy has been developed in conjunction with the NHS Constitution, NHS Standard Acute Contract and the Cancer Reform Strategy. It provides guidance on how the 18 week rules and definitions and the Cancer pathway need to be applied operationally.

## 1.3. Scope of policy

This is an important document. It is intended for use by all staff in the NTC and is available to sponsors for information and guidance in managing patient pathways. It is expected that all staff involved in the treatment of patients and managing the patient process adhere to the AP and associated SOPs.

This policy defines those roles and responsibilities and establishes a number of good practice guidelines to assist staff with the effective management of patients requiring outpatient, diagnostics, inpatient and/or daycase treatment.

This policy is made available to patients as a published document, either on request or via the Circle website.

### 1.4. Aims and objectives

This policy aims to achieve the following:

- Ensures that all patients entering care pathways are part of a comprehensive set of management processes supported by robust Information Management and Technology systems (IM&T) to deliver the desired outcomes as defined in the NTC NHS Standard Acute Contract.
- Defines the roles and responsibilities of staff and establishes good practice guidelines to assist staff with the effective management of the patient pathway.
- Provide a practical and easy to follow 'guide' for those managing the day-to-day administration and clinical management of waiting lists. Although the document cannot predict every eventuality, common sense will be required for cases that fall outside the policy.

### 1.5. Special exemptions

Where the patient is content for their veteran status to be included, this should be clearly stated by GPs when drafting referral letters including, in their clinical opinion, that the condition may be related to military service.

Where a NTC clinician agrees that a veteran's condition is likely to be service-related, they are to prioritise the veteran where possible, but should not be given priority over other patients with more urgent clinical needs.

### 1.6. Overseas visitors

People who do not normally live in the UK are not entitled to use the NHS free of charge, regardless of nationality or whether they hold a British Passport, or have lived and paid National Insurance contributions and taxes in the country in the past.

Entitlement to free NHS treatment is based on residence status alone. NHS (Charges to Overseas Visitors) Regulations 2015 place a legal obligation on the provider/ facility to establish if people whom they are providing NHS hospital services to are not ‘ordinarily resident’ in the UK, establish if they are exempt from charges by virtue of the regulations and if they are not exempt, make and recover charge from them to cover the full cost of their treatment. This is not optional; no one in the organisation has the authority to waive the charge. Circle must not provide relevant services to a chargeable overseas visitor until the estimated full cost of treatment has been received up front, unless doing so would prevent or delay the provision of immediately necessary or urgent treatment.

All patients who have been identified as potential overseas visitors (i.e. who cannot show that they are lawfully and ordinarily resident in the UK) should be highlighted to the Overseas Manager before any appointment is allocated.

### 1.6a Welsh NHS

Responsibility for the NHS in Wales is devolved to the Welsh Government. This means that it is separate from the NHS in England. The existing cross-border protocol between England and Wales sets out an agreement for the care of patients.

The Advice from the Welsh Government and Department of health is that unless reasonable attempts to secure prior authorisation have been made the Welsh commissioners will not accept liability.

### 1.7. Key principles

- The Hospital Director (HD) is responsible for ensuring compliance to this policy within the contracted obligations detailed and its associated SOPs. It should be reviewed annually, in line with Information Standards Board (ISB) or upon receipt of any contractual change. These are then translated in the AP.
- The management of patients and their referral pathway will be equitable and transparent and communication with patients will be clear and concise to allow informed choices and decisions to be made.
- The AP describes and supports the relevant reporting requirements defined within the NHS Standard Acute Contract or agreed subsequently to ensure that Sponsors fulfil their obligations.
- This policy details how the NTC will manage patients who are waiting for treatment on an admitted, non-admitted and/or diagnostic pathway.
- This policy works within the Service Restriction Policy 2017 and we will obtain prior approval for the services that are detailed in this.
- NTC will work to ensure fair and equal access to services for all patients thereby giving priority to clinically urgent patients and treating everyone else in turn.
- NTC will work to meet and reduce the maximum waiting times set by the Department of Health for all groups of patients.
- NTC will negotiate appointment and admission dates and times with patients wherever possible.
- NTC will ensure that management information of all 18 week waiting lists and activity is recorded on the Proxima PAS.
- Achievement of the 18 week pathway will be monitored through Patient Tracking Lists (PTL), which measures the patient's length of wait.
- Monitoring of achievement of the Cancer Targets will be uploaded to the cancer waiting times (CWT) digital Cancer portal system.
- In most circumstances, patients should not be referred for acute services unless they are fit, ready and willing to access services within a maximum of 18 weeks.
- The polling ranges on the National NHS E-Referrals system (ERS) should be set at a relevant number of days/weeks that support delivery of the 18 week Referral to Treatment (RTT) pathway.
- The polling range for 2WW cancer referrals is set at 14 days in order to support the Cancer Targets.

### 1.8. Referrals

- NHS E-Referrals will be the referral method to ensure the patient receives choice of provider, date and time of first appointment.

- The Directory of Services (DoS) enables GPs to refer by consultant team, if requested by the patient. The NTC will accept referrals to a named consultant led team, as long as the referral is clinically appropriate.
- Referrals should be sent on the standardised referral pro-forma where these exist.

### 1.9. Private patients

Patients referred to NTC for an NHS service following a private consultation or private treatment will join the 18 week pathway at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list will be determined by the same criteria applied to NHS patients. Referrals or IPTs should clearly identify that this is a private patient transferring over to the care of NHS.

NTC also provides private healthcare covering a range of specialities and services for both self-funding and private medical insurance patients.

### 1.10. Roles and Responsibilities in managing the patient pathway

**The NTC Hospital Director** is accountable for the delivery of this policy and adherence to relevant Key Performance Indicators (KPI's) under the NHS Standard Acute Contract

**The NTC Head of Finance and Performance** is responsible for monitoring adherence to agreed national standards and coordinates the delivery of mitigating actions in instances where these are not being achieved.

**The NTC Operations Managers** support and advise the Hospital Director in all aspects of referral management.

**The Administration Lead** is accountable for operationally managing the systems in place to monitor the application of this policy and to ensure that patients are treated consistently and fairly in accordance with national guidance. He/she has accountability to manage the systems, processes and administration staff in accordance with this policy, supported by the SOPs. In particular, the Administration Lead is responsible for the following:

- Acts as a point of contact for external Sponsor enquiries (sometimes urgent).
- Ensures that the process of transferring patients to other providers is carried out appropriately.
- Ensures the management of systems for patient tracking, including where patients are delayed on the pathway but not rejected.
- Oversees the management of all administrative staff associated with the NTC, ensuring all staff receive the appropriate training and development to continually improve the patient experience.
- Defines staff competencies and provides access to training and development
- Supervises performance monitoring and audit reporting to ensure compliance to standards.
- Manages the review process of audit reports which monitor the patient pathway.

**The Registration and Referrals Co-ordinator (R&R)** is responsible for the following:

- Processes all referrals and IPTs received Via ERS and ensures registration onto the NTC PAS within **48 hours**.
- Manages referral Minimum Data Set (MDS) compliance, (i.e.) ensuring that all referrals received contain the obligatory minimum dataset required for treatment at the NTC, including checks against any age thresholds.
- Acts as a point of contact for external sponsor or GP enquiries, and ensures that patients progress smoothly on their pathway.

- Service Restriction Policy (SRP) R&R are responsible for obtaining approval for procedures with low clinical value form the local CCGs.

The Registration and Referrals team support and advise the Registration and Referrals Co-ordinator in the above.

**Gateway Co-ordinators**

- Manage all administrative staff associated with the gateway, except dedicated Cancer Patient Navigators.
- Define staff competencies relating to adherence to the AP and provide access to training and development.
- Work collaboratively with Clinical Leads to ensure all patients progress their pathway in a timely manner from referral receipt to an appropriately scheduled appointment.
- Supervise performance monitoring and audit reporting to ensure compliance to standards.
- Ensure that all patients are offered appointments in line with their clinical priority, scheduling urgent referrals prior to routine referrals.
- Ensure that session closure systems are in place and that outcomes are correct and up-to-date.
- Escalate any referral with a clinical priority that cannot be scheduled appropriately to the relevant Operations Manager.
- Manage capacity and demand for outpatient and daycase sessions.

**Senior Gateway Receptionists/Senior Gateway Booking Clerks**

- Work with the Gateway Co-ordinator to enable smooth and efficient patient pathways within the gateway.
- Support escalation (where necessary) to the Gateway Co-ordinator for advice.

**Booking Clerks**

Administer patient referrals and sequential treatment in accordance with this AP and its associated SOPs:

- Administer the patient pathway within PAS.
- Record any NTC or patient initiated cancellation/DNA and reschedule or refer patient back to GP as appropriate.
- Ensure that PAS reflects up-to-date, accurate information.
- Escalate any action diverting a patient from their pathway and agreed treat by date to their Gateway Co-ordinator to ensure appropriate action is taken.
- Ensure that Cancer Wait Records are created for all 2WW referrals received on the gateway.

**Gateway Receptionists**

- Provide a first point of contact for patients at the gateway reception, playing a key role in ensuring that the service runs smoothly and efficiently.
- Update patient information/data on PAS.
- Book follow-up appointments for patients, ensuring that they are provided with a choice of date/time in the clinically appropriate timeframe.
- Ensure all patients either leave with an appointment or information pertaining to the partial booking process
- Conduct the clinic closure process in accordance with the SOP.

**Information Co-ordinator & Information Clerks**

- Support the operational teams by providing staff with timely, accurate and appropriate information.
- Ensure that mechanisms are in place to collect data accurately according to the requirements of the Department of Health.

Produce and distribute the weekly Patient Tracking List (PTL) to the NTC HD. Medical Admin Lead

- Supports the Medical Admin staff in the production of letters and results for the consultants at the TC.
- Supports the Clinical Units with Medical Admin queries.
- Escalates any areas of concern to the Operations Managers.

**Medical secretaries**

- To provide efficient and high quality secretarial and administrative support to Consultants/Nurse Specialists and their teams.
- To ensure letters are sent out to the GPs in the agreed KPIs with the CCGs
- To work in close co-operation with staff and other health professionals to ensure a first class service.
- To be an active and supportive member of the department's administrative and clerical team.

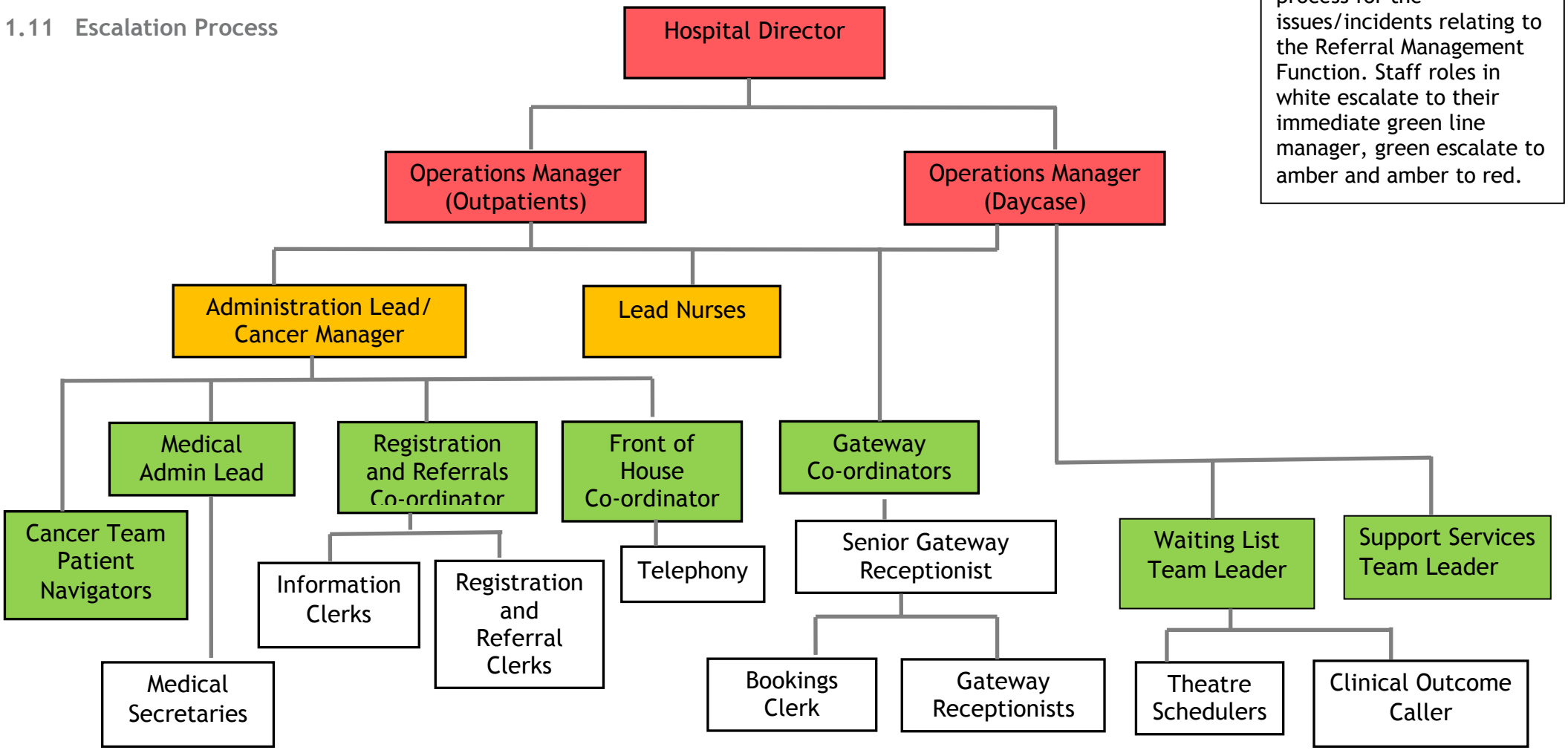
**The Cancer Services Manager** supports the 2WW patient pathway escalating any concerns to the Operations Manager.

**Cancer Services Patient Navigators**

- Ensures that the patient's pathway is tracked throughout their Cancer journey, co-ordinating hospital appointments, investigations and treatment within National Cancer Targets.
- Identify patients who may potentially breach the targets and take appropriate positive action with the clinical teams to negate this possibility.
- Provide updates on patient pathways at the weekly Health Community meeting and give details of any potential breaches that require action by the provider and clinical teams.
- Provide all root cause analysis (RCAs) for patients that have breached their 62 day target and, if over 104 days, ensure that Harm reviews are completed.

## 1.11 Escalation Process

**Escalation Process:**
The structural chart indicates the escalation process for the issues/incidents relating to the Referral Management Function. Staff roles in white escalate to their immediate green line manager, green escalate to amber and amber to red.



## 1.12 National priorities

**Targets for Patient Access**
With effect from October 2015, the RTT (Referral to Treatment) rules suite has been updated to reflect the removal of the provision to apply adjustments to RTT pathways for patient initiated delays.

All organisations are now measured against a 92% incomplete pathway operational standard.

**National Capacity Assumption**
NTC hold contracts with neighbouring trusts to provide contingency capacity as and when required.

## Section 2

## 18 week rules overview

The 18 week RTT pathway measures the patient's journey from the point of referral to the first definitive treatment.

The 18 week standard applies to elective pathways that may involve medical or surgical consultant-led care. The decision as to whether or not an 18 week clock is applicable to a pathway is dependent on who makes the referral and into what type of service.

The Department of Health 18 Week Rules & Definitions Policy provides further definition of the 18 week target and includes information on referrals that commence an 18 week clock and those that do not.

### 2.1. Sources of referral that commence an 18 week clock

An 18 week clock starts when a referral is made by any healthcare professional or service permitted by a Sponsor to make such referrals, either to:

- A consultant led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring healthcare professional or general practitioner.
- A referral management or assessment service, which may result in an onward referral to a consultant-led service before responsibility is transferred back to the referring healthcare professional or general practitioner.
- A waiting time clock starts upon a self-referral by a patient on to a consultant-led treatment pathway, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional permitted to do so. (NTC do not currently accept self-referrals).

***Note:*** *Referrals to a consultant-led service, undertaken by Nurse Specialists / Consultant and Allied Health Professionals are included in the 18 week pathway.*

All aspects of the patient pathway must be concluded within 18 weeks including investigations and diagnostics.

The "clock" stops at the point at which the patient receives their first definitive treatment or a clinical decision is made that treatment is not required.

### 2.2 Pathway definitions

An **Outpatient Pathway (Non-Admitted)** is a pathway that results in a clock stop for treatment that does not require an admission.

An **Admitted Pathway** is a pathway that ends in a clock stop for admission for treatment (daycase or inpatient).

#### 2.2.1 Clock stops

The 18 week clock stops when:-

- **First definitive treatment** - the clock stops on the date that the patient receives the first definitive treatment intended to manage their condition.

- **When a clinical decision is made that treatment is not required -** the clock stops on the date that the clinical decision is communicated to the patient.
- **For Day Case admission** - the clock stops on the day of admission, with the exception of patients that do not have their procedure carried out.
- **When a patient chooses to decline treatment** - the clock stops on the date that the patient declines treatment, having been offered it.
- **When a period of active monitoring is commenced -** the clock stops on the date that the clinical decision to commence active monitoring is made and is communicated to the patient.
- **When a decision is made to return the patient to primary care for non-medical/surgical consultant-led treatment -** the clock stops on the date that this is communicated to the patient.
- **When a clinical decision is made to add a patient to a transplant list** - the clock stops on the date they are added to the list.

### 2.2.2 Clock stops for DNAs

The 18 week clock stops when:-

- **A patient DNAs their first new appointment following the initial referral that started their 18 week clock**, the act of failing to attend their first appointment stops and nullifies the clock.(See 2.3 for clock information following clinical review of referral). Should the decision be made to refer the patient back to the GP/GDP, there needs to be evidence to show this is not contrary to their best clinical interest and the GP/GDP receives communication to such effect.
- **A patient DNAs their follow-up appointment and is subsequently discharged back to the care of the GP/GDP**, provided that discharging the patient back to primary care is not contrary to their best clinical interest and the GP/GDP receives communication to such effect. The clock stops on the day of the DNA appointment. Best endeavours will be made to re-arrange a follow-up with the patient following their DNA.

In both of the above scenarios, the provider must demonstrate clear communication to the patient via one of the below referral methods:

**NHS E-Referrals -** the patient will have their appointment booked by the Referrals Assessment Service (RAS) and will be sent a confirmation letter from the NTC.

### 2.2.3 Clock pauses

**Please note clock pauses do not apply to outpatients. Please see Patient Choice Section 6 (admitted pathway) for further details.**

### 2.3. New 18 week clock starts

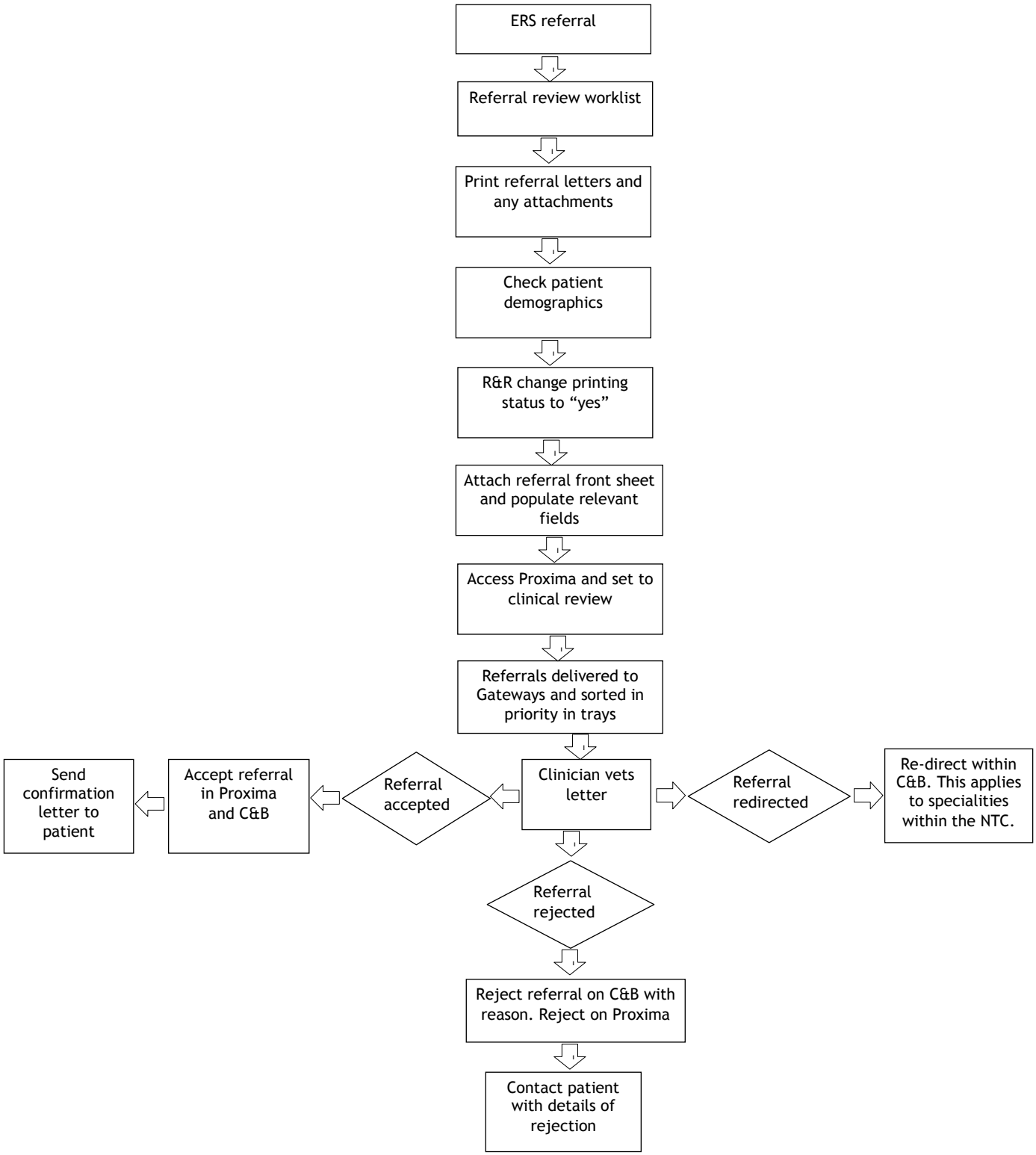
Upon completion of an 18 week pathway, a new 18 week clock starts:
When a patient becomes fit and ready for the second of a consultant-led bilateral procedure

- Upon the decision to start a substantively new or different treatment that does not already form part of the patient's agreed care plan.
- Upon a patient being re-referred into a medical or surgical consultant-led speciality or referral management service as a new referral.
- When a decision to treat is made following a period of active monitoring.
- When a patient DNAs the first appointment following the initial referral that started the 18 week clock and the clinician, upon clinical review, determines that the patient should be re-scheduled – the clock starts from the date of the clinical review by the clinician.

# Section 3

# The patient pathway

## 3.1. NHS ERS-referral pathway



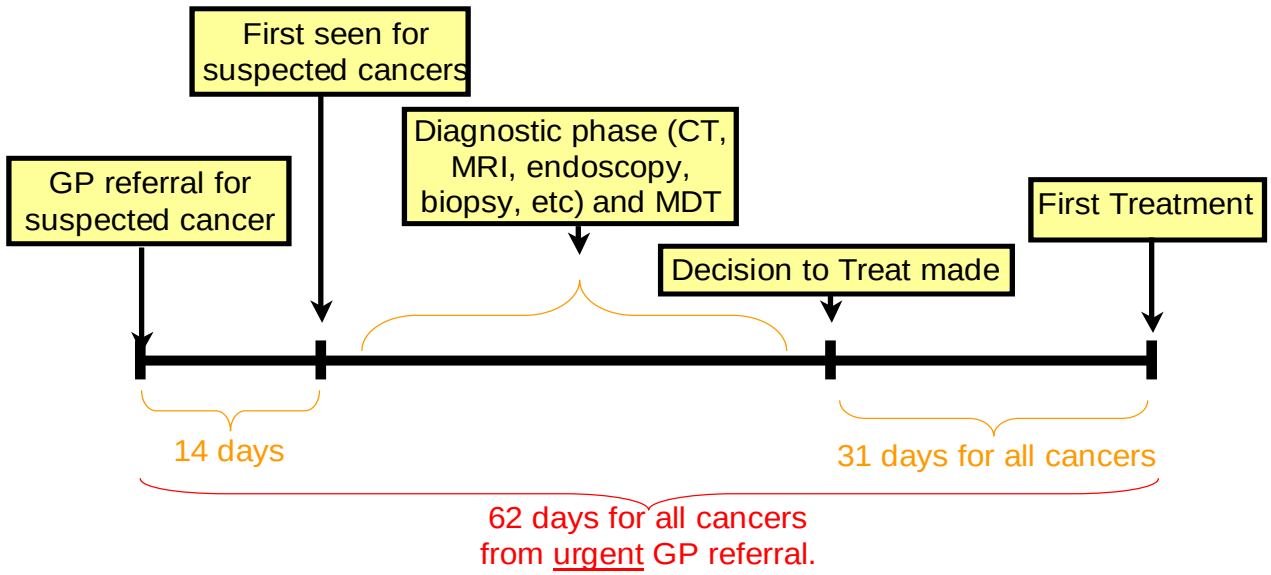
### 3.2 The cancer pathway

Within the National Cancer Plan (2000) and the Government Cancer Reform Strategy (2020) there are a number of commitments and targets relating to waiting times for treatment, as follows:

- 2WW 31 day standard - maximum one month wait from urgent GP referral (2WW) for suspected cancer to first definitive treatment for children's, testicular cancers and acute leukaemia.
- 31 day standard - maximum one month wait from diagnosis, Decision to Treat Date (DTT) to first definitive treatment for all cancers. The DTT is the date when the discussion regarding treatment options has taken place with the patient, NOT the outcome of the Multidisciplinary Team Meeting (MDT).
- 62 day standard - maximum two month wait from urgent GP referral for suspected cancer to first definitive treatment for all cancers.

In addition, there is also the existing two-week waiting time standard:

- 14 day standard - maximum two-week wait for an urgent GP referral for suspected cancer to date first seen (includes direct-to test as well as outpatient appointment) for all suspected cancers. The clock starts on the day after the referral is received.




### 3.3 Minimum data set (MDS) requirement

All referrals received by the NTC will have a fully completed MDS in accordance with Department of Health (DH).

### 3.4 Referral criteria for outpatient

The inclusion criteria for outpatient referrals include the provision of the following MDS items:

- The outpatient speciality for which the patient is referred.
- Name, date of birth, NHS number, full address (including postcode) and contact telephone number.
- GP/GDP's practice address.
- Any other relevant information including additional requirements such as communication, disability needs and transport requirements.
- The reason for the referral and the priority.

- Details of relevant medical history.
- Medication which the patient is known to be currently taking.
- Known allergies.
- The date of the referral.
- All relevant Clinical information specific to the tumour site that the GP is referring for.

In making a referral the relevant Sponsor will ensure that the referring body complies with the CQC's registration requirements.

### 3.5 Referral criteria for day surgery

**Internal service requests**

For patients who require a daycase procedure following an outpatient consultation at the NTC, the clinician will complete SRP form according to the SRP Policy for the referring CCG and a NTC daycase booklet, and must ensure that the procedure falls within the NTC casemix and that the patient meets the criteria outlined below for general or local anaesthesia.

**Inter-provider transfers (IPTs)**

For referrals to daycase surgery, the referring body will complete the NTC IPT form. The completed form must include the MDS devised by the DH. In addition, the referring body must ensure that the procedure falls within the NTC casemix and that the patient meets the following criteria outlined below for general or local anaesthesia.

**General anaesthetic**

- Have access to a telephone 24 hours a day.
- Have a responsible adult carer for 24 hours post procedure.
- Have a responsible adult escort home and suitable transport.
- Be ASA 1, 2, 3 stable.
- We currently do not have a limit on a patient's BMI but patients that have a higher than normal BMI (40 and above) are assessed on a case-by-case, individual risk basis.
- Not be on a drug regime that makes surgery unacceptable e.g. unstable diabetics requiring IV insulin infusions.
- Not live more than one hours drive away (an hour plus drive will be discussed with the anaesthetist).

**Local anaesthetic**

- Have access to a telephone 24hrs a day.
- Not be on a drug regime that makes surgery unacceptable e.g. unstable diabetics requiring IV insulin infusions.

Also recommended –

- Have a responsible adult carer for 24hrs post operation.
- Have a responsible adult escort home.

## Section 4

## Outpatients (Non-Admitted Pathway)

NTC offer named clinician functionality through NHS E-Referrals that gives referrers the opportunity to select the name of a particular consultant that they would like their patient to see. This may be a consultant that the referrer feels of value to the continuity of care for the patient. This option is only used when specifically required.

Routine practice is that referrals are made to a service rather than an individual. However, if it is stated in the referral that a patient wishes or has a clinical need to see a specific consultant, NTC will strive to ensure that this is achieved, wherever possible.

Generic referrals will ensure that there is an equalisation of waiting lists and that the maximum waiting time for all patients will be minimal in line with 18 Week and Cancer guidelines.

There are 6 recognised referral streams:

- Referrals via Choose & Book (ERSNHS E-REFERRALS)
- Consultant to Consultant (in line with CCG policy)
- Inter-Provider-Transfers (IPTs)
- Suspected Cancer referrals (2WW)
- Onco- Alert –notification of incidental find of cancer

### 4.1 Referrals via NHS E-Referrals

The 18 week clock starts from the point at which the Unique Booking Reference Number (UBRN) is converted. If the referral has come through an interface service on ERSNHS E-Referrals using a linked UBRN, the 18 week clock starts on the date of the first UBRN conversion, not the date that the patient books their appointment in secondary care.

If there are no slots showing when either the referrer or patient attempts to book an appointment within the GP practice, the Telephone Appointment Line (TAL), via the patient, via the interface or web application, within their chosen service, or a technical error occurs, the request can then be deferred to the provider. The patient's details will then appear on the Appointment Slot Issue (ASI) work list. All patients whose details have been sent to the NTC will be contacted to arrange a convenient date for their first appointment within 4 days of notification.

**Three attempts** should be made to contact the patient by telephone (two daytime and one after 5pm); if gateway staff are unable to contact the patient by telephone by the end of the second working day following receipt of the ASI, they should send a letter to the patient asking the patient to contact them to arrange their appointment.

Where gateway staff are unable to book ASIs received via ERSNHS E-Referrals, the following escalation mechanism will be used to ensure that all referrals are booked promptly and effectively:

The Gateway Co-ordinators will reactively instigate one or more of the following actions in conjunction with the clinical unit:

- Extend the polling range.
- Organise an additional (ad hoc) clinic.
- Reinstate a previously cancelled clinic (organise additional cover).

- Convert the ratio of New/Follow-ups accordingly (in specific clinics).

### 4.2. Paper GP referrals

Paper referrals are not received by the NTC, they must use the EERS referral system and, the 18 week clock will commence at the point that the referral is when the UBRN is converted.

### 4.3 Consultant to consultant referrals

For consultant to consultant referrals, the policy outlined by the CCG will be followed. **(Please see Appendix A).**

### 4.4 Inter-provider transfers (IPTs)

Referrals received from another provider will keep the clock start of the original referral as this is a continuation of the same treatment pathway. All 18 week information will be included in the IPT.

### 4.5 Suspected cancer (2WW) referrals

Day zero of the 14-day clock starts on the day the referral is received by NTC.

### 4.6 Suspended outpatients

In line with 18 week guidance, patients on an outpatient waiting list cannot be suspended.

### 4.7 Receipt and registration of referrals

All referrals will come via ERS and will be registered on PAS within 48 hours. This includes those referrals that may have an incomplete MDS.

Any missing NHS numbers will be sourced from the NHS E-Referral system to avoid unnecessary delay in processing the referral. Any further information required to complete the MDS will be requested.

After **three business days**, any referral that cannot be accepted will be escalated to the Registration & Referrals Co-ordinator. A resolution will be sought with the referrer within two business days, which the Registration & Referrals Co-ordinator will lead. If no resolution is concluded, the referral will be rejected on Proxima and returned to the originating referrer.

All referrals are categorised according to the priority status identified by the referrer prior to internal clinical review.

Any referral created and attached to a patient within PAS will be legitimate and, as such, a patient will not have a duplicate entry of the same referral for the same pathway entered on Proxima.

### 4.8 Advice and guidance

Advice and Guidance is an ERSNHS E-Referrals functionality that allows one clinician to seek advice from another.

Upon receipt of a request, the Gateways will liaise with the relevant clinician and ensure a response is provided within 2 working days (As per CQUIN 2017/19).

### 4.9 Rejected referrals in NHS E-Referrals

All rejected referrals, and the reasons for them, will be recorded on PAS and ERSNHS E-Referrals within 24 hours of the decision to reject.

The gateway administration staff will ensure that the patient is telephoned to confirm that their referral is rejected and the RTT clock will be stopped. This will be confirmed by a letter to the GP and patient.

Suspected Cancer (2WW) referrals cannot be rejected without prior communication from the clinician to the patient's GP.

### 4.10 Rejected consultant referrals

All rejected consultant referrals, and the reasons for them, will be recorded on PAS within 24 hours of the decision to reject.

The gateway administration staff will ensure that the patient and GP are telephoned to confirm that the patient's referral is rejected and the RTT clock will be stopped. This will be confirmed by a letter to the GP and patient.

Suspected Cancer (2WW) referrals cannot be rejected without prior communication from the clinician to the patient's GP.

### 4.11 Clinical review

All routine and urgent referrals received by the NTC will be clinically reviewed to establish appropriateness of referral as follows:

- 2WW patients will be seen and treated in accordance with the National Cancer Strategy.
- Routine/urgent patients will be seen and treated in accordance with national 18 Weeks guidance.
- Where the condition relates to a period of service in the Armed Forces, the veteran should receive priority treatment subject to clinical need. However this does not prioritise veterans over someone with a greater clinical need.

### 4.12 Patient information

All new patients (including ERSNHS E-Referrals), regardless of their method of booking must be sent:

- A letter confirming the time, date and location of their appointment.
- Patient Guide.
- Patient Information Sheet.
- Any additional information which is required for their appointment, such as health questionnaires.

### 4.13 Scheduling

The scheduling of patients' appointments will be undertaken in accordance with both clinical and chronological prioritisation in line with national and local targets. Specifically, the NTC will conform to 18 week guidelines as detailed by the Sponsors to ensure that the NTC manage the patient pathway appropriately. The following stages will be adhered to.

#### 4.13.1 Generation of a service request

From an accepted referral within PAS, one or more legitimate service requests will be assigned. Each service request will be raised within 48 hours of acceptance of the referral and an appointment attached to it. The patient will be offered choice of appointment if the referral was not created via ERSNHS E-Referrals, where choice would have already been offered.

### 4.13.2 NHS E-Referrals
Patients who have been referred through ERSNHS E-Referrals will have already booked their appointment.

### 4.13.3 Unavailability of appointments
If an appointment is not available, the gateway administration staff should escalate the capacity issue to their Gateway Co-ordinator, to ensure that all legitimate service requests have an agreed appointment allocated within the correct timeframe.

### 4.13.4 Reasonable offers
For written and verbal offers of an appointment or admission to be reasonable, the following waiting time guidance should be followed for referrals that have **not** come through ERSNHS E-Referrals:

- For a **written** appointment to be deemed reasonable, the patient is to be offered an appointment with a **minimum** of **three weeks'** notice.
- For a **verbal** appointment to be deemed reasonable, the patient is to be offered an appointment with a **minimum** of **two weeks'** notice with a minimum of **three** different dates
- If a patient chooses to accept an appointment that is earlier than the **three** weeks' notice, this is still deemed reasonable.

Cancer Waiting Times guidance remains unchanged.

### 4.13.5 Patient choice / deferral
In line with RTT guidance, there are no blanket rules that apply to a maximum length to patient initiated delays. Clinicians should provide booking staff with guidelines as to how long (in general) patients should be allowed to defer their treatment without further clinical review.

Patients who request a delay longer than this should have a clinical review to decide if this delay is appropriate. If the clinician is satisfied that the delay is appropriate then we shall accommodate the delay, regardless of the length of wait reported.

If the clinician is not satisfied that this delay is appropriate, then the clinical risks should be clearly communicated to the patient and a clinically appropriate TCI date agreed.

If the clinician feels that it is in the best clinical interest of the patient to discharge the patient back to the care of their GP and inform them that treatment is not progressing then this must be made clear to the patient.

### 4.13.6 Active monitoring
A clinical decision can be made to start a period of active monitoring.

There will be times when the most clinically appropriate option for a patient is that they are actively monitored over a period of time, rather than undergoing any further tests, treatments or other clinical interventions at that time. When a decision to commence a period of active monitoring is agreed with and communicated to the patient, this stops a patient's 18 week clock.

Stopping a patient's clock for a period of active monitoring requires careful consideration on a case-by-case basis and its use needs to be consistent with the patient's perception of their wait.

#### 4.13.7 Verbal contact with the patient

Gateway administration staff will attempt to contact new patients whose referrals have not come through ERSNHS E-Referrals and follow-up patients via telephone on **three consecutive occasions** (i.e. two day time calls and one after 5pm) to arrange a convenient appointment.

NB: **this is dependent upon the speciality and volume of patients.**

#### 4.13.8 Non-Verbal contact with the patient

**New and follow-up patients:** If gateway staff are unable to contact the patient by telephone, they should send a letter to the patient by first class post asking the patient to contact them to arrange their appointment.

Any patient due a follow-up appointment after their consultation will have their appointment partially booked. Six weeks before the appointment is due, a letter will be sent to the patient requesting they contact the NTC to arrange a convenient appointment.

If no contact has been made by the patient after three weeks, the NTC will attempt to contact the patient via telephone on three occasions. If this is unsuccessful then it is passed for clinical review and a decision is made as to whether the patient is discharged back to the care of their GP.

NB: this is dependent upon the speciality and volume of patients.

### 4.14 Appointment letter

As soon as an appointment date has been booked, an appointment letter will be created on PAS and sent as confirmation. The letter is an audit trail of the arrangements and will contain the following core details:

- Patient's name.
- Date letter sent to patient.
- Date and time of appointment.
- Where to report on arrival.
- Contact number for queries relating to the appointment.
- Name of the clinician who is responsible for the clinic that they are booked into.

### 4.15 Patient initiated cancellations

Patients who change their appointment should, if possible, be given an alternative date at the time of change. The amended appointment and all dates offered or declined are recorded on the appropriate service request on PAS to give a complete audit trail, both on the system and in the patient record.

Patients referred for suspected cancers should not be referred back to their GP unless the referral has been reviewed by a clinician and discussed with the patient and/or the GP.

#### 4.15.1 Patient initiated cancellations for new appointments

If a new patient needs to cancel their appointment, they must be available to accept another reasonable offer in line with their pathway, as outlined in 4.12.4.

#### 4.15.2 Patient initiated cancellations for follow-up appointments

If a follow-up patient needs to cancel their appointment, it must be rescheduled in line with the 18 Week treat-by date, where applicable.

### 4.16 NTC initiated cancellations for non-clinical reasons

**NTC Initiated Cancellations for new patients**

Patients whose appointments are cancelled by the NTC for non-clinical reasons will be rescheduled in line with their 18 week treat-by date.

**NTC Initiated Cancellations for follow-up patients**

Patients whose appointments are cancelled by the NTC for non-clinical reasons will be rescheduled in line with their 18 week treat-by date

### 4.17 Monitoring of cancellations

NTC initiated cancellations will be monitored by the Gateway Co-ordinators, and if this leads to issues with capacity it must be escalated to the relevant Operations Manager.

### 4.18 Cancellations / reductions of clinics / sessions

The only acceptable reason for any clinic to be cancelled is due to the absence of medical staff. This can result from planned annual/study leave or unplanned sickness absence. Clinics should not be cancelled for any other purpose unless there are exceptional circumstances.

**Notice period for clinic/session cancellations**

- A minimum of 6 weeks' notice should be given when a clinician requires a clinic to be cancelled or reduced. A Clinic Cancellation/Reduction Proforma must be completed and emailed to the relevant speciality inbox for the Gateway Co-ordinator to action.

**Short-notice clinic/session cancellations**

- If a clinic is at risk of being cancelled within 6 weeks or less, the Gateway Co-ordinator will inform the relevant Operations Manager and agree a solution
- Where patients have to be cancelled at short notice (less than 6 weeks) their most recent/relevant clinic letters must be reviewed by clinical staff on NOTIS.
- Patients should be rescheduled in order of a) their clinical need and b) their wait time, ensuring that no patient exceeds the waiting time target. To achieve this, additional capacity within existing clinics may need to be agreed with the clinician and Gateway Co-ordinator in consultation with the Operations Manager.
- In the event of any emergency or exceptional circumstance, any responsible clinician undertaking a theatre session or clinic must immediately inform the Gateway Co-ordinator, Lead Nurse and Operations Manager in order for contingency arrangements to be made to accommodate scheduled patients. Under no circumstances must any clinician leave the NTC or their scheduled patients without escalating such exceptional circumstances/ emergencies.

### 4.19 Outpatients who did not attend (DNA)

The patient has the right to be responsible for his/her own health and with the introduction of patient choice and the ERSNHS E-Referrals system, patients have an increasing opportunity to ensure their appointment is convenient to them.

#### 4.19.1 DNA of new appointment

In each situation where a patient does not attend a scheduled appointment and the reason is unknown, the clinician in charge of that clinic session will review the notes of the patient. At the discretion of the clinician a decision, based on clinical need, will be made and the appropriate

rescheduling/discharge of that patient will be undertaken. The gateway receptionist will then update the patient's referral reflecting the consultant's decision to either:

- Discharge the patient back to the care of their GP/GDP and stop the 18 week clock. A dictated or standard letter will be sent to the patient and the GP/GDP informing them of this.
- Book the patient a further appointment, stopping their existing clock and commencing a new 18 week clock. 1 attempt must be made to contact the patient via telephone to agree a further appointment date; if no telephone contact is made then the patient will be sent the next available new appointment. In both cases, the patient must be sent a confirmation letter.

#### 4.19.2 Subsequent DNAs

If a patient DNAs an appointment, it is a clinical decision as to whether a further appointment is required or whether they are referred back to the care of their GP.

#### 4.19.3 2WW DNAs

For 2WW appointments, if a patient fails to attend their appointment, they will be contacted and a further appointment scheduled, the 2WW clock is adjusted and the 14 day rule applies.

If a patient turns up to their appointment in a condition that prevents the clinician from carrying out a required procedure (e.g. not taking their bowel preparation prior to an endoscopy), this is treated as a DNA and the 2WW clock is restarted (if this was their first appointment).

#### 4.19.4 Patients who arrive late for their appointment

Patients are permitted a minimum of 15 minutes from the time of their appointment to arrive before they are treated as a DNA. If a patient arrives after this time, they are seen at the clinician's discretion. If the clinician will not see the patient, a further appointment may be booked and the 18 week clock is restarted, except for 2WW patients.

### 4.20 Outpatient tracking

On completion of the outpatient episode, on departure of the patient or at closure of the clinic, the patient status will be entered on PAS.

As well as recording this information, the clinician will record the 18 week clock outcome of the attendance on the patient's outcome form. This is then entered into PAS to complete the 18 week RTT information. 100% of patient outcomes must be captured to achieve accurate clock data for 18 week adherence monitoring. It is the responsibility of individual consultants and the clinical unit to ensure compliance against this standard.

All routine correspondence is typed, reviewed and sent to GP within seven days of the patient being seen. Urgent correspondence will be processed within 48 hours.

#### 4.20.1 Patients who arrive but do not wait for their appointment

Patients who arrive for their appointment but then decide that they do not want to wait to see the clinician will be tracked through the PAS system as having not seen a healthcare professional

### 4.21 Inter-provider transfers (IPTs)

If a patient needs to be transferred to another provider for a surgical procedure, outpatient appointment or diagnostic procedure (dependent upon the speciality), the consultant or nurse in charge must complete an Inter-Provider Transfer (IPT) form, to include the following information:

- Patient demographics.

- Date of completion of form.
- Patient GP details.
- Referring organisation name.
- Referring clinician name.
- Receiving organisation name & speciality.
- RTT status and latest 18 week clock start date.
- Required surgical/diagnostic procedure or appointment request and if a specific surgeon/clinician is required.

### 4.22 The vulnerable patient

It is essential that patients, who are vulnerable for whatever reason, have their needs identified at the point of referral from outpatients.

This group of patients includes:

- Patients with learning difficulties or psychiatric problems.
- Patients with physical disabilities or mobility problems.
- Patients who require an interpreter.
- Patients who pose an increased anaesthetic risk (uncontrolled epilepsy, diabetes, congenital heart disease).
- Elderly patients who require community care.
- Patients with Dementia.

Communication with this patient group is required to establish their needs and, where appropriate, other agencies should be involved.

### 4.23 Accessible Information

We aim to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with all staff and services at the NTC.

## Section 5

# Diagnostics (non-admitted and admitted pathway)

### 5.1 Definition

A diagnostic test is defined as a test or procedure used to identify a person's disease or condition to allow a medical diagnosis to be made.

A patient's waiting time for a diagnostic test or procedure begins when the request for the test or procedure is made and ends when the patient receives the test or procedure.

### 5.2 National targets and rules

The maximum waiting time for the diagnostic stage of treatment is **six weeks.**

For the purpose of RTT recording, this does not include waits for diagnostic tests or procedures where

- The patient is waiting for a planned (or surveillance) diagnostic test or procedure, (i.e.) a procedure or series of procedures as part of a treatment plan which, for clinical reasons, is carried out a specific times or repeated at a specific frequency (i.e. check Cystoscopy).
- The patient is waiting for a test or procedure as part of a screening programme (e.g. National Breast Screening Programme; routine repeat smear test).
- The patient is an expectant mother booked for confinement.
- The patient is currently admitted to hospital and is waiting an emergency or unscheduled diagnostic test or procedure as part of their inpatient treatment.

A pause **cannot** be applied to a patient on a waiting list for a diagnostic test/procedure.

Where a diagnostic test is being undertaken in an outpatient setting (non-admitted) the outpatient section of the policy must be adhered to (see Section 4).

Where a patient is being admitted as a daycase or inpatient for a diagnostic test then the daycase section of the policy (admitted pathway) must be adhered to (see Section 6).

### 5.3 Request review, acceptance and rejection

There will be a maximum time limit of three days to review diagnostic referrals and change the priority set by the referrer, if necessary.

Referrals will be accepted in Diagnostics according to internal protocols and Ionising Radiation Medical Exposure Regulations (IR(ME)R2017). Rejected referrals will be returned to the referring clinician. Resubmitted referrals will start a new diagnostic wait time.

NOTE: the 18 week RTT clock position will not be altered whether the diagnostic referral is accepted or not.

### 5.4 Reasonable offer of diagnostic appointment

It is good practice that all patients have their diagnostic test booked on the same day that they attend their out-patient appointment. **The same rules apply as those applicable to an outpatient reasonable offer of appointment.** (See Section 4.12.4).

For diagnostic test or procedure appointments which are not made on the day of the outpatient appointment, the patient should be offered an appointment by letter which gives a minimum of **three weeks'** notice of the appointment. Patients are given their diagnostic appointments within the six week target. If this is not achieved then it must be escalated to the Gateway Co-ordinator.

### 5.5 DNAs for diagnostic appointments

Where a patient does not attend a scheduled diagnostic appointment and the reason is unknown, the administration staff will endeavour to contact the patient and ascertain the reason for DNA.

One of the following actions will be taken dependant on the reason:

- Refer the patient back to the clinician who requested the diagnostic test, to decide whether the patient should be referred back to their GP.
- Schedule the patient a further diagnostic appointment and communicate this to the relevant Gateway Co-ordinator so that they can inform the referring clinician.

If a patient subsequently DNAs a second diagnostic appointment, they will be referred back to the care of the clinician who requested the diagnostic test, to decide whether the patient should be referred back to their GP.

If a 2WW patient DNAs a diagnostic appointment, the patient will be telephoned and the appointment immediately rebooked. If the patient subsequently DNAs a further time, the referring consultant should be contacted within 24 hours of the second DNA.

### 5.6 The vulnerable patient

It is essential that patients who are vulnerable for whatever reason, have their needs identified at the point of referral from outpatients.

This group of patients includes:

- Patients with learning difficulties or psychiatric problems.
- Patients with physical disabilities or mobility problems.
- Patients who require an interpreter.
- Patients who pose an increased anaesthetic risk (uncontrolled epilepsy, diabetes, congenital heart disease).
- Elderly patients who require community care.

Communication with this patient group is required to establish their needs and, where appropriate, other agencies should be involved.

## Section 6

## Inpatient and day case (admitted pathway)

### 6.1 Service Restriction Policy (SRP)

Patients who are having a procedure that requires a SRP to be completed and the funding agreed by the CCG prior to the procedure will be chronologically managed in accordance with the 18 week guidance and the SRP policy. The CCG will either accept (within 48 hours) and provide an authorisation number for the procedure to go ahead, in which case the normal procedure for selecting patient applies, or request more information or reject.

If more information is requested, this is supplied to the CCG. If it is rejected, the patient needs to be informed that the CCG will not fund this procedure (consultants will have told the patients in the consultation that the procedure will require acceptance by the CCG).

### 6.2 Selecting patients for admission

All patients will be chronologically managed in accordance with the 18 week guidance. Patients on a cancer pathway or patients whose daycase form indicates that they require an urgent procedure will be clinically prioritised.

- Reasonable notice – **three weeks'** notice in all cases and an offer of two dates verbally or one date for written offers. Any patient unavailability must be recorded on PAS.
- Where the condition relates to a period of service in the Armed Forces the veteran should receive priority treatment subject to clinical need. However this does not prioritise veterans over someone with a greater clinical need

### 6.3 Patients with a decision to treat

The decision to add a patient to a daycase waiting list must be made by a consultant, or under an arrangement agreed with the consultant. Patients must be clinically and socially ready for admission on the day the decision to admit is made.

Patients already on an 18 week pathway who have agreed a treatment plan with the clinician but require an additional assessment prior to surgery, must have this incorporated into their 18 week pathway.

#### 6.3.1 Pre-operative assessment

Patients who require pre-operative assessment based on the daycase criteria are deemed fit once the decision to treat has been made at consultation. All patients will have a service request raised for their pre-operative assessment and procedure.

#### 6.3.2 Pre-operative assessment did not attend (DNAs)

In the event of a routine patient not attending their pre-operative assessment, the patient will be contacted and rescheduled. Three attempts at various times are required to re-book the appointment. If contact is not successful, a letter is to be sent to the patient asking them to contact us to reschedule.

#### 6.3.3 Managing the outcome of pre-operative assessment

If the patient is clinically and/or socially unfit for the proposed procedure, the referral will be processed in one of the following ways:

- The patient is placed on active monitoring (Watchful Wait) for a maximum period of **six weeks**; the patient will then be advised to return to their GP. The GP will be informed of clinical actions necessary to make their patient fit for treatment. Once this period has expired, a pre-operative nurse will telephone the patient to arrange a further pre-operative assessment.

If the patient is deemed clinically and/or socially unfit and this cannot be improved during a period of active monitoring, the referral will be rejected back to the referring clinician, for clinical review.

### 6.4 Information to the patient

The majority of patients will be sent a To Come In (TCI) letter confirming their date of admission, with the exception of clinical priority patients. If a leaflet is required for the intended procedure, this must be given to the patient whilst at the gateway or included with the letter.

As soon as a procedure date has been booked, a TCI letter is created on Proxima and sent as confirmation. The letter is an audit trail of the arrangements and will contain the following core details:

- Patient's name
- Date letter sent to patient
- Date and time of procedure
- Where to report on arrival
- Contact number for queries relating to the appointment
- Name of the consultant who will be carrying out the procedure
- Any other relevant clinical information/advice

### 6.5 Patients who become clinically unfit for treatment following their successful pre-operative assessment

In the event of a patient becoming unfit after they have been scheduled, an assessment must be made on the likely duration of the period of unavailability.

### 6.6 Reasonable offers

For written and verbal offers of an admission to be reasonable, the following waiting time guidance should be followed:

- For a **written** appointment to be deemed reasonable, the patient is to be offered an appointment with a minimum of **three weeks'** notice.
- For a **verbal** appointment to be deemed reasonable, the patient is to be offered an appointment with a **minimum** of **two weeks'** notice with a minimum of **two** different dates
- If a patient chooses to accept an appointment that is earlier than the three weeks' notice, this is still deemed reasonable.

### 6.7 Patient unavailability / clock pauses

These patients are exceptional and will be provided for within the NTC's operational tolerance. Clinical review may be required based on the patient's unavailability.

#### 6.7.1 Patient cancellations

Patients who cancel an admission date for a valid reason must be given a re-arranged date at the time of the cancellation that is within the 18 week waiting time standard.

### 6.7.2 Daycase – did not attend (DNAs)

In the event of a routine patient not attending for their TCI date, the patient will be contacted and rescheduled or discharged to the care of their GP, at which point the 18 week clock is stopped. The organisation must be able to demonstrate that:

- The TCI appointment offered was reasonable.
- Discharging the patient (i.e. removing the patient from the waiting list) represents no clinical risk.
- Prior to discharge, the patient case notes are reviewed by the consultant or team and, if indicated, the patient is rescheduled.

Clinical priority admissions such as urgent and suspected cancer patients will be rescheduled and offered a further admission date within the appropriate timeframe. If the patient DNAs a second TCI date, the patient will be discharged and returned to the care of their consultant.

### 6.8 Hospital initiated cancellations of admissions

Where a patient's admission has been cancelled on the day of admission for non medical reasons, this must be recorded as a hospital cancellation and the patient rescheduled in accordance with their 18 week pathway.

Patients cancelled by the hospital on the day of admission must be treated within **28 days** of the cancellation or prior to the end of the 18 week pathway, whichever is the earliest.

### 6.9 Contacting the patient pre-admission

For daycase admissions, the NTC will attempt to contact the patient to confirm their TCI date at least **one business day** beforehand.

### 6.10 Method of admission

Elective admission is when the decision to admit is predictable. Emergency admission is when admission is unpredictable and at short notice because of clinical need.

If it is decided it is an elective admission, the elective admission type is recorded as one of the following:

**Waiting list admission** - a patient admitted electively from a waiting list, having been given no date of admission at the time a decision was made to admit.

**Booked admission -** a patient admitted, having been given a date at the time a decision to admit was made.

**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.

### 6.11 The vulnerable patient

It is essential that patients, who are vulnerable for whatever reason, have their needs identified at the point of referral from outpatients.

This group of patients includes:

- Patients with social developmental and sensory disabilities, learning difficulties or psychiatric problems.
- Patients with physical disabilities or mobility problems.

- Patients who require an interpreter.
- Patients who pose an increased anaesthetic risk (uncontrolled epilepsy, diabetes, congenital heart disease).
- Elderly patients who require community care.
- Patients with Dementia.

Communication with this patient group is required to establish their needs and, where appropriate, other agencies should be involved.

### 6.12 Transfers between clinicians & providers

#### 6.12.1 Transfers between Clinicians

Patients may only be transferred to another clinician if they have explicitly agreed to this. Patients have the right to be treated by the consultant he/she was originally seen by, or by one of their team.

The original consultant and the receiving consultant must both be notified and must agree to the change.

Any refusal by the patient to be transferred to another consultant will not affect the waiting time of the patient.

#### 6.12.2 Transfers to other NHS providers

For transfers to other NHS providers, an IPT form must be completed and sent to the new provider.

#### 6.12.3 Transfers to independent sector for NHS treatment

Transfer to private providers will be in consultation with the patient and the consultant. An IPT form must be completed and sent to the new provider.

If a patient does not wish to be transferred, the original provider must ensure the patient is admitted for treatment in compliance with 'Your Guide to the NHS' (2001). The waiting time will continue uninterrupted. The patient must not experience an extended waiting time in their 18 week pathway due to the transfer.

Identifying patients for transfer will happen in a timeframe that ensures patients do not exceed the maximum wait.

Where patients are transferred to another Independent Sector Provider under the same NTC clinician, the patient will be notified of the new venue, emphasising that the clinician will remain the same.

### 6.13 Categorising patients requiring multiple procedures

Patients that require scheduling for multiple procedures in different specialities will have a referral created for each referred condition.

### 6.14 Categorising patients requiring bilateral procedures

If the patient is referred for a bilateral procedure which cannot be performed as a single admission, the patient will have surgery on one side first and the other later. The patient should therefore be:

- Scheduled for the first side upon the decision to admit creating an operative referral on PAS for that side.
- At post surgery review, the patient will be scheduled for the second side, starting a new 18 week clock.

### 6.15 Discharge of daycase patients

A discharge summary will be generated electronically and forwarded to the GP at the point of discharge and will reach the GP within 10 working days following the patient's discharge. Further detailed letters/communication will be generated where it is clinically appropriate.

### 6.16 Closing daycase sessions

On departure of the patient or at closure of the theatre session, the patient status will be entered on PAS.

The clinician will record the 18 week clock outcome of the attendance on the patient's outcome form. This is then entered into PAS to complete the 18 week RTT information. 100% of patient outcomes must be captured to achieve accurate 18 week information. It is the responsibility of individual consultants and the clinical unit to ensure compliance against this standard.

## Section 7

## Monitoring compliance to the access policy

The overall aim of the Access Policy is to improve access to services for patients and ensure all patients are treated consistently and in line with appropriate national guidance. It is therefore essential that performance against the standards identified within the policy are monitored and improved upon to protect patients' access to the NTC's services.

The monitoring of internal systems, rather than just purely monitoring data outputs of the systems is an integral part of the NTC's plans to modernise its services.

The Information Team will develop reporting systems and processes in order to support the key stakeholders involved in the referral pathway.

The Hospital Director will be responsible for looking at the information produced and agreeing any action required. The Operations Managers, working alongside the Administration Lead, will be instrumental in changing practice to ensure achievement of the standards.

## Section 8

## Targets and tolerances

| Frequency | Return code | Return description | National targets |
|---|---|---|---|
| Weekly | CWTPTL | Cancer PTL (Open Exeter) | National Cancer Pathway standards |
| Monthly | 18RTT, 18ADJ, & PS | Monthly 18 week Patient Tracking List (PTL) | 90% for outpatients<br>95% for admitted patients<br>92% for incomplete |
| Monthly | MAR | Monthly Activity | N/A |
| Monthly | OP & APC | Commissioning Data Sets (CDS) | N/A |
| Monthly | DM01 | Monthly Diagnostics | <6 weeks |
| Monthly | Cancer Report 1.1 | 14 day target | 93% |
| Monthly | Cancer Report 2.1 | First line treatments | 96% |
| Monthly | Cancer Report 2.8 | Subsequent treatments | 94% |
| Monthly | Cancer Report 3.1 | 62 day priority 3 target patients | 85% |
| Monthly | Cancer Report 4.1 | 62 day priority 2 target patients – screening (N/A for NTC) | 90% |
| Monthly | Cancer Report 5.1 | 62 day consultant upgrades | No national tolerance |
| Quarterly | QAR | Quarterly Activity | N/A |
| Annually | Self-Assessment | CQC Self-Assessment | Compliance against regulations under each regulated activity |
| Quarterly | PVH | CQC KPIs | Compliance |
| Quarterly | KC65 Part A | Amount of colposcopy referrals received | N/A |
| Quarterly | KC65 Part B | Waiting time for colposcopy assessment | 99% within6weeks |
| Quarterly | KC65 Part C | Amount of procedures undertaken at colposcopy clinics, defined by nature of treatment | N/A |
| Quarterly | KC65 Part D | Time elapsing before women are informed of their biopsy result | 100% within 4 weeks |
| Quarterly | KC65 Part E | Histological result for each biopsy, which indicates whether cancer or a pre-cancerous condition has been identified from the sample taken. | 100% within 8 weeks |