Patient Access Policy
(18 Week Referral to Treatment (RTT) and Cancer Waiting Times)

To whom this document applies: All Administrative Staff, Clerical Staff, Clinicians, Clinical Nurse Specialists, Service Managers and Operational Managers who participate in the monitoring and management of cancer waiting times

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Contributors: Please See Procedural Development, Consultation Proposal Form – page 2

Archiving information held by the secretary of the Procedural Documents Approval Committee
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<th>Title:</th>
<th>Patient Access Policy (18 Week Referral to Treatment (RTT) and Cancer Waiting Times)</th>
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<tr>
<td>Policy</td>
<td>Procedure ☑️ Guideline ☐ Protocol ☐ Standard ☐</td>
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**Name of person presenting document:**
Terri Agnew – Referral to Treatment Programme Lead

**Reason for document development/review:**
Inclusion of updated reconciliation forms (Appendix D).

**Names of development team (including a representative from all relevant disciplines):**
Access Policy RTT Reference Group

**Who has been consulted?**
- Chief Operating Officer
- Service Manager, Trauma and Orthopaedics
- Assistant Service Manager, Outpatients and Booking
- Service Manager, Cancer Services
- Service Manager, General and Specialist Medicine
- Interim Service Manager, Women’s, Children’s and Genito-Urinary Medicine
- Assistant Service Manager, Trauma and Orthopaedics, ENT, Medical Photography, Orthodontics and Oral Surgery
- Multi Professional Education and Development Manager
- Deputy Service Manager, Children’s Services
- Service Manager, General Surgery, Urology and Ophthalmology

**Does this document require presentation and agreement from Health and Safety Committee or Staff Partnership Forum prior to PDAC approval?**  Yes ☑️ No ☐

**Specify groups of staff to whom the document relates:**
All Administrative Staff, Clerical Staff, Clinicians, Clinical Nurse Specialists, Service Managers and Operational Managers who participate in the monitoring and management of cancer waiting times.

**Source of supporting evidence (references etc.):**
National Referral to Treatment Consultant led waiting times 2014

**Are there resource implications?**  Yes ☑️ No ☐

**Does the Procedure/Guideline meet latest NHSLA, Risk Management Standards, Essential Standards of Quality and Safety (CQC)?**  Yes ☑️ No ☐

**Does this Procedure/Guideline include children, if applicable?**
1. Does this document apply to children?  Yes ☑️ No ☐
2. Are there aspects of this document that differ with regard to the treatment of children?  Yes ☑️ No ☐

If yes, please state who has been consulted
- Lead Paediatrician for Children’s Cancer Services
- Deputy Service Manager, Children’s Services
- Interim Service Manager, Women’s, Children’s and Genito-Urinary Medicine

A Trust review will occur every two years unless national guidance states otherwise. Review must be carried out yearly.

**Date:** November 2014
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Introduction
This policy describes how the Trust monitors and reports performance relating to Referral to Treatment (RTT) Waiting Times and is consistent with 18 Weeks Guidelines 2014. It includes national dataset requirements for both waiting times and clinical datasets.

It is vital that this policy is applied across all services to ensure that the Trust meets national waiting time targets.

The intention of this policy is to ensure that referrals are handled efficiently and equitably, in line with national guidance and to ensure that the patient’s best interests and wishes are at the forefront of the way Colchester Hospital University NHS Foundation Trust (CHUFT) operates.

This policy aims to ensure that:

- As defined in the NHS constitution, patients have the right to expect to be seen and treated within national operational standards ensuring timely diagnosis and treatment, equity of care and patient choice.

  Patients of the same clinical priority will wherever possible be offered dates for appointment or treatment in chronological order, based on the number of days remaining on their cancer pathway, with the exception of patients showing flexibility to accept short notice appointments or TCIs.

- All patients receive their first appointment/treatment within the targets set out in the RTT suite of Rules taking into account clinical pathways and patient choice.

  Patients will be given reasonable notice and choice of appointments and TCI dates as defined within the policy.

- Administrative and clinical staff throughout the Trust take responsibility for moving patients along the agreed clinical pathway in the timescale set out within this policy.

- All internal documentation/referrals clearly state all relevant target dates.

- Clinical support departments adhere to and monitor performance against agreed maximum waiting times for test/investigations in their department.

- Accurate data on the Trust’s performance against the National Cancer Waiting Times is recorded in the Somerset Cancer Register and reported to the National Cancer Waiting Times Database (NCWTDB) within predetermined timescales.

- CHUFT will monitor the cancer patient pathway by using Patient Administration System (PAS) functionality and Patient Tracking Lists (PTL) measuring the patient length of wait from referral to new outpatient appointment, diagnostic test and treatment. Patients on a cancer pathway are tracked using the Somerset Cancer Register.

This policy assumes all General Practitioners/General Dental Practitioners (GP/GDP) are informing patients that they are being referred as a two week wait (2ww) and that it is a fast track pathway that will mean patients may be offered a series of appointments at short notice over a maximum two month period.
1. Definition of Terms

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 clock stop.

A
Active monitoring
A patient’s 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 clock would start when a decision to treat is made following a period of active monitoring (in previous guidance also known as watchful waiting).

Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to refer the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such and also stops a clock.

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

Admission
The act of admitting a patient for a day case or inpatient procedure.

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

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

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

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

Clinical decision
A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clock pause</td>
<td>See pause.</td>
</tr>
<tr>
<td>Consultant</td>
<td>A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. The operating standards for referral to treatment excludes non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.</td>
</tr>
<tr>
<td>Consultant-led</td>
<td>A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient’s appointment, but he/she takes overall clinical responsibility for patient care.</td>
</tr>
<tr>
<td>Convert(s) their UBRN</td>
<td>When an appointment has been booked via Choose and Book, the UBRN is converted. (Please see definition of UBRN).</td>
</tr>
<tr>
<td>DNA – Did Not Attend</td>
<td>DNA (sometimes known as an FTA – Failed to attend). In the context of the operating standards, this is defined as where a patient fails to attend an appointment/admission without prior notice.</td>
</tr>
<tr>
<td>Decision to admit</td>
<td>Where a clinical decision is taken to admit the patient for either a day case or inpatient treatment.</td>
</tr>
<tr>
<td>Decision to treat</td>
<td>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.</td>
</tr>
<tr>
<td>First definitive treatment</td>
<td>An intervention intended to manage a patient’s disease, condition or injury and avoid further intervention. What constitutes First Definitive Treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.</td>
</tr>
<tr>
<td>Fit (and ready)</td>
<td>A new patient pathway and clock should start once the patient is fit and ready for a subsequent bilateral procedure. In this context, fit and ready means that the clock should start from the date that it is clinically appropriate for the patient to undergo that procedure, and from when the patient says they are available.</td>
</tr>
<tr>
<td>Healthcare science intervention</td>
<td>See Therapy or Healthcare science intervention.</td>
</tr>
<tr>
<td>Interface service (non-consultant-led interface)</td>
<td>All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment</td>
</tr>
</tbody>
</table>
between traditional primary and secondary care. The operating standard/right relates to hospital/consultant-led care. Therefore, the definition of the term ‘interface service’ within the context of the operating standards does not apply to similar ‘interface’ arrangements established to deliver traditionally primary care or community provided services, outside of their traditional (practice or community based) setting.

The definition of the term does not also apply to:

- Non consultant-led mental health services run by Mental Health Trusts.
- referrals to ‘practitioners with a special interest’ for triage, assessment and possible treatment, except where they are working as part of a wider interface service type arrangements as described above.

<table>
<thead>
<tr>
<th>N</th>
<th>Non-admitted pathway</th>
<th>A pathway that results in a clock stop for treatment that does not require an admission or for ‘non-treatment’.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non consultant-led</td>
<td>Where a consultant does <strong>not</strong> take overall clinical responsibility for the patient.</td>
<td></td>
</tr>
<tr>
<td>Non consultant-led Interface service</td>
<td>See interface service.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>O</th>
<th>Operational Standards</th>
<th>We will define success by what our patients tell us, but patients’ views need to be underpinned by measures of delivery that organisations can report and monitor progress on operationally.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>We will continue to measure performance against the minimum operational standards of 90 per cent (admitted patients) and 95 per cent (non-admitted patients).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>These operational standards allow for patient initiated delays (patients who choose to wait longer than the maximum 18 weeks period) and clinical exceptions (patients for whom treatment in 18 weeks is not in their best clinical interests) on referral to treatment pathways.</td>
</tr>
</tbody>
</table>

| P | Pause/clock pause | A clock may be paused only where a decision to admit for treatment has been made, and the patient has declined at least 2 reasonable appointment offers for admission. The clock is paused for the duration of the time between the earliest reasonable offer and the date from which the patient makes themselves available again for admission for treatment. |
R
Reasonable offer
Where a decision to admit, as either a day case or inpatient has been made, many patients will choose to be admitted at the earliest opportunity. However, not all will, and it would not be appropriate to pause a clock for patients who cannot commit to come in at short notice.

A clock may only be paused therefore when a patient has turned down two or more ‘reasonable offers’ of admission dates.

A *reasonable offer* is an offer of a time and date three or more weeks from the time that the offer was made.

If patients decline these offers and decide to wait longer for their treatment, then their clock may be paused from the date of the first reasonable offer and should restart from the date that patients say they are available to come in.

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

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

In the context of the operational standards, a clock only starts on referral to a referral management and assessment service where that service may onward-refer the patient to a surgical or medical consultant-led service before responsibility is transferred back to the referring health professional.

S
Straight to test
A specific type of direct access diagnostic service whereby a patient will be assessed and might, if appropriate, be treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional.

Substantively new or different treatment
Upon completion of a referral to treatment period, a new pathway and clock starts upon the decision to start a substantively new or different treatment that
does not already form part of that patient’s agreed care plan.

It is recognised that a patients’ care often extends beyond the 18-week maximum 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 pathway and 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 patients agreed care plan is one that must be made locally by a care professional in consultant 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 Choose and Book. The UBRN is used in conjunction with the patient password to make or change an appointment.

2. Roles and Responsibilities

Chief Executive
The Chief Executive has overall responsibility and accountability for delivering access targets as defined in the NHS Plan, NHS Constitution and Operating Framework.
Chief Operating Officer
The Chief Operating Officer is responsible for ensuring that there are robust systems in place for the audit and management of Cancer access targets against the criteria set within this Cancer Services Operational Policy. The Chief Operating Officer will monitor Cancer waiting times through the Divisional Performance meetings and will review all external reports for verification.

Associate Director for Surgery and Anaesthetics
Responsible for the monitoring of performance in the delivery of the 18 weeks RTT targets and for ensuring the clinical divisions deliver the activity required to meet the 18 Weeks RTT targets.

Service Managers
Responsible for the monitoring of performance in the delivery of the RTT target and for ensuring the specialities deliver the activity required to meet the waiting list targets.

Hospital Consultants
Consultants have a shared responsibility with their Service Managers for managing their patients’ waiting times in accordance with the maximum guaranteed waiting time of 18 weeks.

Clinical Nurse Specialists
Clinical Nurse Specialists have a shared responsibility with their Consultants and Service Managers for managing their patients’ waiting times in accordance with the maximum guaranteed waiting time.

Contact Centre
The contact centre is responsible for arranging appointments and for carrying out the operating procedures for the administration of the patient's referral and for entering all information onto the PAS system accurately.

Associate Director for Business Informatics
Responsible for administering data required for managing and reporting RTT waiting times, activity and outcomes. Business Informatics ensure there is a robust Standard Operating Procedure for the external reporting of performance.

Waiting List Clerks/Medical Secretaries
Responsible for ensuring waiting lists are managed to comply with the RTT Operational Policy and in line with their job descriptions.

MDT Co-ordinators and Data Clerks
Responsible for monitoring the RTT pathway for patients, ensuring it is managed in line with this policy and assisting in the pro-active management of patient pathways on PAS in line with their job descriptions.

All Staff for whom this document applies
All staff will ensure that any data created, edited, used, or recorded on Trust IT systems within their area of responsibility is accurate and recorded in accordance with this policy and other Trust policies relating to collection, storage and use of data in order to maintain the highest standards of data quality and maintain patient confidentiality.

All 2ww patient referrals, diagnostics, treatment episodes and waiting lists must be managed on the Trust's PAS and Somerset system. All information relating to patient activity must be recorded accurately and in a timely manner.
3. Process

3.1 National Operating Standards
The following national operating standards apply to all patients:
- 95% of non-admitted patients will receive their first definitive treatment within 18 weeks (127 days) of their referral.
- 90% of admitted patients will receive their first definitive treatment within 18 weeks (127 days) of the referral.
- No patient will wait longer than 6 weeks for a diagnostic test or image.
- All patients with suspected cancer who are referred urgently by their GP must be seen within 14 days of the GP decision to refer being made.
- All patients diagnosed with any form of cancer will receive their first treatment within 31 days of diagnosis.
- All patients referred through the urgent 14-day cancer referral route and subsequently diagnosed with cancer will receive their first treatment within 62 days of the date of referral.
- Patients who are not referred through the urgent 14-day pathway but who have highly suspicious symptoms may be added to the 62-day pathway at the request of a hospital specialist, as will any patients referred from screening services.

For further information regarding management of Cancer patients, please go to the Cancer Policy which can be located on the Trust’s intranet.

As a general principle, the Trust expects that before a referral is made for treatment that the patient is both clinically fit for assessment and possible treatment of their condition, and ready to start their pathway within two weeks of the initial referral. The Trust will work with North East Essex Clinical Commissioning Group (NEE CCG) GPs and other primary care services to ensure that patients understand this before starting an elective pathway.

The Trust can have fines imposed by the NEE CCG for non-compliance of 18 weeks RTT targets. The fines that can be imposed are shown in Appendix C.

3.2 Principals of Referral-To-Treatment (RTT) Pathways
Patients have the right to start consultant-led treatment within 18 weeks from referral, and be seen by a specialist within 2 weeks of GP referral for suspected cancer or, where this is not possible, for the NHS to take all reasonable steps to offer the patient a quicker appointment at a range of alternative providers if the patient makes such a request.

As part of the referral to treatment pathway the national rules make reference to clock starts and stops.

3.3 Clock Starts
A clock starts when a GP, dentist or other healthcare professional refers a patient to the Trust for any elective service (other than planned care) for the patient to be assessed and, if appropriate, treated before responsibility is transferred back. This includes the following:
- Any referral to a consultant-led service.
- Any referral to an interface service (All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care).
- Includes self-referrals to these services (where agreed by commissioners and providers).
For paper referrals this is the date the Trust receives the referral. For Choose & Book referrals the clock starts on the date the patient calls to make an appointment and gives their unique booking reference number.

If following completion of a referral-to-treatment period, a patient requires treatment for a substantially new or different condition then a new clock starts. This is a clinical decision made in consultation with the patient.

3.4 Clock Pauses
Once the decision to admit has been made, the patient’s clock may only be paused to take account of the patient’s choice to delay their admission. **It is the Trust’s policy to offer two admission dates with at least three weeks’ notice.** Please refer to the Cancer Services Operational Policy, document number 365.

In the circumstances where the patient is unable to accept these two dates, their clock will be paused from the 1st reasonable offer date until the date that the patient has stated they will be available.

The Trust will apply a pause for up to **8 weeks maximum.** If the patient is unable to be treated within this longer period they will normally be referred back to their GP. If they wish to be treated within six months the Trust will normally accept a subsequent self-referral. The Trust will not pause patient’s pathway for clinical reasons.

3.5 Clock Stops
The **clock stops** when the patient receives the first definitive treatment for the condition for which they have been referred. A patient’s **First Definitive Treatment** is an intervention intended to manage a patient’s disease, condition or injury and avoid further intervention. This may occur following a consultation, receipt of results from a diagnostic test or following surgery.

All patients will be managed according to their clinical urgency. An admitted pathway means that the patient requires admission to hospital, as either a day case or an inpatient, to receive their first definitive treatment.

A non-admitted pathway means that the patient does not require admission to hospital to receive their first definitive treatment, i.e. that treatment is given or prescribed in outpatients.

Patients can also have clock stops for non-treatment. The following are examples where patient’s clocks will be stopped for non-treatment reasons:

- Patient is returned to primary care for care (this includes primary care based therapy).
- Clinical decision to start a period of active monitoring.
- Patient declines treatment.
- Clinical decision not to treat.

3.6 Active Monitoring
The concept of Active Monitoring (watchful waiting) stops the clock and caters for periods of care without (new) clinical intervention e.g. three monthly routine check-ups for diabetic patients. This is where it is clinically appropriate to:

- Monitor the patient in secondary care without clinical intervention.
- Further diagnostic procedures are required.
• When a patient wishes to continue to be reviewed as an outpatient, or have an open appointment, without progressing to more invasive treatment.

Active monitoring (watchful waiting) can be initiated by either the patient or the clinician. Periods of active monitoring will not exceed 6 months. Patients should be reviewed after a period of active monitoring to agree a revised treatment plan or discharge to primary care.

If after a period of active monitoring, the patient or the Care Professional then decides that treatment is now appropriate, a new clock starts. There is then a new patient pathway in which the patient must receive their first definitive treatment within a maximum of 18 weeks.

Referrals from Primary Care to the following services will not start the clock:
• Therapy, 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.

3.7 Clinically Initiated Delays or Patient Unfit for Treatment
If a patient is not fit for surgery the Trust will ascertain the likely nature and duration.

If the reason is that they have a condition that itself requires active treatment then the Trust and the CCG have agreed that they will either be discharged back to the care of their GP or will be actively monitored within the Trust for their original condition. Either action results in their pathway and clock being stopped.

If the reason is transitory (such as a cold) then they will be offered a further pre-screening and treatment date within four weeks. This will allow patients with minor acute clinical reasons for the delay, such as a chest infection, time to recover and the clock will continue to run during this time.

If a patient has a clinical condition that is not able to be resolved within four weeks and requires further medical intervention before the patient is able to undergo the planned surgery they will be discharged and returned to their GP.

The patient may require further clinically appropriate management of their on-going chronic or clinical condition but once the patient is fit to proceed they should be re-referred to the consultant for assessment which would initiate a new clock start and pathway.

3.8 Tolerances
There are important reasons why not everyone can or should be treated within the operating standards:
• Patients for whom it is not clinically appropriate to be treated in 18 weeks (CLINICAL REASONS).
• Patients who choose to wait longer for one or more elements of their care (CHOICE).
• Patients who (choose not to) do not attend appointments (CO-OPERATION).

These patients are taken into account in the tolerance set as part of the delivery standard. 5% non-admitted patients and 10% admitted patients.
Where a referral goes initially to a Clinical Assessment Service (CAS) the patient’s clock starts on the date on which the CAS receives the referral. When referrals are sent onto CHUFT the patient can already have waited for 16 weeks; these referrals would have to be managed within our tolerance allowance.

3.9 Capturing Patient’s Treatments and Clinic Outcomes
Each step along the patient’s pathway including the outpatient appointment, diagnostic appointment, pre-assessment, admission, discharge, any decision by the patient or clinician to delay further treatment at any stage must be recorded in PAS as either a clock start, on-going activity of an already ticking clock, a clock stop, or as activity which is not part of the operating standards.

Outpatient Reconciliation Forms
Must be used to obtain clinical information about the patient’s treatment status. This information is then inputted on to the PAS system. These forms must be completed for all patients in any setting that is on an RTT pathway. Please refer to Appendix D.

They need to be accurately filled in with all necessary information at the time. If not completed this may delay patient treatment. The lack of completion of the current form means that many staff spend many hours working out where a patient is on their pathway.

A code exists for each type of activity and this code must be recorded in PAS within the referral to treatment history at each point during the pathway. The Consultant will usually complete the outcome forms during the outpatient appointment; the form will include the intended management of the patient and future appointment if required. The codes are listed in Appendix B.

Patients may have more than one clock ticking simultaneously (patient pathways) if they have been referred to and are under the care of more than one clinician at any point in time. Each pathway has to be measured and monitored separately and will have a unique pathway ID number in PAS.

3.10 Consultant to Consultant Referral for a Condition Unrelated to the Original Referring Condition
Consultant to Consultant referrals are supported by North East Essex Clinical Commissioning Group (NEE CCG) if the patient is being referred onto another clinician within or outside of the Trust for assessment or treatment as part of the initial referral (existing pathway). The clock will remain active until the patient receives definitive treatment.

If a consultant sees a patient in clinic having been referred for condition A, and then following the consultation, refers on to another consultant (within or outside of the Trust) for a different condition (condition B) the referral will not be supported by NEE CCG. The patient should be referred back to the GP outlining the need to be referred onto another provider, service or clinician.

If the referral is sent onto another clinician for a separate condition it will start another clock (Condition B). The clock which was started by the original referral for condition A continues to tick.

Consultant (or consultant-led service) referrals will start a new clock, specifically:
- If during a referral for one condition, the consultant newly identifies another condition. This will start a second 18 Week Pathway clock (a 31 day clock will start if cancer is the new condition). The first original clock will still be ticking.
Separate conditions or complications developed with pregnancy, or if a new-born baby is suspected of having a condition requiring medical or surgical consultant-led treatment.

- New conditions are identified as a result of a genetic test.
- In cases where a decision to treat is made (at follow-up outpatients) for a patient whose programme of long-term care needs to be medical or surgical consultant-led.
- If further treatment is required after active monitoring (watchful waiting) then a new patient pathway and clock start would begin.

3.11 Bilateral Procedures
Where a patient requires a bilateral procedure and the second procedure is not undertaken at the same time as the first, a new clock starts when a patient is fit and ready for the second treatment.

3.12 Ongoing Clocks
A patient has an on-going clock if they have had a clock start but have not yet had either their first definitive treatment or decision not to treat or been placed on active monitoring (watchful waiting).

**Activity within an 18 week RTT period which does not stop the clock (ongoing activity in the pathway/request to other service):** This might be a follow up appointment, or request for a diagnostic test/image or adding a patient to a waiting list for admission.

**Transfer to another healthcare provider (Transfer to another Health Care Provider – expected back/not expected back):** If a patient is referred from Colchester Hospital to another as part of their RTT period, their patient pathway and clock should keep ticking. The originating provider should ensure that the patient's initial RTT clock start date forms part of the onward referral information. In some instance these patients will be returning to the originating Trust with the clock continuing to tick.

The Trust will use the agreed Inter-provider Transfer Pro-forma (ITP) to communicate the relevant information about the patient’s treatment status. When receiving ITPs the relevant information must be entered on to the PAS. This is to ensure the Trust has an accurate record of the patient’s treatment status. Appendix A.

3.13 Managing DNAs/Cancellations
**Patient does not attend (DNAs) their first care activity following referral (Failure to attend 1st appointment after referral):** All appointments must be clearly communicated to the patient but if a patient fails to attend the first activity (appointment or diagnostic test) in their pathway they should be discharged back to the GP. However the RTT rules do state that if you offer another appointment following the 1st DNA, their patient pathway and RTT clock is nullified and they are no longer counted in the overall returns.

They must still be treated within maximum national waiting time standards.

**Children, Vulnerable adults and Cancer patients are exceptions and should be treated in accordance with their treatment policy.**
Patient DNAs Subsequent Activity on Pathway:
NEE CCG and CHUFT have agreed that when a patient DNAs a subsequent appointment, diagnostic test, image, pre-assessment appointment where the appointment has been clearly communicated to the patient; their clock will be stopped and they will be returned to the care of the GP. Should the patient wish to receive treatment, then they can be re-referred by their GP – a new clock would start on receipt of the re-referral at the Trust.

If a patient fails to attend on the day of surgery the patient will be discharged back to their GP. Children, Vulnerable adults and Cancer patients are exceptions and should be treated in accordance with their treatment policy

Child DNA (not brought into their appointment) on pathway:
Any patient who did not attend their first appointment after initial referral can have their RTT clock nullified. Providers will need to be able to demonstrate that the appointment offer was reasonable and clearly communicated to the patient/patient’s parent/carer/guardian.

A new clock will start on the date the provider receives notice of any subsequent re-referral.

If the patient subsequently contacts the Trust to rebook their first appointment, this will start a new 18 week clock, commencing on the date that the patient contacts the Trust and rebooks their new appointment.

Note: If a child (up to the age of 18 years of age) or ‘vulnerable adult’ does not attend - a second appointment may be offered – a further DNA will result in the patient being referred back to GP with a copy of the letter to health visitor/School Nurse, social worker (where known) and parents/carer. This applies to both manual and Choose and Book referrals. It is good practice that contact is made with the parents/carers to inform of the importance of the consultation.

Where a child or young person is not brought for a second time, a significant event sheet should be completed with details of the non-attendance and placed in the child/young person’s notes under the clinical alert divider. A Health Information Sharing Form should also be completed and sent to the professionals involved in the child/young person’s treatment including the hospital safeguarding children team. The original copy should be placed in the patients notes within the correspondence section. Please refer to the Safeguarding Children and Young People Policy, document number 180.

For children/young people that fail to attend phlebotomy appointments, the consultant should be notified of the appointment.

Suspected cancer referrals are managed according to different national and local policies and are NOT subject to the above 1 strike and out policy (see CANCER DEFINITIONS and STANDARDS).

Patient Cancels Care Activity for the Second Time: The CCG and Trust has agreed that when a patient cancels care activity for the second occasion on each element of their pathway (e.g. patient cancels an outpatient appointment or a pre-op assessment appointment twice), then their clock will be stopped and they will be returned to the care of the GP. Should the patient wish to receive treatment, then they can be re-referred by their GP – a new clock would start on receipt of the re-referral at the Trust.
**Decision Not To Treat/No Treatment Required:** When the clinician determines that treatment is not required or a decision that no treatment is to occur; the patients’ clock is stopped. The patient should be returned to the care of the GP.

A decision not to treat/no treatment required may occur outside a clinical consultation, for example if a patient is discharged on the basis of a test result which is communicated to the patient and their GP by letter. This can occur at any stage of the patient’s pathway and will stop the clock.

**Patient Refuses to Wait where a Wait Exceeds 60 Minutes from their Original Appointment Time:** Patients need to be informed of the waiting time on arrival to clinic. Patients should not have to wait longer than 30 minutes after their appointment time but delays in clinic are sometimes unavoidable.

If a patient informs the receptionist that they are unable to wait longer than 1 hour past their appointment time the receptionist should record the outcome on PAS as a hospital initiated cancellation and offer another appointment.

**Patient Declines Offered Treatment:** Patients may choose not to proceed with the treatment offered and therefore their clock is stopped. The refusal information should be accurately recorded onto the PAS system.

**Patient Dies Before Treatment:** When a patient dies before they receive treatment, their RTT clock will be stopped. This is automatically entered onto the patient’s pathway when the patient is deceased on PAS.

### 3.14 Exclusions from Elective Care Operational Standards

- Emergency admissions.
- Obstetric patients.
- Elective patients undergoing planned procedures (removal of metalwork, procedures related to age/growth, check cystoscopies etc.)

### Approach to Management of Patients Pathways

This section covers the general principles that govern the progression of patients through pathways.

### 3.15 Patient’s Entitlement to NHS Treatment

The Trust has a legal obligation to identify patients who are not eligible for free NHS treatment. The National Health Service provides healthcare for people who live in the United Kingdom. People who do not normally live in this country are not automatically entitled to use the NHS free of charge – regardless of their nationality or whether they hold a British Passport or have lived and paid National Insurance contributions and taxes in this country in the past.

All NHS Trusts have a legal obligation to:

- Ensure that patients who are not ordinarily resident in the UK are identified.
- Assess liability for charges in accordance with Department of Health Overseas Visitors Regulations.
- Charge those liable to pay in accordance with Department of Health Overseas Visitors Regulations.

The Human Rights Act 1998 prohibits discrimination against a person on any ground such as race, colour, language or religion. The way to avoid accusations of discrimination is to ensure that everybody is treated the same way.
This Trust needs to check every patient’s eligibility. An NHS card or number does not give automatic entitlement to free NHS treatment. Therefore, every time a patient begins a new course of treatment at the hospital, frontline staff must ask the following two questions, known as Stage 1 questions:

“Where have you lived for the last 12 months?”

All outpatient appointment letters will request patients to bring evidence of having the right to live in the UK to their outpatient appointment, examples will be given.

If you have any queries regarding patients’ eligibility, then please contact the Private Patient and Overseas Manager.

3.16 NHS Constitution
The NHS Constitution sets out the following right for patients:

‘You have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.’

Patients have the right to start consultant-led treatment within 18 weeks from referral, and be seen by a specialist within 2 weeks of GP referral for suspected cancer or, where this is not possible, for the NHS to take all reasonable steps to offer the patient a quicker appointment at a range of alternative providers if the patient makes such a request.

3.17 Managing the Transfer of Private Patients

3.17.1 Patients Transferring from the Private Sector to the NHS
Patients can choose to convert between an NHS and private status at any point during their treatment without prejudice. Colchester Hospitals and North East Essex Clinical Commissioning Group (NEE CCG)s have agreed that all patients wishing to transfer from the private service to the NHS, must be returned to their GP to be offered choice and onwards referral to an NHS provider. No patient should be referred direct to Colchester Hospital from the private service without an appropriate referral letter from the GP.

Patients who are referred via their GPs from a private service can be added direct to the NHS waiting list on the referral received date. They do not need an NHS appointment prior to addition.

Cancer patients are exceptions and should be treated in accordance with their treatment policy

3.17.2 Patients Transferring from the NHS to Private
NHS Patients already on NHS Waiting Lists opting to have a private procedure must be removed from the NHS Waiting List.

NHS patients moving to the private sector must be entered on PAS as NHS patients moving to Private treatment.

If a patient chooses to go privately for their diagnostic procedures the patient will be transferred back to their GP who will arrange the private diagnostic procedure. The referrer will receive the diagnostic report and will be responsible for arranging a new referral. A new clock will start when the new referral is received along with the
diagnostic report. The patient may be placed directly on a waiting list if required or may be asked to attend an outpatient appointment to decide treatment plan.

3.17.3 Patients Transferring from the NHS to a Private Provider for Ongoing Treatment (following two cancellations for surgery)
NHS Patients already on NHS Waiting Lists who have been unable to receive treatment at CHUFT should be offered the opportunity to have their treatment within the private sector. Patients remain on CHUFT’s waiting list and are subject to the NHS waiting times. Service managers are responsible for ensuring that patients are transferred and treated in a timely manner and that the PAS system is updated.

NHS patients moving to the private sector must be entered on PAS as NHS patients moving to Private treatment.

3.18 Low Priority Treatments – Patients Requiring Commissioner Approval
No referral for an excluded procedure should be accepted without an exceptional treatment approval form being completed. If the referral does not have the relevant approval, the referral should be rejected and returned to the GP for them to request exceptional treatment funding via the relevant CCG or NHS England panel.

In some instances it will not be apparent until the outpatient consultation that the patient requires an excluded procedure, when it is identified at the outpatient consultation the relevant clinician should inform the patient and then complete the proforma required by the CCG in full, and submit to the exceptional treatment panel for approval.

- The CCG will ensure that the request is dealt with promptly to avoid delay in the 18 week clock.
- The CCG will ensure that all GP’s are aware of the procedures covered under the prior approval process.
- There will be no effect to the patients 18 week clock.

Clock stops can only be made to a patient’s RTT pathway when treatment occurs or a decision not to treat is made. No adjustments or clock stops can be made to a pathway whilst a panel or approval board assesses requests. Commissioners are therefore to hold panels in line with the 18 week timeframes for any patient referred for assessment who has already commenced an RTT pathway.

If the request is refused a clock stop code shall be entered onto the patient’s pathway at this point (decision not to treat). Information should be entered onto the PAS to provide the detail regarding the exceptional treatment case. When funding approval is required for treatment, the patient will not be placed on the waiting list until approval is obtained from commissioners.

Patients on Cancer pathways continue on their pathways and are not returned to the care of the GP – see Cancer Services Operational Policy, document number 365, for details of how to progress the patient.

3.19 Access to Health Services for Military Veterans
In line with December 2007 guidance from the Department of Health all veterans and war pensioners should receive priority access to NHS care for any conditions which are related to their service subject to the clinical needs of all patients. Military veterans should not need first to have applied and become eligible for a war pension before receiving priority treatment.

GP’s should notify the Trust of the patient’s condition and its relation to military service when they refer the patient so that the Trust can ensure that it meets the
current guidance for priority service over other patients with the same level of clinical need. In line with clinical policy patients with more urgent clinical needs will continue to receive clinical priority.

3.20 Maternity Patients
The maternity pathway is non RTT but where a maternity patient consults and/or has surgery for an unrelated pregnancy condition the RTT pathway will be followed, i.e.

Woman referred to general surgeons with gallstones. If she requires surgery then she will start a new RTT pathway.

However if the problem is pregnancy related, i.e. gestational diabetes she will remain on the same maternity non RTT pathway.

Patients who are on an active RTT pathway who require their treatment to be deferred until after their pregnancy (clinical decision) will go on active monitoring until after the birth of the baby, i.e. woman referred on cervical screening direct referral pathway.

3.20.1 Early Pregnancy Pathway
Women seen in the Early Pregnancy Unit are on a non RTT emergency pathway. However if they miscarry and require a surgical procedure (evacuation of retained products of conception) they will be entered on the elective waiting list on an active RTT pathway (clock start). The expectation is that patients will be treated as an emergency.

3.21 Reasonable Notice
The Boards of CHUFT and NEE CCG have agreed that a reasonable offer of a date for an outpatient appointment or diagnostic test is two dates with the earliest being a minimum of one week for a verbal offer and for a written offer a minimum of a two calendar weeks.

Patients accepting short notice appointments or treatment dates will have the date and time confirmed by telephone, text or e-mail. Short notice is classified as an appointment within the next five days. The patient will not receive a confirmation letter by post due to the short notice time period.

Short notice appointments within endoscopy will have written confirmation sent to them when bowel preparation is needed.

Reasonable notice for an elective admission for a verbal offer is two dates with the earliest a minimum of three calendar weeks away and for a written offer is a date with a minimum of three calendar weeks away.

All offers of dates to patients, for outpatient, diagnostic or inpatient episodes must be recorded in PAS at the time the offers are made.

The aim of clinic and admissions booking staff will always be to find a date appropriate for a patient’s clinical priority and convenient to that patient.

Therefore 2 attempts to contact every patient by telephone will always be made if an appointment or admission date is less than (three) weeks away, one of which will be after 6.00 p.m. and the attempts will fall on different days. All contacts must be recorded accurately in the comments field in the outpatient booking screen in PAS.

Any adult safeguarding concerns (including DNAs) must be recorded in the patient’s notes. Please refer to the Safeguarding of Vulnerable Adults from Abuse (SOVA) Procedure, document 215. If an adult patient has been identified as lacking mental
capacity or there is concern around a patient’s mental capacity to accept/decline an appointment this should be discussed with the Adult Safeguarding Team on extension 5923 or 07768 560533. Please also refer to the Assessing Mental Capacity Procedure including Deprivation of Liberty Guidance, document number 331.

Within endoscopy under current Joint Advisory Group (JAG) Guidelines, Urgent patients who may not necessarily be on a suspected cancer pathway need to be given an appointment within 2 weeks therefore reasonable notice for verbal offers is 4 days and written offers 7 days. All Endoscopy patients will be contacted by telephone to agree the appointment as part of the Standard Operating Procedure.

3.22 Booking Process
It is Trust policy to ensure that patients will be offered more choice in booking their outpatient appointments. The reasonableness notice period rules must be followed.

Choose and Book enables the patient to choose appropriate hospitals, dates and times for their treatment, internal booking services within Colchester Hospital should replicate this part of their operational procedures.

Patients must be offered choice of dates and times and where possible locations for their outpatient appointment. This should be carried out in consultation with the patient or provide an option for patients to contact the hospital to agree their appointment.

If the appointment is re-scheduled then the actual appointment booking system type used to make each appointment should be recorded at the time the appointment is agreed or sent to the patient.

Trust Internal Milestones

- Referral Received by Provider or CAB
- 1st Outpatient
- Decision to treat
- Treatment

(6) weeks (13) weeks (17) weeks

The Trust will aim to deliver patient care within the above internal operating standards and time periods.
3.22.1 Outpatients – General Principles

The key outpatient operational standards.

- The Trust’s internal operating standards are to achieve a maximum wait of 6 weeks by specialty.

General Principles

- Patients are seen in the order of clinical priority and date on list.
- Patients are kept fully informed and have a single point of contact at the Trust.
- Any contact with the patient should be documented on the PAS system using the Admin Contact Function.
- Registering of referrals on PAS to be completed within 24 hours.
- Referrals should be accepted or rejected as appropriate within 48 hours by the consultant and amended on PAS.
- There must be a New Referral for a patient with an existing condition if the request for further consultation is 6 months after the discharge of the original referral.
- Referrals and waiting times are correctly counted.
- Staff must abide by the parameters of the clinic structure (template) available; unless vacancies occur thereby swapping new and follow-up slots accordingly to ensure full capacity is maintained. This must only be done in conjunction with the outpatient booking team.
- The Trust will operate a waiting list system based on taking patients in turn except for emergencies and cancer 2 week waits.
- Patients should be given appointments in date order to ensure equity of access.
- Cancelled slots must not be given to the next “routine” referral that comes to hand. They should be used to bring forward the longest waiting patients.
- When making the appointment, the booking on PAS must be linked to the appropriate referral, which has already been logged. Staff must ensure that duplicate referrals are not created as this causes double counting of referrals and miscalculation of the patient’s waiting time.
- The patient will be sent a confirmation letter regarding their booked appointment. The letter must be clear and informative and should include a point of contact and telephone number to call if they have any queries. The letter should explain clearly the consequences should the patient cancel the appointment or fail to attend the clinic at the designated time.
- If the patient has accepted a short notice appointment no confirmation letter will be sent due to the short time period between the offer and the date of the appointment.
- Where cancellations are initiated by the Trust, patients should be booked as close to their original appointment as possible, and within 2 weeks of the cancellation date.
- All patients will be given a specified time of appointment, no block bookings of appointment times will be administered to the clinics.
- Only nominated staff will book appointments into the clinics.
- The policy of this Trust is that minimum of 6 weeks’ notice of clinic cancellations must be given. Clinical Director and Divisional Operational/Service Managers must give authorisation for cancellations under 6 weeks.
- The definition of a cancelled clinic is when a clinic is cancelled by the hospital – cancelled clinics are usually re-scheduled within 6 weeks.
- Template changes will only be actioned for:
  - 2 week Cancer Criteria.
  - Help in reducing Waiting Times.
  - Authorisation for other reasons by the Associate Director of Operations.
When patients cancel their appointments and do not wish to have another appointment CHUFT will inform their GP. The referral must then be discharged on PAS.

When patients have their appointment changed or request a change to their appointment and have hospital transport booked it is the responsibility of the patient to contact the transport department to re-arrange. When re-arranging an appointment the booking clerk should ensure that the patient understands what to do regarding their transport needs.

3.22.2 Managing Referrals Letters
- The aim of the Trust is to receive the majority of referrals via Choose & Book.
- The Trust and the CCG will continue to work together to ensure all referrals are appropriate for the services the Trust provides.
- All referrals must be addressed and sent to the contact centre.
- If referrals bypass the agreed route then they should be date stamped and entered onto PAS immediately where received, prioritised by the Consultant and returned to the contact centre.
- All referrals (both paper and electronic) must include full demographic details, including NHS number and telephone numbers (both day and evening, if possible) to reduce administrative time contacting the patient.
- Generic ‘Dear Doctor’ referrals will be allocated to the appropriate consultant with the shortest waiting time.
- Consultant annual leave, study leave or sickness, delaying the review of referral letters, must not disadvantage the patient; Divisions must work with the consultants to ensure there are contingency arrangements to cover periods of leave.
- An Inter-provider Transfer Form will be used by Trust Staff when referring patients to ‘other’ Providers. The same template must be used when referring patients within the Trust for the same condition. The template would be used when there is no other pre-existing template in place i.e. Cancer. This is to ensure national compliance regarding provision of information for tertiary referrals. Please see the Tertiary referral pro-forma. A copy of this can be found on the Trust Intranet under Electronic Forms or can be utilised from the electronic ward template within the digital dictation screens. A similar template should be received for Tertiary Referrals from ‘other’ Providers.

3.22.3 Cancer Referrals
To meet the required NHS Cancer Waiting Times 2013, suspected cancer referrals must be seen by a consultant within 14 days of decision to refer.

3.22.4 Referral Letters through a Clinical Assessment Service (CAS)
CAS referrals may have clock starts already applied, all relevant clock information should be accurately recorded in PAS. CAS referrals are subject to the same operating standards as GP referrals. The waiting time accrued in triage forms part of the patient’s pathway wait time.

3.22.5 Referrals – Written Advice from Consultant
Where a referral is received, that requires the consultant/other medical professional to respond in writing with advice, rather than arranging an outpatient appointment, the referral must be updated accordingly on PAS. This must be actioned at the time of the written response being generated by the medical secretary.
3.22.6 Inappropriate Referrals
If a consultant deems a referral to be clinically inappropriate, it must be sent back to the referring GP with an explanation of why. The referral decision must be updated and discharged accordingly on PAS.

If a referral has been made and the special interest of the Consultant does not match the needs of the patient, the Consultant should transfer the patient to the appropriate colleague where such a service is provided by the Trust and the referral amended on PAS.

3.22.7 Registration/Post Checking
All new written paper referrals must be date stamped and registered within 24 hours of receipt of the referral letter. Referral letters must be passed to the Consultant within 24 hours of receipt. It must be ensured that referral letters are delivered prior to and immediately after Bank Holidays.

Referrals should be prioritised by the Consultant within 48 hours of receipt by the Consultant and then sent directly to the booking department.

Appointment letters must be sent to the patient within 24 hours of the appointment being booked.

3.22.8 Template Changes
Templates should reflect the mix of referrals and the capacity required to deliver the Access targets. They identify the number of slots available for new and follow-up appointments, and specify the time each clinic is scheduled to start and finish. The length of time allocated for each clinic varies from three to four hours.

All requests for template and temporary clinic rule changes will only be accepted in writing on the specified pro-forma with Service Manager or Deputy Service Manager’s sign off. Completed forms need to be sent to the Clinic Change Team for changes to be applied.

Non-outpatient managed areas should also use this form. All requests for template changes must be made with at least 6 weeks’ notice to allow Outpatient Services Staff the necessary time to implement the change.

3.22.9 Cancellation of Clinic Sessions/Part Sessions
All clinics should be monitored closely. An analysis of clinic cancellations including those with less than 6 weeks’ notice are circulated on a weekly basis and discussed at the service business meeting as part of the RTT sustainability monitoring.

3.22.10 Annual and Study Leave
All requests for annual and study leave by Consultant and ‘career grade’ doctors must be approved with a minimum of 6 weeks before leave is to be taken. At the time leave is requested the form ‘Notification of Senior Medical and Dental Staff Leave’ must be completed and approved within the Division in question.

Notification will only be accepted in writing on the appropriate leave form that clarifies the arrangements to cover duties during absence on leave.

The original form is to be completed and forwarded to the Booking Team, who will then cancel the clinic as per instructions. The reason for the cancellation will be recorded and form part of the monthly cancellation clinic report.
Clinics that require cancellation as a result of annual/study leave with less than 6 weeks’ notice, will require written approval by the Associate Director of Operations/Divisional Director. The Outpatient Manager and the Service Manager must be informed.

Where cancellations are initiated by the hospital, patients should be booked as close to their original appointment as possible, according to clinical priority, but within the specified annual target.

3.22.11 Cancellation of Appointments

- The cancellation of an appointment can be by the patient, GP, Consultant or hospital.
- For all new referrals, where the patient cancels an appointment, any further appointment must be offered within the specified target date and within two weeks of the cancelled appointment. An alternative appointment will be offered at the time of cancellation whenever possible.
- All patients will receive confirmation of their appointment this can be via a text message, an e-mail or an appointment letter.
- Short notice cancellation patients must be informed that the confirmation will be sent via text or e-mail and that no confirmation letter will be sent.
- Patients who cancel before the appointment time are recorded on PAS with details of the reason for the cancellation. An alternative appointment is offered.
- When patients cancel their appointments and do not wish to have another appointment, inform the patient to contact their GP with this information. The referral must then be discharged on PAS.
- Patients wishing to cancel their appointment following validation will have their referral discharged back to their GP. A clock stop will be recorded on PAS at patient request.
- If a patient cancels an outpatient appointment anywhere in an RTT pathway, another appointment should be re-arranged if required. This appointment must be made within 2 weeks of the original appointment. If an appointment is not available within 2 weeks, this must be escalated to the Outpatient Manager for resolution as the RTT clock is still ticking. This will require exception reporting. If the next appointment cannot be accepted by the patient, then they will be returned to the care of their GP.
- If the patient cancels an outpatient appointment date for a (second) time the patient will be returned to the care of the GP and the patient’s clock will stop. If they are subsequently re-referred by the GP, this will start a new patient pathway.
- If the hospital cancels a patient’s appointment anywhere on an RTT pathway, the clock continues to tick. Patients should not be cancelled more than once by the Hospital at any part of their pathway.

3.22.12 Contents of the Appointment Letter

- The appointment letter should contain the following details:
  - Patient’s full name.
  - Patient’s hospital number & NHS number.
  - Date letter sent to patient.
  - Date and time of appointment.
  - Where to report on arrival.
  - Who to contact to confirm, postpone or queries relating to the appointment date.
  - Any other response required from the patient either by telephone (to a named individual) or on an enclosed response slip (with a business reply envelope).
  - What happens if the patient cancels or DNAs.
• The associated literature should contain:
  o Arrangements for transport.
  o Any other information about the planned treatment.

3.22.13 Diagnostics
Many patients require diagnostics to determine the appropriate diagnosis and therefore subsequent treatment of a patient. Diagnostic tests can be in the form of a blood test or an endoscopy procedure or an x-ray. Diagnostic tests and the associated report must be performed within 6 weeks of request for the test, to ensure delivery of the national operating standards.
The DNA and cancellation rules apply to diagnostic patients with the exception of Children, Vulnerable Adults and Cancer patients. Diagnostic patients cannot have their clock “paused” as it does not apply to diagnostic patients.

Within Endoscopy on the day cancellations must be approved by the Service Manager.

Diagnostics should take into account the patients clock when appointing patients as this may require them to be seen sooner than the maximum waiting time for a diagnostic. Within endoscopy all standards are compliant with JAG waiting time standards and the unit has a defined Standard Operating Procedure in place to ensure compliance.

GP Requested Diagnostics
Where a GP requests a diagnostic to determine whether onwards referral to secondary care or management in primary care is appropriate, the patient's RTT clock does not start unless there is an agreed treatment pathway that enables patients to undergo the diagnostic test prior to seeing a consultant.

The patient must have the diagnostic procedure within 6 weeks of referral into Diagnostics.

If the GP refers the patient to secondary care following a diagnostics procedure, the patient commences on a pathway in line with the operating standards and the clock commences on the date the RTT referral is received.

Where a GP refers a patient for a diagnostic prior to an Outpatient appointment with a consultant, as part of an agreed pathway then the patient is on an RTT pathway and the clock starts on receipt of the referral. The patient must have the diagnostic procedure within 6 weeks of referral.

Note – it is the GPs responsibility to be clear on the referral whether they are sending the patient for treatment or to request a diagnostic to make a decision regarding treatment.

Other Requested Diagnostics
Where a diagnostic is requested by a health care professional from the hospital, then the patient must have the diagnostic procedure within 6 weeks of the decision or sooner if their clock requires.

3.22.14 Pre-Operative Assessment
Where Pre-Operative Assessment is required: patients should be pre-operatively assessed as soon as possible after the Decision to Admit is made to ensure patient is fit for procedure. Pre-operative assessment can be completed up to 3 weeks in
advancing of the TCI. If a patient cancels or DNAs a second pre-operative assessment the patient will be discharged back to the GP.

**Children, Vulnerable adults and Cancer patients are exceptions and should be treated in accordance with their treatment policy.**

As a general principle, the Trust expects that before a referral is made for treatment that the patient is both clinically fit for assessment and possible treatment of their condition, and ready to start their pathway within two weeks of the initial referral.

The Trust will work with North East Essex Clinical Commissioning Group (NEE CCG), GPs and other primary care services to ensure that patients understand this before starting an elective pathway.

### 3.22.15 Elective Admissions

The key inpatient and day case therapeutic standards and milestones:

- The Trust’s internal milestones are to achieve a maximum wait of 6 weeks for an outpatient appointment by specialty.
- Maintain existing cancer waiting time standards of a maximum wait of 31 days from decision to treat to treatment, and 62 days from urgent referral to treatment for all cancers.
- Maintain improved access to services across the patient pathways of 13 week maximum wait for revascularisation.
- Patients are admitted depending on their clinical priority and waiting time.
- All patients will be kept fully informed from the point of entry onto a waiting list to their admission offer and have a known point of contact at the Trust.
- Users will maintain waiting lists on PAS in a timely manner to ensure that waiting times are correctly calculated.
- Patients will be offered a TCI, where appropriate, at any of the Trust’s sites or outsourced providers.

#### Overview of the Inpatient and Day Case Waiting List

Patients on the **Active Waiting List** are waiting for elective admission for treatment and are currently available to be called for admission.

Patients on the **Planned Waiting list** are waiting to be admitted as part of a planned sequence of treatment or investigation, e.g. check cystoscopy OR where the procedure has to be performed at a set point linked to a clinical criteria, e.g. where a child needs to be four years old before a procedure can be performed OR where the date of admission is determined by the needs of the treatment, e.g. a child needs to be 4 years old/certain size before a procedure can be performed.

Patients on the cardio version planned list will be placed back on the elective list once their INR levels are within the approved range, this may result in patients being moved from one list to another dependant on their INR levels fluctuating.

#### Contents of the To Come In (TCI) Letter

- The ‘To Come In Letter’ should contain the following details:
  - Patient’s full name.
  - Patient’s hospital number.
  - Patient’s NHS number.
  - Date letter sent to patient.
  - Date and time of admission.
  - Procedure date.
  - Instructions regarding medication.
  - Eating/drinking instructions.
- Where to report on arrival.
- Who to contact to confirm, postpone or queries relating to the admission dates.
- The Trust Policy on what happens if the patient cancels or DNAs.
- Expected length of stay or date of discharge.
- Request to check if bed is available on the day of admission.
- Any other response required from the patient either by telephone (to a named individual) or on an enclosed response slip (with a business reply envelope).

- The associated literature should contain:
  - Arrangements for transport.
  - Who to contact to discuss the operation.
  - What the patient can expect if the admission has to be postponed.
  - How long it is likely to be before they can return to work or resume normal lifestyle.
  - Any special care needs that are normal to expect on discharge.
  - Any other information about the planned treatment.

### 3.2.16 Cancellation of Elective Surgery

No patient should have his or her admission cancelled. However this may occur in exceptional circumstances.

The appropriate Associate Director of Operations must authorise a cancellation where the patient has been cancelled previously by the hospital.

In the event that the Trust has to cancel a patient’s elective procedure on the day of admission or day of surgery for a Non-clinical reason – the patient must be offered another TCI date within 28 days of the cancelled operation date. The Trust is monitored on the number of breaches of this national key operating standard. Please see Appendix A for the national reference codes.

### 3.23 Delivery of Policy and Support

#### 3.23.1 Responsibilities and Accountabilities

The Access Policy Reference Group will provide advice and support to all staff in the effective implementation of this policy.

The accountability for effective implementation and adherence to this policy sits with all supervisors, leads and managers of clinical and non-clinical staff responsible directly or indirectly for the delivery of RTT.

Service Managers are responsible for ensuring their staff comply with the policy and are fully trained by receiving the appropriate annual training and to keep records of staff training.

#### 3.24 Responsibilities of Service Managers in the Management of Waiting Lists:

- To maintain an up to date and accurate waiting list.
- To enter patients onto Waiting lists, or update a provisional waiting list entry to full entry, within 48 hours of Decision to Admit being made and to inform the patient that they are on a waiting list.
- To ensure when a decision to admit is made in a clinic, the clinic attendance date = Original Date on list.
- To enter all patient contact details within Additional Information on the Waiting list entry screen (to maintain a full audit trail).
• To ensure patients are given adequate notice and choice relating to Admission dates.
• To ensure patient pauses are entered according to policy.
• To enter full free text reasons for pauses and cancellations onto PAS.
• To regularly validate waiting lists to ensure lists are complete and correct at all times.
• To ensure PAS is updated correctly and timely with any Patient Choice decisions.
• To ensure the patient’s appropriate waiting time status is accurately & timely recorded on PAS.

3.25 Adherence to Policy
The Data Quality Team will routinely monitor the appropriate application of this policy. This will be monitored by the Patient Access Group, which is comprised of Service Managers.

Where issues arise with any member of staff in complying with the policy, the issue will be resolved between the Data Quality Team and the individual concerned. Any failure to reach agreement will be referred to the appropriate Line Manager. Failure to reach agreement at this stage will be referred to the appropriate Associate Director with responsibility for operational standards.

4. Training
All staff involved in the RTT pathway will be expected to undertake waiting times training via an e-learning programme.

All MDT Co-ordinators and Data Clerks will have additional training adjusted to their needs, which is also delivered via an e-learning programme.

4.1 Somerset Cancer Register Training
Dependent on the individual user needs and access level required a member of the Cancer Information Services Team will arrange for the user to attend a training session or meet with them on an individual basis.

Staff will not be granted read/write access to the Somerset Cancer Register system without the appropriate level of training being undertaken in accordance with their role.

5. Evidence Base
National Referral to Treatment Consultant led waiting times 2014, Department of Health
Human Rights Act 1998

6. Monitoring Compliance and Audit
It is the responsibility of the Information Services Team to run a weekly programme of audits for data completeness and data anomalies.

Any data anomalies are flagged to the relevant Service Manager for investigations and correction. Response to the Cancer Information Services Team must occur within 24 hours of the query being raised in order not to delay the audit programme and to ensure accurate performance available at all times.

In addition, a data quality programme will be established to review the following:
• Comparative audit of data on the PAS.
• Comparative audit of diagnosis code on PAS, and case notes.
• Comparative audit of cases removed from the 18 week pathway and re- within 4 weeks of removal.

This will involve a random selection of cases notes from each body site to be reviewed and will be led by the Service Manager.

Audits will be undertaken both internally as part of the internal cycle and externally as part of the Trust external audit programmer to provide assurance to commissioners and key stakeholders that data is timely and correctly recorded and collected according to national standards.

7. **Dissemination, Implementation and Access to the Document**
This policy is available on the Trust intranet. All staff are notified via email, of the policy and any amendments. Printed copies of this document are uncontrolled.
## National Codes

<table>
<thead>
<tr>
<th>National Code</th>
<th>Treatment Status Description</th>
<th>Clock status</th>
<th>Definition and examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>First activity</td>
<td>Clock start</td>
<td>Use for any referral from GPs or their practices or Dentists as the patient is added to the registered referrals list. Use for the first appointment in a new patient pathway, for example starting a new pathway under the same consultant e.g. for a second cataract or second joint operation or a substantially different treatment. Use if adding a patient directly to a waiting list without any outpatient appointment.</td>
</tr>
<tr>
<td>11</td>
<td>End of Active Monitoring / watchful waiting</td>
<td>Clock start</td>
<td>Use if a patient has been on active monitoring and treatment is now needed. If this decision is taken at an outpatient appointment code 11 is recorded as the outcome of the clinic appointment (as well as clinical outcome of “add to waiting list”).</td>
</tr>
<tr>
<td>12</td>
<td>Consultant referral for a new condition</td>
<td>Clock start</td>
<td>Where a referral is added to the registered referral list for a new condition and that referral has been received from another consultant rather than from primary care this code should be recorded.</td>
</tr>
<tr>
<td>20</td>
<td>Subsequent activity</td>
<td>Clock ongoing</td>
<td>Use for anything that occurs in the pathway after the first activity on the pathway occurs i.e. outpatient appointment or diagnostic test, but where first treatment has not yet started.</td>
</tr>
<tr>
<td>20</td>
<td>Request to Phlebotomy</td>
<td>Clock ongoing</td>
<td>Request to Phlebotomy as part of the patients pathway.</td>
</tr>
<tr>
<td>20</td>
<td>Request to Physiology</td>
<td>Clock ongoing</td>
<td>Request to Physiology as part of the patients pathway.</td>
</tr>
<tr>
<td>National Code</td>
<td>Treatment Status Description</td>
<td>Clock status</td>
<td>Definition and examples</td>
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<tr>
<td>--------------</td>
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</tr>
<tr>
<td>20</td>
<td>Request to Cardiology</td>
<td>Clock ongoing</td>
<td>Request to Cardiology as part of the patients pathway.</td>
</tr>
<tr>
<td>20</td>
<td>Request to Imaging test</td>
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<td>Request to Imaging test as part of the patients pathway.</td>
</tr>
<tr>
<td>20</td>
<td>Request to Urodynamics</td>
<td>Clock ongoing</td>
<td>Request to Urodynamics as part of the patients pathway.</td>
</tr>
<tr>
<td>20</td>
<td>Request to Endoscopy</td>
<td>Clock ongoing</td>
<td>Request to Endoscopy as part of the patients pathway.</td>
</tr>
<tr>
<td>20</td>
<td>Request to Neurophysiology</td>
<td>Clock ongoing</td>
<td>Request to Neurophysiology as part of the patients pathway.</td>
</tr>
<tr>
<td>20</td>
<td>Referral to another Consultant for the same condition</td>
<td>Clock ongoing</td>
<td>Referral to another Consultant for the same condition as part of the patients pathway.</td>
</tr>
<tr>
<td>20</td>
<td>Request to Nuclear Medicine</td>
<td>Clock ongoing</td>
<td>Request to Nuclear Medicine as part of the patients pathway.</td>
</tr>
<tr>
<td>20</td>
<td>Request to Therapy Services</td>
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<td>Request to Therapy Services as part of the patients pathway.</td>
</tr>
<tr>
<td>20</td>
<td>Request to Sleep Studies</td>
<td>Clock ongoing</td>
<td>Request to Sleep Studies as part of the patients pathway.</td>
</tr>
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<td>National Code</td>
<td>Treatment Status Description</td>
<td>Clock status</td>
<td>Definition and examples</td>
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<tr>
<td>20</td>
<td>Request to Vestibular test</td>
<td>Clock ongoing</td>
<td>Request to Vestibular test as part of the patients pathway.</td>
</tr>
<tr>
<td>20</td>
<td>Request to Audiology</td>
<td>Clock ongoing</td>
<td>Request to Audiology as part of the patients pathway.</td>
</tr>
<tr>
<td>20</td>
<td>Test and report complete</td>
<td>Clock ongoing</td>
<td>Use once the test and report following a diagnostic test/ image is completed and sent to the referrer.</td>
</tr>
<tr>
<td>20</td>
<td>Add to diagnostic elective waiting list</td>
<td>Clock ongoing</td>
<td>Use when the patient has been added to the diagnostic elective waiting list.</td>
</tr>
<tr>
<td>20</td>
<td>Add to therapeutic elective waiting list</td>
<td>Clock ongoing</td>
<td>Use when the patient has been added to the therapeutic elective waiting list.</td>
</tr>
<tr>
<td>21</td>
<td>Transfer to another Health Care Provider – Expected back</td>
<td>Clock ongoing</td>
<td>Use when a patient is referred to another Trust/ Consultant for the same condition and is expected to be returned to the Trust/ Consultant for the patient’s pathway to be completed e.g. sent to Trust A for a specialised diagnostic test but treatment will occur at Trust B.</td>
</tr>
<tr>
<td>21</td>
<td>Transfer to another Health Care provider-not expected back</td>
<td>Clock ongoing</td>
<td>Use when a patient is referred to another Trust/ Consultant for the same condition and they are not anticipated back to the referrer, the referral should also be discharged.</td>
</tr>
<tr>
<td>National Code</td>
<td>Treatment Status Description</td>
<td>Clock status</td>
<td>Definition and examples</td>
</tr>
<tr>
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</tr>
<tr>
<td>30</td>
<td>First Treatment</td>
<td>Clock Stop</td>
<td>Use when the patient’s first definitive treatment is given, whether this is as an inpatient or an outpatient. Use this at the start of the treatment (not when treatment is complete). This may be the outcome of an outpatient appointment (where drugs are prescribed for example), an outpatient appointment for treatment (e.g. the first appointment of a course of physio) or an admission for therapeutic surgery.</td>
</tr>
<tr>
<td>98</td>
<td>Clock stopped at other provider</td>
<td>Clock Stop</td>
<td>Use when the clock has been stopped at another provider.</td>
</tr>
<tr>
<td>31</td>
<td>Active monitoring – patient initiated</td>
<td>Clock Stop</td>
<td>The patient may choose to decline treatment at the present time and start a period of active monitoring/ watchful waiting, perhaps to see how their condition develops or to consider their options. This may be an outcome of a clinic appointment, or perhaps occur when a patient is on a waiting list and telephones an admissions clerk.</td>
</tr>
<tr>
<td>32</td>
<td>Active monitoring – HCP initiated</td>
<td>Clock Stop</td>
<td>Use this where the clinician wishes to monitor the patient’s condition over time. This occurs for example when the outcome of a clinic appointment is not to treat or request diagnostics but to review again in a number of months. This may also be used for admitted patients if their treatments plan changes, e.g. it is decided after admission not to proceed with surgery.</td>
</tr>
<tr>
<td>33</td>
<td>Failure to attend 1st care activity after referral - DNA</td>
<td>Clock Stop</td>
<td>Use when a patient DNA’s their first appointment/episode on a pathway and are NOT discharged. For example, if a patient DNA’s their first outpatient appointment, or if they DNA pre-admission having been added to a waiting list without an outpatient appointment first.</td>
</tr>
<tr>
<td>National Code</td>
<td>Treatment Status Description</td>
<td>Clock status</td>
<td>Definition and examples</td>
</tr>
<tr>
<td>---------------</td>
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<td>------------------------</td>
</tr>
<tr>
<td>34</td>
<td>Decision not to treat</td>
<td>Clock Stop</td>
<td>Use when a patient is discharged with no onward referral. Use if there is a decision not to treat - when either no treatment required at this point or if it is not appropriate to treat at this point.</td>
</tr>
<tr>
<td>35</td>
<td>Patient declined offered treatment</td>
<td>Clock Stop</td>
<td>Use if a patient declines a treatment plan at any point.</td>
</tr>
<tr>
<td>35</td>
<td>DNA subsequent activity or patient cancellation – referred back to GP care</td>
<td>Clock Stop</td>
<td>Use when a patient either DNAs a subsequent activity on a pathway e.g. pre-operative assessment, OR where they cancel.</td>
</tr>
<tr>
<td>36</td>
<td>Patient died before treatment</td>
<td>Clock Stop</td>
<td>This code will be entered automatically onto PAS as part of the death notification process.</td>
</tr>
<tr>
<td>90</td>
<td>After treatment, first treatment occurred previously</td>
<td>Non-RTT activity</td>
<td>Use this for any activity after the first definitive treatment has started, e.g. follow up appointments after an admission.</td>
</tr>
<tr>
<td>91</td>
<td>Active monitoring- Care Activity during period of active monitoring</td>
<td>Non-RTT activity</td>
<td>Use where active monitoring is underway and continues with this episode (e.g. no decision to treat has been made) and the patient is receiving care from the Trust i.e. a follow-up appointment.</td>
</tr>
<tr>
<td>National Code</td>
<td>Treatment Status Description</td>
<td>Clock status</td>
<td>Definition and examples</td>
</tr>
<tr>
<td>--------------</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>92</td>
<td>Not yet referred — diagnostic for GP to decide on onwards referral</td>
<td>Non-RTT activity</td>
<td>Use for referrals from GPs for diagnostic tests only where the patient will go back to their GP to receive their result and decision on where treatment should occur.</td>
</tr>
<tr>
<td>98</td>
<td>Activity not applicable — not part of referral to treatment pathway</td>
<td>Non-RTT activity</td>
<td>Use for activity which is not part of a treatment pathway. This is the code which applies to emergency admissions or where first definitive treatment has already occurred. This code is also for referrals to non-consultant led services e.g. dietetics, hearing aid repair, physiotherapy.</td>
</tr>
</tbody>
</table>
### Treatment Function Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Treatment Function Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>General surgery</td>
</tr>
<tr>
<td>101</td>
<td>Urology</td>
</tr>
<tr>
<td>102</td>
<td>Transplantation Surgery</td>
</tr>
<tr>
<td>103</td>
<td>Breast Surgery</td>
</tr>
<tr>
<td>104</td>
<td>Colorectal Surgery</td>
</tr>
<tr>
<td>105</td>
<td>Hepatobiliary &amp; Pancreatic Surgery</td>
</tr>
<tr>
<td>106</td>
<td>Upper Gastrointestinal</td>
</tr>
<tr>
<td>107</td>
<td>Vascular Surgery</td>
</tr>
<tr>
<td>110</td>
<td>Trauma &amp; Orthopaedic</td>
</tr>
<tr>
<td>120</td>
<td>ENT</td>
</tr>
<tr>
<td>130</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>140</td>
<td>Oral Surgery</td>
</tr>
<tr>
<td>141</td>
<td>Restorative Dentistry</td>
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<tr>
<td>142</td>
<td>Paediatric Dentistry</td>
</tr>
<tr>
<td>143</td>
<td>Orthodontics</td>
</tr>
<tr>
<td>144</td>
<td>Maxillo-Facial Surgery</td>
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<tr>
<td>150</td>
<td>Neurosurgery</td>
</tr>
<tr>
<td>160</td>
<td>Plastic Surgery</td>
</tr>
<tr>
<td>161</td>
<td>Burns Care</td>
</tr>
<tr>
<td>170</td>
<td>Cardiotoracic Surgery</td>
</tr>
<tr>
<td>171</td>
<td>Paediatric Surgery</td>
</tr>
<tr>
<td>172</td>
<td>Cardiac Surgery</td>
</tr>
<tr>
<td>173</td>
<td>Thoracic Surgery</td>
</tr>
<tr>
<td>174</td>
<td>Cardiotoracic Transplantation</td>
</tr>
<tr>
<td>180</td>
<td>Accident &amp; Emergency</td>
</tr>
<tr>
<td>190</td>
<td>Anaesthetics (Out-patient use only)</td>
</tr>
<tr>
<td>191</td>
<td>Pain Management</td>
</tr>
<tr>
<td>192</td>
<td>Critical Care Medicine</td>
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<tr>
<td>211</td>
<td>Paediatric Urology</td>
</tr>
<tr>
<td>212</td>
<td>Paediatric Transplantation</td>
</tr>
<tr>
<td>213</td>
<td>Paediatric Gastrointestinal</td>
</tr>
<tr>
<td>214</td>
<td>Paediatric Trauma &amp; Orthopaedics</td>
</tr>
<tr>
<td>215</td>
<td>Paediatric Ear Nose &amp; Throat</td>
</tr>
<tr>
<td>216</td>
<td>Paediatric Ophthalmology</td>
</tr>
<tr>
<td>217</td>
<td>Paediatric Maxillo-Facial</td>
</tr>
<tr>
<td>218</td>
<td>Paediatric Neurosurgery</td>
</tr>
<tr>
<td>219</td>
<td>Paediatric Plastic Surgery</td>
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<tr>
<td>220</td>
<td>Paediatric Burns Care</td>
</tr>
<tr>
<td>221</td>
<td>Paediatric Cardiac Surgery</td>
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<tr>
<td>222</td>
<td>Paediatric Thoracic Surgery</td>
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<tr>
<td>241</td>
<td>Paediatric Pain Management</td>
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<tr>
<td>242</td>
<td>Paediatric Intensive Care</td>
</tr>
<tr>
<td>251</td>
<td>Paediatric Gastroenterology</td>
</tr>
<tr>
<td>Code</td>
<td>Treatment Function Title</td>
</tr>
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<td>------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>252</td>
<td>Paediatric Endocrinology</td>
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<tr>
<td>253</td>
<td>Paediatric Clinical</td>
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<tr>
<td>256</td>
<td>Paediatric Infectious Diseases</td>
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<tr>
<td>257</td>
<td>Paediatric Dermatology</td>
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<td>258</td>
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<tr>
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<td>Paediatric Metabolic Disease</td>
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<td>262</td>
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<td>280</td>
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<td>Community Paediatrics</td>
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<td>307</td>
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<td>Sleep Studies (Respiratory Physiology)</td>
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<td>400</td>
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<td>Midwife Episode</td>
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<td>Speech &amp; Language Therapy</td>
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<td>700</td>
<td>Learning Disabilities</td>
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<td>710</td>
<td>Adult Mental Illness</td>
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<tr>
<td>711</td>
<td>Child &amp; Adolescent</td>
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<tr>
<td>712</td>
<td>Forensic Psychiatry</td>
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<td>Psychotherapy</td>
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<td>Eating Disorders</td>
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<td>Addiction Services</td>
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<td>Liaison Psychiatry</td>
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<td>Psychiatric Intensive Care</td>
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<td>Perinatal Psychiatry</td>
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<td>Interventional Radiology</td>
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<td>822</td>
<td>Chemical Pathology</td>
</tr>
<tr>
<td>840</td>
<td>Audiology</td>
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</table>
### Non-compliance Fines  
**Appendix C**

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>TARGET</th>
<th>FINANCIAL PENALTY</th>
<th>APPLICATION OF CONSEQUENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>18 WEEK REFERRAL TO TREATMENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-week wait from referral to treatment for admitted patients.</td>
<td>90%</td>
<td>Subject to contract conditions.</td>
<td>Monthly.</td>
</tr>
<tr>
<td>18-week wait from referral to treatment for non-admitted patients.</td>
<td>95%</td>
<td>Subject to contract conditions.</td>
<td>Monthly.</td>
</tr>
<tr>
<td>18-week wait from referral for incomplete pathway.</td>
<td>92%</td>
<td>Subject to contract conditions.</td>
<td>Monthly.</td>
</tr>
<tr>
<td>Patients waiting &gt;52 weeks for admitted, non-admitted or incomplete pathways.</td>
<td>0</td>
<td>£5,000 per patient.</td>
<td>Monthly.</td>
</tr>
<tr>
<td><strong>DIAGNOSTIC TEST WAITING TIMES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-week wait from referral for a diagnostic test.</td>
<td>99%</td>
<td>2% of revenue derived from the provision of the locally defined service line in the month of the under-achievement.</td>
<td>Monthly.</td>
</tr>
<tr>
<td><strong>ACCIDENT &amp; EMERGENCY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-hour wait from arrival at A&amp;E department to patient admission, transfer or discharge.</td>
<td>95%</td>
<td>2% of revenue derived from the provision of the locally defined service line in the month of the under-achievement *.</td>
<td>Quarterly.</td>
</tr>
<tr>
<td>15-minute handovers between ambulance and A&amp;E.</td>
<td>0</td>
<td>£200 per patient waiting over 30 minutes and £1,000 per patient waiting over 60 minutes.</td>
<td>Monthly.</td>
</tr>
<tr>
<td>12-hour trolley waits in A&amp;E.</td>
<td>0</td>
<td>£1,000 per patient waiting for more than 12 hours.</td>
<td>Monthly.</td>
</tr>
<tr>
<td><strong>CANCER ACCESS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-week wait from urgent GP referral for suspected cancer to first appointment.</td>
<td>93%</td>
<td>2% of revenue derived from the provision of the locally defined service line in the month of the under-achievement *.</td>
<td>Quarterly.</td>
</tr>
<tr>
<td>2-week wait from urgent GP referral for breast symptoms to first appointment</td>
<td>93%</td>
<td>2% of revenue derived from the provision of the locally defined service line in the month of the under-achievement *.</td>
<td>Quarterly.</td>
</tr>
<tr>
<td>31-day wait from diagnosis to first definitive treatment.</td>
<td>96%</td>
<td>2% of revenue derived from the provision of the locally defined service line in the month of the under-achievement *.</td>
<td>Quarterly.</td>
</tr>
<tr>
<td>31-day wait for subsequent treatment (surgery).</td>
<td>94%</td>
<td>2% of revenue derived from the provision of the locally defined service line in the month of the under-achievement*.</td>
<td>Quarterly.</td>
</tr>
<tr>
<td>31-day wait for subsequent treatment (anti-cancer drug treatment).</td>
<td>98%</td>
<td>2% of revenue derived from the provision of the locally defined service line in the month of the under-achievement*.</td>
<td>Quarterly.</td>
</tr>
<tr>
<td>62-day wait from urgent GP referral to first definitive treatment.</td>
<td>85%</td>
<td>2% of revenue derived from the provision of the locally defined service line in the month of the under-achievement*.</td>
<td>Quarterly.</td>
</tr>
</tbody>
</table>
Appendix D

Agreement to Pay Form
Overseas Patients

Section A – Personal Details
Surname ............................................
Forename ...........................................
Telephone Number ..........................
Passport Number .............................

Mr/Mrs/Miss/Other ..........................
Date of Birth .................................
Nationality .................................

Post Code ....................................

Section A – Personal Details

Overseas Address ..........................................................
..........................................................
..........................................................

Zip Code ........................................

EHIC yes/no  Passport yes/no  Visa yes/no

Copies taken  □  □

Section B – Insurance Details – delete as applicable Self-funding / Insured
Insurers Name ..................................................
Insurers Address ...........................................
Post Code/Zip Code .................................
Country ............................................
Insurance Policy No ..............................
Authorisation/Claim Code ...........................

Section B – Insurance Details

Section C – Procedure Details
A&E date of admission ..........................
Consultant ..........................................
Clinic Consultation – Yes/No
Outpatients Procedures ..........................

Outcome ............................................
Code ............................................
Date of Clinic ..................................

Proposed Surgical Procedure ..................

Proposed Date ..................................

Importance Guidance – please read in full before signing.

Patients from the EU on production of your EHIC card all charges will be levied to your country; this can be produced following your discharge from hospital. If your EHIC card is not produced and your hospital treatment is any more than A&E you will be charged as a Private Patient. All non-payments will be reported to the Home Office.

A replacement EHIC a Provisional Replacement Certificate (PRC) to prove entitlement may be produced instead. It is the responsibility of the Patient or their Representative to arrange the issue of the PRC from their member state.

This Agreement to Pay form covers services provided to you by CHUFT (Colchester Hospital University NHS Foundation Trust) only. It does not cover any agreement that you have made privately with your Doctor/Practitioner. This will be billed to you separately, and we would advise you to seek an estimate prior to commencing any treatment from the clinician concerned.

Charges will be levied for each hospital attendance and treatment. If multiple treatments are necessary, it is expected that you will continue to be treated privately for the full course of your treatment, and charged accordingly.

If you are not entitled to free NHS treatment you are classed as Self-Funding some charges are payable and will need to be cleared prior to treatment /consultation, and can be done by cash or cheque at the General Office, or by Debit/Credit card via the Debtors Office 01206 74 2647. It is your responsibility to pay all hospital charges and recoup from your Holiday Insurance yourself, if held.

Specialist consumables, longer than expected hospital stay, unexpected Intensive Care, (including High Dependency Care or extended Recovery), certain drugs used and some tests/procedures will be charged to yourself following your discharge/hospital attendance.

[Type text]
Please return completed form to Karen Tonks, Overseas Patient Manager, Admin Corridor 2, Colchester General Hospital, Turner Road, Colchester, Essex. CO4 5JL

Policy: 138
Version: 8
If you have any queries regarding your charges, or payment in general, please contact the Overseas Patient Manager on 07995 953847.

Section D – Patient Declaration

I agree to accept full liability for payment for the procedure should there be any shortfall payment by the insurer. I understand that the Trust may contact my insurance company in advance to determine the existence of the policy I have described in this agreement to pay form.

I understand that the price that will be payable to the Trust will include the price of the procedure, plus the costs of consumables incurred by the Trust in undertaking that procedure plus charges in respect of accommodation and services provided for me as determined by the Trust under sections 65(3) and 66 of the NHS Act 1977. I understand that such charges do not include any payment for the services of the responsible Consultant medical/dental/paramedical practitioner, or those of any other practitioner for example Pathologist, Radiologist or Anaesthetist with whom I make private arrangements (either directly or indirectly).

Consent to Share Information:

I consent to CHUFT sharing any information by law with Government Agencies such as Border Force, and the Home Office. Information will be regarding issues such as Visa applications and unpaid NHS bills. Confidential medical information will not be shared.

I authorise provision of copies of medical notes/invoices to my insurer to enable the processing of the claim and for the payment processing system.

I confirm that the above information is complete to the best of my knowledge and that in the interests of security, the Trust reserves the right to instruct an appropriate agency to verify and details that I have included on this form.

Date entered the UK..............................

Signed ........................................................................ Date .................................
(Patient/Representative)

Name in Full ............................................. Relationship to Patient..............................................

Section E

<table>
<thead>
<tr>
<th>Clinician</th>
<th>Hospital Number</th>
<th>Ward/Department</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date Form Received ..........................................................

Procedure ................................................ Procedure Code ..............................................

Finance Code ...................................................

Consumables Used                                      Price Excluding VAT

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[Type text]

Please return completed form to Karen Tonks, Overseas Patient Manager, Admin Corridor 2, Colchester General Hospital, Turner Road, Colchester, Essex. CO4 5JL
Agreement to Pay Form
Private Patients

Section A – Personal Details
Surname ................................................. Mr/Mrs/Miss/Other .................................................
Forename ................................................. Date of Birth .................................................
Telephone Number ..................................... Hospital Number .................................................
Address .................................................................................................................... Post Code .................................................

Section B – Insurance Details – delete as applicable Self-funding / Insured
Insurers Details Axa / Aviva / Bupa / Other .................................................
Insurance Policy No ................................................. Authorisation/Claim Code .................................................

Section C – Procedure Details
Consultant .................................................
Clinic Consultation – Yes/No Date of Clinic .................................................
Radiotherapy Preparation code ................................................. Radiotherapy Delivery Code .................................................
Number of Multiple Attendances (Radiotherapy/UVA/UVB) .................................................
Outpatients Procedures/Diagnostic ................................................. Code .................................................
Day case Procedure ................................................. Code .................................................
Proposed Surgical Procedure ................................................. Code .................................................
Proposed Date ................................................. Estimated length of in-patient stay .................................................

Importance Guidance – please read in full before signing.
This Agreement to Pay form covers services provided to you by CHUFT (Colchester Hospital University NHS Foundation Trust) only. It does not cover any agreement that you have made privately with your Doctor/Practitioner. This will be billed to you separately, and we would advise you to seek an estimate prior to commencing any treatment from the clinician concerned.

Charges will be levied for each hospital attendance and treatment. If multiple treatments are necessary, it is expected that you will continue to be treated privately for the full course of your treatment, and charged accordingly.

If you are Self-Funding some charges are payable prior to treatment /consultation, and can be done by cash or cheque at the General Office, or by Debit/Credit card via the Debtors Office 01206 74 2647.

Specialist consumables, longer than expected hospital stay, unexpected Intensive Care, (Including High Dependency Care or extended Recovery), certain drugs used and some tests/procedures will be charged to yourself following your discharge/hospital attendance.

If you have any queries regarding your charges, or payment in general, please contact the Private Patient Manager on 07795 953847.
Please return to Karen Tonks, Private Patient Manager, Admin Corridor 2, Colchester General Hospital, Turner Road, Colchester Essex. CO4 5JL

Policy: 138
Version: 8
Section D – Patient Declaration

I agree to accept full liability for payment for the procedure should there be any shortfall payment by the insurer. I understand that the Trust may contact my insurance company in advance to determine the existence of the policy I have described in this agreement to pay form.

I understand that the price that will be payable to the Trust will include the price of the procedure, plus the costs of consumables incurred by the Trust in undertaking that procedure plus charges in respect of accommodation and services provided for me as determined by the Trust under sections 85(3) and 66 of the NHS Act 1977.

I understand that such charges do not include any payment for the services of the responsible Consultant medical/paramedical practitioner, or those of any other practitioner for example Pathologist, Radiologist or Anaesthetist with whom I make private arrangements (either directly or indirectly).

Consent to Share Information:

I authorise provision of copies of medical notes/invoices to my insurer to enable the processing of the claim and for the payment processing system.

I confirm that the above information is complete to the best of my knowledge and that in the interests of security, the Trust reserves the right to instruct an appropriate agency to verify and details that I have included on this form.

Signed ………………………………………………………………………………………… Date ……………………………
(Patient)

Name in Full ……………………………………………………………………………………………………………………………..

Patient Representative

Full Name………………………………………… Relationship to Patient…………………………………………………………

Signed………………………………………… Date…………………………………………………………

<table>
<thead>
<tr>
<th>Consumables Used</th>
<th>*Delete as applicable</th>
<th>* Price Including/Excluding VAT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Admin

Date Form Received ……………………… Date of Payment…………………………………………………………

Authorisation Code…………………… Date of Authorisation…………………………………………………………

Please return to Karen Tonks, Private Patient Manager, Admin Corridor 2, Colchester General Hospital, Turner Road, Colchester Essex. CO4 5JL
Appendix E

Patient Access Policy – Abridged Version for Children’s Services

Clock Starts
A clock starts when a GP or other healthcare professional refers a Child/Young Person (CYP and/or parent) for assessment, diagnosis and, if appropriate, treatment before responsibility is transferred back. This includes the following:
- Any referral to a consultant led service.
- Includes self-referrals.

For paper referrals – the date the referral is received.

For Choose and Book referrals – the date the CYP calls to make an appointment and gives their unique booking reference number.

If, following completion of a referral-to-treatment period, a CYP requires treatment for a substantially new or different condition then a new clock starts. This is a clinical decision made in consultation with the CYP.

Clock Stops
The clock stops when the CYP receives the first definitive treatment for the referred condition. A CYP’s First Definitive Treatment is an intervention intended to manage a CYP’s disease or condition. This may occur following a consultation, receipt of results from a diagnostic test.

CYPs can also have clock stops for non-treatment. The following are examples where CYPs clocks will be stopped for non-treatment reasons:
- Clinical decision to start a period of active monitoring.
- CYP declines treatment.
- Clinical decision not to treat.

Active Monitoring
The concept of Active Monitoring (watchful waiting) stops the clock and caters for periods of care without (new) clinical intervention e.g. three monthly routine check-ups for diabetic CYPs.

This is where it is clinically appropriate to:
- monitor the CYP in secondary care without clinical intervention.
- further diagnostic procedures are required.
- when a CYP wishes to continue to be reviewed as an outpatient.

Active monitoring (watchful waiting) can be initiated by either the CYP or the clinician. Periods of active monitoring will not exceed 6 months. CYPs should be reviewed after this time to agree a revised treatment plan or discharge to primary care.

If, after a period of active monitoring, the CYP or the care professional then decides that treatment is now appropriate, a new clock starts. There is then a new CYP pathway in which the CYP must receive their first definitive treatment within a maximum of 18 weeks.
Consultant to Consultant Referral (C2C)
Consultant to Consultant Referrals are commissioned (permitted) for all children under 17 years, for the same or for unrelated condition. (Conditions that can be managed appropriately in primary care should be referred back to the GP).

If the CYP is being referred onto another clinician within or outside the Trust for assessment or treatment as part of the initial referral (existing pathway), the clock continues until the CYP receives definitive treatment. The Trust will use the agreed Inter-provider Transfer Pro-forma (ITP) to communicate the relevant information about the CYP’s treatment status to external organisations.

Consultant (or Consultant-led service) referrals will start a new clock if:
• separate conditions or complications, or if a new-born baby is suspected of having a condition requiring medical or surgical Consultant-led treatment.

Managing DNAs/Cancellations
If a CYP does not attend (DNAs) their first appointment, they could be discharged back to the referrer if there are no safety, social or safeguarding concerns. This will be a clinical decision, considering the referral reason. The GP will be informed by standard letter (Appendix 1).

If there is a second DNA and/or third DNA (depending on clinical condition/professional judgement), a standard letter will also be issued, the CYP will be returned to the GP/referrer and a copy of the letter sent to the GP/Health Visitor/School Nurse, Social Worker and parents/carer. This applies to all referrals. (This replaces the requirement for a significant event sheet). However, if there are complex safeguarding concerns that should not be included in this standard letter, a Health Information Sharing Form should be completed and sent to the above professionals and the hospital Safeguarding Children Team. The letter will include the following statement:

‘As per Lord Laming 2009 – this child has failed to attend their outpatient appointment on at least one occasion. It is the referrer’s responsibility to assess the potential impact of this non-attendance on the child’s health and welfare. If the concerns are significant then a referral should be made to the appropriate agency.’

A significant event sheet must be completed with details of the non-attendance and placed in the clinical notes under the clinical alert divider.

For CYP that fail to attend phlebotomy appointments, the Consultant should be notified before further appointments are booked.

All appointments should be offered as Full Booking – see Reasonable Notice overleaf. All relevant appointment letters will include the relevant section regarding the DNA policy and the consequence of cancelling 2 appointments.

Decision Not To Treat/No Treatment Required:
A decision not to treat/no treatment required may occur outside a clinical consultation, e.g. if a CYP is discharged on the basis of a test result which is communicated to the CYP and their GP by letter. This can occur at any stage of the CYP’s pathway and will stop the clock – an Admin Contact must be entered on PAS.

CYP Refuses to Wait – Wait Exceeds 60 Minutes from their Original Appointment Time:
The CYP needs to be informed of the waiting time on arrival to clinic. The CYP should not have to wait longer than 30 minutes after their appointment time. If a CYP informs
the Receptionist that they are unable to wait longer than 1 hour past their appointment
time the Receptionist should record the outcome on PAS as a hospital initiated
cancellation and offer another appointment.

Reasonable Notice
A reasonable offer of an outpatient appointment date or diagnostic test is two dates
with the earliest being a minimum of one week for a verbal offer and for a written
offer a minimum of a two calendar weeks.

The CYP accepting short notice appointments (within next 5 days) will have the date
and time confirmed by telephone, text or e-mail. All offers of dates to the CYP for
outpatient, diagnostic or inpatient episodes must be recorded in PAS at the time the
offers are made.

Therefore 2 attempts to contact every CYP by telephone will always be made if
an appointment is less than (three) weeks away, one of which will be after 6.00
p.m. and the attempts will fall on different days. All contacts must be recorded
accurately in the comments field in the outpatient booking screen in PAS.

Outpatients – Additional General Principles
- The Trust’s internal operating standards are to achieve a maximum wait of 6
  weeks by specialty.
- CYPs are seen in the order of clinical priority and date on list.
- Any contact with the CYP should be documented on the PAS system using the
  Admin Contact Function.
- Referrals should be date stamped and entered onto PAS immediately where
  received, prioritised by the Consultant and returned to the Children’s Outpatients
  Department/Primary Care Centre (PCC) within 24 hours.
- Referrals should be accepted or rejected as appropriate within 48 hours by the
  Consultant and amended on PAS.
- Cancelled slots should be used to bring forward the longest waiting CYP, not to
  the next “routine” referral.
- Where cancellations are initiated by the Trust, the CYP should be booked as close
to their original appointment as possible, and within 2 weeks of the cancellation
date.

Inappropriate Referrals
If a Consultant deems a referral to be clinically inappropriate, it must be sent back
to the referrer with an explanation of why. The referral decision must be updated and
discharged accordingly on PAS (See Appendix 2).

If a referral has been incorrectly sent to and/or received, then the receiving speciality
will send to the appropriate speciality; but the initial received date must remain the
same, and the speciality only changed.

Cancellation of Appointments
CYPs who cancel before the appointment time are recorded on PAS with details of the
reason for the cancellation. An alternative appointment is offered within 2 weeks of the
original appointment where possible. If an appointment slot is not available within 2
weeks, this must be escalated to the Service Manager as the RTT clock is still ticking.
If the next appointment cannot be accepted by the CYP, then they will be discharged
and returned to the referrer.
If the hospital cancels a CYP’s appointment anywhere on an RTT pathway, the clock continues to tick. CYP should not be cancelled more than once by the hospital.

When a CYP cancels their appointment for the second occasion, they will be discharged and returned to the referrer. The CYP can be re-referred – a new clock would start on receipt of the re-referral.

**Diagnostics**
Diagnostic tests and the associated report must be performed within 6 weeks of request for the test. The responsible Consultant can review the result and instruct and Admin Contact following e.g. telephone consultation to stop the clock.

**GP Requested Diagnostics**
Where a GP requests a diagnostic test (phlebotomy), the CYP’s clock does not start.
The following treatment status codes are available and one must also be recorded:

<table>
<thead>
<tr>
<th>National code</th>
<th>Treatment Status Description</th>
<th>Clock status</th>
<th>Definition and examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>First Activity</td>
<td>Clock start</td>
<td>Use for any referral from GPs/other health providers – the CYP is added to the registered referrals list.</td>
</tr>
<tr>
<td>11</td>
<td>End of Active monitoring/watchful waiting</td>
<td>Clock start</td>
<td>Use if a CYP has been on active monitoring and treatment is now needed. If this decision is taken at an outpatient appointment, code 11 is recorded as the outcome.</td>
</tr>
<tr>
<td>12</td>
<td>Consultant referral for a new condition</td>
<td>Clock start</td>
<td>Where a referral is added to the registered referral list for a new condition and that referral has been received from another consultant rather than from primary care this code should be recorded.</td>
</tr>
<tr>
<td>20</td>
<td>Subsequent activity</td>
<td>Clock ongoing</td>
<td>Use for anything that occurs in the pathway after the first activity on the pathway occurs, i.e. outpatient appointment or diagnostic test, but where first treatment has not yet started.</td>
</tr>
<tr>
<td>20</td>
<td>Request to Phlebotomy</td>
<td>Clock ongoing</td>
<td>Request to Phlebotomy as part of the CYPs pathway.</td>
</tr>
<tr>
<td>21</td>
<td>Transfer to another Health Care Provider</td>
<td>Clock ongoing</td>
<td>Use when a CYP is referred to another Trust/Consultant for the same condition and they are not anticipated back to the referrer, the referral should also be discharged.</td>
</tr>
<tr>
<td>30</td>
<td>First treatment</td>
<td>Clock stop</td>
<td>Use when the CYP’s first definitive treatment is given. This may be the outcome of an outpatient appointment (e.g. drugs are prescribed/advice given).</td>
</tr>
<tr>
<td>31</td>
<td>Active monitoring – CYP initiated</td>
<td>Clock stop</td>
<td>The CYP may choose to decline treatment at the present time and start a period of active monitoring/watchful waiting, perhaps to see how their condition develops or to consider their options. This may be an outcome of a clinic appointment.</td>
</tr>
<tr>
<td>32</td>
<td>Active monitoring – clinician initiated</td>
<td>Clock stop</td>
<td>Use this where the clinician wishes to monitor the CYP’s condition over time. This occurs when the clinic outcome is not to treat and review in a number of months.</td>
</tr>
<tr>
<td>National code</td>
<td>Treatment Status Description</td>
<td>Clock status</td>
<td>Definition and examples</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>33</td>
<td>Failure to attend 1st activity after referral - DNA</td>
<td>Clock Stop</td>
<td>Use when a CYP DNA’s their first appointment/episode on a pathway and are NOT discharged. For example, if a CYP DNA’s their first out-patient appointment.</td>
</tr>
<tr>
<td>34</td>
<td>Decision not to treat</td>
<td>Clock stop</td>
<td>Use when a CYP is <strong>discharged</strong> with no onward referral – when either no treatment required at this point or if it is not appropriate to treat at this point.</td>
</tr>
<tr>
<td>35</td>
<td>CYP declined offered treatment</td>
<td>Clock stop</td>
<td>Use if a CYP declines a treatment plan at any point.</td>
</tr>
<tr>
<td>36</td>
<td>CYP died before treatment</td>
<td>Clock stop</td>
<td>This code will be entered automatically onto PAS as part of the death notification process.</td>
</tr>
<tr>
<td>90</td>
<td>After treatment, first treatment occurred previously</td>
<td>Non – RTT activity</td>
<td>Use this for any activity after the first definitive treatment has started, e.g. follow up appointments after an admission.</td>
</tr>
<tr>
<td>91</td>
<td>Active monitoring- Care Activity during period of active monitoring</td>
<td>Non – RTT activity</td>
<td>Use where active monitoring is underway and continues with this episode (e.g. no decision to treat has been made) and the CYP is receiving care from the Trust i.e. a follow-up appointment.</td>
</tr>
<tr>
<td>92</td>
<td>Not yet referred – diagnostic for GP to decide on onwards referral</td>
<td>Non – RTT activity</td>
<td>Use for referrals from GPs for diagnostic tests only where the CYP will go back to their GP to receive their result and decision on where treatment should occur.</td>
</tr>
<tr>
<td>98</td>
<td>Activity not applicable- not part of referral to treatment pathway</td>
<td>Non – RTT activity</td>
<td>Use for activity which is not part of a treatment pathway. This is the code which applies to emergency admissions or where first definitive treatment has already occurred. This code is also for referrals to non-Consultant led services e.g. dietetics, hearing aid repair, physiotherapy.</td>
</tr>
</tbody>
</table>
Dear

I was sorry not to see you at your clinic appointment. You will receive a further appointment date and time in a separate letter.

Please do not hesitate to contact the paediatric team if you have any concerns prior to the next appointment

Yours sincerely
Dear 

I was sorry not to see you at your outpatient clinic appointment today.

I note that this is the second consecutive appointment that you have not attended.

It is very important that you see a health care professional on a regular basis to help with the on-going management of your health.

I will send you a further clinic appointment on this occasion, but if you are unable to attend that appointment I will need to discharge you from clinic and ask you GP to re-refer you when you/they feel this is appropriate.

Yours sincerely
Dear Dr

Patient Name has now failed to attend three clinics and I am therefore unable to send a further appointment.

As Patient Name has ?disease/condition it is important that they receive regular review. I would be grateful for your help in organising review of Patient Name at, for example, their next repeat prescription request. When Patient Name is ready to re-engage with our care please re-refer her/him back to the ??? clinic.

Yours sincerely

cc. Patient

'As per Lord Laming 2009 – this child has failed to attend their outpatient appointment on at least one occasion. It is the referrer’s responsibility to assess the potential impact of this non-attendance on the child’s health and welfare. If the concerns are significant then a referral should be made to the appropriate agency.'
Appendix 2

Template for Inappropriate Referrals

Colchester Hospital University NHS
NHS Foundation Trust

Dear Dr <<>>

Re: Your referral for <<>>, dated <<>>

Thank you for your referral letter which has been reviewed by one of our acute general paediatric consultants. On this occasion the referral has not been deemed suitable for the clinic you referred to for the following reason(s):

☐ This child should more appropriately be initially seen and assessed in one of our speciality clinics.

☐ This child should more appropriately be initially seen and assessed in one of our general paediatric clinics.

☐ The problems described in your referral would more appropriately be dealt with by community paediatrics.

☐ The patient’s age falls outside the age range for this clinic.

☐ This referral would be more appropriately directed to a non-paediatric speciality within CHUFT i.e.

...........................................................................................................................................................................

☐ This referral would be more appropriately directed to a non-paediatric speciality not based at CHUFT i.e.

...........................................................................................................................................................................

ACTIONS TAKEN:

☐ An alternative appointment has therefore been arranged in ........................................ clinic.

☐ Your referral has been passed on to ............................................... for an appointment to be arranged.

☐ Your referral has been returned to you and we would suggest that you try to arrange an appointment with the appropriate non-paediatric speciality.

Please convey our apologies for any inconvenience caused to the patient but we hope this will be offset by the child being seen in clinic that will be more appropriate for him/her. If you would like to discuss this further, please contact Dr. <<>>.

Yours sincerely

CHILDREN’S OUTPATIENT BOOKING

CHUFT
Appendix – 18 Week Pathway Action Cards

18 Week Referral To Treatment Pathways

Patient treated in Outpatients Department

- **GP referral**
  - **TS = 10**
  - Outpatient appointment
    - **TS = 10**
    - First activity
      - Treatment given in Outpatients
        - **TS = 30**
      - Patient referred for diagnostics
        - **TS = 20**
        - Patient attends Outpatient appointment for follow-up
          - **TS = 30**
          - Treatment given in Outpatients
          - **TS = 31**
          - Watchful waiting
            - **TS = 32**
            - Patient discharged
              - **TS = 34**

Policy: 138
Version: 8
18 Week Referral To Treatment Pathways

Clock Starts in Outpatients

GP referral

Outpatient appointment

Patient pathway ends
- Treated
- Discharged
- Active monitoring - hospital
- Active monitoring - patient
- Patient declines treatment
- Patient transferred to another Trust
18 Week Referral To Treatment Pathways

Patient DNA's 1st OP Appointment

GP referral

Outpatient appointment - patient DNA's

Patient discharged back to GP

2nd OP appointment

TS = 10

Patient clock removed from monitoring

TS = 10

TS = 33

Clock start

Clock stop

Clock start

Clock stop
18 Week Referral To Treatment Pathways

Patient DNA's follow up OP Appointment

GP referral

First Outpatient appointment - patient attends

Follow up Outpatient appointment - patient DNA's

Routine appointment

Patient discharged back to GP

Patient attends

Patient offered second appointment at Consultant's discretion

Patient DNA's again - discharged to GP
18 Week Referral To Treatment Pathways

Outpatient attendance outside a clinic

Patient booked to attend outside a clinic (ward)

Was patient referred to a consultant led service?

Yes

Check whether 18 week pathway for this condition already exists for this patient

No

Record treatment status of 98

Yes

Auto-generate a new pathway ID and record outcome against that pathway

Record outcome against existing pathway

TS = 10

TS = 98
18 Week Referral To Treatment Pathways

Patient discharged outside a clinic appointment

TP = 10
GP referral

TP = 10
Outpatient appointment

Patient referred for diagnostics

Patient attends diagnostics

Add an ADMINISTRATIVE CONTACT IN PAS Discharge the patient
TP = 34

Results of tests indicate patient can be discharged directly without coming back to clinic

Clock start

Clock end
18 Week Referral To Treatment Pathways

Direct referral to diagnostics (straight to test)

GP referral to diagnostics

Diagnostic tests

Patient back to GP for results and action

Patient booked directly into clinic for onward treatment by consultant

Follow-up care

Patient pathway ends
- Treated
- Discharged
- Transfer to another Trust
- Active monitoring - hospital
- Active monitoring - patient
- Patient declines treatment
18 Week Referral To Treatment Pathways

Clock stops at diagnostic appointment

- **GP referral** (TS = 10)
- **Outpatient appointment** (TS = 10)
- **Patient referred for diagnostics** (TS = 20)
- **Patient attends diagnostic appointment**
  - **Diagnostic procedure converts to therapeutic and no further action or follow up required** (TS = 30)
  - **Diagnostic reveals no cause for concern or further follow up - patient informed and discharged** (TS = 34)
  - **Diagnostic reveals no cause for concern, or converts to therapeutic procedure, patient needs follow up but no further treatment intended at present time** (TS = 34)
    - **Follow up outpatient appointment** (TS = 90 or TS = 91)

Ongoing pathway - if further treatments decided new clock starts as applies