Tameside and Glossop Integrated Care NHS Foundation Trust

Patient Access Policy

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Policy Statement

This policy outlines the way in which the Tameside and Glossop Integrated Care NHS Foundation Trust will manage patients who are waiting for investigations / treatment on a referral -to -treatment, non-referral-to-treatment, cancer or diagnostic pathway.

Equality Impact

Tameside and Glossop Integrated Care NHS Foundation Trust ('T and GCIC') strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of health care, T and GCIC' aims to ensure that no-one is placed at a disadvantage as a result of its policies and procedures. This document has, therefore, been equality impact assessed by the Executive Team to ensure fairness and consistency for all those covered by it. The results are shown in the Equality Impact Tool (Appendix B).

VERSION CONTROL SCHEDULE

Version number	Issue / Review Date	Amendments from previous issue
1- Draft	July 2015	
2- Final	August 2016	Minor amendments, inclusion of reference to GM Cancer Waiting Times guidance.
3- Revised Version	January 2019	New content to reflect changes to practice (e.g. ERS/ Advice and Guidance)
4. Revised Version	May 2019	Section on Rapid Access to Treatment for Employees added.
5. Revised Version	August 2019	Adapted to consider community access.
6 Revised Version	July 2020	Includes community access policy.
7 Revised Version	August 2020	Includes statement about patients with learning disabilities.

DOCUMENT CONTROL

Summary of consultation process	Shared with operational and clinical staff and amended accordingly.
Control arrangements	To be reviewed each year in line with changes to relevant national access standards.
Associated documentation and references	• The Single Oversight Framework; • Operating procedures documents for Outpatient Department, Booking and Scheduling Team, RTT Tracking Team, Divisions and Cancer Team; • Department of Health RTT guidance.

DOCUMENT COMPLIANCE MONITORING ARRANGEMENTS

Minimum requirement to be monitored	Compliance with Access Policy Standards (e.g. DNAs, cancellations, planned episodes)
Process for monitoring e.g. audit	On-going monitoring through use of compliance reports written by the Trust's Information Team and managed at Executive RTT Group
Responsible individual / group/ committee	Operational Group, Executive RTT Group
Frequency of monitoring	Daily
Responsible for preparation / approval of compliance report/ action plan	Operational Teams
Group that is responsible for review of results / approval of action plan	Operational Group, Executive RTT Group
Group / committee that is responsible for monitoring of action plan	Operational Group, Executive RTT Group

CONTENTS

SECTION ONE

Introduction

1.1. Aim of the policy

The policy aims to provide information on the waiting-times standards that apply to patients referred for elective treatment (cancer and non-cancer related). It outlines the way in which the Trust will manage waiting lists and the responsibilities of staff in relation to this. The policy also includes how the Trust will respond in those instances in which patients choose to cancel or defer appointments.

1.2 About this document

The policy is based on the Department of Health's measurement and reporting guidance (as at January 2012) and will be reviewed in light of further guidance. It includes references to Department of Health websites for more detailed guidance.

The document will be supported by robust operating standards and processes relating to the booking and scheduling of patients. It will be applied consistently across the organisation.

It is essential that all staff involved in the management of patients waiting for elective investigations or treatment have a clear understanding of their roles and responsibilities in this process.

Every process in the management of patients waiting for treatment, must be clear and transparent to the patients and to partner organisations and must be open to inspection, monitoring and audit.

1.3 Key principles

a) This Policy covers the way in which Tameside and Glossop Integrated Care NHS Foundation Trust will manage patients who are waiting for treatment on an elective pathway (cancer and non-cancer related). This policy is aligned to the NHS Constitution 2010. It relates to all patients requiring access to:

- Outpatient appointments and outpatient procedures (hospital- based and community services);
- Elective inpatient treatment;
- Elective day-case treatment;
- Diagnostic tests.

All patients with suspected or diagnosed cancer will be managed in line with NHS cancer targets. The management of cancer waiting times differs slightly from those that apply to other patient groups. Please refer to Section 5.

b) GPs/GDPs (or other referrers) should only refer patients who are ready to commence treatment without due delay. For those procedures that require prior approval from commissioners this should, as far as possible, be obtained by the GP/GDP before referral to secondary care. In those instances where it was not possible to determine this before referral, then the Trust will request approval prior to treatment.

c) All waiting lists must be held on the Trust's Patient Administration System or other Trust-approved electronic systems.

d) Patients will be treated according to their clinical priority and then in chronological order, and whenever possible, within national and locally agreed waiting times.

e) The Trust will seek to make best use of its resources for the benefit of all patients by seeking to reduce the number of patients who Do Not Attend (DNA). Patients will be encouraged to be responsible for keeping their appointments.

f) The Trust will ensure that its Directory of Services is up-to-date and accurately reflects the services provided.
g) Standard letters of invitation, removals from the list, etc., should be generated from the local PAS or other approved Trust systems. This provides a uniform approach and an audit trail.
h) Any potential breaches of waiting times standards must be notified to the relevant operational managers.
i) The Trust aims to negotiate appointment and admission dates and times with patients.
j) The Trust will work to ensure fair and equal access to services for all patients.
k) All staff involved in the implementation of this policy, both clinical and clerical, will undertake training and regular annual updating. Policy adherence will be part of the administrative staff appraisal process.

1.4 Roles and Responsibilities

This section outlines the responsibilities of key groups of staff within the Trust in relation to this policy. The list is not exhaustive, but provides an overview of the ways in which different staff groups can support timely access to services.

All staff are responsible for ensuring that the principles of this policy are followed. The Executive Team is responsible for ensuring that this policy is applied in all cases and that the appropriate infrastructure is in place to enable delivery. Effective maintenance of waiting lists and clarity of reporting is dependent upon clear lines of responsibility being established for every aspect of waiting-list management.

1.4.1 GPs and Other Referrers

- Prior to referral onto an elective pathway, GPs should ensure that patients are ready and available to receive treatment within a period of 18 weeks.
- GPs and other referrers will ensure that patients are referred using appropriate clinical guidelines and that they understand their responsibilities, potential steps in the pathway and timescales from the point of referral.
- GPs should ensure that when referring patients with ‘safeguarding concerns’ that this is clearly communicated in writing as part of the referral process.
- GPs and other referrers will give clear information to the patient about the need to attend appointments and they will be reminded of the consequences if they fail to attend appointments.
- GPs and other referrers will ensure that all relevant diagnostic investigations are carried out prior to referral. This information will be available in the Tameside and Glossop Integrated Care Foundation Trust’s Directory of Services.
- GPs must refer via ERS (Electronic Referral System) for all consultant- led services; and via EMIS for all community-led non-consultant services.
- GPs should consider the use of Advice & Guidance prior to making a referral for hospital consultant-led services.

1.4.2 Patients

- Patients must be ready, willing and available to attend an initial appointment within 6 weeks of referral.
- Patients must inform the Trust and their GP of any change to their name, GP, address or contact number(s).
- Patients must be available for treatment in an 18-week period from the date of their initial referral.
- Patients should keep their appointment, make every effort to arrive on time and inform the Trust, with as much notice as possible, if they cannot keep their appointment. This will enable the Trust to re-utilise the clinic slot for another patient.
- Patients must inform their GP of any changes in their medical condition that may affect their attendance or clinical priority.

- Where a parent/guardian/carer is supporting the patient, they should undertake to ensure that the patient fulfils their responsibilities.
- Patients who no longer wish to have treatment, for whatever reason, must advise both their GP/referrer and the hospital consultant.
- Patients must notify the Trust in advance if they are unable to attend their appointment. If they do so, they will be recorded as a patient cancellation.
- If a patient fails to cancel (and does not attend) their first appointment, the hospital will record this as a DNA and this may result in a discharge back to the referrer.
- Where a patient cancels their first appointment, after the appointment time has passed, they will be recorded as a DNA, but consideration will be given to re-booking the patient by the responsible clinician.
- Where patients repeatedly cancel or DNA appointments Tameside and Glossop Integrated Care NHS Foundation Trust reserves the right to return the patient to their GP until a time they are ready and available (please see Section 5 for full details).

1.4.3 Consultants and Clinical Teams

- In order to offer choice to patients and reduce the number of hospital cancellations of appointments, consultants and their clinical teams are required to provide at least 8-weeks' notice before the commencement of leave. Anyone wishing to take leave with less than 8-weeks' notice must request this via the relevant Divisional Director.
- Consultants and their clinical teams will help to ensure that patients' Referral-to-Treatment (RTT) waits can be calculated accurately through:
  - Completion of Clinic Outcome Sheets in clinic which identifies whether a patient's waiting time has stopped or is to continue;
  - Completion of Elective Admission Proforma in clinic, which identifies that a patient has been added to the elective waiting list;
  - Authorisation of all elective/ outpatient- procedure lists;
  - Complying with the process as outlined in this policy relating to the management of consultant- to- consultant referrals and Inter-Provider Transfers;
  - Completion of a cancer upgrade proforma, when relevant, in line with the Trust's Upgrade Policy;
  - Reviewing results in a timely manner;
  - Completion of an ATR (Awaiting Test Results) outcome form to indicate: the next step of the patient pathway; follow- up timescale; or discharge in line with the ATR Policy.
- Consultants and clinical teams are responsible for working within the guidelines outlined in the Trust's Patient Access Policy.

1.4.4 Outpatients Department & Community Central Booking Team

- The Outpatient Department / Community Central Booking Team is responsible for ensuring that all referrals (paper and electronic) are registered accurately on PAS with all necessary data items completed.
- Central Booking Teams are responsible for returning paper referrals to the relevant GP informing them that they must refer using ERS / EMIS.
- The Outpatient Department / Community Central Booking Team will negotiate reasonable appointment dates and times with patients for all referrals (paper and electronic) received.
- The Outpatient Team / Community Central Booking Team is responsible for the management of outpatient / community appointments according to clinical priority, followed by chronological order.
- The Outpatient Team / Community Central Booking Team will escalate capacity issues in line with their departmental operational policy, providing a clear escalation process, with identified triggers for all involved.

- The Outpatient Department / Community Central Booking Team is responsible for allocating follow- up appointments chronologically. Any capacity issues will be escalated to the Directorate teams in line with the departmental Operational Policy.
- The Outpatient Department will ensure that the correct hospital Outpatient Outcome Form is attached to the medical record as part of the clinic-preparation process. Following completion of the form in outpatients, the Team will record the correct information on PAS using the relevant RTT status code.
- On admitting patients, the Outpatient Department will ensure that the correct RTT status is recorded on PAS.
- All outpatient team members are responsible for working within the guidelines outlined in the Trust's Patient Access Policy.

1.4.5 Elective Access Booking & Scheduling Team

- The Elective Access Booking & Scheduling clerks are responsible for the daily addition of patients to the inpatient, day-case and outpatient-procedure waiting lists, working in collaboration with clinicians.
- The Effective Use of Resource Tracker must ensure that all patients listed as relevant to the Effective Use of Resource Policy meet the criteria.
- The Elective Access Booking & Scheduling clerks will schedule patients for diagnostics, investigations and treatments according to clinical priority and then in chronological order using the patient target list (PTL).
- The Elective Access Booking & Scheduling clerks will negotiate reasonable admission and pre-operative assessment /anaesthetic dates and times with all patients.
- The Elective Access Booking & Scheduling clerks are responsible for updating and recording accurate information relating to those patients who choose to defer treatment as inpatient or day-case.
- The Elective Access Booking & Scheduling clerks are responsible for updating and managing pre- operative- assessment /anaesthetic- assessment outcomes and DNAs.
- The Elective Access Booking & Scheduling Manager will manage and oversee the management of all patient wait times, ensuring that patients are admitted for treatment in line with their expected admission date, and that all cancellations are dated within the required time.
- The Elective Access Booking & Scheduling Manager will escalate capacity issues in line with the Elective Operational Policy, providing a clear escalation process, with identified triggers for all involved.
- The Elective Access Booking & Scheduling Manager will manage all on- day cancellations, including 28- day cancellations in line with the Access Policy.
- All elective access staff are responsible for working within the guidelines outlined in the Trust's Patient Access Policy.

1.4.6 Referral to Treatment Tracking Team

- The Referral-to-Treatment Tracking Team is responsible for liaising with other departments (e.g. Theatres, Day Service Units, Endoscopy Units, Programmed Investigation Units) to determine the RTT status of the patient following admission for diagnostic procedure.
- The Referral-to-Treatment Tracking Team is responsible for ensuring accurate validation of any patient on an RTT pathway.
- All tracking team staff are responsible for working within the guidelines outlined in the Trust's Patient Access Policy.

1.4.7 Divisional Management Teams

- The management of waiting times is the responsibility of the Divisional Management Teams and therefore active management of inpatient, outpatient, community and diagnostic waiting lists is essential.

- Divisional Management Teams must ensure that follow-up appointments are managed appropriately and that sufficient capacity is available for patients on RTT and non-RTT pathways to be reviewed without delay.
- Divisional Management Teams are responsible for ensuring compliance with all aspects of the Trust's Patient Access Policy and should ensure that they work with other departments to facilitate this.

1.4.8 Medical Secretaries

- Medical secretaries will support the administrative processes required to collect and monitor RTT data by advising the Referral-to-Treatment Tracking Team of changes/updates to a patient's RTT pathway status. In some circumstances the secretary will be made aware of a change to the patient's management that may require an amendment to the RTT status (for example, the patient contacts the secretary to advise that they no longer require treatment or following investigation the consultant advises that the patient can be discharged).
- Medical secretaries will comply with the processes outlined in this policy relating to the management of consultant- to- consultant referrals and Inter-Provider Transfers.
- Medical Secretaries are responsible for the monitoring/tracking of patients on the Awaiting Test Results (ATR) PTL.
- Medical Secretaries are responsible for escalating bottlenecks/ delays in outstanding tests and reporting to the Secretarial Manager to avoid delays in patients' pathways.
- Medical Secretaries are responsible for managing the patients who DNA their diagnostic test with all consultants, in line with Access Policy.
- Medical Secretaries are responsible for updating outcomes from the consultant ATR outcome slip, closing any pathways and referrals where required.
- Medical Secretaries are responsible for working within the guidelines outlined in the Trust's Patient Access Policy.

1.4.9 Cancer Tracking Team

- The Cancer Tracking Team is responsible for the timely pathway management of patients referred to specialist services with a suspicion of having cancer. The Trust conducts cancer pathway management in line with the national Cancer Waiting Time Targets.
- The Cancer Tracking Team is responsible for liaising with other departments (e.g. Central Booking Office, Theatres, Day Service Unit, the Endoscopy Unit, and the Programmed Investigation Unit) to ensure that each patient is reviewed, has diagnostic procedures and is treated within the timeframes set for the relevant tumour- specific clinical pathway.
- The Cancer Tracking Team is responsible for ensuring accurate validation of any patient on a cancer pathway.
- All cancer tracking team staff are responsible for working within the guidelines outlined in the Trust's Patient Access Policy.

1.4.10 Radiology Team

- The Radiology department is responsible for ensuring timely access to diagnostic procedures (excluding colonoscopy). All protocols for referral to radiology are managed in line with IR(ME)R 2000, NICE, IOG and the Trust Requesting and Reporting Policy.
- The Radiology department is responsible for ensuring that there are procedures and policies in place to ensure timely access to a radiological opinion within defined timescales supporting RTT, urgent care and cancer standards.
- The Radiology department is responsible for liaising with all referrers to ensure that the most appropriate test is conducted for every patient.

- The Radiology department will, whenever possible, negotiate reasonable admission dates and times with patients.
- The department is also responsible for completion of cancer upgrade forms, as required.

1.4.11 All Staff

- Other staff (both administrative and clinical) will be required to have an understanding of this policy and work within its guidelines. It is the responsibility of managers to identify the areas for which staff may require training, in order to support the delivery of RTT, non-RTT, cancer and diagnostic standards, and to ensure that they receive it.

1.4.11.1 People with a Learning Disability and/or Autism

- People with a ***learning disability and/or autism*** generally have worse physical, and mental health, than people without a learning disability and/or autism. On average, the life expectancy of women with a learning disability and/or autism is 18 years shorter than for women in the general population; and the life expectancy of men with a learning disability and/or autism is 14 years shorter than for men in the general population (NHS Digital 2017).
- Making reasonable adjustments can mean removing barriers that people with a learning disability, and/or autism, face, or providing something extra for someone with a learning disability, and/or autism, to enable them to access the healthcare they need. Healthcare professionals have a legal duty to provide reasonable adjustments for disabled people (Public Health England, 2016).
- Tameside and Glossop Integrated Care Foundation Trust is committed to removing barriers to healthcare for people with a learning disability, and/or autism. No person with a learning disability, and/or autism, will be automatically discharged from services for non – attendance at an arranged appointment. People who do not attend appointments should be referred back to the Community Learning Disability Team, who will work with the hospital liaison nurse to ensure that the person receives the care they need.

SECTION TWO

The section provides an overview of the Referral-to-Treatment (18-week) standards. It also provides an overview of other standards related to elective care; the various types of waiting lists and the management of these are outlined.

It is important to note that non-consultant led pathways are excluded from monitoring under the RTT (18 week) waiting times standards.

2.1 Waiting Times & Referral to Treatment Standards

From March 2008 the concept of waiting times for the different stages of treatment (outpatient, diagnostic, and inpatient) was replaced by that of the 18-week, Referral- to-Treatment (RTT) pathway. RTT is concerned with the patient's journey from referral to first definitive treatment, rather than measuring the time spent waiting at different stages of the pathway.

Measurement of the RTT pathway is based on clock starts and clock stops. Generally speaking, the RTT clock starts when a patient is referred into a medical or surgical consultant-led service (regardless of setting) in which it is expected that the patient will be assessed and, if appropriate, treated. The clock stops when: a clinical decision is made that treatment is not required; when a patient declines treatment; when first definitive treatment begins; or if the patient commences active monitoring.

NHS providers are required to report:

- Patients whose RTT clock is still running (incomplete pathways);
- Patients waiting greater than 52 weeks for treatment.

2.2 Required Levels of Performance for National Indicators

2.2.1 Referral to Treatment

The required performance against the standard is as follows:

- 92% of patients on an incomplete (open) pathway to have waited less than 18 weeks;
- No patient should wait greater than 52 weeks for treatment.

2.2.2 Diagnostic waiting times

'Diagnostic' means a test or procedure used to identify a person's disease or condition and which allows a medical diagnosis to be made. Tests carried out as part of national screening programmes do not count as a diagnostics test/procedure for the purposes of this access policy.

The diagnostic clock starts when the request for a diagnostic test or procedure is made. For E-referrals (Choose and Book), this is the time that the UBRN is converted (i.e. when the patient has accepted an appointment). Patients waiting for two separate diagnostic tests/procedures should have two independent waiting time clocks – one for each test/procedure.

The Department of Health's policy states that ***no more than 1% of patients should be waiting longer than six weeks for a diagnostic test*** (based on a census reported at the end of each month).

2.2.3 Cancer Waiting Times

In addition to reporting RTT data, providers must also continue to monitor and report on cancer waiting times. The guidance around cancer waiting times is different in some

aspects. For this group of patients, information must be provided against both RTT waiting times and cancer waiting times. *Please refer to Section 6.*

2.2.4 Cancelled Operations

In those instances where a patient has an elective inpatient or day-case procedure cancelled for a non- clinical reason on the day of surgery or following admission, there is a requirement to treat the patient within 28 days, or fund the patient's treatment at a time and hospital (this may be a private provider or other trust) of the patient's choice.

2.3 Management of Waiting Lists

In order to comply with national requirements, and to accurately identify those patients who are waiting for investigations or treatment, the Trust has a number of waiting lists. It is important that patients who are waiting for treatment are recorded on the correct list. Access to the waiting-list functions on the Trust's Patient Administration System (PAS) is at the discretion of the System Manager and will only be provided to staff whose role necessitates access to this information.

2.3.1 Outpatient and Community Waiting List (New Patients)

All GP referrals made to consultant- led services should be made via ERS. Any paper GP referral will be returned to the GP Practice, advising that an electronic referral will be required. All community referrals should be made via EMIS.

Internal or consultant- to- consultant / clinician-to-clinician referrals will be added to the waiting list within 48 hours of being received. This waiting list includes those patients waiting for a first outpatient appointment (hospital & community services) regardless of the source of referral. The Outpatient Department / Community Central Booking Team is responsible for the accuracy of data held on this list and will book patients from the list based firstly on clinical urgency and then chronologically.

The Outpatient Department / Community Central Booking Team is responsible for escalating concerns in relation to excess demand to Divisions in order for capacity issues to be addressed. The Outpatient Department is responsible for the management of appointment slot issues on the E-referral service (Choose & Book) when patients cannot book appointments due to insufficient capacity.

2.3.2 Outpatient and Community Follow-Up Waiting List

The Outpatient Department / Community Central Booking Team is responsible for the management of the follow-up waiting list, reviewing demand for follow-up clinics against agreed capacity outlined in clinic templates. In the event that there is insufficient capacity to meet demand the Outpatient Department / Community Central Booking Team is responsible for escalating these issues to the relevant Divisions in order for the capacity shortfall to be addressed.

2.3.3 Non-Admitted Waiting List

This waiting list includes all patients who have been referred to a consultant- led service and remain on an open RTT pathway following an initial outpatient appointment, but have not yet been added to a waiting list for admission. The list will include patients who are waiting a further follow-up appointment, as well as a diagnostic test that does not require admission (e.g. CT scan). The purpose of the non-admitted list is to support the management of patients through their pathway, since it allows operational teams to track patients and address potential delays. In addition to appearing on the non-admitted list, patients waiting radiological tests (e.g. X-ray) will also be captured on the Radiology Waiting List. The Radiology Information System (RIS) includes all patients waiting for radiological tests and not just those subject to the RTT operational standard.

The Referral- to- Treatment Tracking Team are responsible for validating the waiting list and will be required to escalate actions to the appropriate departments (e.g. appointments booked outside of patients' 18-week breach dates).

2.3.4 Inpatient & Day-Case Waiting List (Admitted List)

This list includes those patients who are awaiting admission as an inpatient ,day-case or out patient procedure. The admission may be required for a diagnostic test (e.g. gastroscopy) or for a therapeutic intervention (e.g. knee replacement). At the point of adding the patient to the list it must be made clear whether the patient is to undergo a

diagnostic or therapeutic intervention. This distinction is necessary to ensure that patients awaiting a diagnostic test do not exceed the maximum waiting-time standard of six weeks. In some instances it may have been the clinician's intention to undertake a diagnostic test, but it becomes apparent that treatment can be given (e.g. a patient is admitted for a diagnostic examination of the bladder and during the procedure the clinician removes a small bladder tumour which is the cause of the patient's symptoms). In this instance the diagnostic test became a therapeutic intervention and the RTT clock stops. Alternatively, the clinician may intend a procedure to be therapeutic, but it becomes diagnostic (e.g. a patient is admitted for removal of a cyst, but during the procedure the clinician decides that only a biopsy should be taken). In this scenario the RTT clock would continue. The correct outcome must be recorded following the patient's admission.

2.3.6 Planned Waiting List

Patients on a planned waiting list are not waiting for treatment to commence but for continuation of care. Patients should only be placed on the planned list if they have undergone initial treatment/diagnostic test and a period of time is required to elapse before the next stage of treatment can be commenced. Therefore, patients on the planned list are not routinely on an RTT pathway.
The planned list may include:

- Patients who require periodic review as an inpatient/day-case in order for an ongoing condition to be monitored (e.g. surveillance gastroscopy, colonoscopy, cystoscopy etc.).
- Patients for whom the clinical team may request that a period of time elapses following initial treatment before any subsequent treatment is undertaken (e.g. an orthopaedic surgeon may request that metalwork inserted to support healing of a fracture is only to be removed after a certain period of time).
- On some occasions a child may require surgery that they cannot have until they reach an optimum age; this patient can be classed as **planned** although in most instances it would be more appropriate to request the GP to re-refer the child at a later date or to appropriate Trust.
- Patients undergoing a series of treatments (e.g. a patient may attend for a course of pain- relieving injections on a three-monthly basis).

The planned list must not be used to hold patients who wish to defer surgery or are unable to have surgery due to underlying medical conditions.

All patients on the planned list must have an 'expected date of admission' which should not be exceeded.

When a patient on a planned list does not have the procedure within two weeks of the planned date they will be managed in accordance with RTT rules and an RTT clock will start.

In planning capacity, managers must take into account patients waiting for planned procedures.

2.4 Awaiting Test Results PTL (ATR PTL)

This list contains patients that are waiting for a diagnostic test or patients that are awaiting results post diagnostic testing. The Active ATR is used to manage patients waiting for diagnostic tests/ results on an RTT pathway. The Planned ATR is used to manage patients that have undergone initial treatment/diagnostic test, and a period of time is required to elapse before further investigations/ diagnostic tests are commenced. When adding a patient to the ATR, it is required that the diagnostic tests that the patient is awaiting are clearly identified in the comments, that the correct urgency is recorded and that the tests have been ordered by the consultant. The ATR PTL is based on clinical priority and includes the following times to breach:

- cancer patients (2ww) – seven- day breach date;

- urgent patients – 14- day breach date;
- routine patients – 42- day breach date.

An ATR access plan will be added to the Trust's PAS (Patient Administration System) as part of the clinic-outcome process. At the point of the clinic letter being typed, it is the responsibility of the Medical Secretary to ensure (where a diagnostic test is identified) that the ATR Access Plan has been entered and that the correct clinical priority has been assigned and the test has been requested by the consultant. Where the Support Secretary/ Medical Secretary cannot identify an appropriate access plan, they are responsible for ensuring that this is entered onto the PAS system.

The secretarial team is responsible for ensuring that:

- patients' diagnostic tests have been requested;
- patients are monitored by urgency and then in chronological order;
- all delays are escalated in line with the ATR Policy;
- when results return, they are viewed by the clinician in a timely manner;
- all result- outcome slips are completed by the clinician and indicate the next step for the patient;
- requests for follow-up appointments are moved to the Central Booking Office Outpatient PTL with an indicated time-frame for appointment;
- that the necessary checks are made with regards urgency, changing the 'do not offer before' date and ticking the 'all resources checked' box;
- patients are removed from the ATR PTL and all access plans are correctly closed when the clinician reviews the results and decides to discharge the patient from their care;
- a discharge letter is sent to GP/ patient.

2.5 Bilateral procedures

An RTT clock will commence at the point at which the patient was referred for the first stage of treatment. When the first stage of treatment has been completed, the RTT clock will stop. Upon completion of the first stage of treatment, a new RTT clock will start when the patient becomes fit and ready for the second- stage procedure.

2.6 Patient Choice

The Trust may be able to offer patients an earlier date with another consultant/ different clinic and advise the patient of this. Patients may only be transferred to another clinician if they have explicitly agreed to this. If the patient declines the offer to transfer then this must not affect their waiting time.

Some patients may state that they prefer to be seen / treated by a doctor of a particular gender. The Trust will comply with the patient's wish if this is practicable. GPs are asked to ensure that this request is included in the referral letter. If the service does not employ a doctor of the required gender within the requested specialty, the Trust reserves the right to return the referral letter to the GP.

2.7 War Veterans

All veterans are entitled to priority access to NHS hospital care for any condition, as long as it's related to their service, whether or not they receive a war pension.

2.8 Management of Children

Any child under the age of two should not be listed for elective surgery at TGICFT. It is expected that these patients will be referred on to an appropriate alternative provider and the patients wait time will continue without impediment.

2.9 Rapid Access to Treatment for Employees

The Trust will facilitate rapid access to treatment for its employees whenever possible, in order to support an earlier return to work. Under this scheme, the relevant GP refers the employee via the e- referral service and rapid access is requested by the patient and applied, whenever circumstances allow, to outpatient appointments, diagnostic tests and hospital admissions for treatment. This does not necessarily entitle employees to preferential appointments, nor does it include the use of private facilities or private treatment.

2.10 Consultant- to- Consultant Referrals

Every effort will be made to ensure that patients are seen in the correct clinic at the outset of the RTT pathway; however if, following the initial consultation, a decision is made that the patient should be seen by another specialist, the RTT clock will continue from the original referral date.

Where patients are transferred from one consultant to another (e.g. Consultant A leaves the Trust and patients are transferred to Consultant B) the RTT clock will continue under the original referral to the trust.

The appointment for the second consultant must be offered following the original consultation. Divisions must ensure the referral letter to the second consultant and the completed Lorenzo form is available in time for the new appointment.

Referrals for a different, unrelated condition to the original referral (excluding urgent referrals, suspected cancer referrals and other agreed exclusions) must be discharged and referred back to the GP to support patient choice.

2.11 Transfers to other NHS Providers

In cases of transfer to other NHS providers the above process will be followed; however, the whole treatment will be transferred and the patient will be removed from T and GCIC's waiting list. Such transfers will not take place unless the accepting provider agrees to treat within the maximum waiting-time period. The Business Manager will be responsible for ensuring contractual arrangements are in place, and for guaranteeing this prior to the transfer.

2.12 Transfers to Private Providers

Transfers to alternative providers will be made after consultation with the patient and the consultant. A completed RTT Minimum Data Set (MDS) proforma must be attached to the onward referral letter.

If a patient does not wish to be transferred, the original provider must ensure the patient is admitted for treatment (waiting times will continue uninterrupted). The patient must not experience an extended waiting time in their RTT pathway due to the transfer.

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

Where patients are transferred to the private sector under the same T and GCIC consultant, the patient and the consultant will be notified of the new venue.

Where a patient is transferred to a private provider and a new consultant, they must be made aware of this.

SECTION THREE

3.1 Referral to Treatment Rules Overview

The RTT standard applies to patients on elective pathways that involve (or may involve) medical or surgical consultant-led care. It sets a maximum time of 18 weeks from the point of initial referral, up to the start of any treatment necessary for all patients who want it, and for whom it is clinically appropriate. A regularly- updated FAQs is available at ***www.england.nhs.uk*** **.**

It is important to note that non-consultant led pathways are excluded from monitoring under the RTT (18 week) waiting times standards.

The decision as to whether an RTT clock commences is dependent upon **who** makes the referral and into **what** type of service the referral is made.

3.2 Referrals that Commence an RTT clock

Referrals from the following may start an RTT (18 week) clock:

- General Practitioners (GPs);
- General Dental Practitioners (GDPs);
- General Practitioners (and other practitioners) with a special interest (GPwSIs);
- Hospital consultants;
- Optometrists and Orthoptists;
- Accident & Emergency (A&E) Minor Injury Units (MIU);
- Walk-in-Centres (WiC);
- Genitourinary medicine clinics (GUM);
- National screening programmes;
- Specialist nurses or commissioner- approved allied health professionals;
- Self-referrals if verified by the patient's GP;
- Prison health services.

3.2.1 A referral, from the healthcare professionals outlined above, starts an RTT clock when it is expected that:

- The patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional;
- Any treatment will, or may, be carried out by a medical or surgical consultant-led service irrespective of setting.

3.2.2 Referrals from primary care to the following services start RTT clocks

Medical or surgical consultant-led services irrespective of setting including:

- Referral-management centres (this covers arrangements known as clinical advisory centres, integrated clinical assessment and treatment services, interface services etc.);
- Cancer services – identified as a suspected cancer referral (a 62-day cancer-target clock also starts);
- Rapid Access Chest Pain Clinics (a 14-day waiting time target for first outpatient/assessment applies);
- Diagnostic services, provided the patient will be assessed and, if appropriate, treated by a medical or surgical consultant-led service, before responsibility is transferred back to the referring health professional (i.e. 'straight-to-test' scopes etc.);*
- Practitioners with special interests if they are part of a referral-management arrangement as defined;
- Referrals to a consultant-led service, undertaken by Nurse Specialists / consultant and Allied Health Professionals ***are included*** as an RTT pathway;

- Straight to test - the GP refers the patient to a secondary-care consultant for a diagnostic test (e.g. gastroscopy). This does start an 18-week clock since the GP has determined that the patient requires intervention from a consultant-led service.

*Note: Referrals from primary care to diagnostics

3.2.3 Referrals to services from secondary care which start an RTT clock

In some circumstances an RTT clock will start in a secondary-care setting. Consultant- to-consultant (for consultant-led services) referrals do start a clock, specifically for:

- A different condition newly identified by the consultant and unrelated to the original condition for which the patient was referred (e.g. cardiology problem identified at assessment following orthopaedic referral). This may cause a second RTT clock to start (and a 31-day clock if cancer is the new condition) with any first clock still ticking.
- A consultant- to- consultant referral for the same condition continues the RTT clock that commenced in primary care (e.g. clinician refers to colleague who may sub-specialise in the management of specific conditions).
- A patient may attend A&E, Urgent Treatment Centre or the MAU and it is identified that they require the commencement of an elective pathway within a medical or surgical specialty.*
- In cases where a patient has been initially admitted as an emergency and it is identified that they require further treatment as an elective patient (e.g. patient is admitted with acute cholecystitis and listed for cholecystectomy).
- Separate conditions or complications developed with pregnancy, or if a new-born baby is suspected of having a condition for which they are referred to medical or surgical consultant-led service for elective treatment.
- New conditions identified as a result of a genetic test.
- In cases where a patient has not been on an RTT pathway (e.g. may have been on active monitoring) and a new decision to treat within a medical or surgical consultant-led service is made.

  *This does not apply to fracture or to anti-coagulant clinics since this is regarded a continuation of a non-elective pathway.

3.3 Referrals that do not commence an RTT (18 week) clock

Referrals from primary care to the following services do not start the clock:

- Allied Healthcare Professionals (e.g. physiotherapy), healthcare science or mental health services that are not medical or surgical consultant-led (including multi-disciplinary teams and community teams run by mental-health trusts) irrespective of setting;
- Diagnostic services if the referral is not part of a ‘straight-to-test’ arrangement;*
- Primary dental services provided by dental students in hospital settings;
- Obstetric services;
- Patients who have been seen in the private sector as private patients and who wish to transfer to NHS care. An RTT clock starts when an NHS provider accepts responsibility for the patient. The RTT standard does not apply to those patients who are treated as private patients within an NHS hospital.

  *Referrals from primary care to diagnostics
- GPs can request advice and guidance via the ERS system. During the advice- and-guidance period, the patient remains the responsibility of the GP. An RTT clock will only commence when a referral is submitted.

Direct Access - the GP refers for diagnostic reasons and, upon receiving the results, makes a decision about referring the patient onto secondary care. An RTT clock does not start since the GP has not yet determined whether further intervention is required.

3.4 Inter- Provider Transfers

A minimum dataset (MDS) has to accompany every patient transferred between providers. It must include the clock start date and RTT status and must be obtained for: referrals or transfers from other providers; and referrals and direct additions to the list from interface services. The Trust must provide the MDS for patients transferred/ referred to another provider.

SECTION FOUR

4.1 Referral to Treatment Clock Starts and Stops

This section describes at which points an RTT clock should be commenced and when it can be stopped. It is important to note that a patient's clinical care will often continue although an RTT clock has been stopped.

It is important to note that non-consultant led pathways are excluded from monitoring under the RTT (18 week) waiting times standards.

4.2 The Points at Which RTT Clocks Start

- In the case of a referral from primary care or a self-referral, the clock start is recorded as the date when the referral is received at the provider.
- In the case of an E-Referral (Choose & Book) the clock start is recorded as the date that the patient converts their Unique Booking Reference Number (UBRN).
- If a patient is booked into a secondary-care-based Referral Assessment Service (RAS), the clock starts on the date the GP provided the patient with the telephone appointment – not the date of the telephone appointment.
- If the referral is from an interface service or another acute provider, then clock start details must be obtained from the referring organisation. In general, if this service has only assessed the patient then the clock start will commence on the date that the referring service received the referral from the patient's GP/GDP.
- If the interface service provided a first definitive treatment that was subsequently determined to be unsuccessful or if the patient is referred on following active monitoring then the clock start will be when T and GCIC receives that referral.
- If the referral is from one consultant-led service to another for a different condition (e.g. cardiology problem identified at assessment following orthopaedic referral) the clock starts when the consultant decides to refer. This also applies when a clinician in the Emergency Department makes a referral to a specialty requesting that the patient is reviewed on an elective basis. The clock starts on the date that the consultant decides to refer and not the date when the referral is received.
- If the referral is from one consultant-led service to another for the same condition (e.g. clinician refers to a colleague who may sub specialise in the management of a specific condition) the clock start is the date the initial referral was received from primary care. Consultant- to- consultant referrals for the same condition do not start new RTT clocks.
- In cases where a patient has been initially admitted on a non-elective pathway and it is identified that they require further treatment as an elective patient (e.g. patient admitted with acute cholecystitis who is listed for cholecystectomy), the start of the RTT clock is the date that a decision to list was made. In those circumstances where a decision to list cannot be made during the non-elective episode (e.g. the team caring for the patient need to refer to another specialty for further advice or to carry out the procedure), the RTT clock will start on the date of referral to the other consultant-led team.
- If a patient has been on active monitoring and a decision is made that medical or surgical consultant-led intervention is required then a new RTT clock will commence at the time the clinician identifies that further intervention is required.

4.3 The Points at Which RTT Clocks Stop

- First definitive treatment - the clock stops on the date that the patient receives the first definitive treatment intended to manage his or her condition;
- For inpatient or day-case admissions, the clock stops on the day of admission;
- For treatment provided in an outpatient setting, the clock stops on the day the patient attends;

- Clinical decision that treatment is not required - the clock stops on the date that the clinical decision is communicated to the patient;
- Patient choice to decline treatment - the clock stops on the date that the patient declines treatment, having been offered it;
- Active monitoring - the clock stops on the date that the clinical decision to commence active monitoring is made;
- Decision to return the patient to primary care for non-medical/surgical consultant-led treatment in primary care- the clock stops on the date that this is communicated to the patient;
- The date on which a medical device is fitted;
- Receipt of first definitive advice from a consultant geneticist if treatment by the genetics service (e.g. counselling) is not required and if the original referral was direct to the consultant geneticist;
- Therapy (for example physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science interventions (e.g. hearing-aid fitting) if that is what the medical or surgical consultant-led service decides is the intervention required to manage the patient's disease, condition or injury and avoid further intervention;
- The point at which a patient is added to a transplant waiting list.

4.4 First Definitive Treatment

First definitive treatment can be:

- Outpatient treatment (or medical or surgical consultant-led treatment irrespective of setting) if no subsequent inpatient or day-case admission is expected;
- First-line treatment – less intensive treatments or medical management attempted with the intention of avoiding more invasive procedures or treatment;
- Inpatient or day-case treatment;
- Diagnostic tests turned into therapeutic procedures during the investigation.

4.5 Interventions That Do Not Stop an RTT Clock

The following examples do **not** stop the RTT clock:

- Administration of pain relief before a surgical procedure takes place, or other steps to manage a patient's condition in advance of definitive treatment;
- Consultant-to-consultant referrals where the underlying condition remains unchanged;
- The act of making a tertiary referral or a referral from one provider to another;
- The clock does not stop if a provider rejects a referral, stating that their service is not appropriate for this patient. The referrer must re-refer the patient to an appropriate service without delay.*

*Note: This means that T and GCIC may inherit waits from other providers (e.g. ICATS, acute trusts) if patients are rejected as unsuitable by these providers.

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[1] Sections 3 & 4 are taken from the Department of Health's Referral-to-Treatment Rules Suite

SECTION FIVE

5.1 Legitimate Exceptions and Delays

Patient-initiated delay can make it difficult for the NHS to provide treatment within 18 weeks. The way in which patient-initiated delay will be managed is detailed in this section.

- Prior to referral onto an RTT pathway GPs should ensure that patients are ready and available to receive treatment within this timeframe;
- There are some differences between the guidance that must be applied to patients on a cancer pathway (refer to section 6);
- Hospital cancellations do not stop the RTT clock.

5.2 Discharging (returning) patients to the referring services following patient delays

Where it is appropriate to return a patient back to their referring service due to any of the reasons laid out within section 5 of this policy the following criteria must be met:

- There must be clear evidence that appropriate reasonable offers of appointments/ admission dates have been communicated to the patient;
- If the patient cancels multiple appointments within ERS;
- Discharging the patient must not be contrary to their best clinical interest;
- The rules laid out in this policy must have been followed;
- The needs of vulnerable patients are protected and measures are in place to ensure that potential safeguarding risks are managed appropriately and in line the Trust's Safeguarding Children and Safeguarding Adults Policies.[2]

5.3 Reasonable Offers of Appointment

- The current definition of a **'reasonable offer'** is that it gives the patient a minimum of **2-weeks' notice for outpatient and diagnostic appointments** and **3-weeks' notice for inpatient and day-case** procedures. *Please note that the definition of a reasonable offer is not applicable to cancer patients due to the urgency of the condition.* This does not mean that a patient cannot be offered an appointment date within a time period of less than 2/3 weeks as many patients would be happy to accept this. It does mean, however, that in those instances in which a patient is unable to accept an appointment within these time periods their waiting time must not be prejudiced.
- Whenever possible a reasonable offer should be the result of a discussion with a patient, rather than a fixed appointment offered by post.
- When appointments are booked through the E-referral/ CAB system the patient will have selected the appointment date and time that is convenient to them. All appointments booked outside E-referral system should, whenever possible, be made in negotiation with the patient. The process of negotiating an appointment date will often occur as part of a telephone conversation with the patient.
- All appointment offers should be recorded on the PAS system in order to demonstrate that reasonable offers were made and to provide an audit trail. All letters regarding appointments should also be generated through PAS.[3]

5.4 Patients who choose to delay treatment on the outpatient and diagnostic pathways

The section below outlines the way in which the Trust (in agreement with commissioners) will manage patient-initiated delay in relation to the booking of outpatient and diagnostic appointments.

- The patient will be provided with a minimum of 2-weeks' notice for outpatient and diagnostic appointments. Some patients will turn down reasonable appointments

[2] Department of Health's RTT Rules Suite, October 2015
[3] Department of Health's RTT Rules Suite, October 2015

because they prefer, for example, to go on extended holiday or because of work commitments.

- Those patients who advise that they are available to attend within two weeks of referral may be offered an appointment within this timeframe.
- In the event of a patient declining a reasonable offer (i.e. a date and time of appointment with at least 2-weeks' notice for an outpatient or diagnostic test), the patient should be offered an alternative date. This second date does not have to be 2 weeks from the original date offered, but should not be within a period during which the patient has indicated they are unavailable. If a patient is offered the 1st March and advises the team that he/she is on holiday until the 7th March, the first reasonable offer would be recorded as 1st March and the next date offered must be after the 7th March.[4]
- If the patient declines a second offer of a date then they should be advised that this may result in their referral being returned to their GP and a re-referral will be necessary when the patient is available to attend.
- If a patient cancels two consecutive appointments the RTT clock will be stopped, and the Trust reserves the right to refer the patient back to the GP.
  Referral back to the GP would stop the 18-week clock and a new RTT clock would start at the point when the patient and GP agree to re-refer for treatment. The rationale for referring back to primary care is to ensure that the GP is aware that the patient is not attending for the care for which they were referred. This is particularly important in safeguarding children and vulnerable adults.
- If a patient attends for their outpatient appointment and does not wait to be seen by the clinician and does not inform a member of staff that they cannot wait this will be recorded as a 'DNA' on PAS and in the case-notes and the RTT clock will be stopped. If the patient wishes to rebook another appointment a new RTT clock will start. Alternatively the trust reserves the right to refer the patient back to the GP.
- If a patient declines or cancels two appointments for a diagnostic test the relevant department will inform the clinician who referred or accepted the patient for the test/procedure. The referring clinician will then make a decision on whether to return the patient to their GP.
- If, after declining or cancelling two appointments for a diagnostic test, a patient is re-appointed to either a diagnostic appointment or an outpatient appointment and they proceed to decline an offer or cancel the appointment, the patient will be automatically discharged back to their GP (and the appropriate Trust clinician informed).[5]

5.5 Patients who choose to delay treatment at the point of listing for admission as an inpatient/day-case

- Some patients will choose to delay their surgery because of personal circumstances and may be unavailable for admission from the point at which the decision to admit is made (e.g. a patient who is a student and wishes to delay their admission until the summer holidays). This would mean that offering actual dates would be inappropriate because the patient would be unavailable.
- Where patients choose to defer surgery, the Trust will accommodate this. The clinician will need to decide if the time period that the patient wishes to wait will compromise the treatment plan, and whether the patient will require further assessment prior to attending for surgery.
- If the clinician decides that further assessment will not be necessary then the patient should be listed for surgery and the date that they wish to make themselves available for treatment must be recorded on PAS. A comment should be made on PAS that the patient has opted to defer surgery.

[4] The first three bullet-points in this list are taken from the Department of Health's RTT Rules Suite, October 2015
[5] The last five bullet-points in this list are local policy, but conform to national guidance providing the conditions listed in Section 5.2 are met

- In the event that the patient wishes to extend this period of time, this should only be done following discussion with the relevant clinician.
- In circumstances where the clinician decides that deferral of treatment would require the patient to be reassessed at a later date (e.g. return for further follow up), the patient should be returned to the care of their GP and re-referred at a more appropriate time.[6]

5.6 Additions to the Inpatient and Day-case Waiting List

- Patients should not be added to the inpatient or day-case list if their surgery requires funding approval from commissioners. In such cases, the patient will either be discharged back to the GP, or a funding request form will be completed by the treating consultant, and then sent to the relevant commissioner and monitored by the Effective Use of Resources tracker until funding has been authorised.
- If it is evident that the patient is unfit for surgery then a decision needs to be made by the clinician as to the next step in the patient's pathway. This may include:
  - Return the patient to the care of their GP (clock stop - decision not to treat);
  - In those instances where the patient's condition is deemed to be clinically urgent and referral back to GP is inappropriate, the hospital consultant may need to seek the advice/intervention of a consultant colleague in another specialty. In this case the RTT clock will continue until such time as the patient receives the treatment originally intended;
  - It may become apparent that (following further assessment) the original procedure cannot be undertaken and an alternative treatment plan is required. The RTT clock would continue until the new treatment is provided.[7]

5.7 Patients who choose to delay treatment after the point of listing for admission as an inpatient / day-case

- Where a decision to admit for a treatment has been made (i.e. the patient is listed for treatment as an inpatient / day-case) and following this the patient wishes to defer the treatment for a period of **up to 6 weeks**, then this should be noted on the PAS.
- If the patient wishes to defer the treatment for a period **more than 6 weeks** the patient must be informed that this will be discussed with the relevant clinician.[8]
- If the clinician decides that further deferral would require the patient to be re-assessed at a later date, e.g. return for further follow-up, the patient should be returned to their GP requesting that the patient is re-referred at a more appropriate time. If no further appointment is required, the patient may contact the Booking and Scheduling Team when they are ready for surgery.
- Where a patient cancels an admission date, having previously agreed to attend, the patient will be advised that a second cancellation will result in them being removed from the waiting list and referred back to their GP.[9]
- In those instances where a patient has an elective inpatient or day-case procedure cancelled for a non- clinical reason on the day of surgery, or following admission, there is a requirement to treat the patient within 28 days, or fund the patient's treatment at a time and hospital (this may be a private provider or other trust) of their choice. The Trust has met its obligations providing it makes an offer of admission within the 28-day period.

[6] Department of Health's RTT Rules Suite, October 2015
[7] Department of Health's RTT Rules Suite, October 2015
[8] The four-week rule is local policy, but giving the clinician the right to decide means that the policy conforms to national guidance
[9] Local policy, but conforms to national guidance providing the conditions listed in Section 5.2 are met

5.8 Patients who do not attend (DNA)

- Any patient who did not attend their first appointment after initial referral will have their clock nullified (i.e. it is as if the referral never existed since effectively the patient has chosen not to start their pathway) and their referral will be returned to the GP or other referrer. A new clock will start on the date the provider receives notice of any subsequent re-referral as laid out in *DH RTT consultant-led waiting times Rules Suite section 3.e.'*[10]
- A DNA at any other point along the pathway will result in the patient being returned to the care of their GP; the act of discharging the patient will stop the RTT clock.
- Patients who cancel their appointment with less than 24 hours' notice, or on the day of the appointment, may be treated as a DNA.[11]
- If in exceptional circumstances the clinician decides that it is clinically necessary to rebook the appointment, then the Trust will make contact with the patient to negotiate an appropriate appointment date. In this scenario the RTT clock will continue.[12]
- Where patients cannot be contacted, an invite letter will be sent requesting them to contact the hospital. If the patient fails to respond within 14 days they will be discharged back to their GP and the clinician will be notified to assess any potential safeguarding risks.[13]
- Where a patient has been re-appointed after a previous DNA, or cancellation, and the patient proceeds to DNA a further appointment, they will be automatically discharged back to their GP, the appropriate clinician informed (where appropriate: i.e. vulnerable patients, children) and the Safeguarding Team notified.[14]
- In cases where the patient, GP or other referrer believes that this was not a true DNA and the Trust can't prove otherwise, the patient should be reinstated and this should be escalated to the Outpatient Directorate Manager (outpatient appointments) or the Elective Access Manager (inpatient and day-case appointments). The patient's pathway must be re-opened and continue as if never closed.[15]
- Where a child or vulnerable adult DNAs an appointment, the case will be reviewed by the consultant and a decision will be made to: discharge the patient, book a further appointment or make further enquiries. If there are on-going concerns, the child or vulnerable adult would be discussed with the Safeguarding Team for Children or Adults, and further action taken if needed.[16]

5.9 Patients who are unsure about proceeding with treatment

Where patients request time to decide whether they wish to commence a specific form of treatment (medical or surgical) the patient should be given a reasonable amount of time to consider this. The Trust would define reasonable as being no more than four weeks. When a patient wishes to take more than four weeks to consider their options, their RTT clock will be stopped and the patient may be returned to the care of their GP. Where the Trust retains the care of the patient, a new RTT clock would commence when the patient decides to proceed with treatment.[17]

5.10 Patients who want to be seen by a doctor of a specific gender

Some patients may state that they prefer to be seen / treated by a doctor of a specific gender. The Trust will comply with the patient's wish if this is practicable. GPs are asked to ensure that this request is included in the referral letter.

[10] Department of Health's RTT Rules Suite, October 2015
[11] Local policy
[12] Local policy/ process that conforms to the Department of Health's RTT Rules Suite, October 2015
[13] Local policy/ process consistent with the Department of Health's RTT Rules Suite, October 2015
[14] Local policy, but conforms to national guidance providing the conditions listed in Section 5.2 are met
[15] Local policy/ process consistent with the Department of Health's RTT Rules Suite, October 2015
[16] Local policy/ process consistent with the Department of Health's RTT Rules Suite, October 2015
[17] Department of Health's RTT Rules Suite, October 2015

If a doctor of the required gender is not available (due to leave or absence), and the referral is not urgent, then it may be possible to arrange a further appointment when a suitable doctor is available. If the referral is urgent and a doctor of the required gender is not available (due to leave or absence), the Trust will comply with the patient's wishes and agree a suitable appointment date/time, but this may not be within the required standards for urgent or suspected cancer referrals.

If the service does not employ a doctor of the required gender, the Trust will return the referral letter to the GP.[18]

5.11 When it is not clinically appropriate to treat within the RTT (18 week) standard

In some cases, treatment within 18 weeks may prove not to be possible for clinical reasons. For instance:

- If a series of tests must be done in sequence;
- When a second condition presents itself that needs to be treated before the first;
- When the patient and consultant have agreed that the patient should receive a second opinion which despite best efforts adds a critical delay;
- When the patient is medically unfit to be treated within a reasonable optimisation period;
- Any patients for whom there is genuine clinical uncertainty about the diagnosis, but where watchful waiting (and clock stop) is inappropriate.[19]

5.13 Communication and Documentation

If the clock is stopped because of a clinical decision not to treat, then the clock stops on the date that the clinical decision is communicated to the patient.[20]

[18] Department of Health's RTT Rules Suite, October 2015
[19] Department of Health's RTT Rules Suite, October 2015
[20] Department of Health's RTT Rules Suite, October 2015

SECTION SIX

Cancer Access

This section of the Trust's Patient Access Policy has been developed to support the achievement of the national cancer standards and provides guidance on how the rules and definitions need to be applied by those responsible for delivering cancer services at T and GCIC.

Management of referrals between GPs and secondary care is a matter for local policy, though the detail of such protocols must retain both the essence of the cancer- waiting-times (CWT) rules and the 'spirit' of those rules. The best interest of the patient must be the key principle of any local policy.[21]

This element of the Trust's Access Policy is consistent with the ***Greater Manchester and Cheshire Cancer Access Policy***, which is based upon the ***National Cancer Waiting Times (CWT) Guidance, Version 9***.

This section of the Trust's Patient Access Policy should be read in conjunction with the remainder of the Policy. Many of the general guidelines in the Patient Access Policy can be applied to patients on a cancer pathway.

The NHS Cancer Plan (2000) and the NHS Plan (2000) set out a vision of a service for patients on a suspected cancer pathway, and those on a routine pathway, designed around the patient with a ten-year programme of investment and reform to transform the system and put it at the forefront of best-practice internationally.

The NHS Cancer Plan set out that patients referred with suspected cancer should wait no longer than 14 days for first outpatient assessment or first diagnostic test. It also stated that from decision-to-refer to first treatment should be no longer than 62 days.

The NHS Cancer Plan also states that patients not referred via the two-week rule system, but subsequently found to have a diagnosis of cancer, should wait no longer than 31 days from a decision-to-treat to first treatment.

The Cancer Reform Strategy (Dec 2008) extended access and treatment for a cancer pathway to include:

- All patients referred with breast symptoms to be seen within 14 days (excluding referrals for reconstruction) by Dec 2009;
- Patients from National Screening Programmes to be upgraded to a 62-day pathway if cancer suspected or confirmed from Jan 2009;
- Consultant upgrade of routine patients to a 62-day pathway from Jan 2009;
- All subsequent treatments for primary, recurrent and metastatic cancers within 31 days of decision-to-treat or the earliest clinically appropriate date.

This policy outlines the access expectations of the patient journey from the point of referral to the start of treatment under the cancer-waiting-times rules. It sets out the principles that will apply at the different stages of the journey to ensure that the rules and guidelines for cancer pathways are applied fairly and consistently, and in ways that deliver the intended benefits for NHS patients and NHS organisations.

6.1 Required Level of Performance

The cancer waiting times service standards are:
a) Maximum two weeks from:

[21] CWT 8.1

i) receipt of urgent GP/GDP referral for suspected cancer to first outpatient attendance [***Operational Standard of 93%***];
ii) receipt of referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment [***Operational Standard of 93%***]**.**

b) Maximum 31 days from:
i) decision to treat to first definitive treatment [***Operational Standard of 96%***];
ii) decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is:
(1) surgery [***Operational Standard of 94%***]
(2) drug treatment [***Operational Standard of 98%***]
(3) radiotherapy [***Operational Standard of 94%***].

c) Maximum 62 days from:
(i) receipt of urgent GP/GDP referral for suspected cancer to first treatment [***Operational Standard of 85%***];
(ii) receipt of urgent referral from NHS Cancer Screening Programmes (breast, cervical and bowel) for suspected cancer to first treatment [***Operational Standard of 90%***];
(iii) date of consultant upgrade of urgency of a referral to first treatment [***No Operational Standard as yet***].

d) Maximum 31 days from receipt of urgent GP referral to first treatment for children's cancer, testicular cancer, and acute leukaemia [***No separate Operational Standard – Monitored within 62-day standard***].

6.2 Roles and Responsibilities

Referrer Responsibilities

- Ensure that the patient is clinically suitable for referral via the two-week wait referral method and intended pathway of care.
- Ensure that the patient is adequately informed that they are being referred urgently on a suspected cancer pathway and is prepared to be seen within the required timescales.
- Ensure that the patient is prepared to be treated within the appropriate timescales.
- All two-week wait referrals must be made via the E-referral Service (Choose and Book) where the service is available.
- Initiate the referral through the use of the E-referral Service (Choose and Book) attaching the appropriate referral pro-forma for that tumour site.

Patient Responsibilities

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

Trust Responsibilities

- Deliver all activities within the national maximum treatment time milestones and targets where clinically appropriate.
- Ensure that only patients fit for surgery are added to the elective waiting list.
- Investigate breaches of cancer pathways or national maximum treatment time milestones.

6.3 Cancer Waiting Times Clock Starts and Stops

Clock Starts

- A two-week wait clock starts when a General Medical Practitioner / General Dental Practitioner, or service permitted by the commissioner to make such referrals, refer a patient with suspected cancer and when the provider receives and accepts such referral.[22]
- If the patient goes 'straight-to-test' following a two-week wait (2WW) referral the receipt of the referral is the clock start and the date of the test is the 'date first seen' under the two-week wait rule.[23]
- A 62-day pathway commences on receipt of a two-week wait (2ww) referral. If the patient goes on to have a cancer diagnosis then treatment has to be delivered 62 days from receipt of the 2ww referral.[24]
- Upon upgrade of a routine referral (clock start) to delivery of treatment should be within 62 days.[25]
- A 31-day pathway commences at the point of decision to treat and treatment should be delivered within 31 days of this.[26]

6.4 Clock Pauses / Restarts

- If a patient DNAs their first 2ww appointment, the clock may be re-set to the date upon which the patient rebooks their appointment.[27]
- A clock may be paused where a decision to admit has been made, and the patient has declined two reasonable appointment offers for admission. The clock is paused for the duration of the time between the first reasonable offer and the date from which the patient says that they are available.[28]
- A clock may be paused when a patient declines a reasonable offer of admitted treatment. In the case where there are a number of clinicians (of equal expertise) in a team, but one particular consultant is on leave and the patient insists on waiting for this consultant, the clock would stop from the TCI date offered and would restart from the date the consultant is back from leave.[29]

6.5 Clock Stops

Clock stops for treatment

A clock stops when:

- ***First definitive treatment*** provided by an interface service begins (date of admission for surgery);
- ***Consultant-led*** first definitive treatment begins;
- A ***clinical decision*** is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list (if no other active cancer treatment is given in the interim).
- ***Therapy or healthcare-science intervention*** provided in secondary care or at an interface service begins, if this is what the ***consultant-led*** or ***interface service*** decides is the best way to manage the patient's disease, condition or injury and avoid further interventions.

[22] *(CWT 8.1 – Ref 3.1.1)*
[23] *(CWT 8.1 – Ref 3.1.28)*
[24] *(CWT 8.1 – Ref 3.3)*
[25] *(CWT 8.1 – Ref 3.8)*
[26] *(CWT 8.1 – Ref 3.9)*
[27] *(CWT 8.1 Ref 4.1.1)*
[28] *(CWT 8.1 Ref 4.1.1)*
[29] *(CWT 8.1 Ref 4.1.58)*

6.6 Clock stops for 'non-treatment'

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

- It is clinically appropriate to return the patient to primary care for any non-medical/surgical consultant-led treatment in primary care ;
- A clinical decision is made to embark on a period of active monitoring/watchful waiting;
- A patient declines treatment having been offered it;
- A clinical decision is made not to treat;
- A patient DNAs any other appointment along the pathway and is subsequently discharged back to the care of their GP, provided that:
    a) The provider can demonstrate that the appointment was clearly communicated to the patient;
    b) Discharging the patient is in their best clinical interests;
    c) Discharging the patient is carried out according to local, publicly available, policies on DNAs.

These local policies are clearly defined and developed to specifically protect the clinical interests of vulnerable patients (e.g. children or those with learning disabilities, or mental-health issues) and are agreed with clinicians, commissioners, patients and other relevant stakeholders.

6.7 Patient Choice

Outpatient and Diagnostic Appointments

- If the patient is not willing to accept two appointment dates offered separately, then a new clock may be started from the date of the second appointment cancellation. Alternatively the Trust reserves the right to refer the patient back to the GP.
- If the patient chooses a date outside the two-week deadline they will remain within the 2-week wait cohort and the 62-day cohort if cancer is confirmed. Operational standards take into account an element of patient choice.
- If the patient is unavailable for the whole of the 14-day period due to a pre-arranged holiday or commitments, the clock-start date (receipt of referral) is when the patient makes themselves available, and the appointment should be within 14 days of this. This is in the best interest of the patient in that it avoids the referral being returned to the GP.[30]
- A 2ww referral can only be downgraded after discussion and agreement with the referring GP; referrals should not be downgraded unless the GP has agreed.[31]
- All routine breast referrals (except those for reconstruction or family history) will be seen within 14 days of receipt of referral.
- The 62-day standard relates to the three national screening programmes:
    1. Breast – clock start is receipt of referral for further assessment;
    2. Bowel – clock start is receipt of referral for an OPA with screening nurse to discuss colonoscopy;
    3. Cervical – clock start is receipt of referral for colposcopy.
- If anyone is suspected of having cancer on these programmes they are automatically monitored against the 62-day standard until cancer has been ruled out or treatment for cancer commenced.
- If anyone is suspected of having cancer on any other screening programme then this suspicion should be notified to their GP who should initiate an urgent referral for suspected cancer. This would trigger both the two-week-wait standard and, if cancer was diagnosed, the 62-day standard.

[30] (*CWT 8.1 Ref:3.1.20*)
[31] (*CWT 8.1 Ref:3.1.25*)

- If a patient refuses to have a key diagnostic test they will be removed from the 62-day cancer pathway, and will be monitored as a 31-day cancer pathway once a decision to treat has been agreed.[32]

6.8 Upgraded Referrals

- A consultant can upgrade a patient from a routine to urgent referral.
- Patients can be upgraded by the consultant or another member of the team:
    1. When triaging or reviewing the referral;
    2. After the first diagnostic test;
    3. At an MDT discussion.
- Once upgraded the patient will be managed as a 62-day pathway (date of decision to upgrade to first treatment within 62 days).
- The start date is the date the referral is upgraded.

6.9 Inpatient and Day-case Admissions

- A patient requiring inpatient or day-case admission will be given a reasonable offer of an admission date within the required cancer waiting times targets. It is important to note that due to the urgency of the treatment for suspected/ confirmed cancer patients it is not always possible to conform to the 3-weeks' reasonable notice guidance as with routine admissions.
- Where a patient makes themselves unavailable for admission, for example a patient who has a pre-booked holiday, then this may mean that offering actual dates that meet the reasonableness criteria would be inappropriate (as the patient would be being offered dates that the provider already knew they couldn't make). In these circumstances, the clock should be paused from the date of the earliest reasonable offer that the provider would have been able to offer the patient until the date the patient is available.[33]
- In the situation where a patient has previously accepted a reasonable date offered for inpatient admission and then wishes to change the date of admission, this will be managed as a clock pause.
- Where a patient wishes to transfer to an elective NHS pathway for treatment, following a private consultation, a 31-day cancer pathway will commence once a decision to treat has been agreed, or at receipt of referral if decision-to-treat date was in the private consultation period.
- Patients will be advised of the need for treatment/ surgery, but the decision-to-treat date will not be confirmed until the clinician is in receipt of all relevant diagnostic test /investigation results to support the treatment / management plan. The 31-day cancer waiting time clock will commence at this point.

6.10 Patient Initiated Delays

Did Not Attend (DNA)

- When a patient does not attend (DNA) their first appointment following the initial two-week wait referral, they will not be returned to their GP, but the clock will be re-set to the date the patient rebooks their appointment.[34]
- If the patient DNAs two appointments following their two-week wait referral the patient will be referred back to their GP provided that:
    1. the provider can demonstrate that the appointment was agreed with and communicated to the patient;
    2. discharging the patient is not contrary to their best clinical interests;
    3. discharging the patient is carried out according to local, publicly available, policies on non-attendance (DNAs).[35]

[32] (*CWT 8.1 Ref: 3.3.14*)
[33] *(CWT 8.1 Ref 4.1.1)*
[34] *(CWT 8.1 Ref 4.1.1)*
[35] *(CWT 8.1 Ref 4.1.22)*

- If a consultant overrides the DNA protocol for clinical reasons or for issues of patient vulnerability the cancer waiting times clock will commence when the Trust makes contact with the patient.
- The DNA guidance above does not apply to children.[36] If a child DNAs an appointment, at any stage of the cancer waiting times pathway, their clock should continue, and the GP should be informed.

6.10.1 Patient Not Contactable

Where a patient does not respond to communication to agree a date for an appointment, the patient will be discharged and returned to the GP and the clock will stop. The Trust will write to the referrer to confirm that this has happened and to indicate that the patient would need to be referred again if treatment is still needed.

6.10.2 Patient Cancellations

- In relation to cancer pathways, a patient cancellation is defined as a patient failing to attend an appointment/ admission or giving less than 24-hours' notice that they will not be able to attend. [37]
- Patients who cancel their appointment with less than 24 hours' notice, or on the day of the appointment, may be treated as a DNA and have their cancer waiting time clock stopped with a new clock commencing from that date.[38]
- Where a patient cancels an appointment at an outpatient or diagnostic stage of the cancer pathway they will be able to re-book their appointment. Patients who cancel and re-book/ DNA (in any combination) any appointment more than twice will be removed from the 62-day pathway and monitored as a 31-day cancer pathway. This is in the best interest of the patient in that it avoids the referral being returned to the GP.
- Where a patient wishes to change the date of an inpatient or day-case admission they should be appointed a date of their choice, and the decision details recorded. **The clock is paused for the duration of the time between the date of cancelled admission and the date from which the patient says they are available**. If the patient is not willing to accept any dates, then the patient will be removed from the elective waiting list, and 62-day cancer pathway monitoring, and the referring clinician will be informed.
- The referring clinician will be advised of any patient who cancels and re-books their inpatient or day-case admission more than twice.
- If a patient is removed from a cancer pathway for any reason, but the referrer feels that reinstatement to the pathway is necessary, reinstatement should take place at the clinically most appropriate place on the pathway.

6.11 Provider Initiated

Hospital Cancelled Appointments / Diagnostic Tests

- In the event that the Trust cancels a patient's appointment, the cancer waiting times clock will continue.
- In the event that a repeat diagnostic test is required the cancer waiting time clock will continue.
- In all cases it is the Trust's responsibility to re-book the patient and treat within the maximum referral treatment times. This can include, and only with the prior agreement of the patient, a decision to transfer the care to another provider if the cancer pathway cannot be delivered in the required timeframe.

[36] Defined in The Children Act 2004 and Children Act 1989 as anyone under the age of 18 years
[37] Local policy
[38] Local policy

6.12 Patients Who Are Medically Unfit

- A patient will be considered to be medically unfit in the short-term when suffering from a condition or co-morbidity, which prevents the continuation or delivery of treatment, but which is **likely** to be resolved in less than three weeks. At any stage of the cancer pathway the patient will be re-booked at a time when they are likely to be fit.
- A patient will be considered to be medically unfit in the long-term when suffering from a condition or co-morbidity, which prevents the continuation or delivery of treatment, but which is **unlikely** to be resolved in less than three weeks.
- If a patient's treatment plan changes, or their cancer is re-staged, due to them being medically unfit in the long-term, active monitoring may be applied where this is appropriate, with the patient's full agreement and understanding. A new 31-day / second or subsequent cancer-waiting-time clock will commence once the patient becomes fit to continue with their original treatment plan.[39]

6.13 Transfers to Independent Providers

Where a patient is referred from an NHS Provider to an independent-sector organisation as part of their NHS cancer pathway, the clock will continue and the NHS Provider will be responsible for the monitoring and reporting of performance for the patient's cancer pathway. The admission date at the independent provider is taken as the start of treatment and will stop the clock.

6.14 Inter-Provider Transfers

- The minimum core Inter-Provider Transfer dataset should accompany the transfer of patients between providers, using the Greater Manchester & Cheshire Cancer Network Communication and Referral Protocol (CaRP) Proforma.
- The Trust will comply with the agreed timescales for inter-provider transfers as stated in the Greater Manchester & Cheshire Cancer Network Inter-provider Transfer Policy.

6.15 Interventions Not Normally Funded

- There may be occasions where commissioning authorisation is required for a clinical referral. Where a clinical referral requires authorisation from a commissioner, this authorisation must be obtained prior to the referral being made.
- When authorisation is given, a new Referral- to- Treatment / cancer clock will start on receipt of the subsequent referral in secondary or tertiary care. In the case that authorisation is not approved, the referral should be returned to the originator by the relevant commissioner and no clock will apply.
- Where the request for authorisation is made within an open Referral- to- Treatment/ cancer pathway, the clock will continue and the commissioner will be responsible for ensuring that delays to the patient are minimised.

6.16 Patients excluded from monitoring under the cancer standards

Any patient:

- with a non-invasive cancer:
  - situ (with the exception of breast which is included);
  - basal cell carcinoma (BCC);
- who dies prior to treatment commencing;
- receiving diagnostic services and treatment privately. However:
  - where a patient chooses to be seen initially by a specialist privately but is then referred for treatment under the NHS, the patient should be included under the existing and/ or expanded 31-day standard;
  - where a patient is first seen under the two-week standard, then chooses to have diagnostic tests privately before returning to the NHS for cancer

[39] Local policy

treatment, only the two-week standard and 31-day standard apply. The patient is excluded from the 62-day standard as the diagnostic phase of the period has been carried out by the private sector.

SECTION SEVEN

Community Services Access Policy

This section of the Trust's Patient Access Policy outlines the way in which the Tameside and Glossop Integrated Care Foundation Trust will manage patients who are waiting for a Community Services appointment. **This policy should be used in conjunction with the Patient Access Policy.**

Procedure Statement

Version:	**Version 3**
Name of originator/author/job title:	Hannah Gallagher Deputy Directorate Manager – Community
Date issued:	July 2020
Date document reviewed:	
Next review date:	July 2021
Target audience:	Community Central Booking Team, Directorate Management Teams, Clinical Teams, Performance and Information Team.

Policy Summary
This document sets out how Tameside and Glossop Integrated Care Foundation Trust (T&GICFT) will manage the pathway of patients for Community Services.
EQUALITY IMPACT Tameside and Glossop Integrated Care Foundation Trust strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of health care, T&GICFT aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed by the Executive Team to ensure fairness and consistency for all those covered by it regardless of their individuality.

VERSION CONTROL SCHEDULE		
Version number	**Issue / Review Date**	**Amendments from previous issue**
1	January 2020	Initial Draft
2	February 2020	Amends made to policy. Draft awaiting approval
3	June 2020	Policy circulated to community teams and implemented from 1st July 2020

Document Control

Summary of consultation process	
Control arrangements (Reviews shall generally be undertaken every 2-3 years or more frequently to take account of organisational learning)	This policy will be subject to review by the Directorate Manager – Outpatients and Health Records every 2 years or more frequently if external bodies updates on current RTT Guidance in the meantime.

Contents:		**Page**

1. Introduction

This document sets out Tameside and Glossop Integrated Care Foundation Trust's (T&GICFT) Operational Procedure for the Community Central Booking (CCB) team. It details how T&GICFT will approach the management of community services referrals, waiting lists and patient experience. It has been developed using current guidance from the Department of Health, and other sources of best practice.

The overall purpose of the document is to establish a consistent approach to the management of patient waiting lists and times across the organisation.

2. Objectives

To ensure all staff involved in community services are aware of and follow the processes outlined in this document, in order to provide equitable access for patients through effective waiting list management whilst enabling the Trust to achieve the required access standards, taking into account national rules and guidelines.

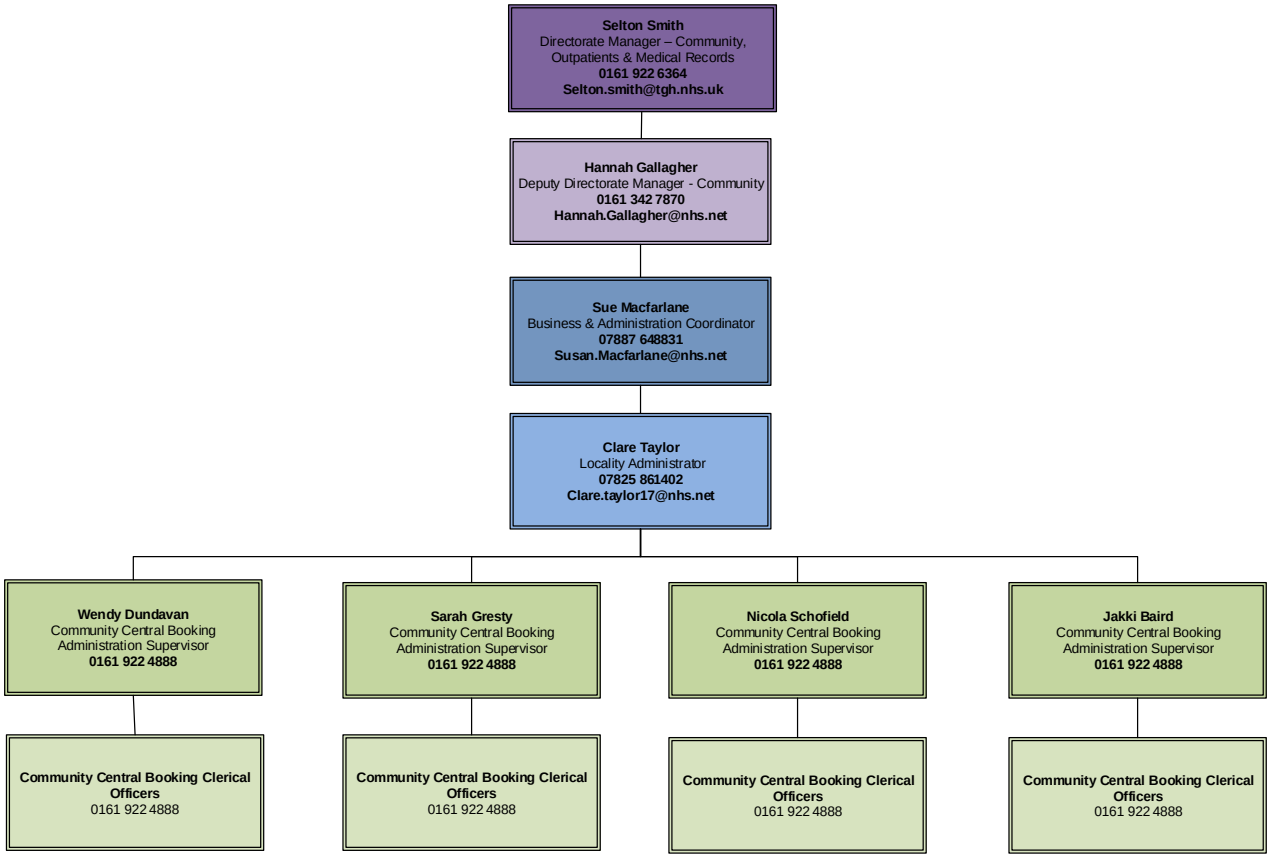
The key principles of this policy are:

- Ensure T&GICFT is a choice for patients and referrers via a robust directory of services.
- Ensure a seamless pathway for patients.
- Ensure both new and follow- up patients are treated firstly by clinical priority and then chronologically.
- Engage with the patient throughout the pathway providing choice of appointment date and time, whilst managing patient expectations.
- Improve the patient experience as they move through the clinical pathways, minimising unnecessary delays where possible.
- Ensure patients receive treatment according to clinical priority in the first instance, followed by chronological order.
- To ensure that all community clinic sessions are fully utilised, maximising resources where possible.
- Provide a professional service to our patients upon arrival and ensure that patients are seen within a reasonable time.
- Ensure patients are offered a chaperone in line with Trust Policy.
- To treat every patient with dignity and respect.

3. Scope

This document has been designed to be a reference guide for all staff involved with community services and sets out the standards required.

4. Structure, Duties and Responsibilities



4.1 Directorate Manager – Community, Outpatients and Health Records

The Directorate Manager will ensure that all staff are aware of this procedure and the importance of following the correct processes. The Directorate Manager has overall responsibility for adherence to the procedures detailed in the Operational Procedure. The Directorate Manager will be responsible for reviewing this procedure.

4.2 Deputy Directorate Manager Community

The Deputy Directorate Manager will support the Directorate Manager in the operational delivery and performance management of community administration services ensuring key access targets as well as DNA performance / utilisation are maintained and sustained. The post- holder will be expected to work independently to manage the departments, in line with service requirements and local/national policies.

4.3 Business & Administration Coordinator/Locality Administrator

The Business & Administration Coordinator/Locality Administrator will ensure that the processes outlined in this document are implemented and adhered to, without deviation, on a day –to- day basis. They will be responsible for accuracy of data held on EMIS that is relevant to waiting times (cancellations, patient preferences etc.).

The Business & Administration Coordinator/Locality Administrator will ensure the accuracy of information for all patients scheduled onto EMIS using information received from multi-disciplinary sources.

The Business & Administration Coordinator/Locality Administrator will provide assurance that the escalation procedures are followed by the Community Central Booking Team.

The Business & Administration Coordinator/Locality Administrator is responsible for the day- to- day management of the Community Central Booking Team and will ensure that adequate training is provided for existing and new members of the team.

4.4 Community Central Booking Supervisors

The Community Central Booking Supervisors will support the Business & Administration Coordinator/Locality Administrator in ensuring the processes outlined in this document are implemented and adhered to, without deviation, on a day- to- day basis.

The Supervisors will also be responsible for monitoring compliance against key departmental metrics and escalating capacity concerns via the escalation process.

4.5 Community Central Booking Clerical Officers/Scheduling Clerks

All Clerical Officers and Scheduling Clerks have a responsibility to ensure that they comply with the guidance in this operational procedure. All members of staff within the Community Central Booking Team are to provide a professional, friendly service to our patients.

Lack of clinic capacity/availability to be able to book patient appointments will be highlighted via the Supervisors for further escalation to the relevant Directorate team.

4.6 Clinic Clerical Officers/Administrators

All Clerks and Administrators have a responsibility to ensure that they comply with the guidance in this operational procedure.

Clinic Clerical Officers/Administrators are to provide a professional friendly service to our patients and visitors.

All Clinic Clerical Officers/Administrators will ensure that all patient demographic information is verified and updated at each point of contact on both EMIS and within the patient medical record.

4.7 Clinicians

All clinicians have a responsibility to clinically review all referrals electronically on EMIS within one working day and record any triage comments and/or changes that are required for Clerical Officers to action. Any changes to clinical priority must be identified.

Clinicians will need to return any rejected referrals to the referrer as per the Receipt and Management of Referrals into Community Services Standard Operating Procedure.

Clinicians must manage and provide appropriate capacity for their services and understand current waiting times against agreed maximum booking windows.

Task functionality must be used when communicating with Community Central Booking Team.

All clinicians must follow the annual leave policy for clinical staff and provide at least six weeks' notice for the cancellation and reduction of treatment room clinics.

4.8 Directorate Management Teams

The Directorate Management Teams have a responsibility to ensure that adequate capacity is available for all patients added to all waiting lists to enable the Trust to achieve the required standards against local and national targets.

The Directorate Management Teams have a responsibility to ensure that their respective clinical teams have robust processes in place in order to ensure that patients are booked into community clinics within agreed timeframes.

The Directorate teams are responsible for cancelled patients where by a clinic is cancelled with less than 6 weeks' notice (excluding sickness).

5. Access Policy Standards

5.1 General Principles

5.1.1 Community Services Waiting List

All GP referrals made to community services should be made via EMIS. Any paper GP referrals will be returned to the GP Practice, advising that an electronic referral will be required.

Internal referrals received from other community services via Community- to- Community EMIS will be added to the waiting list as soon as the referral is received and accepted electronically. This waiting list includes those patients waiting for a first appointment regardless of the source of referral. The Community Central Booking Team is responsible for the accuracy of data held on this list and will book patients from the list based firstly on clinical urgency and then chronologically.

The Community Central Booking Team is responsible for escalating concerns in relation to excess demand to Divisions in order for capacity issues to be addressed. The Community Central Booking Team is responsible for the management of appointment slot issues on EMIS when patients cannot book appointments due to insufficient capacity.

The Community Central Booking Team is responsible for escalating concerns in relation to capacity issues to the Directorate teams via local performance meetings.

5.1.2 Community Follow-Up Waiting List

Individual community services are responsible for the management of follow-up appointments, reviewing demand for follow-up clinics against agreed capacity outlined in clinic templates. In the event of insufficient capacity to meet demand, the Clinic Clerical Officers/Administrators are responsible for escalating these issues to the relevant service lead in order for the capacity shortfall to be addressed. The Community Central Booking Clerical Officers/Supervisors will have an overview of follow-up appointments and will also escalate any capacity shortfalls to the relevant service lead and Locality Administrator/Business and Administration Coordinator.

5.1.3 Community Referrals

Please see Standard Operating Procedure for Receipt and Management of Referrals in to Community Services.

March 2020 SOP
Receipt and Manage

5.1.4 Patients who Do Not Attend (DNA)

Any patient who did not attend their first appointment after initial referral will be discharged from the service. If in exceptional circumstances, the clinician decides that it is clinically necessary to rebook the appointment, the clinician will contact the Community Central Booking Team to request that the patient is re-booked an appointment. Where patients cannot be contacted, an opt- in/invite letter will be sent requesting them to contact the service. If the patient fails to respond within 21 days they will be discharged.

Where a child or vulnerable adult DNA an appointment, the case will be reviewed by the individual service and a decision will be made to: discharge the patient, book a further appointment or make further enquiries. If there are on-going concerns, the child or

vulnerable adult would be discussed with the individual service and/or the Safeguarding Team for Children or Adults, and further action taken if needed.

Where a patient has been re-appointed after a previous DNA, or cancellation, and the patient proceeds to DNA a further appointment, they will be automatically discharged and the clinician informed (where appropriate: i.e. vulnerable patients).

In cases where the patient, GP or other referrer believes that this was not a true DNA and the Trust can't prove otherwise, the patient should be reinstated.

All patients who DNA must have their pathway closed down on EMIS.

For the Health Visiting service, children are unable to DNA from this service and the Promoting Engagement Policy must be followed. See Health Visiting operational handbook or visit http://tghwebapp/documents/HCPPolicyV6.pdf for further information.

5.1.5 Patient Cancellations and Appointment Offers

Patients who cancel on the day will be classified as a DNA. Only in exceptional circumstances will a patient be offered an alternative appointment.

In the event of a patient declining a reasonable offer (i.e. a date and time of appointment with at least 2-weeks' notice), the patient should be offered an alternative date. This second date does not have to be 2 weeks from the original date offered, but should not be within a period during which the patient has indicated they are unavailable. If a patient is offered the 1st March and advises the team that he/she is on holiday until the 7th March, the first reasonable offer would be recorded as 1st March and the next date offered must be after the 7th March.

If the patient declines a second offer of a date then they should be advised that this may result in their referral being rejected/closed and a re-referral will be necessary when the patient is available to attend.

For people identified as having a learning disability, if a patient cancels two consecutive appointments, they will be referred back to the Learning Disability Team. This is to ensure that people with learning disabilities are able to access healthcare in line with 'Valuing People 2001' and 'Equalities Act and Reasonable Adjustment 2010'.

For the Health Visiting service, children are unable to DNA from this service and the Promoting Engagement Policy must be followed. See Health Visiting operational handbook or visit http://tghwebapp/documents/HCPPolicyV6.pdf for further information.

For any services that currently use an opt-in service, please see individual operational handbooks for appointment offers.

5.1.6 Clinic Cancellations

All community clinic cancellations or reductions must be processed by the Community Central Booking Team chronologically. All cancellation requests must be submitted via the online standard proforma with the appropriate authority.

Clinic reductions/cancellations with less than six weeks' notice must be agreed by the Directorate Managers and Divisional Directors and must provide clear instructions about where the patients are to be rebooked.

All cancellations/reductions must be recorded. Patients must be telephoned by the Community Central Booking Team if the appointment is within two weeks with an explanation of the appointment cancellations, along with an apology and offer of an

alternative appointment convenient to the patient. If the patient cannot be contacted, the Community Central Booking Team will make an appointment and send the letter in the post. For those appointment cancellations greater than two weeks, the patient must receive a cancellation letter with a clear apology for the inconvenience along with an alternative appointment date. The Directorate teams are responsible for cancelled patients whereby a clinic is cancelled with less than one week's notice (excluding sickness)

5.1.7 Patients who want to be seen by a practitioner of a specific gender

Some patients may state that they prefer to be seen / treated by a practitioner of a specific gender. The Trust will comply with the patient's wish if this is practicable. Referrers are asked to ensure that this request is included in the referral letter.

If a practitioner of the required gender is not available (due to leave or absence), and the referral is not urgent, then it may be possible to arrange a further appointment when a suitable practitioner is available. If the referral is urgent and a practitioner of the required gender is not available (due to leave or absence), the Trust will comply with the patient's wishes and agree a suitable appointment date/time.

If the service does not employ a practitioner of the required gender, the Trust will return the referral to the referral source.

5.1.8 Patients not entitled to NHS Treatment

People who are 'ordinarily resident' in the UK may use community services without charge, but those who are visiting the UK are subject to charges unless they come under an exemption as outlined by the Department of Health paper 'Making a Fair Contribution', Feb 2017.

The Deputy Directorate Manager - Health Records is responsible for ensuring effective systems exist within the organisation to administer overseas activity.

All Staff must adhere to the Overseas Visitors Policy & Procedures across the ICFT.

5.1.9 Informal Complaints

Informal complaints will be dealt with in a prompt and professional manner. Patient complaints should be escalated to the most appropriate member of the Management Team, whether that be clinical or administration so that every effort can be made to resolve the patient's issue.

5.2 Operational Processes

5.2.1 Creating clinic templates on EMIS

All requests for template creations (both recurrent and ad-hoc clinics) will be made via an electronic request form where approval would have been obtained by the Team Leader and/or Clinical Pathway Lead/Associate Directorate Manager prior to submission of the request form.

The Clinical Team will:

- Agree that the nursing or clinical resources are available
- Agree that the clerical infrastructure is in place
- Identify that there is adequate capacity within the community service to undertake the clinic(s) including room availability
- Ensure clinical cover is in place
- Design the clinic template including volume of new and follow-up slots, the volume of slots to be open on EMIS and the time of all slots

- Provide two weeks' notice so there is time to contact patients and ensure clinics are fully utilised.

The Community Central Booking Office Team will:

- Review the template request ensuring all relevant information is included
- Check templates are designed to ensure smooth patient flow throughout the clinic
- Develop template on EMIS.

5.2.2 Referral Management

All referrals must be registered on the EMIS system within 48 hours of receipt.

All referrals must be sat within 'Inbound' on EMIS for the relevant clinician(s) to triage the referral. This will not delay the scheduling of patients into treatment room clinics.

5.2.3 Appointment Slot Issues via EMIS

ASIs are attempts made by referrers or patients to book a new community clinic appointment via the Community Central Booking team. It is important from a patient experience perspective that the number of ASIs is kept to an absolute minimum and below the 5% national target. The Community Central Booking Supervisor will review the number of ASIs on a weekly basis and liaise with the Deputy Directorate Manager in order to ensure sufficient capacity is available.

5.2.4 Booking First Community Clinic Appointments

In the event of capacity being available, the Community Central Booking Clerical Officers will attempt to contact all URGENT patients or where appointment is less than 2 weeks' notice via telephone, to offer an appointment date and time. In the event of the patient being un-contactable, the Community Central Booking Clerical Officers will continue to attempt to offer an appointment throughout the day as well as sending out an appointment by letter.

Where there is no capacity to book a first appointment, the Community Central Booking Clerical Officers must review all available capacity including follow-up capacity with a view to converting a slot where possible. When the Community Central Booking Clerical Officers cannot identify a slot within the agreed timeframes, this must be recorded on the individual community service PTL and escalated via the escalation process for capacity.

The Deputy Directorate Manager - Community will meet with both Associate and Directorate Managers on a regular basis, if required, to discuss capacity issues. Associate Directorate Managers are expected to provide the Community Central Booking Clerical Officers with resolutions to capacity issues if the Community Central Booking Clerical Officers have exhausted all available opportunities. In any instance where this is not possible, this must be escalated through the Directorate Management Team.

5.2.5 Overbooking

The overbooking of clinics should only be done with the clinicians or senior management consent.

5.2.6 Clinic Utilisation

Clinic utilisation is recognised as a key component of service efficiency. 95% of available slots must be utilised. The Community Central Booking Clerical Officers must review the clinic slots on EMIS on a daily basis to identify available slots (including follow-up slots) following patient cancellations. The clerks will convert the timeslot to the correct appointment classification if requested by clinician or senior management.

5.2.7 Retrieval of Health records for Community Clinics

All health records must be available at the point of clinical care. Health records in paper format, if required, must be retrieved from community sites a minimum of two days in advance of the clinic. Community Clinic Clerical Officers must refer to the missing case-note escalation procedure when health records cannot be located.

5.2.8 Health Record Preparation

Paper health records must be prepared to the following standard:

- No loose documentation;
- Front sheet available;
- Case note folder of suitable quality;
- No information on the front of the case-note folder with the exception of patient name.

Referral letters are stored on EMIS for clinical staff to review whilst in clinic.

5.2.9 Reception – on Arrival

In the majority of cases reception is the first point of contact with a member of the Trust's staff. Staff must be polite, professional and must adhere to the Trust's uniform policy. Clerical Officers/Administrators must be sufficiently trained in customer service principles in order to fulfil their roles.

Clerical Officers/Administrators must undertake the following tasks:

- Welcome the patient
- Ascertain appointment information
- Check patient demographics
- Confirm patient contact details and ethnic origin
- Enquire if patient has lived anywhere other than the UK in the last three years
- Provide patient with appointment information
- Advise the patient where to take a seat.

Receptions must be opened between the standard hours of 08:30 – 17:00 Monday to Friday with the exception of the Primary Care Centres which open between the hours of 08:00 – 20:00.

5.2.10 Community Clinic – Patient Waiting Area

Whilst patients are waiting for their appointment it is important to keep patients informed of the waiting time in clinics. If there is a delay in clinic, nursing or support staff must provide an explanation to patients and an apology on behalf of the Trust.

Waiting areas must be open and available to accept patients ten minutes prior to their appointment.

5.2.11 Booking of Appointments

If the patient requires a follow up appointment they must be advised to report back to the reception, where the receptionist will make another appointment (providing there are no capacity issues). For some community services, the patient should have been handed the follow- up form to hand into the receptionist; this will contain the appointment details. The receptionist must offer an appointment before the patient leaves clinic. In the event of insufficient capacity within six weeks, and the appointment required is of an urgent nature, the receptionist must discuss this with the clinical team before the patient leaves in order to resolve the capacity shortfall. Routinely, where there is no capacity available, the receptionist will inform the patient that they will be contacted with an appointment and

escalate to the Deputy Directorate Manager. Community to liaise with the appropriate team leader.

All staff must adhere to the operating instructions for the management of follow- up patients.

5.2.12 Recording Patient Outcomes

Immediately upon a patient's arrival in clinic, attendance must be recorded on EMIS.

Following the patient's appointment the clinician/nursing staff must record the following on the EMIS patient record:

- The outcome of the appointment
- The future appointment status of the patient; i.e. discharge or follow-up appointment.

It is expected that clinical, nursing and clerical teams work in collaboration to ensure that this data is readily available at the end of the clinical session.

'Non-attendance' must be recorded on EMIS within 48 hours of the appointment time. Clinic Administrators are responsible for ensuring compliance within clerical teams. 'Non-outcomes' must be recorded on EMIS within 48 hours of the appointment time. Service Leads are responsible for ensuring compliance within clinical teams.

6 Escalation Procedures

6.1. Capacity Issues

The Community Central Booking Team will escalate capacity issues recorded on the new PTL once all available options have been exhausted.

The Deputy Directorate Manager will meet with Directorate teams, if required, to discuss capacity and utilisation information.

6.2 Short- Notice Cancellations

In the event of community clinic cancellations with less than six weeks' notice becoming a regular occurrence with specific clinical teams, the Community Central Booking Team must escalate to the Business & Administration Coordinator, who will liaise with the relevant Directorate representative. Areas of concern will also be discussed with Senior Management.

6.3 Patient-Related Issues

In the event of patients raising issues in relation to the Access Policy (e.g. DNA/ patient cancellation policy), the Community Central Booking Team must escalate these concerns, in the first instance, to the Community Central Booking Supervisor.

If the concerns cannot be addressed, the Community Central Booking Supervisor must then escalate to the Locality Administrator/Business & Administration Coordinator for a decision. The Business & Administration Coordinator can seek advice and guidance from the Deputy Directorate Manager.

7. Quality & Performance Monitoring

The Business & Administration Coordinator/Locality Administrator is responsible for ensuring the following:

- Community Service PTL (plus DNAs and cancellations) are reviewed on a daily basis by the Community Central Booking Team.
- Slot utilisation on EMIS is reviewed and actioned on a daily basis by the Community Central Booking Team.

- Ensuring Contact Centre performance (including referral management) is maintained.
- Use reports generated via the data warehouse for the management of the community services waiting list.

8. Training/ Communication Plan

Each area of the Community Administration Directorate will have a procedure guide, which will include the following:

- Community Services Operational Procedure
- Standard Operating Procedures and Handbooks for all Community Clinical Services
- Operating instructions
- IM&T training for EMIS.

Training plans in each of the respective areas will be completed by each staff member to ensure that they are fully trained on each aspect of their role.

This Policy and the Patient Access Policy will be communicated to all community staff by the following routes:

- ICFT intranet page
- Team meetings
- Local Induction for new starters.

9. Relevant Performance Reports

Performance reports are essential for the effective management of compliance with the Access Policy these will be monitored individually on a daily/weekly plan by the Community Central Booking team.

Report Description	Location	Frequency of Report	Actions	Responsibility For Monitoring

7.1 General Points

- Addition to the waiting list will be entered on PAS following completion of the Elective Admission Proforma, completed in outpatient clinics.
- The 'original date-on-list' recorded on PAS will reflect the date the decision to admit was made. This is usually the date of the outpatient clinic.
- Removals, admissions, cancellations and did not attends (DNAs) will be recorded on PAS on the day of the event.
- Pre-operative assessment DNAs / cancellations / removals will be acted upon by Pre-operative Assessment nurses who will notify the relevant Booking & Scheduling Clerk to action on PAS.
- Whomever the patient notifies of their cancellation, it is that person's responsibility to ensure that the appropriate Booking Clerk is notified to action this on PAS. All communication with the patient must be recorded in PAS. It must be made clear to patients who to contact in case of cancellation or changes in circumstances.

To ensure consistency and standardisation of reporting, all waiting lists are to be managed using the PTLs provided by the Information Team which are available on the Trust's Intranet.

7.2 Patient Access Policy Review

The Patient Access Policy will be reviewed on an annual basis to take account of any changes in national guidance/ new directives. The Patient Access Policy Review Team will consist of the following people: Divisional Leads, Elective Access Manager, Outpatients representatives, the Head of Information, the Director of Performance and Informatics.

Necessary changes throughout the year will be issued as amendments to the Policy. Such amendments will clearly reference the section to which they refer and indicate the date on which they were issued.

7.3 Training & Communication

All staff using hospital systems must have training for any system they will be using and be competent before they receive access and/or a Smart card.

7.4 Policy Awareness

An initial training programme will commence soon after introduction of the new Policy. Attendance for all Outpatient, Community and Elective Booking Clerks will be mandatory and recorded.

Monthly communications regarding the operational processes to support the application of the Access Policy will be undertaken in the relevant team meetings. Amendments to the Policy will be issued at these meetings.

SECTION EIGHT

Definitions

This section aims to provide clear definitions of the terms used in this Policy especially where they have a particular meaning within the context of RTT.

18-week referral to treatment period	The part of a patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other RTT clock stop point.
A	
Active monitoring	An RTT clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage. A new RTT clock would start when a decision to treat is made following a period of watchful waiting/ active monitoring. Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to refer the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such (this stops an 18-week clock). If a patient is subsequently referred back to a consultant-led service, then this referral starts a new RTT clock. Active Monitoring can also be used on cancer pathways.
Access plan	Lorenzo (T and GCIC''s PAS) terminology meaning waiting list.
Admission	The act of admitting a patient for a day-case or inpatient procedure.
Admitted pathway	A pathway that ends in a clock stop for admission (day-case or inpatient).
Advice and Guidance	GPs can use the Advice and Guidance function within ERS to seek advice from hospital consultants as an alternative to referral. If referral for an outpatient appointment is required, an RTT clock will begin at this point.
B	
Bilateral (procedure)	A procedure that is performed on both sides of the body, at matching anatomical sites (for example, removal of cataracts from both eyes).
C	
Choose and Book	See E-Referral Service
Clinical decision	A decision taken by a clinician or other qualified care professional, in consultation with the patient.

Consultant-led	A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each of a patient's appointments, but he/she takes overall clinical responsibility for a patient's care.
Convert(s) their UBRN	When an appointment has been booked via the E-referral Service /Choose and Book, the UBRN is converted. (Please see definition of UBRN).
D	
Day-case	Patients who are admitted to hospital for a diagnostic test or treatment and are expected to be discharged on the same day.
DNA – Did Not Attend	DNA (sometimes known as an FTA – Failed to Attend). In the context of RTT this is defined as when a patient fails to attend an appointment/ admission without giving prior notice.
Decision to admit	Where a clinical decision is taken to admit the patient for either a day-case or inpatient episode.
Decision to treat	Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day-case, but also includes treatments performed in other settings; e.g. as an outpatient.
E	
E—Referral Service/ ERS (previously Choose & Book)	A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic.
F	
First definitive treatment	The first intervention intended to manage a patient's disease.
Fit (and ready)	A new RTT clock should start once the patient is fit and ready for a subsequent bilateral procedure. A new RTT clock should start from the date that the patient says they are available for treatment once it has been established that it is clinically appropriate for the patient to undergo the procedure.
H	
Healthcare Science intervention	See Therapy or Healthcare Science intervention.
I	
Inpatients	Patients who require admission to hospital for a diagnostic test or treatment and are expected to remain in hospital for at least one night.
Inter-provider Transfer	The transfer of patients between healthcare providers. This may occur between NHS organisations and to/ from private healthcare providers.

N	
Non-admitted pathway	A pathway that results in a clock stop for treatment that does not require an admission.
Non consultant-led	Where a consultant does not take overall clinical responsibility for the patient.
Non consultant-led Interface Service	See interface service.
O	
Outpatients	Patients referred by a GP (General Practitioner) or another consultant for a clinical consultation and/or treatment.
P	
Performance	We will define success by what patients tell us, but patients' views need to be underpinned by measures of delivery that organisations can report and monitor progress on operationally. The measure of delivery for organisations will continue to be that reported in the: monthly Referral- to- Treatment datasets for incomplete pathways; the national cancer returns; and the national diagnostic waiting-time submission.
Planned Waiting List	Planned Waiting List patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or surgical investigation. These patients are not waiting for treatment, only for planned continuation of treatment. Examples include: Removal of screws/metal work; Age/growth- related surgery; Investigation/treatment sequences.
R	
Referral Management or Assessment Service	Referral management or assessment services are those that do not provide treatment, but accept GP (or other) referrals and provide advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient. Referral Management and Assessment Services should only be in place where they carry clinical support and abide by clear protocols that provide benefits to patients. They must not be devices either to delay treatment or to avoid having clinical discussions with GP Practices about good referral practice. In the context of RTT, a clock only starts on referral to a referral management and assessment service where that service may onward-refer the patient to a surgical or medical consultant-led service before

	responsibility is transferred back to the referring health professional.
S	
Straight-to- test	A specific type of direct access diagnostic service whereby a patient will be assessed and may, if appropriate, be treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional.
Substantively new or different treatment	Upon completion of an RTT Referral- to-Treatment period, a new RTT clock starts at the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan. It is recognised that a patient's care often extends beyond the Referral- to- Treatment period, and that there may be a number of planned treatments beyond first definitive treatment. However, where further treatment is required that was not already planned, a new RTT clock should start at the point the decision to treat is made. Scenarios where this might apply include: • where less 'invasive/intensive' forms of treatment have been unsuccessful and more 'aggressive/intensive' treatment is required (e.g. where Intra-Uterine Insemination (IUI) has been unsuccessful and a decision is made to refer for IVF treatment); • patients attending regular follow-up outpatient appointments, where a decision is made to try a substantively new or different treatment. In this context, a change to the dosage of existing medication may not count as substantively new or different treatment, whereas a change to medication combined with a decision to refer the patient for therapy might. Ultimately, the decision about whether the treatment is substantively new or different from the patient's agreed care plan is one that must be made locally by a care professional in consultation with the patient.
T	
Therapy or Healthcare Science intervention	Where a consultant-led or interface service decides that therapy (for example physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science (e.g. hearing-aid fitting) is the best way to manage the patient's disease, condition or injury and avoid further interventions.
U	

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