

## University Hospitals Sussex

### Patient Access Policy

<b>Version:</b>	UHSC046
<b>Category and Number:</b>	1
<b>Approved By:</b>	Trust Executive Committee
<b>Date Approved:</b>	February 2022
<b>Name of Author:</b>	Marianna Windham RTT Performance Manager/Ashley Stanford RTT Lead
<b>Name of Responsible Committee/Individual</b>	Trust Executive Committee
<b>Name of Responsible Director</b>	COO
<b>Date Issued:</b>	February 2022
<b>Review Date:</b>	February 2025 (or earlier if National changes )
<b>Target Audience:</b>	All UHSX Staff who administer an elective patient pathway and CCGs/Primary Care
<b>Accessibility:</b>	This policy is available in electronic format only

Document Control /History	
Revision No	Reason for Change
1	Update

Consultation
General Managers
Trust Board
CCG
Patient Representation Group

# Patient Access Policy

## Contents

Section		Page
1	Introduction	4
2	Purpose	5
3	Definition of Terms Used	6
4	Duties, Roles and Responsibilities	9
5	Policy	14
	5.7 – National Access Standards	15
	5.9 – The Patient’s Rights (NHS Constitution)	16
	5.10 – Referral to Treatment (RTT) Clock Principles	16
	5.11 – Access to Services UHSx for Staff	17
	5.12 – Access to Health Services for Military Veterans	17
	5.14 – Private Patients Transferring to NHS Care	18
6	Outpatients	19
	6.1 – Unnecessary and Incomplete Referrals	19
	6.4 – New Patient Referrals via e-Referral System (ERS)	20
	6.17 – Consultant to Consultant Referrals	22
	6.20 – Referral’s from Interface or Referral Management or Assessment Service	22
	6.22 – Inter-provider Transfers (Tertiary Referrals)	23
	6.24 – Outpatient Reasonable Offer Criteria	23
	6.27 – Outpatient Patient Cancellations	23
	6.29 – Outpatient 1 <sup>st</sup> New Appointment Patient Did Not Attend (DNA)	24
	6.30 – DNA Subsequent Appointments (OPD, Diagnostics, TCI)	24
	6.31 – Safeguarding Children who DNA	24
	6.32 – Parent asking to Cancel and Discharge their Child	25
	6.33 – Outpatient Appointment – Hospital Cancellations	25
	6.37 – Outpatient Follow-up Appointments	25
	6.41 – PIFU- Patient Initiated Follow up	26
	6.42 – Active Monitoring (previously known as Watchful Waiting)	26
7	Diagnostic Tests	26
	7.1 – Prioritisation	27
	7.2 – Diagnostic Tests – 18 week Clock Continues	27
	7.3 – Direct Access Diagnostics	27
	7.4 – Straight to Test Diagnostics	27
	7.5 – Diagnostics Reasonable Offer Criteria	27
8	Elective Inpatient and Day-case Procedures	28
	8.1 – Determining Patient Priority	28
	8.5 – TCI Reasonable Offer Criteria	28

## Patient Access Policy

Section		Page
	8.8 – Planned Patients	29
	8.14 – Bilateral Procedures	30
	8.15 – Patient ‘Thinking Time’	30
	8.16 – Patient Choice and Unavailability	30
	Patients who choose to delay treatments	30
	8.19 – Medically Unfit	31
	8.21 – Pre-Operative Assessment (POA)	31
	8.28 – Patient Did Not Attend POA Appointment	32
	8.30 – Evidence Based Intervention Procedures ( EBI)	32
	8.35 – Hospital Cancellations of TCI date	33
	8.40 – Patient Cancellations of TCI Date	34
	8.45 – Patient Did Not Attend TCI Date	35
9	Cancer Patients	35
10	Training	45
11	Monitoring Arrangements	45
12	Stakeholder Engagement and Communication	45
13	Due Regard Assessment Screening	46
14	Associated documentation	47
15	References	48

# Patient Access Policy

## 1. INTRODUCTION

- 1.1 The policy describes how the Trust manages access to its key services and ensures fair treatment for all patients. The successful management of patient waiting lists is key to achieving Department of Health Operating Framework objectives in reducing waiting times and improving Patient Choice.
- 1.2 The NHS Plan emphasised that what patients want is effective, appropriate health care without having to wait an unacceptably long time. It set out targets for reducing waiting times for both outpatients and inpatients.
- 1.3 The NHS Constitution 2010 gives NHS Staff, Patients and Public, purpose, principles and values on what they can expect from the NHS all in one place. It brings together a number of rights, pledges and responsibilities for Staff and Patients alike.
- 1.4 The over-riding principle is that of getting patients treated not keeping them waiting. The process of managing waiting lists must be transparent to the public.
- 1.5 University Hospitals Sussex NHS Foundation Trust is committed to ensuring that patients receive treatment in accordance with the NHS Constitution, national objectives and targets. This policy has been agreed with the Planned Care Board, aligns across all Sussex Providers and in consultation with the Sussex commissioning and Clinical Advisory Groups.
- 1.6 This policy sets out the Trust's and Commissioner operating standards for managing patient access to secondary care Consultant-led services from referral to first definitive treatment across a maximum pathway of 18 weeks. It is designed to ensure fair and equitable access to hospital services managed according to clinical priority and upholds the right of all patients not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, Health inequalities, pregnancy and maternity or marital or civil partnership status.
- 1.7 This policy will provide the Trust with a coherent approach to the management of waiting lists, scheduling and booking across the organisation. It will ensure that patients are treated in line with local and National Policies regarding Vulnerable Adults, Patients with Learning Disabilities, Safeguarding Children Policies and War Veteran Guidance. The trust is committed to the delivery of Same Sex Accommodation preserving and protecting patient and client privacy and dignity whilst in Hospital, through the provision of segregated facilities for men and women.
- 1.8 It is essential that all staff involved in the management of patients waiting for elective treatment have a clear understanding of their roles and responsibilities in this process. This includes clinical, managerial and administrative staff. Every process in the management of patients who are waiting for treatment must be clear and transparent to the patients and to partner organisations and will be open to inspection, monitoring and audit.
- 1.9 The policy details how patients will be managed administratively at all points of contact within the hospital Trust and should be implemented by staff in conjunction with any supporting Standard Operating Procedures.

# Patient Access Policy

- 1.10 The overall aim of the policy is to ensure patients are treated in a timely and effective manner, specifically to:
- Ensure patients receive treatment according to their clinical priority, with priority given to clinically urgent patients and treat everyone else in turn with clinical reviews along the patient pathway for patients wishing to delay, decline or cancel.
  - Reduce waiting times for treatment and ensure patients are treated in accordance with agreed targets.
  - Reduce the number of cancelled operations for non-clinical reasons
  - Allow patients to maximize their right to patient choice in the care and treatment they need.
- 1.11 This policy should be used in conjunction with the policy for the management of Private Patients and the criteria for Evidence Based Interventions.

## 2. PURPOSE

- 2.1 This Policy will reflect the overall expectations of the Trust and local Commissioners on the management of referrals and admissions and treatments into and within the organisation, and an operational guide for those staff involved in the management of these pathways. It also sets out the roles and responsibilities, processes to be followed, and establishes a number of good practice guidelines to assist staff with the effective management of patients who need to come into hospital for elective treatment such as an outpatient, inpatient, day case, or for a diagnostic test.
- 2.2 The policy is not intended to replace local and departmental operational policies and procedures, but act as a framework to support them. It will be reviewed every three years or more frequently to ensure that it accurately reflects changing local, regional and national priorities.
- 2.3 This policy is intended to be of interest to and used by all those individuals within UHSX who are responsible for referring patients, managing referrals, adding to, and maintaining waiting lists for the purpose of organising patient access to hospital treatment and services. The principles apply to both medical and administrative staff.
- 2.4 Patients on a Cancer Pathway are managed according to the Trusts and National Separate Policy rules herein.

## 3. DEFINITION OF TERMS USED

The following is a list of the definitions that are used in this policy:

<b>Active monitoring (Watchful Waiting)</b>	Where it is clinically decided in-conjunction with the patient to start a period of monitoring in secondary care without clinical intervention or diagnostic procedure at that stage. Can be initiated by either Clinician or Patient
---	---

## Patient Access Policy

<b>Active waiting list (elective waiting and elective planned)</b>	The list of elective patients who are fit and able to be treated at that point in time. The active waiting list is also used to report national waiting time statistics.
<b>Admission</b>	The act of admitting a patient for a day case (Does not require an overnight bed) or inpatient procedure (Requires an overnight bed)
<b>Admitted pathway</b>	A pathway that ends in a clock stop for admission (day case or inpatient).
<b>Advice &amp; Guidance (A&amp;G)</b>	This is functionality within e-Referrals (ERS) which allows one clinician to seek advice from another.
<b>Bilateral (procedure)</b>	A procedure that is performed on both sides of the body, at matching anatomical sites. For example, removal of cataracts from both eyes.
<b>Cancellation ( Hospital Initiated )</b>	If the Trust cancels a patient's operation or procedure on the day of, or after admission for non-clinical reasons, the Trust is required to rearrange treatment within 28 days of the cancelled date or within target wait time whichever is soonest.
<b>Cancellation ( Patient Initiated )</b>	A Cancellation is when a patient gives any advance notice. A cancellation is a cancellation even if notice is very short. By cancelling an appointment a patient has shown a willingness to engage with the NHS
<b>Chronological order (in turn)</b>	The general principle that applies to patients categorised as requiring routine treatment. All routine patients should be seen or treated in the order they were initially referred for treatment in accordance with Priority Clinical Input
<b>Consultant-led</b>	A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.
<b>Converts their UBRN</b>	When an appointment has been booked through e-Referral, the UBRN (unique booking reference number) is converted. The reference number that a patient receives on their appointment request letter when generated by the referrer through e-Referrals. The UBRN is used in conjunction with the patient password
<b>CWT</b>	Cancer Waiting Times
<b>Decision to admit</b>	Where a clinical decision is made to admit the patient for either day case or inpatient treatment.

## Patient Access Policy

<b>Decision to treat – DOWL (date on waiting list)</b>	Where a clinical decision is taken to treat a patient as an inpatient, day case or in an outpatient setting.
<b>Did Not Attend (DNA)</b>	Patients who have agreed or been given reasonable notice of their date of admission or pre-assessment (inpatients/day cases ), appointment date ( outpatients, diagnostic appointment) and who, without notifying the Trust, fails to attend.
<b>Elective admission / elective</b>	Inpatients are classified in two groups; emergency and elective. Elective patients are so called because the Trust can 'elect' to treat them. Their admission is arranged in advance.
<b>Elective Planned</b>	An appointment /procedure or a series of appointments/procedures that form part of an agreed programme of care, which is required for <u>clinical reasons</u> to be carried out, at a specific time or repeated at a specific frequency.
<b>Elective waiting</b>	Patients waiting elective admission.
<b>e-Referral System (ERS)</b>	NHS e-Referral System (ERS) is a national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment.
<b>First definitive treatment</b>	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgment in consultation with others as appropriate, including the patient.
<b>Incomplete pathways</b>	Patients either on an admitted, non-admitted or diagnostic pathway still waiting for treatment.
<b>Non-admitted pathway</b>	A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment'.
<b>Non consultant-led</b>	Where a consultant does not take overall clinical Responsibility for the patient, i.e. Physiotherapy.
<b>Outpatients</b>	Patients referred by a general practitioner (medical or dental) or another consultant / health professional for clinical advice or treatment.

## Patient Access Policy

<b>Patient Choice</b>	With effect from October 2015, the RTT Rules Suite has been updated to reflect the removal of the provision to apply adjustments to RTT pathways for patient-initiated delays. Clinicians should provide a clinical review for patients wishing to defer their treatment
<b>Patient Tracking List (PTL)</b>	A report used to ensure the maximum waiting time targets are achieved by identifying all patients that have been referred to and under the care of, but not yet discharged from the Trust.
<b>Referral Management or Assessment Service</b>	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.
<b>Referral to Treatment (RTT)</b>	From December 2008 the maximum waiting time for NHS patients is 18 weeks from referral to treatment. An RTT period is the time between a person's referral to a consultant-led service, which initiates a clock start, and the point at which the clock stops for any of the reasons set out in the RTT national clock rules, for example the start of first definitive treatment or a decision not to treat.
<b>To Come In (TCI)</b>	A proposed future date for elective admission. The offer of admission, or TCI date, is a formal offer in writing of a date of admission. A telephone offer should be confirmed by a formal written offer, wherever possible.
<b>Substantively new or different Treatment</b>	Upon completion of a referral to treatment period, a new clock starts upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan. Where further treatment is required that was not already planned, a new clock should start at the point the decision to treat is made.
<b>UBRN ( Unique Booking Reference Number )</b>	The reference number that a patient receives on their appointment request letter when generated by the referrer through the NHS e-Referral Service. The UBRN is used in conjunction with the patient password to make or change an appointment



# Patient Access Policy

## 4. Duties Roles and Responsibilities

- 4.1 Whilst responsibility for achieving targets lies with the Directorates, accuracy of the referral and waiting list information is the responsibility of all staff that have access to, and responsibility for the upkeep of systems that hold referral and waiting list information, during the course of their work.
- 4.2 This policy will be applied consistently and without exception across the Trust. This will ensure that all patients are treated equitably and according to their clinical need and are inclusive of military patients. Cancer patients will be prioritised according to national guidance. Non-NHS patients including overseas visitors are not covered by this policy and are not entitled to treatment within 18 weeks however they may be entitled to emergency care. The Trust will work with local CCGs, GPs and other primary care services to ensure that patients understand this before starting an 18 week pathway. Local commissioners are responsible for ensuring robust communication links are in place to feedback information to GPs.
- 4.3 Local CCGs will work with their commissioned, professional diagnostic services, consultant-led community services and Referral Management Services to ensure that pathways referred into UHSX have appropriate waiting times prior to onward referral. UHSX will also support this process and work with the services, highlighting any on-going concerns to the CCGs.
- 4.4 The NHS Constitution states that patients have a right to be treated within 18 weeks. This is a maximum wait not a target and the majority of patients will need to be seen in a much shorter timeframe to ensure compliance with the overall target. It is the Trust's intention is to treat 100% of patients within 18 weeks where clinically appropriate and the patient chooses to do so. No minimum waiting time will be applied.
- 4.5 Services not covered by the 18 week pathway include; non-medical consultant-led mental health services, maternity services and public health services provided or commissioned by local authorities.
- 4.6 General roles and responsibilities for implementation and operation of the policy are as follows:
- 4.6.1 **Chief Executive:**  
The Chief Executive is ultimately accountable to the Trust Board for ensuring that effective processes are in place to manage patient care and treatment that meets National, local and NHS Constitution targets and standards and for achieving these targets.
- 4.6.2 **Chief Delivery and Strategy Officer:**  
The CDO is the executive lead for clinical operations and is responsible for:
- Through the Trust Director of Operations, Directorate and Divisional

## Patient Access Policy

Management Teams, ensuring that effective processes are in place to manage patient care and treatment that meet national, local and NHS Constitution targets and standards.

- With CDO and Directorate Managers for achieving access targets, including referral to treatment times, e-Referral System (ERS) and cancelled operations.
- For implementing Trust wide monitoring systems to ensure compliance with this policy and avoid breaches of the targets.
- For keeping the Trust Board and Trust Senior Management Team informed of progress in meeting access target and any remedial action taken.
- Delivering operational targets for service delivery in line with the annual business plan to include national targets – including 18 weeks, cancer waiting times and all other key access targets.
- Responsible officer for the management, communication and dissemination of Patient Access Policy.
- Ensuring that principles of managing demand, activity, capacity and variation are embedded in service development and part of the business cases for investment and development of services.

### 4.6.3 Director of Operations

Is responsible for:

- Management of the Chief Delivery and Strategy Officer's business plan ensuring delivery against key objectives for the Directorate's
- With Directorate Managers for monitoring progress against achievement of the targets and taking action to avoid any potential breaches.
- With Directorate Managers for managing any actual breaches in achieving targets.
- Quality assuring and producing accurate performance management data for use by Trust managers and for reporting data to external sources.
- Ensuring reporting reflects national best practice.
- Working with the local CCGs to evaluate, agree and implement transformational change to pathways where appropriate.

### 4.6.4 Directorate Managers, Care Group Managers, Clinical Directors and Directorate Lead Nurses/Matrons:

The Managers for each service have overall responsibility for implementing and adherence to this policy within their Directorate/Specialty. This includes:

- Ensuring that effective processes are in place to manage patient care and treatment that meet national, local and NHS Constitution targets and standards for each specialty within the Directorate.
- Managing resources allocated to the Directorate with the aim of achieving access targets. This includes having the staff and other resources available to operate scheduled outpatient clinics, patient treatment and operating theatre sessions and avoid the need to cancel patient treatment.
- Achieving access targets, including referral to treatment times, e-Referrals and cancelled operations.
- Ensuring that the duties, responsibilities and processes laid down in this

## Patient Access Policy

policy are implemented within the Directorate.

- Ensuring all relevant staff within their Directorate are aware of this policy and receive training as detailed in this policy.
- Implement effective monitoring systems within their Directorate to ensure compliance with this policy and avoid breaches of the targets; escalate any actual or potential breaches to the Director of Operations, who will escalate to the Chief Delivery and Strategy Officer as appropriate.
- Implementing systems and processes that support data quality and for validating data to ensure that all reports are accurate and produced within agreed timescales.
- Implementing a process of regular review of clinical pathways to ensure that these are patient focused, efficient, and secure constant improvement against the key performance targets.
- Directorates to operate in line with national and local good practice i.e. to hold a weekly Patient Tracking List (PTL) meeting with the standard Trust agenda, and also to be present at and attend the weekly Trust-wide RTT meeting, identifying and escalating any performance issues through this process.
- Working with the local CCGs to evaluate, agree and implement transformational change to pathways where appropriate.

### 4.6.5 Consultants:

Each consultant is responsible for:

- Allocating via the system that manages referrals, a clinical priority and forwarding the referral to the Booking staff within 3 working days of their receipt at the Trust.
- All referrals judged either incomplete or inappropriate should be returned to the originating referrer with a brief clinical explanation within 3-working days.
- All advice and guidance requests should be responded to by the requested consultant or designated deputy within 3-working days. Compliance with this will be monitored.
- All referrals made using the e-Referral System (ERS) should be reviewed by the provider clinician if, however, the provider clinician delegates any of these tasks, even if this is within a standard protocol, they need to be satisfied that those whom they delegate are competent, appropriately qualified, experienced and are provided with sufficient information to undertake the task delegated to them. The clinician will still be responsible for the overall management of the patient, and accountable for the decision made by the delegate.
- Any referrals which are not reviewed within this agreed 3-day timeframe will be escalated to the Directorate by the Referral Management Team.
- To ensure that the plan for the patient is recorded in a timely and appropriate manner so that administrative teams clearly know how to administer patient pathways, e.g. accurate completion of TCI cards, completion of clinic outcome forms and all electronic versions of recording.
- Managing the patient's care and treatment and working with their Directorate Managers, Clinical Directors, and clinical colleagues to ensure that this is provided within timescales laid down in national, local and NHS constitution targets and standards.

## Patient Access Policy

- Clinically Reviewing patients on their waiting lists using the Prioritisation of Waiting Lists Framework
- Managing junior medical staff to ensure that scheduled outpatient clinics, patient treatment and operating theatre sessions are held and avoid the need to cancel patients.
- Working with colleagues to prevent the cancellation of patient admissions for non-clinical reasons and taking action to reschedule any patients cancelled in line with timescales set out in this policy.
- Communicating accurate waiting time information to patients, their families and carer's and dealing with any queries, problems or complaints in line with Trust policy.
- Assisting with the monitoring of waiting lists, data quality and production of reports.
- Working with the local CCGs to evaluate, agree and implement transformational change to pathways where appropriate.

### 4.6.6 **Waiting List Management – Outpatient Appointment Booking & Reception Staff** (and those staff designated to make outpatient appointments including for diagnostic tests and treatment):

- To receive outpatient referrals and ensure that they are date stamped, and enter details on to the Trust's patient administration system (PAS) / Referral Management System (RMS) within 1- working day.
- To refer them to the appropriate specialty to assign clinical priority.
- Once clinical priority assigned, to contact the patient (either by letter or phone) and agree an outpatient appointment with reasonable notice.
- To ensure cancellation reasons and all other relevant information to the patient's appointment are recorded on PAS.
- To ensure PAS is updated correctly and in a timely way, ideally on the same day but within 24 hours with any patient choice decisions.
- To ensure the appropriate referral to treatment RTT status is accurately recorded on PAS.
- To refer any problems or suspected / potential breaches of policy or compliance with RTT targets to the Directorate and Divisional Management Team.
- Once the patient has attended their outpatient appointment, reception staff will book a follow-up appointment as appropriate as documented on the clinic outcome sheet.

### 4.6.7 **Waiting List Management – Inpatients Booking Clerks /Waiting List Officers** (and those staff designated to make inpatient and day case appointments including for diagnostic tests and treatment):

- To maintain an up to date and accurate waiting list.
- To add patients to the waiting list within 3-working days of a decision to admit and inform the patient in writing that they are on a waiting list. This would be three days from receipt of TCI card or booking form.
- To correctly record the 'decision to admit' date on PAS.

## Patient Access Policy

- To ensure all patient contact details with any additional information required is correctly recorded on PAS.
- To ensure patients are given reasonable notice as per national guidance which is 3-weeks (21-days) and a choice relating to admission dates as outlined in this policy.
- To ensure that all admission offers are recorded on PAS.
- To record all reasons for cancellations on PAS, to include Patient Choice delays.
- To ensure the appropriate RTT status is accurately recorded on PAS.

### 4.6.8 General Medical / Dental Practitioners and other referrers:

As a general principle, the Trust expects that:

- Before a referral is made for treatment on an 18-week pathway, the patient is ready, willing and able to attend for an appointment and undergo any treatment that may be required within 18 weeks, after the initial referral. This will include being both clinically fit for assessment and possible treatment of their condition.
- The 1<sup>st</sup> New patient appointment upon referral is booked via the National e-Referral system mandated from 1<sup>st</sup> October 2018. Patients referred via paper processes will have their referral returned to the referrer to make via e-Ref system.
- The Trust also expects that patient contact details are correct and that the referral urgency and appropriate specialty are clearly marked.
- The Trust relies on GP's and other referrers, supported by local commissioners to ensure patients understand their responsibilities and potential pathway steps and timescales when being referred. This will help ensure patients are:
  - Referred under appropriate clinical guidelines.
  - Offered a choice of provider as outlined in national guidance.
  - Aware of the speed at which their pathway may be progressed.
  - In the best possible position to accept timely appointments throughout their treatment.

### 4.6.9 Patients:

Patients also have a role to play as outlined in the NHS Constitution these include:

- Attending their hospital appointment or ensuring that they contact the hospital to cancel it, giving as much notice as possible if they are unable to attend.
- Managing their own health, where possible, by following clinical advice.
- Use the part of the service appropriate for their needs.
- Be involved in the management of their treatment pathway.
- Ensuring that they inform their healthcare provider of any changes in personal circumstances, particularly contact details and registered GP.

### 4.6.10 All staff:

- All staff are responsible for ensuring that any data created, edited, used or

## Patient Access Policy

recorded on the Trust's PAS system within their area of responsibility is accurate and recorded in accordance with this policy and other Trust policies relating to the collection, storage and use of data in order to maintain the highest standards of data quality and maintain patient confidentiality.

- It is the responsibility of all members of staff to understand the RTT Principles and definitions.
- Staff are advised that knowingly recording false RTT information and providing the same to NHS England or any other stakeholder may lead to internal disciplinary action and/or referral to the Trust's Local Counter Fraud Specialist
- All patient referrals, treatment episodes and waiting lists must be managed on the Trust's PAS system or other approved reporting systems authorised by the director of IT, and all information relating to patient activity must be recorded accurately and in a timely fashion.

# Patient Access Policy

## 5. POLICY

- 5.1 Patients will be treated in order of their clinical need. Patients of the same or comparable clinical priority will be treated on a 'first come first served' chronological principle, according to case mix. Clinicians will prioritise patients and have oversight of any decisions along the patient care pathway with discussions at all stages with the patients on their waiting lists.
- 5.2 The process of waiting list management will be transparent to the public and communications with patients (or parents / carers for children and vulnerable patients) will be timely, informative, clear and concise.
- 5.3 Waiting lists will be managed equitably with no preference shown on the basis of provider or source of referral.
- 5.4 As a general principle, the Trust expects that before a referral is made for treatment on an 18 week pathway the patient is both clinically fit for assessment and possible treatment of their condition, and ready to start their pathway.
- 5.5 Patients will only be added to, or remain on, an elective waiting list if they remain fit for treatment, and will be in a position to accept dates for treatment within reasonable timeframes as defined in this policy. Any patient who becomes unfit and or declines treatments will have a review and discussion with their clinician to determine any impact or alternatives to their treatment plans.
- 5.6 Tolerances – there are very important reasons why not everyone can or should be treated within 18 weeks these include:
- Patients for whom it is not clinically appropriate to be treated within 18 weeks (Clinical)
  - Patients who choose to wait longer for one or more elements of their care (Choice)
  - Patients who do not attend appointments (patients who choose not to cooperate).  
These patients are taken into account in a tolerance set as part of the delivery standard, currently 92%.
- 5.7 **National Access Standards**  
The Trust will ensure that the following access standards are met:
- The percentage of incomplete pathways within 18 weeks will equal or exceed 92%.
  - Zero tolerance of any referral to treatment waits of more than 52 weeks.
  - The percentage of patients waiting 6 weeks or more for a diagnostic test will be less than 1%.
  - All patients who have operations cancelled on or after the day of admission for nonclinical reasons will be offered another binding date within 28 days, or the patient's treatment will be funded at the time and hospital of the patient's choice.
  - No patient will have an urgent operation cancelled for a second time.
  - A maximum 2-week wait from an urgent GP referral for suspected cancer to date first seen by a specialist for all suspected cancers.
  - A maximum 31-day wait from diagnosis to first definitive treatment for all cancers.
  - A maximum 62-day wait from urgent GP referral for suspected cancer to first definitive treatment for all cancers.

## Patient Access Policy

- A maximum 31-day wait from urgent GP referral for suspected cancer to first definitive treatment for children's cancers, testicular cancers and acute leukemia.
- A maximum 62-day wait from referral from a cancer screening programme to first treatment for all cancers.
- A maximum 62-day wait from a consultant decision to upgrade the urgency of a patient they suspect to have cancer to first treatment for all cancers.
- A maximum 31-day wait for all subsequent treatments for new cases of primary and recurrent cancer where an Anti-Cancer Drug Regimen, surgery or radiotherapy is the chosen cancer treatment modality.
- A maximum two week wait from referral for breast symptoms (where cancer is not initially suspected) to date first seen.

5.8 Where it is not possible for the Trust to meet the NHS constitution, or at the request of the patient, the Trust will assist them in contacting either the relevant CCG or NHS England (depending on which of these organisations commissions their care) so they can investigate offering the patient a range of suitable alternative providers that would be able to see or treat them more quickly.

### 5.9 **The Patient's Rights (NHS Constitution):**

Patients have a right to expect to be seen and treated within national operational standards for waiting times, in addition to this the department of health has set out other patient expectations, these include:

- To be seen by a health professional whom they trust.
- To get a clear explanation of their condition and what treatments are available.
- To know what the risks, benefits and alternative treatments are.
- To give written consent before any operation or procedure.
- To see their patient records and be sure that the information recorded will remain confidential (data protection act 1998).
- Young people aged 13 – 19 years also have standards that affect their care in an outpatient setting ('you're welcome standards').

### 5.10 **REFERRAL TO TREATMENT (RTT) CLOCK PRINCIPLES**

#### 5.10.1 **The 18 Week Clock Starts when:**

- An RTT clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to:
  - a) a consultant led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner;
  - b) An interface or referral management or assessment service, which may result in an onward referral to a consultant led service before responsibility is transferred back to the referring health professional or general practitioner.
- An RTT clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional.



## Patient Access Policy

- Upon completion of an RTT period, a new RTT clock only starts:
  - a) When a patient becomes fit and ready for the second of a consultant-led bilateral procedure
  - b) Upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.
  - c) Upon a patient being re-referred in to a consultant-led; interface; or referral management or assessment service as a new referral;
  - d) When a decision to treat is made following a period of active monitoring.
  - e) When a patient rebooks their appointment following a first appointment DNA that stopped and nullified their earlier clock.

### 5.10.2 The 18 Week Clock Stops when:

The 18 week clock stops when a patient receives their first definitive treatment. This is defined as an intervention intended to manage a patient's disease, condition or injury and avoid further intervention for the condition for which they were referred. This may occur following a consultation, receipt of results from a diagnostics test or following surgery.

The following clinical decisions stop the clock, on the date the decision is communicated to the patient, GP or original referrer if not the GP:

- First definitive treatment (consultant led, treatment in an interface service or therapy in secondary care if most appropriate way to manage the patient.)
- Decision not to treat
- Decision to start a period of active monitoring.
- Patient declines treatment.

### 5.10.3 After the 18 Week Clock Stops:

Upon completion of an 18 week RTT period, a new clock starts:

- When a patient becomes fit and ready for the second of a consultant led bilateral procedure with a new pathway.
- Upon decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan with a new pathway.
- Upon a patient being re-referred into a consultant-led service as a new referral, with a new pathway.
- When a decision to treat is made following a period of active monitoring, using the same pathway.
- When a patient rebooks their appointment following a first appointment DNA that stopped and nullified their earlier clock. *Note: this will use the same pathway.*

### 5.11 ACCESS TO SERVICES FOR UHSX STAFF:

In line guidance from NHS employers, UHSX staff can be prioritised by a clinician if earlier treatment will assist the staff member to return to work sooner and in turn supporting hospital services. Patients who are clinically urgent must always take priority.

## Patient Access Policy

### 5.12 ACCESS TO HEALTH SERVICES FOR MILITARY VETERANS:

*Securing Excellence in Commissioning for the Armed Forces and Their Families*, (April 2013) set out how:

- The NHS CB [NHS England] will commission all secondary and community health services for serving personnel, mobilised reservists and service families registered with Defence Medical Services (DMS) GP practices.
- Clinical commissioning groups (CCGs) will commission services for reservists, veterans and their families, and the families of serving personnel not registered with DMS GP practices.

5.13 The Armed Forces Community should enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in the area that live. They should also retain their position on any waiting list, if moved around the UK due to the Service person being posted. Veterans receive their healthcare from the NHS, and should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need.

The Armed Forces Community includes:

**Regular Personnel-** individuals currently serving as members of the Naval Service (including the Royal Navy and Royal Marines), Army or Royal Air Force.

**Reservists-** Volunteer reservists who form the Royal Naval Reserve, Royal Marine Reserve, Territorial Army, Royal Auxiliary Air Force and Regular Reservists who comprise the Royal Fleet Reserve, Army Reserve and Royal Air Force Reserve.

**Veterans-** Those who have served for at least one day in HM Armed Forces, whether as a Regular or Reservist

**Families of Regular Personnel, Reservists or Veterans-** The immediate family of those in the categories listed above. This is defined as spouses, civil partners and children for whom they are responsible, but can where appropriate extend to parents, unmarried partners and other family members.

**Bereaved-** The immediate family of Service Personnel and veterans who have died, whether or not that death has any connection with Service.

### 5.14 PRIVATE PATIENTS TRANSFERRING TO NHS CARE:

Patients can choose to convert between NHS and Private care at any point in their journey without prejudice.

5.15 The 18 week clock starts at the point at which clinical responsibility for the patient's care transfers to the NHS (i.e. when the Trust accepts the referral for the patient.) Private patients transferring in this way will be treated in turn within the terms of this Patient Access policy and as such the patient will not be able 'jump the queue'.

5.16 Any change of status must be accompanied by an assessment of the patient's clinical priority for treatment as an NHS patient, and in consultation with their General Practitioner. A patient's entitlement to access NHS healthcare should not be affected by a decision by a patient to fund part or all of their healthcare needs privately.

## Patient Access Policy

- 5.17 A patient who has chosen to pay privately for an element of their care, such as a diagnostic test, is entitled to access other elements of care as an NHS patient, provided the patient meets NHS commissioning criteria for that treatment. However, at the point that the patient seeks to transfer back to NHS care:
- The NHS Commissioning Board is at liberty to request the patient be reassessed by an NHS clinician.
  - The patient will not be given any preferential treatment by virtue of having accessed part of their care privately, AND
  - The patient will be subject to standard NHS waiting times.
- 5.18 If first treatment has already started or been given, then a referral from private to NHS care would not start a new clock and the patient will be on a non-RTT pathway, unless the patient requires a substantially new course of treatment in which case a clock and RTT pathway would start at the point clinical responsibility for the patient is accepted.
- 5.19 If a patient who is already on an NHS waiting list decides to have their procedure privately, the Consultant will instruct for the 18 week clock to stop, ending their pathway and thereby removing them from the NHS waiting list, transferring them to private care
- 5.20 If a patient is on an 18 week pathway and is offered treatment in the private sector under the care of an NHS consultant, to reduce the time waiting for treatment, they will remain on their 18 week pathway under the care of the Trust.
- 5.21 Please refer to the Trust's Private Patient Policy for further advice and guidance.

## 6. OUTPATIENTS – GENERAL PRINCIPLES:

The Trust will continue to work with commissioners to ensure all referrals are made appropriately and to establish protocol driven referrals where appropriate. If a clinician reviewing a referral letter deems the referral to be inappropriate then it must be returned to the referrer, with an explanation as to why it is inappropriate and advice on best management within 3-working days, and the e-Ref system/ PAS updated. Regular meetings and monitoring of new referral criteria should be on-going between clinical and managerial teams within both the Trust and commissioners.

### 6.1 Unnecessary and Incomplete Referrals:

An unnecessary referral for a clinical reason would be defined as a referral into a provider for one of the following reasons:

- A referral for a clinical reason that could have been treated in either primary care or within a community setting.
- A referral that could have been dealt with by using e-Referrals advice and guidance.
- A referral for a clinical reason that has not been commissioned i.e. a procedure of low clinical value, cosmetic procedure or service commissioned through an alternative provider (for example specialist Orthopaedic Centre).

## Patient Access Policy

- A referral sent to the wrong department or specialty.

6.2 An incomplete referral is defined as a referral where a key piece of patient or clinical information is missing. This would include diagnostics, BMI, smoking status, NHS number, patient demographics or specific reason for referral.

6.3 The Trust will accept all clinically appropriate referrals but referrals that are felt to be incomplete make it difficult for the clinical teams to assess appropriateness and thus may be returned to the referring GP/GDP with an explanation and reason why the referral has been returned. e-Ref and PAS must be updated and the clinical urgency can be downgraded to routine.

### 6.4 **New Patient Referrals via NHS e-Referral System (ERS)**

ERS is a national electronic referral service (previously called Choose and Book) that facilitates patient choice of named clinician, hospital, date and time for their first outpatient appointment. The patient is allocated a unique booking reference number (UBRN).

All patients referred and being seen for their First New Outpatient Appointment must be booked via the e-Ref system.

From 1<sup>st</sup> October 2018 UHSX will reject any referrals not sent via the e-Ref National Programme System for routine or urgent GP to Consultant led services in line with NHS England National Paper Switch off.

The Trust will ensure that all GP to consultant-led new patient clinics have sufficient slots available to manage patients within national targets.

6.5 Patients exercising choice of hospital and choosing to receive treatment at UHSX will be referred in one of the following ways:

- The GP (or administrative staff) will book an outpatient appointment by choosing one of the available clinical appointment slots accessed via ERS computer system. The GP surgery will print a letter confirming the appointment and attendance details and give these to the patient prior to their leaving the surgery.
- For patients not wishing to book a clinic appointment immediately, or when no appointment is available on the system as not a directly bookable service, they will be given a UBRN after the GP has entered the initial referral on the e-Ref system. The patient can then subsequently access the e-Ref website themselves and book an outpatient appointment, or contact the national call center to organise an appointment. The patient will either print details from the website or the national call center will read all the details over the telephone to the person making the booking.
- Where no appointment slots are available in the relevant service at the Trust, the patient or referrer may use the 'Defer-to-Provider' process. In such requests the patient will be contacted within 10-days with an appointment date. In this situation, the clock starts at the at the point of referral.

6.6 The RTT clock starts when a patient activates their UBRN, this can be done either by the

## Patient Access Policy

referring GP, (or administration team) booking an appointment using the e-Ref, by the patient themselves making a booking on line using the e-Ref, or by the patient contacting the national call centre. The hospital will be notified of the appointment details as soon as the appointment is booked and will show on the relevant specialty work list and this will start the 18 week clock.

- 6.7 When the appointment has been booked, it will appear on the individual consultants work list which they are required to confirm whether or not they accept the referral and grade accepted referrals according to clinical urgency. E-Ref should be graded by a clinician or their delegate within the Trust standard of 3-working days and should be managed in one of three ways: - Accept, Redirect or Reject. Any referrals not acceptable are either moved to another consultant or returned to the patients GP within 3-working days and any referrals which are not reviewed within 3-working days will be automatically accepted by the Trust and the clinician will be expected to see the patient as booked.
- 6.8 Patients have the right to choose a named consultant and this must be respected and on that basis GPs must retain flexibility to refer to a named consultant team. However the Trust will offer the patient a choice of an alternative consultant if the named consultant wait would exceed the maximum waiting time target, but they are not obliged to accept this, and their clock is unaffected if they do not.
- 6.9 If an e-Ref appointment has been booked in the correct specialty, but in an incorrect clinic, it is the responsibility of the receiving clinician to re-direct the appointment to the appropriate clinic rather than returning to GP. The patient must be informed if the appointment is to be re-booked and given the opportunity to agree a convenient date within agreed Trust timeframe. The 18 week clock continues ticking throughout this process.
- 6.10 If the e-Ref appointment has been booked in an incorrect specialty, it is the responsibility of the receiving clinician to return the referral to the referring GP within 3-working days. The rejection will stop the 18 week clock.
- 6.11 Referrers are asked to ensure letters are received within a maximum of 5-days for a routine referral and 1-day for an urgent referral to enable the Trust to confirm the correct booking slot and ensure that the appropriate clinical information is available for the clinician to review.
- 6.12 GPs can request individual consultants to provide advice and guidance under the e-Ref process. Any advice and guidance requests must be reviewed by the clinician to whom they are directed or designated deputy, and responded to within two working days of receipt.
- 6.13 All new paper based referrals outside of the first New Outpatient Appointment via e-Ref (with the exception of 2-week cancer waits referrals) will be date stamped, scanned and entered on to the PAS system within 1-working day of receipt of the referral letter. This date is entered on to the system as the first date the referral was received by the Trust. If the patient has had an assessment, but received no treatment in a primary care clinic or Referral Management Centre or any other provider then the 18 week clock start is the date that the referral was received in the Referral Management Team. The same principle applies for

## Patient Access Policy

referrals from other Trusts – e.g. the wait transfers with the patient.

- 6.14 Referrals must include full demographic details, including NHS number and telephone numbers (day, evening and or mobile if possible) to reduce administrative time spent contacting the patient. It is the responsibility of the referring GP to ensure the referral letter contains accurate and up to date demographic information regarding the patient. All referrals from other Trusts must complete an inter-provider form. If the referral is to be rejected because it is inappropriate or lacking sufficient information for a decision to be made regarding appropriateness, then a letter should be sent to the referrer with an explanation within 3-working days.
- 6.15 Appointment must be sent to the patient within 1-working day of the appointment being booked. If an appointment is to be within 10 working days, the patient must be telephoned to agree the appointment. Where no contact can be made on the telephone, a first class letter will be sent. Patients are allocated appointment times in order of clinical priority and date of their 18 week RTT clock start to ensure equity of access. Clinical priorities should be kept to a minimum i.e. urgent cancer referrals, urgent or routine. All other referrals should be dealt with in chronological order.
- 6.16 Patients referred to the Trust under the 2-week symptomatic breast referral process must wait a maximum of 2-weeks from urgent GP referral to their first offered appointment within the specialty. To ensure all possible patients are seen within 2 weeks this will apply to all breast referrals including those not made under the 2-week cancer process.
- 6.17 **Consultant to Consultant Referrals:**  
When a consultant identifies a possible non-urgent medical condition in a patient other than that identified in the original GP referral or reason for admission, the patient will be referred back to their GP. This will allow the GP to decide, in consultation with the patient, whether a new hospital referral is appropriate and, if so, give the patient choice of provider. This will start a new 18-week clock and pathway under the e-Ref system.
- 6.18 Similarly, if the patient has been referred internally (for the same condition) by a clinician to another clinician and is still awaiting treatment, then the 18 week clock continues to tick from the original date of referral.
- 6.19 If the patient's condition is identified as clinically urgent e.g. suspected cancer or a cardiology condition then a referral to another consultant in the same Trust (where possible) should be made immediately. In cases such as these the internal referral should be copied to the Booking Hub. Appointments should be undertaken within 10 days if urgent.
- 6.20 **Referral's from Interface or Referral Management or Assessment Service:**  
A referral from one of these services, which may result in an onward referral to a consultant-led service before responsibility is transferred back to the referring health professional or GP will start an 18 week clock and the clock will still be ticking when the patient is referred to the Trust (further detailed guidance on interface services is contained in the DOH rules suite).  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/ReferraltoTreatmentstatistics/DH\\_089757](http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/ReferraltoTreatmentstatistics/DH_089757)

## Patient Access Policy

- 6.21 If therapy or healthcare science intervention is provided by the interface or assessment service because it has been decided that this is the best way to manage the patients disease, condition or injury and avoid further interventions this will stop the 18 week clock and pathway. Any subsequent referral to the Trust would start a new 18 week clock and pathway. For example if it was felt that the patient's condition could be managed with physiotherapy this would stop the clock, but if subsequently it was felt the patient would benefit from secondary care intervention this would start a new clock and pathway.
- 6.22 **Inter-provider Transfers (Tertiary Referrals):**  
Where patients are transferred between providers, including primary care intermediate services, the standard minimum data set (MDS form) **must** accompany the referral, this is to ensure all service providers involved in a patients pathway have adequate information about clock starts and stops to enable the patients pathway to be managed within appropriate time frames.
- 6.23 When a patient is transferred to another provider for clinical treatment in the middle of an 18-week pathway it becomes the responsibility of the receiving provider to report any breach of the national waiting time standards. Thus UHSx clinicians may accept a referral to treat a patient referred to them by a clinician from another hospital for a condition where the 18 week pathway has already commenced and the clock will continue ticking from the date it commenced at the referring hospital. If no treatment has been given then UHSx will become responsible for reporting any breach of the standard and paying the financial penalty.
- 6.24 **Outpatient Reasonable Offer Criteria:**  
All patients offered outpatient (both new and follow-up) appointments must be given reasonable notice. For OPD appointments this is defined as:
- For an appointment offer, reasonable notice has been determined as an appointment date with at least 3 weeks from when the appointment letter is dated/telephone contact.
  - Patients can accept offers of shorter notice appointments.
- 6.26 Patients should be made aware of the Access Policy at the time of referral, to reduce DNA problems and unavailability for appointments. Any patient discharged following clinical review will be advised to return to their referring GP and when they are ready and available can be referred back to the trust. A new 18 week clock and pathway will start.
- 6.27 **Outpatient Patient Cancellations:**  
Letters to patients confirming an outpatient appointment will clearly state that the patient can cancel and rearrange their outpatient appointment regardless of the referral method used. The 18 week clock continues to tick from the original date of referral. If the patient declines, defers, or cancels on two occasions then they will trigger a Consultant review in order to confirm any clinical interests, and discuss their treatment options to ensure there are no negative impacts on their care. If post review the patient is discharged back to their GP, the clock and pathway will stop.
- 6.25 Where the patient does not make contact to re-arrange, then the patient is not fulfilling their

## Patient Access Policy

obligation to make themselves available for appointments and may be discharged back to their GP. This will be only after a clinical review of the patient's referral and in line with best clinical interests of the patient as there may be exceptional circumstances for non-response such as those that are considered vulnerable, and therefore clinicians must have oversight of any decisions to discharge.

6.28 National guidance states if a patient cancels on the day it should be assumed that it was their intention to attend and they should be offered the opportunity to rebook their appointment. Their clock should not be nullified.

6.29 **Outpatient 1<sup>st</sup> New Appointment Patient Did Not Attend (DNA):**

The Trust aims to reduce the incidence of patients failing to attend appointments and acknowledges that it is best achieved by agreeing the date with the patient in advance. The Trust also operates an automatic appointment reminder service in some specialties for new appointments to help reduce DNAs. If a patient fails to attend their appointment (new, follow-up or diagnostic) and it was clearly communicated with reasonable notice as per national guidance and this can be demonstrated, the patient may be referred back to the care of their GP, however, this is a clinical decision and will trigger a review to determine if appropriate to either reappoint or discharge. Both patient and GP will be notified in writing ensuring the referring GP is aware and can action further management of the patient if necessary. The RTT clock will be nullified on the day the patient DNA's and will restart on the day the patient is rebooked.

6.30 **DNA Subsequent Appointments (OPD, Diagnostics, TCI)**

Patient DNAs at any other point on the RTT pathway will not stop the RTT clock, unless the patient is being discharged back to the care of their GP. This is a clinical decision and will trigger a review to determine if appropriate to either reappoint or discharge. Both patient and GP will be notified in writing ensuring the referring GP is aware and can action further management of the patient if necessary

The action of discharging the patient will stop the clock, provided that:

- a) The provider can demonstrate that the appointment was clearly communicated to the patient;
- b) Discharging the patient is not contrary to their best clinical interests, which may only be determined by a clinician as there may be circumstances where the clinician feels it is detrimental to the patient's health if the appointment is not rebooked, in which case the patient must first be contacted to ascertain the reasons for DNA and ensure compliance to attend the rescheduled appointment. All communications must be entered on the PAS system.
- c) Discharging the patient is carried out according to local, publicly available, policies on DNAs;
- d) These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (for example, children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders.

If the above criteria are fulfilled, then the RTT clock stops on the date that the patient is discharged back to the care of their GP.



## Patient Access Policy

### 6.31 **Safeguarding Children who DNA:**

Parents or carers who DNA their child's appointment or ask to change their appointment time for their first new appointment will be offered a new appointment without query and will be given a minimum of 3 weeks' notice for the appointment unless advised otherwise by the clinician in charge.

6.31 Parents or carers who DNA their child's subsequent first appointment or their second appointment in a row will have their case discussed with their Consultant and advice sought as to whether or not to pursue the referral.

### 6.32 **Parent asking to Cancel and Discharge their Child:**

For new appointments, the child can be discharged if a parent or carer chooses to withdraw the referral request. The appointment will be cancelled and a discharge letter sent to the GP and the parent/carer. For follow up appointments these must not be cancelled without Consultant agreement.

### 6.33 **Outpatient Appointment - Hospital Cancellations:**

A minimum of 6 weeks' notice is required from all clinicians, in all but exceptional circumstances, to cancel or reduce any outpatient or diagnostic sessions for reasons of annual, or study leave or on-call commitments. If it is necessary, in exceptional circumstances to cancel or reduce any outpatient session, the Specialty Management Team/Assistant Care Group Manager for that specialty must discuss in person with the relevant clinician and agree re-provision of lost capacity to ensure patients are not disadvantaged and waiting time not increased. If no resolution is found then escalation to the Specialty Management Admin Team and Clinical Director may be required.

6.34 All short notice (less than 6 week) clinic cancellations must be authorised by the appropriate Directorate Manager. The outpatient booking centre staff will not action any short notice cancellations without this authorisation.

6.35 If a patient's appointment has to be rescheduled due to a hospital cancellation, the patient will be contacted to arrange an alternative appointment date and time.

6.36 Appointments must be made as close to the original appointment as possible. This is particularly important when patients need to re-attend for test results, or to review medication as the 18 week clock continues to tick during this time if the patient has not yet had their first definitive treatment.

### 6.37 **Outpatient Follow-up Appointments:**

Follow-up appointments are appropriate when a patient's condition requires continued intervention of specialist clinical expertise. In situations where there is no evidence that further specialist clinical intervention is required (e.g. patient no longer has symptoms or primary healthcare support is considered more appropriate or clinical agreement to discharge to primary care exist) the patient should be discharged to the care of their GP. This will stop the 18 week clock and end the pathway.

## Patient Access Policy

- 6.38 Patients that require an appointment should be booked prior to leaving the clinic or ward, where there is clinic capacity.
- 6.39 If the results of the tests are negative, consideration should be given to the need for a subsequent outpatient appointment. A suitable letter to the patient and GP may be sufficient. The patient must be discharged and if appropriate close the patients referral on PAS. This stops the 18 week clock and ends the pathway.
- 6.40 Telephone clinics can be arranged to manage follow up clinics or ward follow ups. This will be set up as a virtual clinic in PAS. The patient must be discharged and if appropriate close the patients referral on PAS. This stops the 18 week clock and ends the pathway.
- 6.41 **PIFU: Patient initiated follow-up.**  
The trust now operates a PIFU programme in a wide range of specialties where there may be a high proportion of follow-up appointments with low clinical value and strong clinical buy-in for PIFU.

The term patient initiated follow-up (PIFU) describes when a patient (or their carer) can initiate their follow-up appointments as and when required within a specified time frame decided by the clinician, e.g. when symptoms or circumstances change. This helps patients access support when they need it (e.g. during a flare-up of their symptoms) and avoids unnecessary routine 'check in' appointments. The patient is empowered to manage their own condition, and takes responsibility for initiating the appointment.

PIFU is one aspect of personalised follow up which describes the broader concept of when a patient's follow up care is tailored to their individual clinical need, circumstances and preferences.

PIFU will not be appropriate for all patients and this will be decided by the clinician who may wish to keep the patient on a managed follow-up rather than a PIFU pathway. Clinicians should follow principles of personalised care and engage in shared decision making with the patient to assess their individual and clinical risk.

Clinicians should ensure that patients have a good understanding of PIFU and how and when to contact services. Patients should be provided information on which symptoms to watch out for, when to contact the service and details on how to contact the service for an appointment. The information can be sent both digitally (e.g. via email and SMS messages) and as a hard copy handed/posted to the patient so they can keep track of their PIFU information.

The information should also be communicated to the patient's GP so they are kept informed.

- 6.42 **Active Monitoring (previously known as Watchful Waiting):**  
Active monitoring will commence when a clinical decision is made, agreed with the patient, following a diagnosis that it is clinically appropriate to start a period of monitoring whilst the patient receives symptomatic support, without specific clinical intervention at that stage. Active monitoring may be initiated by either a Care Professional or the patient.
- 6.43 It is expected that at the end of the active monitoring period there will be a review during a follow up appointment at which point there should be a new decision whether or not to treat

## Patient Access Policy

the patient. If a decision to treat is made following a period of active monitoring then a new 18 week clock will start on the same pathway.

- 6.44 Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to refer the patient back to primary care with specialist advice for on-going management, then this constitutes a decision not to treat and should be recorded as such and also stops a waiting time clock and ends the pathway.
- 6.45 Transfers to UHSX for after care such as chemotherapy or radiotherapy following first definitive treatment for the same condition at the other hospital are not subject to 18 week pathway requirements. However referrals for cancer related treatment may be subject to cancer targets as set out in section 9.
- 6.46 When a patient is transferred to another Trust for a diagnostic investigation, the 18 week clock continues to tick if no treatment has been given and the on-going management of the patient's pathway remains with UHSX.

### 7. DIAGNOSTIC TESTS – Maximum wait of 6 weeks:

Diagnostic tests attract their own, separate nationally measured maximum diagnostic wait time of 6 weeks. The diagnostic wait time is re-set to zero if a patient does not attend or cancels an appointment. The diagnostic waiting time starts again from the date of the rearranged appointment.

#### 7.1 PRIORITISATION

All Diagnostic tests will require a clinical prioritisation before listing. Clinical prioritisation will help the Trust to understand the level of risk on the waiting list, plan capacity to meet the demand and the priority order in which to treat patients.

- D1: Potentially life-threatening or time-critical conditions eg, cancer, cardiac failure, significant bleeding, chest pain, renal failure, vision loss  
**Patients who are an emergency would fit into this category**
- D2: Potential to cause severe disability or severe reduction to of quality of life eg, intractable pain  
**Urgent patients, including 2ww, would fit within this category**
- D3: Chronic complaints that impact on quality of life and may result in mild or moderate disability  
**Routine patients who would normally be seen within the next 4-6 weeks**
- D4: Chronic complaints that impact on quality of life and may result in mild or moderate disability  
**Routine patients who would normally be seen within the next 6-12 weeks**

#### 7.2 Diagnostic Tests – 18 week Clock Continues:

The 18 week clock may continue to tick, even though a diagnostic clock for the 6 week stage or treatment targets can be reset, therefore, be mindful of this when allowing cancellations. Patients who cancel twice will trigger a clinical review to determine any impact on the care pathway and any further or differing management options with the patient if appropriate.

## Patient Access Policy

- 7.2 Direct referrals from primary care to diagnostic services in secondary care do not start an RTT clock unless they are "straight to test" referrals.
- 7.3 **Direct Access Diagnostics** is where a GP refers a patient directly to secondary care for a diagnostic test/procedure (i.e. without the patient having to attend Consultant OP appointment first). The GP is managing the patient's on-going care. The GP will use the results of the test to inform his or her decision making about the patient's continuing care. This is known as a No-RTT Pathway.
- 7.4 **Straight to Test Diagnostics** is a type of "direct access" where there is a local agreement between primary and secondary care that a GP referring a patient to see a consultant in outpatients can at the same time book the patient in for a diagnostic test at the provider so that by the time the patient attends their first OP appointment, they will have already had the test and the results can be discussed at the first OP appointment. In such instances, the RTT clock starts on the date that the provider receives the referral. This is known as an RTT Pathway.
- 7.5 **Diagnostics Reasonable Offer Criteria:**  
All patients offered diagnostic appointments must be given reasonable notice, this is defined as: Patient contacted by telephone and offered 2 separate appointments with at least 3 weeks' notice of the appointment. Patients can accept offers of a shorter notice appointment.

## 8. ELECTIVE INPATIENTS AND DAYCASE PROCEDURES:

The decision to add the patient to an elective inpatient or day-case waiting list must be made by a consultant or their representative and with the patients consent.

### 8.1 **Determining Patient Priority:**

All patients who are added to the in-patient waiting list will be treated in the chronological order in which they were added unless they have been given a clinical priority of urgent. Military veterans will be treated in line with national guidance.

Clinical prioritisation will help the Trust to understand the level of risk on the waiting list, plan capacity to meet the demand and the priority order in which to treat patients.

When a clinician requests that a patient is listed for surgery, the clinician must assign a priority Code to this patient, using the Royal College of Surgeons (RCS) criteria:

- Priority level 2 (P2): Surgery that can be deferred for up to 4 weeks
- Priority level 3 (P3): Surgery that can be delayed for up to 3 months
- Priority level 4 (P4): Surgery that can be delayed for more than 3 months

NB: Priority 1 (P1) is for patients requiring emergency treatment within 24-72 hours. It is therefore not a category used when listing patients electively. The P-Code should be included on the waiting list card, which may be via PAS or other system.

- 8.2 The Trust operates a policy of shared patient care; this enables patients to be listed to the most appropriate clinician with the shortest wait time to ensure the patient is seen in a timely

## Patient Access Policy

manner and within 18 weeks. However the patient has the right to choose a named consultant without detriment to their waiting time.

- 8.3 The waiting lists will consist of active patients. Planned patients are managed on a planned waiting list.
- 8.4 Selection of patients to replace cancellations should be taken from those who have been pre-assessed and who require completion of their 18 week pathway within these timescales. A patient's clock status is not affected if they choose to decline short notice offers.
- 8.5 **TCI Reasonable Offer Criteria:**  
For patients with a decision to admit for treatment, a reasonable offer of a To-Come-In (TCI) date is considered to be:
- A verbal offer or written offer to a patient is deemed to be reasonable when the patient is offered a minimum of 2 dates on different days with at least 3 weeks' notice before the first of these admission dates
  - A patient may accept an offer of a shorter notice admission date.
- 8.6 If a patient declines an offer of an earlier admission date at less than 3 weeks' notice, they may do so without any adverse effect on their waiting time.
- 8.7 Where the patient does not respond to letters or phone calls, i.e. tried for at least a week with 2 phone calls on 2 separate days, or has not responded to an invite letter within 3 weeks of the letter date then the patient is not fulfilling their obligation to make themselves available for admission. In such cases their case will trigger a clinical review with their Consultant who will need to have clinical oversight and make decisions in agreement with the patient. The GP will also be informed so they can ascertain any reasons as to why the patient has not responded and to resolve any safe-guarding concerns.
- 8.8 **Planned Patients:**  
Defined as patients who require an appointment /procedure or a series of appointments/procedures that form part of an agreed programme of care, which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Patients would only start an 18 week clock at the beginning of the pathway e.g. patients having Lucentis injections: an 18 week clock starts on receipt of the referral; the clock stops on the date of the first treatment but subsequent injections would not start a new clock or a new pathway as they are part of the agreed treatment plan.
- 8.9 When patients on a planned list are clinically ready to commence treatment, they should either receive that appointment or be transferred to an active waiting list and a new 18 week clock should start. This also applies to Diagnostic planned patients.
- 8.10 Each Directorate and Divisional Management Team is responsible for reviewing the planned patient PTL on a weekly basis to ensure compliance. This review will include checking that patients are being brought in, in accordance with their planned review dates and have been listed appropriately to the planned PTL data definition.

## Patient Access Policy

- 8.11 Patients on planned lists are not included in any calculation of the size of the waiting list because their procedures must take place at a clinically determined interval and cannot be performed any sooner than this. Planned patients are monitored via planned patient lists and must have their treatment at their clinically determined interval, this date must be recorded on the PAS system and compliance will be monitored.
- 8.12 Examples of procedures which should be on surveillance or planned lists are:
- Patients waiting for more than one procedure where the procedures need, for clinical reasons to be undertaken in a certain order e.g. injections as part of the pain management service.
  - Follow up check procedures such as cystoscopies, colonoscopies etc.
  - Patients proceeding to the next stage of treatment i.e. Patients undergoing chemotherapy
- Note this is not an exhaustive list. A clinician will decide whether a patient should be added to, or remain on the planned waiting list, and in conjunction with the patient decide a date by which the next stage of treatment will commence.*
- 8.13 For those patients referred to the Trust who are waiting until a certain age to be able to proceed to surgery, if the patient will not be reviewed during the intervening period then their clock stops and the patient is added to the planned waiting list with a review date.
- 8.14 **Bilateral Procedures:**  
Where a patient requires bilateral procedures and the second procedure is not undertaken at the same time as the first, a new clock starts when the patient is fit and ready for the second treatment. These patients will be managed on the active waiting list.
- 8.15 **Patient 'Thinking Time':**  
Where a patient is given 'thinking time' by the consultant, the effect on the RTT clock will depend on the individual scenario. If the agreed 'thinking time' is short e.g. 2 weeks, then the RTT clock should continue to tick. E.g. invasive surgery is offered as the proposed but the patient would like a few days to consider this before confirming they wish to go ahead with the surgery.
- 8.16 If a longer period of 'thinking time' is agreed, then active monitoring is more appropriate. e.g. clinician offers a surgical intervention but the patient is not keen on invasive surgery at this stage, as they view their symptoms as manageable. A review appointment is agreed for a timeline that is clinically appropriate for the patient and the patient is placed on active monitoring (patient initiated). The RTT clock would stop at the point that the decision is made to commence active monitoring.
- 8.17 **Patient Choice and Unavailability:**  
Delays as a result of patient choice are accounted for in the tolerance of 8% set for achievement in the incomplete pathways waiting time operational standard. Patients therefore have an element of choice when booking their appointment or TCI date etc. Management of patients should take into consideration any health inequalities impact. Patients who wish to defer treatment must be recorded on the trust PAS system.

## Patient Access Policy

### 8.18 Patients who choose to Delay Treatments (P6)

- Priority level 6 (P6): The patient chooses to delay their treatment due to personal circumstances

When a patient chooses to delay, for example when they respond to a letter or call, this should be captured on the PAS System. The delay reason is a patient request, and should be clinically reviewed to ensure it is safe for the patient to delay their treatment. Patients should also be assigned a clinical prioritisation, in addition to the patient delay status P6.

It is important to record both statuses. The P2-P4 is a clinical priority and should be assigned by a clinician. The P6 is an administrative priority. For example, if the clinical status for the patient is P2 and the patient wants to delay (P6), it is important to record both P-statuses to allow more accurate reporting.

If a patient who first chose to delay treatment is now ready to proceed with their treatment, The PAS system will need to be updated with a note.

### 8.20 Medically unfit:

If a patient is not fit for surgery the Trust will ascertain the likely nature and duration of the illness. If the reason is that they have a condition that itself requires active treatment then a clinical decision will be made and they will either be discharged back to the care of their GP where it may be more appropriate for their condition to be managed ((e.g. chronic hypertension or AF) clock stops and pathway ends) or they will be actively monitored for their original condition (clock stops).

8.21 If the reason is transitory and likely to resolve reasonably quickly (e.g, such as a cold or viral illness), then patients should contact the waiting list office and agree a new TCI date within a reasonable timeframe of the original date. This will allow patients with minor acute illness time to recover. The 18 week clock will continue to tick during this time. If the patient is not fit after that period a clinical decision will be made which may result in them being discharged and returned to their GP where it maybe more clinically appropriate for the management of their on-going chronic clinical condition. This will stop the 18 week clock and pathway. The patient can then be re-referred back to the Trust when they are considered medically fit.

### 8.22 Pre-Operative Assessment (POA):

Pre-operative assessment ensures that the patient is fit for surgery and anesthesia, and establishes that the patient is fully informed of what will happen to them pre, during and post procedure.

8.23 All patients undergoing elective surgery should attend an initial nurse-led health screening or pre-operative assessment immediately following the decision to list. If patients are deemed unfit they will not be listed for surgery until they are deemed suitably fit. This will ensure early identification of risks pre-operatively improving theatre/hospital efficiency and significantly reducing the number of short notice cancellations for medical reasons.

8.24 If at the pre-operative assessment appointment, further anaesthetic assessment is required, the notes will first be reviewed by an anaesthetist (within 3 working days) and a decision made as to whether the patient will need to proceed to a High Risk Anaesthetic

## Patient Access Policy

Review Clinic (ARC), require additional/alternate clinical assessment or have their op delayed/cancelled; until such time as they can be deemed clinically safe for surgery.

- 8.25 If there is a decision to progress to an ARC, the patient should be given an appointment for review within a 2 week timescale with an immediate outcome for each patient recorded from this clinic as the 18 week clock will keep ticking during this period.
- 8.26 Following assessment, if deemed fit for surgery the patient will remain on the waiting list. The patient will be informed of this decision and that they can proceed with the agreed surgery. The patient will be offered reasonable notice dates in the normal way.
- 8.27 If the patient is deemed not to be fit to proceed with surgery they will be removed from the waiting list and will be informed that they cannot proceed with the agreed surgery. The patient's clinician and GP will be made aware of this decision. Information to assist the GP in managing the patients' health to a level where they can proceed with surgery will be provided as appropriate. The 18 week clock and pathway will stop.
- 8.28 Patients who are deemed fit to be added to the inpatient waiting list by their GP can be reinstated on the waiting list. This will start a new clock.
- 8.29 **Patient Did Not Attend POA Appointment** - If a patient fails to attend a pre-operative assessment appointment then the patient should be contacted, to discuss the reason. If the clinician feels it would be detrimental to the patients' health if an appointment is not rebooked, or if the patient is vulnerable then a further date for pre-operative assessment should be agreed. The 18 week clock will continue to tick. A clinical review will determine if appropriate to rebook or discharge the patient.
- 8.30 MRSA swabs should be obtained from all patients when attending for pre- operative assessment and where patients are found to be positive, they will be referred back to their GP who will be requested to screen the patients and after appropriate clearance, can be referred back to the pre-op clinic in order for an operation date to be given. The clock will continue during this period.
- 8.31 **Evidence Based Intervention Procedures (EBI)**  
In collaboration with the Clinically Effective Commissioning Programme this represents an update to the original LPP policies in respect of all Sussex CCGs.  
The policy is to ensure that the required criteria are met before placing a patient on the Wait List.
- 8.31 All Clinicians must review the policy for the procedures within their specialties and on Consultation with the patient determine if their condition meets the criteria.
- 8.32 Should a patient be assessed and not meet the threshold criteria for a given procedure the patient's GP or Trust Consultant may request the procedure through an Individual Funding Request (IFR), where the IFR form should be completed and submitted to the Commissioners on the grounds of rarity and / or clinical exceptionality.



## Patient Access Policy

8.33 Completed Individual Funding Requests (IFRs) on the grounds of rarity and / or clinical exceptionality for patients who do not meet the threshold criteria for a given procedure will be considered at the Commissioner IFR Panel.

- The requesting clinician is required to affirm that they have discussed the proposed treatment with the patient (or has offered such a discussion) before an IFR request is submitted on their behalf.
- The requesting clinician is required to affirm that the patient has been made aware of the implications of embarking on the IFR process, the fact that it may take some time before a decision can be made and that if the patient is considering privately funding the requested treatment while the IFR is being considered, retrospective funding will not be available even if the IFR is subsequently approved.
- The requesting clinician is required to be mindful that the 18 week clock keeps ticking throughout the process and should be aware of the implications on the patient's pathway. The patient must be added to the waiting list whilst waiting for a decision.

Commissioners need to ensure that IFR requests are responded to as quickly as possible in order to minimise any impact on treatment within 18 weeks.

For the avoidance of doubt, If a referral is received for an opinion / assessment, and the Trust proceeds to treat the patient without confirming that the eligibility criteria has been met, the Commissioner will not pay for this treatment.

8.34 **Hospital Cancellations of TCI Date:**

A minimum of 6 weeks' notice is required from all clinicians, in all but exceptional circumstances, to cancel or reduce any theatre sessions for reasons of annual, or study leave or on-call commitments. If it is necessary, in exceptional circumstances to cancel or reduce any theatre session, the Directorate and Divisional Management Teams for that specialty must discuss in person with the relevant clinician and agree re-provision of lost capacity to ensure patients are not disadvantaged and waiting time not increased. If no resolution is found then escalation to the Directorate Manager and Clinical Director may be required.

8.35 Although the Trust aims to keep hospital initiated cancellations to a minimum there will be occasions when some admission dates are cancelled. Where a patient's operation is cancelled on the day for non-clinical reasons, the Trust must arrange a new date within 2-days of the cancellation so that there is plenty of opportunity to ensure the patient can be treated within the national 28-day target.

8.36 Patients who are booked close to or on their 28-day breach date, must have a contingency plan in place, which includes being first on the list, notes / equipment available and Operations Centre aware that they must not be cancelled. Patients who cannot be treated within 28-days must be offered the option of treatment at a hospital of their choice including private providers at the expense of the Trust. Reasonable offer guidance does not apply to 28-day rule patients on the basis that they were ready and willing for the first date. The 18 week clock will continue to tick.

## Patient Access Policy

- 8.37 In patient procedures cancelled on the day of the appointment must be updated on PAS within 15 minutes of cancellation to enable the hospital to run a real time bed state and manage its capacity.
- 8.38 All short notice TCI cancellations must be authorised by the Directorate Manager, booking center staff will not action any short notice cancellations without this authorisation.
- 8.39 **Patients who Cancel TCI dates:**  
Patients who cancel their own elective admission date for reasons other than sickness or extreme personal circumstances (e.g. death of a close relative, car accident or seriously ill dependent) at less than 48-hrs notice, after receiving reasonable notice of or agreeing the date will have a further offer of treatment, however subsequent cancellations will result in their case triggering a clinical review with their Consultant, and on determining the best interest of the patient, may be removed from the waiting list with discharge back to the care of their GP for any further action in primary care or re-referral when ready, willing and able to proceed. The 18 week clock will stop and the pathway ends.
- 8.40 Patients who contact the Trust to cancel an agreed date for surgery due to sickness or extreme personal circumstances or are deferred on the day of surgery due to a short duration illness which is likely to resolve within a reasonable timeframe such as a viral illness will be cancelled and a new date agreed with the patient. The 18 week clock will keep ticking throughout this period.
- 8.41 Any medical condition that is not thought to be easily manageable or self-limiting within a reasonable timeframe will result in the patient's case being discussed with their Consultant and the patient will be referred back to the care of their GP. This will stop the 18 week clock and end the pathway. Clinicians will manage such cases and with agreement of the patient's best interest.
- 8.42 If a patient cancels 2 consecutive TCI dates that have been provided with reasonable notice, they will be subject to a clinical review and following this may be discharged back to the care of the GP or referring clinician if agreed is in the best interest of the patient.  
Patients who are unavailable for admission for more than 12 weeks despite having been given adequate notice and a choice of dates will be subject to a clinical review and following this may be discharged back to the care of their GP or referring clinician if it is agreed as being in the best interest of the patient. The 18week clock will stop on discharge and the pathway ends.  
In the event the patient does not commit to a treatment, a further conversation re the appropriate use of active monitoring for patient thinking time or self-referral back to GP will be discussed between the clinician and patient. All review dates will be documented on the trust PAS system at each step for visibility and audit purposes.
- 8.43 Post a clinical review, if a clinician feels that it would be detrimental to the health of the patient if the procedure is not rebooked or if the patient is vulnerable or subject to possible safeguarding protocol then the patient should receive a rescheduled admission date. The existing referral will continue and the referral date will be the original date used to determine the patients 18 week pathway.

## Patient Access Policy

### 8.44 Patient Did Not Attend TCI Date:

Patients must be informed clearly in all Trust correspondence that in the event that they DNA an inpatient/day-case procedure they will have their case clinically reviewed by their consultant who will determine if the patient should be reappointed or discharged. The Trust must demonstrate the dates were clearly communicated to the patient with reasonable notice as outlined in this policy. Discharge will stop the 18 week clock and end the pathway. Reappointed patients will continue with the existing referral dates and clocks.

Patients who post clinical review are placed on a monitoring programme will be removed from the waiting list and their clock will stop for monitoring until future decisions are made.

- 8.45 In the event of a child DNA a TCI date, the responsible clinician must undertake a case review considering all information available to them, including clinical and social. Should, following a review, a decision be taken to discharge the patient from hospital care a clear letter to this effect must be sent to the child's GP, copied to the legal parent/guardian and any other professional involved with the child. Adults considered vulnerable will also require careful consideration, with the clinician paying due regard to all information available to them, prior to discharging the patient. Should the patient be discharged a letter must be sent to the GP (or other referrer), the patient, and the patient's carer as well as other professionals involved with the patient.

## 9. **CANCER PATIENTS:** *Taken directly from the Cancer Operational Policy*

This policy stipulates the way in which UHSx will manage patients who are waiting for an out-patient appointment, diagnostic investigation, in-patient or day-case admission on a cancer pathway.

This policy covers the governance and compliance of cancer patient pathways including the delivery of cancer waiting times.

This policy should be used in conjunction with the UHSx Elective Access Policy (Nov 2021)

### **Introduction - Purpose of the Policy**

- To outline the team's main aim and purpose of operation
- How the team supports the delivery of cancer waiting times
- Clear information about roles within the team
- Key principles involved in managing patients on a cancer pathway
- Guidance documents for new and existing staff
- Governance and audit

This document sets out the processes and approach of UHSx in the management of patients against national cancer waiting times. It has been developed in accordance with national objectives, targets and guidance from the Department of Health, including the NHS Constitution and Cancer Waiting Times: A Guide (version 8.19). The overall purpose of the document is to ensure a consistent approach to the management of patients on a cancer pathway across the organisation.

### **Objectives**

To be a reference guide and set the standards required for all staff involved with cancer pathway management.

## Patient Access Policy

To provide operational guidance for all staff involved in the booking and management of patients on a cancer pathway to ensure compliance with national rules and guidelines.

For patients this will ensure:

- Patients with suspected and/or confirmed cancer diagnosis receive treatment according to clinical priority and national cancer waiting time rules
- Patient experience is improved as they move through their clinical pathway

For staff this will ensure:

- Teams and individuals are aware of their responsibilities for moving patients through their clinical pathway in accordance with national cancer waiting time rules
- Departments monitor performance and adhere to waiting time rules in relation to tests, investigations and treatment
- Delays in cancer pathways are escalated at an early stage to Directorate Management Teams
- Accurate, timely and complete data is recorded on the Trust Patient Administration System and Somerset Cancer Registry for reporting performance to the National Cancer Waiting Times Database within statutory timescales.
- The development and implementation of NG12 Guidance on Cancer

### Cancer Waiting Time Standards

<b>Cancer waits – 2 week wait</b>
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – Operational Standard 93%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – Operational Standard 93%
<b>Cancer waits – 31 days</b>
Maximum one month (31-day) wait from decision to treat to first definitive treatment for all cancers – Operational Standard 96%
Maximum 31-day wait for subsequent treatment where that treatment is surgery - Operational Standard 94%
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regime – Operational Standard 98%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – Operational Standard 94%
<b>Cancer waits – 28 days</b>
Maximum four weeks (28-day) wait from urgent GP referral to communication of cancer ruled in or out for diagnosis – Operational Standard 75%
<b>Cancer waits – 62 days</b>
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – Operational Standard 85%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – Operational Standard 90%
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set

# Patient Access Policy

## Duties & Responsibilities:

### **The Directorate Manager for Cancer Services**

The Directorate Manager for Cancer Services will ensure that all cancer services core team staff involved in cancer-pathway tracking are aware of this policy and the importance of following the procedures. Training will be provided to the cancer services core team on this policy together with the Trust's Access Policy. Training will also be provided to new members of the team at induction. The Directorate Manager for Cancer Services is responsible for reviewing this policy.

### **Lead Cancer Information Managers Data Coordinator and Lead Cancer Operational Co-ordinator**

The Lead Cancer Information Managers and Lead Cancer Operational Co-ordinator will ensure that the processes outlined in this document are implemented and adhered to, without deviation by the cancer patient pathway coordinating team, on a day-to-day basis.

The Lead Cancer Data Coordinator Lead Cancer Operational Co-ordinator and Information Managers will ensure that refresher training on this policy and the Trust's Access Policy is included within the cancer services core team annual training programme, in order to maintain skills and knowledge.

### **Administration & Directorate and Divisional Management Teams**

Accountable for the delivery of high-quality, effective and flexible patient access and administration services for the Cancer Directorate. Responsible for the governance, assurance and management of the administrative staff to achieve agreed objectives, national and local targets and quality standards.

### **Cancer Information Team (CIT)**

The Cancer Information Managers Data Coordinator, Lead Cancer Operational Co-ordinator and Senior Information Analyst are responsible for ensuring the patient pathway is validated prior to uploading data to the national cancer waiting time database, demonstrating a true and accurate waiting time for each patient.

### **Patient Pathway Coordinators (PPC)**

To ensure the accuracy of information for all patients managed against national cancer waiting time targets on the Somerset Cancer Registry database, inputting data received from multi-disciplinary sources and tracking patients through their pathway.

All Cancer Patient Pathway Coordinators have a responsibility to ensure that they comply with the guidance in this operational policy.

### **Clinicians**

All clinicians must ensure that before adding a patient to the waiting list for a cancer treatment, the patient is fit, ready and able to come into hospital for their procedure. Clinicians must complete an 'upgrade' form (see appendix) if they wish to upgrade patients to the national 62-day target

Clinicians must make it clear within correspondence when they believe it is clinically appropriate to step the patient off a national cancer 62-day pathway and communicate this clearly with the patient.

# Patient Access Policy

## **Directorate Management teams:**

Responsible for ensuring adequate capacity is available and processes are in place to deliver the national cancer waiting time standards. This includes outpatients, inpatients, diagnostics and the timely reporting of diagnostic tests to prevent delay to the patient pathway. There should be regular checks in place to review capacity and demand and to ensure compliance to the 62 Day Cancer Pathway Milestones.

Directorate Managers must report any deviation from pathway compliance to the Clinical Divisional Leads and Chief Delivery and Strategy Officer.

## **Administrative Booking Clerks/Receptionists**

Responsible for ensuring patient data entered onto PAS accurately reflects the information provided by the referrer, in order that patients can be tracked through their cancer pathway.

Teams have a responsibility to ensure data provided by clinical teams on the clinic outcome proforma is entered accurately onto PAS and actioned where necessary.

## **Stakeholders**

Clinical Commissioning Group

NHS England

Patient Participation Group

Trust Board

Divisional and Clinical Leads

Directorate Managers

## **Cancer Access Policy Standards:**

### **General principles**

- All patients with suspected or diagnosed cancer will be managed in line with national cancer targets.
- All patients will be recorded on PAS to ensure they can be tracked through their clinical pathway.
- All relevant patients will be recorded on the Somerset Cancer Registry database (SCR) which will hold comprehensive records for each patient. The record will include a full Cancer Outcomes and Services Dataset (COSD) detailing cancer waiting time and multi-disciplinary team (MDT) discussion notes.
- Patients will be tracked against national standards with delays actioned and pathway breaches escalated as appropriate.
- Compliance and breaches of the targets will be reported in line with national reporting guidelines. Breach reports must be completed by Directorate and Divisional Management Teams on a monthly basis.
- Data quality checks will be undertaken to ensure data collection systems and the tracking of patient pathways is compliant with cancer waiting times rules.

### **2-Week Wait Critical Referrals Clock Starts**

- Receipt of referral is day 0 for the two week wait national target
- For referrals received electronically the clock start date is the date the electronic referral is received.
- For paper referrals the date the referral is received is the clock start date for pre October 2018 at which point ALL referrals will be electronic in line with the National Paper Switch Off

# Patient Access Policy

Programme.

- All referrals will be registered on PAS within 24 hours of receipt
- When registering the referral on PAS the outpatient priority type must be recorded as referral type “critical (2 week rule) referral”
- All referrals registered on PAS as “critical (2 week rule) referral” will automatically interface from PAS to SCR in near real-time from the Trust’s data warehouse so the patient can be tracked
- When making an outpatient appointment the booking item on PAS must be recorded as **NEW 2 WK RULE**
- Where patients are at the outset referred direct for a test / investigation (e.g. Endoscopy), they must be identified on PAS by adding to the inpatient or day case waiting list as referral type “critical (2 week rule) referral” and referral urgency “urgent – critical referral”
- Where patients are undergoing surgery as treatment for primary or recurrence of cancer, they must be identified on PAS by adding to the relevant consultant inpatient or day case waiting list with a referral urgency “urgent – critical referral”

## 2-Week Wait Critical Referral Clock Stops

- The 2 week wait clock stops when the patient is first seen by a consultant (or member of the team) or in a diagnostic clinic following receipt of referral
- If cancer is excluded at the attendance then the 62 day pathway clock also stops and the patient is either managed on an 18 week pathway or discharged. Written confirmation that the patient has had cancer excluded as a diagnosis, must be sent to the referring GP.
- Cancer waiting time standards for faster diagnosis were introduced in 2020 requiring this to be done within 28 days of the pathway start.
- If cancer is not excluded the patient remains on the 62 day pathway and will continue to be monitored but this also must be communicated to the patient within 28 days of pathway clock start.

## 2-Week Wait Bookings/Cancellations/DNA's/Unable to Attend

- It is best practice to offer patients an appointment within 7 days of the referral being received to ensure the 2WW standard is achieved over holiday and bank holiday periods
- Patients who choose to wait longer than 2 weeks for social reasons must not be referred back to their GP or have their clocks stopped. It is expected that some patients will choose to wait longer and will be recorded as a breach - the operational standard/tolerance takes account of this (IMAS guidelines)
- Patients must not be referred back to their GP or adjustments made to their pathway if they cancel their appointment – patients are permitted to cancel as many times as they wish
- Patients must not be discharged if they DNA their first appointment. The patient must be contacted and rebooked with the 2WW clock restarting from the date the appointment is rescheduled. As long as a patient has been contacted and provided with sufficient notice of their appointment (minimum of 72 hours' notice) any short notice cancellation (within 24 hours of the appointment) will be deemed to be a DNA.
- Patients that DNA their 2nd appointment may be discharged back to the GP with agreement of the clinician – the GP must be informed that no further appointment will be offered without a new referral and this confirmation needs to be provided to the GP in writing.

## 2-Week Wait Inappropriate Referrals

## Patient Access Policy

- If a referral is received with insufficient information to process it, the referrer must be contacted immediately to minimise delay to the patient. Referrals must not be rejected for this reason or the pathway paused or delayed
- Referrals can only be downgraded by a GP. If a clinician believes a referral to be inappropriate this must be discussed with the GP who can authorise for the referral to be converted to a non-2WW referral. If the GP chooses not to downgrade the referral their decision is final and the patient must remain on a cancer pathway. Confirmation of the conversation with the referring Gp must be documented.

### 62 Day Clock Starts

- The clock start date for the 62 day pathway is the receipt of the 2ww referral from the GP, referral from a screening programme or consultant decision to upgrade
- The receipt of referral or upgrade is day 0 in the 62 day pathway
- Where the Trust refers a cancer patient to a tertiary centre for treatment, best practice guidance indicates that the referral should be sent on or before day 38 day of a 62 day pathway. The patient must have completed all diagnostic testing for this date to be captured for reporting for national cancer waiting times. However, there should not be any delay in referring the patient for discussion at an MDM during the diagnostic work up. In April 2017 full breach allocation will be attributed to the organisation that refers later than day 38.
- Where patients are undergoing surgery as treatment for primary or recurrence of cancer, they must be identified on the PAS system by adding to the relevant consultant inpatient or daycase waiting list with a referral urgency “Urgent – critical referral”.

### 62 Day Clock Stops

- The clock stops when cancer is excluded
- The clock stops when first definitive treatment is given, for example:
  - For surgical intervention it will be the date the patient is admitted for surgery
  - For anti-cancer drug therapy it is the date the first drug in an agreed treatment plan is given
  - For radiotherapy it is the date the first fraction is given
  - For patients receiving palliative care with no specific anti-cancer treatment it is the date this plan of care was agreed with the patient
- The clock stops if the patient refuses all diagnostic tests and therefore opts out of the 62 day pathway. If the patient chooses to have the tests at a later stage and cancer is diagnosed, a new 31 day clock would commence.

### 31 Day Clock Starts

- The clock starts on the date the patient agrees a plan for their treatment
  - This can be either at a face to face consultation or telephone consultation with the patient
  - Signing of the consent form by the patient may often occur after they have agreed their treatment plan and it therefore should be noted that this is not the decision to treat date
  - If the patient subsequently changes their mind about their treatment plan (i.e. agrees surgery but later decides to have chemotherapy instead) then the decision to treat date can be amended to the new decision date, however the 62 day period would continue unchanged.



## Patient Access Policy

- If a patient has seen a consultant in the private sector and a decision to treat is made, if the patient requests NHS treatment the decision to treat date is the date that the Trust accepts the referral
- For subsequent treatments the clock start is as above or the earliest clinically appropriate date (ECAD) where there is no new decision to treat, but there has previously been agreed and clinically appropriate period of delay before the next treatment can commence. This might not be the start of subsequent treatment itself, but could be the next activity that actively progresses a patient along the pathway for that treatment to take place, i.e.:
  - A patient with rectal cancer who is to have radiotherapy then surgery, the patient would not be clinically fit for surgery so the ECAD would be set for six weeks after the radiotherapy is complete
  - Where patients are undergoing surgery as treatment for primary or recurrence of cancer, they must be identified on the PAS system by adding to the relevant consultant inpatient or daycase waiting list with a referral urgency “Urgent – critical referral”.

### 31 Day Clock Stops

The 31 day standard stops with first definitive treatment. A treatment is ‘an intervention intended to manage the patient’s disease, condition or injury and avoid further intervention. It is a matter of clinical judgement, in consultation with the patient.’ For cancer waits a first definitive treatment is further defined as the start of the treatment aimed at removing or eradicating the cancer completely or at reducing tumour bulk.

- The clock stops when first definitive treatment is given, for example:
  - For surgical intervention it will be the date the patient is admitted for surgery
  - For anti-cancer drug therapy it is the date the first drug in an agreed treatment plan is given
  - For radiotherapy it is the date the first fraction is given
  - For patients receiving palliative care with no specific anti-cancer treatment it is the date this plan of care was agreed with the patient

### Active Monitoring

- If a diagnosis has been reached but it is not appropriate to give any active treatment at that time, but active treatment is still intended or may be given in the future then patients can be recorded as on active monitoring. I.e.;
  - A patient with a prostate tumour that it is not causing significant problems decides not to pursue active treatment but enter into a period of monitoring.
  - or in line with the revised active monitoring guidance around low/low-intermediate risk prostate cancer (refer to the Cancer Waiting Times guidance for details)
- This must be agreed with the patient; it should be an informed choice to be monitored rather than receive treatment and should not be used for thinking time. For example if a patient is offered a range of treatments and wants to take a couple of weeks to think about it this is not active monitoring
- This option must not be used if a cancer diagnosis is not yet confirmed

### Consultant Upgrades

## Patient Access Policy

- A consultant must upgrade a patient onto a cancer pathway if there is a suspicion of a cancer diagnosis using the 'upgrade' form and sent to the PPC.
- An upgrade onto a cancer pathway can be made at any point on a patient's pathway as long as it is before the decision to treat date is confirmed with the patient

### **Cancer Directorate Operational Standards:**

#### **General Principles**

All patients with suspected or diagnosed cancer will be managed in line with NHS cancer targets.

All relevant patients will be added to the Somerset Cancer Registry Database (SCR) which will hold full and comprehensive records for each patient. Patient records will include MDT discussion and a full Cancer Outcomes and Services Dataset (COSD).

Patients will be tracked against the appropriate local and national standards and any bottlenecks or pathway breaches will be actioned and / or escalated as appropriate.

Compliance/ breaches of target will be reported in line with national reporting guidance.

Data quality checks will be undertaken. Cancer team members will receive comprehensive induction and refresher training to allow them to undertake their duties.

#### **Operational Process**

##### **Adding patients to SCR:**

Referral details for all patients referred to UHSx for treatment by their GP/GDP as a suspected cancer (all tumour groups) and all symptomatic breast referrals will automatically transfer from PAS to SCR. Organisations across Sussex have agreed a communication and referral process, which requires that a Communication and the Inter Provider Transfer Form (IPT) includes accurate demographic and pathway data with each referral between hospital trusts.

The Cancer Patient Pathway Coordinator (PPC) will add any faxed IPT referral details immediately upon receipt on to SCR, to include accurate demographic and patient pathway data. The Cancer Patient Pathway Coordinator will add Screening referrals immediately upon receipt on to SCR, to include accurate demographic and patient-pathway data. The Cancer Patient Pathway Coordinator will upgrade any patient on SCR upon request. The Cancer Patient Pathway Coordinator will work closely with their counterparts at the shared Trusts to track patients and enter treatment data onto SCR for local reporting.

#### **Pathway Management**

The Lead Cancer Data Coordinator and/or Senior Information Analyst will produce and facilitate a full daily cancer Patient Tracking List (PTL), this is now held as a self-accessable live PTL report for the weekly Cancer PTL meeting as well as any intensive meetings requiring pathway/tumour site oversight.

#### **Cancer Patient Pathway Coordinator Duties**

Check the full PTL for their specialty to ensure patient pathways are expedited. To update the tracking notes on SCR to document the patients next step in the pathway in order that the data on the PTL is up to date for the services to be able to expedite investigations and treatment.

## Patient Access Policy

Check agreed, timely next steps are in place for all patients, chase outcome of outpatient appointments, diagnostic tests and treatments and update information for all patients on SCR. Escalate as necessary as indicated by the 62 day cancer pathway milestones.

Meet with the relevant Booking and Scheduling Clerk from the waiting-list team on (at least) a weekly basis, to ensure patients are given a TCI date within the required timescale.

Check the pathology report to identify incidental cancer diagnoses not known to SCR and update SCR for all relevant patients.

Ensure real-time, accurate, comprehensive tracking comments exist on SCR, for each event/relevant patient within their specialty. NB each patient should have an SCR record which includes:

Full demographic detail and PPI

Standard recorded (31, 62, 2nd/subsequent, screening & upgrade)

Diagnosis where known (primary, recurrence, mets etc)

ICD10 diagnosis code

Tests and treatments booked in accordance with agreed pathway so as to avoid unnecessary breaches

Cancer registration dataset completed in the relevant field on the diagnosis screen

All relevant staging

Complete COSD dataset

National audit data where relevant

Ensure the outcome from each patient discussed at the MDT meeting is entered onto SCR, *preferably during the MDT meeting*, but no later than 24 hours following the meeting.

Ensure 'Step Down' instructions are actioned.

Check the PAS record for patients who have DNA(d) their first appointment on the 62 day pathway, to ensure there is an auditable trail prior to adding the adjustment in days to SCR.

Produce an updated cancer PTL for all standards (31, 62, 2nd/subsequent, screening & upgrades) for the weekly PTL meeting. Complete the breach-analysis template for all pathway breaches.

### Step-downs

For all suspected cancer patients where diagnostic results/clinical correspondence appears to indicate that the patient does not have a malignancy, it is the responsibility of the clinician removing the patient from the pathway to document this to the patient and GP and for a copy of this to be filed in the notes (patient letter).

The PPC is also responsible for updating the Somerset cancer tracking system and changing the status of the patient. This can be done in the 'patient diagnosis screen'. The patient status must be changed to 'no new cancer diagnosis identified', the tumour status must be amended to 'non-cancer', and the date of non-cancer entered. The non-cancer details section should be completed with the reason for removing the patient. The 28 day standard fields for the Faster Diagnosis should be completed if the patient was informed of this diagnosis at the time of appointment or step down decision.

## Patient Access Policy

Should any patient initially stepped down from the 62 day pathway later be diagnosed with cancer, this will be treated as an incidental finding and their pathway will be tracked against the 31 day target ('Date of Decision to Treat' to 'First Definitive Treatment').

The date of decision to remove the patient marks the end of the 62 day pathway.

### Escalation process

#### Capacity Issues – Out Patient Appointments

The PPCs will discuss any booked outpatient appointment delays or target breaches with the outpatient clerical team in the first instance. If the delay is not resolved within a maximum 48 hours the PPCs will raise the issue with the relevant Directorate and Divisional Management Teams and if still not resolved the Cancer Directorate Manager, who will escalate as appropriate.

#### Capacity Issues – Diagnostics

The PPCs will discuss any diagnostic appointment delays or target breaches with the relevant departmental booking clerk. . If the delay is not resolved within a maximum 48 hours the PPCs will raise the issue with the relevant Directorate and Divisional Management Teams and if still not resolved the Cancer Directorate Manager, who will escalate as appropriate. A weekly report is sent by the Cancer Information Managers to ensure that any outstanding imaging requests have been dated.

#### Capacity Issues – First Treatment

The PPCs will discuss any booked definitive treatment appointment delays or target breaches with the relevant waiting list clerical team (for in-patient surgical treatments), waiting list clerical team, secretary, administrative team (for day case/out-patient treatments eg chemotherapy) in the first instance. If the delay is not resolved within a maximum 48 hours the PPCs will raise the issue with the relevant Directorate and Divisional Management and if still not resolved the Cancer Directorate Manager, who will escalate as appropriate.

#### Delays to Diagnostic Reporting

If histopathology tests remain unreported after 5 working days, the CPPCs will flag the outstanding reporting to the named Lead Pathologist for each cancer site.

If radiology remains unreported after 2 working days, the CPPCs will flag the outstanding reporting on their tracking notes on the Somerset Cancer Register. A daily report is sent by the Lead Co-ordinators to ensure that any outstanding imaging is reported.

#### Team Meetings

The designated specialty administration managers, Cancer Information Analyst and Lead Cancer Data/Operational Coordinators and Cancer Information Managers chair weekly Cancer PTL meetings, attended by the relevant tumour specific PPC and directorate management representative. Every patient on the Cancer PTL will be reviewed at the meeting, to ensure compliance with national and local cancer targets. Any gaps in tracking comments, identified from the PTL, will be discussed with the PPC at this meeting.

# Patient Access Policy

All actions are minuted and distributed following the PTL within 48 hours.

## **Data Quality & Performance Monitoring/Audit:**

### **Root Cause Breach Analysis (RCA)**

An RCA breach analysis is being distributed to all Directorate and Divisional Managers on a monthly basis.

## **2WW PTL**

The PTL is updated live and available on a daily basis. This includes the 2WW referrals. The Team Leader for the 2WW team will be the main point of contact. Escalations are to be sent to the Operational Manager for booking and planned care.

The Team Leader will escalate to the directorates, if further capacity is required.

## **Pathway Milestones**

Regular audit of 62 day pathway milestones, per tumour site.

## **10 Training**

A cascade programme of training has been developed and will be delivered to all staff groups responsible for the administration and management of patients on an elective pathway. The training will be delivered by key individuals such as the Trust's RTT Pathway Trainer, RTT Performance Manager and the PAS trainers for the technical use of PAS.

- 10.1 Training on the policy will take place in a variety of ways including classroom, group work, 1-2-1 intensive support and e-learning. Comprehensive PowerPoint slide packs have been developed and where access to projectors is not readily available the slide packs will be talked through in hard copy hand-outs.
- 10.2 Directorate and Divisional Management Teams and Team Leaders will be tasked with ensuring that all new staff members involved in managing access targets and waiting times have the required knowledge and skills necessary to manage RTT performance effectively. These key individuals will also ensure that any future guidance in respect of 18 weeks is cascaded to the appropriate staff members through local inductions and periodic updates in a timely manner, and that any additional training is introduced as required.
- 10.3 The 18-Week RTT area on the UHSx Trust intranet site has been revamped to include the training slides on 18-week RTT and the Joint Access Policy.

## **11 Monitoring Arrangements**

- 11.1 This policy will be reviewed every two years, or before if needed.
- 11.2 Triggers for early review many include a change in legislation, national guidance or local practice. Please note this is not an exhaustive list.
- 11.3 Responsibility for archiving trust-wide policies lies with the Communication team.

## **Patient Access Policy**

### **12 Stakeholder Engagement and Communication:**

During the review and revision of this policy a working draft was sent to key members of NHS Brighton and Hove, High Weald Lewes Havens and Horsham and Mid Sussex CCGs for initial review and comment. In parallel to this, the document was circulated internally among the UHSx Access Team. Comments were collated and integrated.

- 12.1 Agreement was given to the CCGs to circulate on a wider basis and it was distributed to 15-20 individuals including GPs within primary care. In parallel the document was shared internally with Directorate Managers and Clinical Directors and other key staff. Comments were invited and collated.
- 12.2 The document was revised and sent to the NHS Intensive Support Team for comment.
- 12.3 A face-to-face meeting occurred with the CCG to approve the primary and secondary care interface issues and agree the policy in principle prior to ratification.
- 12.4 Ratification of this policy will be sourced from the Senior Management Team.

### **13 Due Regard Assessment Screening**

- 13.1 This policy will be published on the Trust intranet and internet sites.
- 13.2 All staff should adhere to the policy.

## Patient Access Policy

### Due Regard Assessment Tool

		Yes/No	Comments
1.	<b>Does the document/guidance affect one group less or more favourably than another on the basis of:</b>		
	• Age	No	
	• Disability	No	
	• Gender	No	
	• Gender identity	No	
	• Marriage and civil partnership	No	
	• Pregnancy and maternity	No	
	• Race	No	
	• Religion or belief	No	
	• Sexual orientation, including lesbian, gay and bisexual people	No	
2.	<b>Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?</b>	No	
3.	<b>If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?</b>	N/A	
4.	<b>Is the impact of the document/guidance likely to be negative?</b>	No	
5.	<b>If so, can the impact be avoided?</b>	N/A	
6.	<b>What alternative is there to achieving the document/guidance without the impact?</b>	N/A	
7.	<b>Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the policy should continue in its current form?</b>	N/A	
8.	<b>Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FRED A principles (fairness, respect, equality, dignity and autonomy)</b>	No	Policy is based on NHS E national guidance for management of elective waiting times

For advice in respect of answering the above questions, please contact [uhsussex.equality@nhs.net](mailto:uhsussex.equality@nhs.net)

### 14 Associated documentation

14.1 This policy is linked to C046a Patient access policy summary for patients and carers

# Patient Access Policy

## 15 References

[https://www.gov.uk/government/uploads/attachment\\_data/file/170656/NHS\\_constitution.pdf](https://www.gov.uk/government/uploads/attachment_data/file/170656/NHS_constitution.pdf)

[https://www.gov.uk/government/uploads/attachment\\_data/file/170649/Handbook\\_to\\_the\\_NHS\\_Constitution.pdf](https://www.gov.uk/government/uploads/attachment_data/file/170649/Handbook_to_the_NHS_Constitution.pdf)

DSCN Notice 09/2007 Earliest Reasonable Offer Date – Pauses

Annex A Principles and Definitions Tackling Hospital Waiting: the 18 week Patient Pathway- an Implementation Framework 10 May 2006

The NHS Constitution 2010

DH Implementation of the right to access services within maximum waiting times March 2010 (Gateway Ref. 13676)

Revision to the Operating Framework for the NHS in England 2012/13

DH Referral to treatment consultant-led waiting times January 2012 (Gateway Ref.17106):

- Rules Suite
- How to Measure
- Reviewing the pathways of patients who have waited longer than 18 weeks before starting their treatment
- The NHS Commissioning Board and CCG's (Responsibilities and Standing Rules) Regulations

2012 NHS Outcomes Framework 2013/14

2013 The NHS Commissioning Board - Securing excellence in commissioning for the Armed Forces and their families March 2013