PATIENT ACCESS POLICY

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1. Introduction

The policy supports the following aims to ensure that:

- Patients' rights to access services within maximum waiting times are met, or for the NHS to take all reasonable steps to offer them a range of alternative providers if this is not possible.
- The numbers of patients awaiting outpatient appointment, elective treatment, imaging or any other diagnostic test and the length of time they have waited, are accurately recorded and patients informed of their anticipated wait.
- The successful management of waiting times for patients is the responsibility of all NHS staff. Service Commissioners must ensure that services are commissioned with sufficient capacity to meet the needs of the population. Clinicians, managers, nursing staff, secretarial and administration staff have an important role in delivering a high quality, efficient and responsive service and managing waiting lists effectively.

2. Purpose

The policy applies to the management of all waiting lists, held by Sussex Community Dermatology Service Ltd (SCDS).

The policy establishes a number of principles and definitions and defines roles and responsibilities to assist with the effective management of waiting lists relating to outpatient appointments, elective treatment, imaging and other diagnostic tests.

2.1 National Waiting Times

2.1.1 Providers must ensure that all patients are offered appointments within the nationally guaranteed maximum waiting times, or waiting times as outlined in the NHS contract or service specification.

2.2 Patient Choice

2.2.1 Patients are able to choose which provider they wish to attend from a national register. Where providers have services available on the NHS e-Referral Service (NHS e-RS) they are required to offer appointments to patients that choose the hospital as their provider, where clinically and geographically appropriate.

2.3 Transparency

2.3.1 Communication with patients will be honest, informative, clear and concise with access to scheduled care transparent to the public.

2.4 Waiting Times Management

2.4.1 All additions to or removals from waiting lists must be made in accordance with this policy. Wherever possible, patients with the same clinical priority will be treated in

chronological order. Patients should only be added to a waiting list when they are medically fit, ready and available for their treatment or investigation.

2.5 User Training

2.5.1 An appropriate training programme will support staff with special regard given to newly recruited and temporary staff. All staff involved in the implementation of this policy and associated procedures will undertake initial training led by their line manager and regular updates distributed via email.

3. Definitions

The following definitions are provided to ensure a common understanding of the terms used through this document:

3.1 **Active Monitoring** (also known as an Open/SOS Appointment)**:** An 18-week clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage.
An RTT clock should only stop with active monitoring where there is clear intention that the patient's condition will be monitored, either through a future outpatient appointment or via a telephone consultation.

A new 18-week clock would start when a decision to treat is made following a period of active monitoring. Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to refer the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such and also stops an 18-week clock.

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

3.2 **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.

3.3 **Clinical Exception**: Where a patient's treatment has not begun within 18 weeks due to a necessary sequence of diagnostic tests that for medical reasons could not be performed within a shorter period, this would be considered a clinical exception.

3.4 **Clock/RTT Start:** The date on which SCDS receives notice of a patient's referral or the date a clinician decides the patient is ready to proceed with treatment following a period of active monitoring.

3.5 **Clock/RTT Stop:** The date on which the patient receives the start of definitive treatment. This is decided by the clinician responsible.

3.6 **Consultant:** 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.

3.7 **Consultant-led:** 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 they will take overall clinical responsibility for patient care.

3.8 **Convert(s) their Unique Booking Reference Number (UBRN)**: When an appointment has been booked via the NHS e-Referral Service, the UBRN is converted. (Please see definition of UBRN).

3.9 **Day Case**: Patients who require minor surgery but do not need an admission to a hospital setting.

3.10 **DNA – Did Not Attend:** Where a patient fails to attend an appointment/admission without prior notice.

3.11 **Decision to treat:** Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatments performed in other settings e.g. as an outpatient.

First definitive treatment: 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.

3.12 **GPSI/GPER:** General Practitioner with a Specialist Interest in Dermatology or GP with Extended Role in Dermatology. A General Practitioner who has obtained the National Diploma in Dermatology in addition to their Medical Degree or submitted their dermatology portfolio to the RCGP.

3.13 **Incomplete Pathways:** Patients on an 18-week RTT pathway who have not yet received the start of treatment for the condition which they were referred.

3.14 **Last minute cancellations:** A hospital or patient cancellation on the day the patient was due to arrive in clinic, after they have arrived, or on the day of operation.

3.15 **NHS e-Referral System:** A national electronic referral service that gives patients a choice of place, date and time for their first appointment.

3.16 **Outpatient:** Patients referred by a General Practitioner or other referrer for clinical advice or treatment in an Outpatient setting.

3.17 **Referral**: This is a request for a care service, other than a specific diagnostic investigation or procedure, to be provided for a patient.

3.18 **Referral to Treatment (RTT) 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 18-week clock stop point.

3.19 **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.

In the context of 18 weeks, a clock only starts on referral to a referral management and assessment service where that service may onward-refer the patient to a surgical or medical consultant-led service before responsibility is transferred back to the referring health professional.

3.20 **Substantively new or different treatment:** Upon completion of an 18-week referral to treatment period, a new 18-week 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 patient's care often extends beyond the 18-week referral to treatment period, and that there may be a number of planned treatments beyond first definitive treatment.

However, where further treatment is required that was not already planned, a new 18-week clock should start at the point the decision to treat is made.

Scenarios where this might apply include:

- 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.

3.21 **Tolerance:** The waiting time standards set the proportion of RTT pathways that must be within 18 weeks. These proportions leave an operational tolerance to allow for

patients for who starting treatment within 18 weeks would be inconvenient or clinically inappropriate. These circumstances can be categorised as:

- Patient choice – patients choose not to accept earliest offered appointments along their pathway or choose to delay treatments
- Co-operation – patients who do not attend appointments along their pathways
- Clinical exceptions – where it is not clinically appropriate to start a patient's treatment within 18 weeks

3.22 **UBRN (Unique Booking Reference Number):** The reference number that a patient receives on their appointment request letter when generated by the referrer through the NHS e-Referral Service. The UBRN is used in conjunction with the patient password to make or change an appointment.

4. Duties & Responsibilities Of Staff

4.1 Role of the Operations/Service Manager

4.1.1 Board level accountability for waiting times and service delivery.

4.1.2 Ensuring that the Key Performance Indicators related to waiting times are reported on.

4.1.3 Delegation of responsibilities relating to provision of outpatient and elective services.

4.1.4 Effective support of managerial decisions and recommendations to ensure provision of appropriate resources.

4.2 Role of Administration Manager/Senior Administrator

4.2.1 Working with clinical and administrative teams within the division to monitor capacity and demand for services and support performance in access to deliver national targets and ensure a positive patient experience.

4.2.2 Notify the Service Manager if they are unable to identify and organise additional capacity when it is required and may result in breaches or delayed treatments.

4.2.3 Identifying the need for additional activity required to meet the demand.

4.2.4 Liaison with the relevant teams to ensure booked dates in the future are brought forward where possible, to prevent a breach.

4.3 Role of the Head of Data/Business Intelligence

4.3.1 Monitor compliance with the waiting times targets in line with the Key Performance Indicators and distribute to Operations/Service Managers regularly.

4.3.2 Provide reports on Referral to Treatment (RTT) performance and patient level detail on a weekly basis to the relevant internal teams.

4.3.3 Submit all NHS data submissions to the relevant organisations in a timely manner.

4.4 Role of All Staff Groups

4.4.1 Admin Service Managers and Admin Line Managers are responsible for ensuring that information is recorded accurately and in a timely manner.

4.4.2 All administrative staff, including Medical Secretaries, are responsible for recording information accurately and timely in accordance with this Policy.

4.4.3 Clinicians are responsible for advising on the clinical priority of each patient and for

indicating this to enable the correct recording of data on the patient pathway.

4.4.4 Individual staff members, including clinicians, are responsible for ensuring that their practices are consistent with the policy and that systems are in place to support effective waiting times management.

4.5 Referrer Responsibilities – Cancer Pathways

Applicable to Kent Integrated Dermatology Service and subcontracted 2WW activity only.

Primary Care clinicians will only refer patients who are available to attend a face-to-face outpatient appointment within two weeks of referring, and will inform the patient that they are referring them for a diagnosis of suspected cancer. The quality of suspected cancer referrals needs to be subject to regular audit, with appropriate feedback to GPs.

Primary care clinicians will refer patients using the Cancer Alliance approved 2WW referral form.

4.6 Provider Responsibilities – Cancer Pathways

Applicable to Kent Integrated Dermatology Service and subcontracted 2WW activity only.

Patients who are referred to SCDS via a 2WW suspected cancer pathway will receive their first treatment as follows:

- no more than 62 days from receipt of referral from GP or consultant upgrade
- no more than 31 days from decision to treat for first treatments
- no more than 31 days from decision/fit to treat date for subsequent treatments
- no more than 28 days from referral of suspected cancer to definitive diagnosis of cancer (also known as Faster Diagnosis pathway).

5. 18-Week Referral to Treatment (RTT)

5.1 A patient's waiting time is calculated from the date of receipt of the new referral to start of definitive treatment, start active monitoring or discharge if no treatment is necessary. Treatment is defined as the start of the first treatment that is intended to manage the patient's disease, condition or injury (this might include a period of active monitoring).

5.2 The right to treatment within 18-weeks from referral will cease to apply in circumstances where the patient may choose to wait longer or delaying the start of treatment is in the best clinical interest of the patient, for example where smoking cessation or weight management is likely to improve the outcome of the treatment. Similarly, where it is to a necessary for the patient to undergo a sequence of diagnostic tests that for medical reasons could not be performed within a shorter period, this would be considered a clinical exception.

We recognise that patients not on an 18-week RTT pathway will still be managed in accordance with this policy and delays will be eliminated wherever possible.

6. Waiting Times & Targets

6.1 The NHS Constitution 2015 brings together the principles, values, rights and pledges that underpin the NHS. It supports patients, the public and staff by clearly setting out their legal right.

6.2 The pledge is *'to provide convenient, easy access to services within the waiting times set out in the handbook to the NHS Constitution which states that: 'patients can expect to start their consultant – led treatment within a maximum of 18 weeks from referral for non-urgent conditions unless they choose to wait longer, or it is clinically appropriate that they do so".*

6.3 For patients with suspected cancer, the waiting times standard is *'a maximum 2 week wait to see a specialist'* from GP referral, unless the patient chooses, despite the urgency of the referral, to wait longer.

6.4 Patients' right to treatment within 18 weeks applies to all Consultant led services.

6.5 If a patient feels concerned that they will or have been waiting longer than 18 weeks, the patient should contact SCDS and/or their local ICB who are responsible for commissioning services.

7. Data Quality

7.1 All targets are reliant on good quality data entry. It will be the responsibility of all staff involved in supporting the patient journey to collect and accurately record this data, i.e. clinician, medical secretary and administration staff.

7.2 All medical secretaries and administration staff will be responsible for the completion of an RTT outcome on the Electronic Patient Record System (EPRS) for all appointments, within three working days. Where a decision is made outside a clinical event that affects an RTT clock, then the RTT outcome will need to be recorded as soon as possible after the decision.

This is necessary to ensure the information is captured about the decision to treat, not to treat or active monitoring which in turn affects whether a clock has stopped, or treatment is about to start.

7.3 Regular audits will be undertaken to assess the comprehensiveness and quality of data collected. Concerns will be raised immediately with the Service Manager.

8. Clinician Absence

8.1 It is expected that for planned cancellations of scheduled clinical commitments at least six weeks' notice is given to provide as much notification as possible to patients and minimise the amount of re-work caused to administration staff.

8.2 In exceptional circumstances where it is not possible to provide six weeks' notice, leave must be authorised by the Service Manager, with the clinician and Clinic Co-ordinator working together to ensure appropriate re-provision of services.

8.3 In the event that a clinic is cancelled at short notice due to sickness, self-isolation or emergency leave, the Senior Administrator should be informed at the earliest opportunity to start contacting patients to rebook. If there is no capacity available to rebook the patients, they must be told at the earliest opportunity that their appointment is cancelled, and then again once additional capacity has been identified.

Patients should also be sent SMS messages to inform them of their cancelled appointment, and then followed-up with a telephone call to confirm receipt.

9. Outpatient Booking Processes

9.1 Referrals

9.1.1 The ICB, referrers and SCDS will work together to ensure that all referrals sent to SCDS are appropriate for the service.

9.1.2 Primary Care clinicians will only refer patients who are fit, ready and able to attend an appointment.

9.1.3 All referrals must include an NHS Number and full demographic details including age, gender, daytime, evening and mobile telephone numbers (where available), to ensure the patient can be contacted promptly, together with any specific requirements that may be needed, i.e. interpreter/patient transport/hoist/chaperone.

9.1.4 All referrals will be entered onto SCDS' electronic system (SystmOne) within five working days of receipt.

9.1.5 GP referrals will be sent through NHS e-RS following the guidelines below:

- Patients are requested by GPs to wait a minimum of 3 days after the date of their GP appointment before telephoning SCDS for an appointment.
- GP surgeries will ensure the referral letter is attached before sending the referral.
- If the referral letter is not attached to Choose and Book when the patient phones, SCDS will request that the patient contacts their GP surgery to request this.

9.1.6 If the patient has specified a clinician, SCDS will honour this request where clinically and geographically appropriate.

If the patient is referred inappropriately or to an inappropriate clinician within the service, the referral shall be redirected to an appropriate service or clinician within the same speciality if this is available. Delays to this process are to be kept to a minimum as the RTT continues to run from the original date of receipt of referral. Where the referral is inappropriate this will be rejected, and the GP/Referrer informed.

9.2 NHS e-Referrals (NHS e-RS)

9.2.1 A Directory of Services (DoS), listing all outpatient services provided by each organisation is published and reviewed annually to provide GPs with adequate information to ensure referral to the correct service.

9.2.2 Patients should be offered an appointment with an appropriate Consultant/Clinician with the shortest wait.

9.3 Rejected Referrals

9.3.1 If a referral has been made through e-RS and the service selected does not meet the needs of the patient, the referral should be returned to Primary Care. In this circumstance, the referrer must then re-refer the patient to an appropriate service without delay.

9.3.2 Clinician to Clinician referrals are appropriate when:

- The onward care of the patient is part of a pathway for which the original referral was received.
- The patient needs to be managed under a cancer pathway (Consultant Upgrade) as delay in sending the patient back to the GP would be inappropriate.

If the patient does not fulfil either of the above criteria, the Consultant should direct the patient back to their GP with the appropriate advice.

9.4 Paper & Faxed Referrals

As instructed by the Integrated Care Board, as of 1st October 2018, all paper and faxed acute referrals will be rejected back to primary care and a request made for these referrals to be sent electronically either via email (for Sussex and Surrey-based services) or e-RS.

9.5 Advice and Guidance (A&G)

A&G services are currently available via e-RS for primary care, and by email for secondary care providers.

West Kent GPs have access to Consultant Dermatologists via the ICB-funded web software Kinesis, however this is being withdrawn from 16th September 2023, so cases will significantly reduce from mid-August onwards. As an interim measure, A&G referrals will be sent via e-RS.

Routine A&G referrals will be responded to by a clinician within three working days and urgent referrals will be responded to within one working day.

9.6 Triaging of Referrals

9.6.1 Referrals are triaged by the team of experienced administrators and booked based on the information provided in the referral letter.
For referrals which may not be appropriate for the service or require a complex pathway, these referrals are triaged by a Consultant Dermatologist.

All referrals are triaged using the local Referral and Treatment Criteria guidance.

9.7 Outpatient Follow Up Appointments

9.7.1 When requesting further appointments, clinicians should specify the clinical requirement and timescale for the patient to be seen within.

9.7.2 Best practice is to agree an appointment with the patient at the time. However, where appropriate, patients can contact the administration office to book their follow-up appointment. Appointments for the next calendar year will be adding to a waiting list and booked when clinics become available.

9.7.3 Wherever possible, the booking process will take into account the individual requirements for appointment times i.e. elderly patients not offered early morning slots.

9.7.4 If after discharge a patient feels they wish to be seen again, if within 3-6 months of the referral the patient can contact SCDS directly and the administration team will liaise with the clinician to see if another appointment is clinically appropriate, or whether verbal advice can be offered to the patient and/or GP. If the patient has not been seen within the service within three months after discharge, the patient will require a re-referral into the service.

9.7.5 Consultants/Clinicians will consider the clinical appropriateness before offering 'open appointments' to patients.

9.8 Slot Availability

9.8.1 SCDS will regularly review available capacity.

9.8.2 e-RS patients who contact SCDS to arrange an appointment but find that no slot is available are advised they will hear from SCDS within 10 working days with the offer of an appointment.

9.8.3 All other referrals where capacity is an issue will be actioned within the same timescale and process.

9.9 Patient Cancellations

9.9.1 SCDS will ensure local systems are in place to enable patients to communicate their cancellation before it becomes a DNA. This will include information on all first appointment letters, informing patients that they risk being discharged back to their GP if they cancel an appointment more than once.

9.9.2 Patients who cancel and re-book any outpatient or diagnostic appointment two or more times will be discharged, and their GP/Referrer informed unless it is clinically inappropriate or reasonable notice of the appointment wasn't given.

9.9.3 Where a patient with suspected cancer cancels their appointment, they should not be referred back to the GP/Referrer after two or more cancellations unless this has been agreed with the patient following discussion with the clinician to whom the patient has been referred. Clinicians must ensure that any decision to refer back to the GP/Referrer is in the best interest of the patient. I.e. if the patient is a hospital inpatient and cannot attend an appointment for the foreseeable future.

9.9.4 If patients cancel with no further appointment required, they will be discharged back to the referrers' care with the GP being informed. The 18 Week pathway will be updated to stop the clock as the patient has declined treatment.

9.10 Clinic Cancellations

9.10.1 In order to maintain clinical safety SCDS will make every possible effort to ensure that appointments are not cancelled.

9.10.2 Clinicians will be expected in all but exceptional circumstances to give a minimum of 6 weeks' notice of any outpatient session to be cancelled. In circumstances where short notice cancellations are unavoidable, the clinician will be expected to work with the appropriate Clinic Co-ordinator to arrange cover or offer an additional clinic session within an acceptable timescale in order to maintain waiting times.

9.10.3 Where appointments do need to be cancelled or changed, SCDS will aim to provide patients with a minimum of 4 weeks' notice.

9.10.4 Patients should be re-booked as close to their original appointment date as possible as the RTT clock remains ticking.

9.10.5 When patients have chosen an appointment at a specific site and the clinic is subsequently cancelled, care must be taken to ensure patients are still treated in an acceptable timescale in order to maintain waiting times. This may require patients being seen at alternative sites as patient choice relates to the provider and not the site on which the provider holds the clinic.

9.10.6 Wherever possible, patients who have been cancelled previously should not be cancelled for a second time.

9.11 Patients Who Do Not Attend a First Outpatient Appointment

9.11.1 The 18-week clock rules states that if a patient DNAs their first appointment after initial referral, they will have their clock nullified and the patient will be written to in order to allow them two calendar weeks to contact the administration office for a new appointment. A new clock starts on the date subsequent contact is received.

9.11.2 The SMS reminder service reminds patients of future appointments, two days in advance, providing them with the opportunity to change or cancel their appointment before it becomes a DNA.

9.11.3 The 18 Week rules for DNAs do not differentiate between adults and children. However, consideration should be given to allocating a second appointment, before discharging children, vulnerable adults, cases of clinical urgency, i.e. two week wait patients or others as clinically indicated. In this instance, the RTT clock will be reset to the date of the DNA.

9.11.4 The rebooking of patients who DNA on two or more occasions should be considered on a case by case basis.

9.11.5 Where a cancer patient DNAs their initial outpatient appointment, they will be offered a further appointment within two weeks of the DNA and the clock start date reset. If the patient DNAs twice in a row they will be referred back to the care of their GP/Referrer. Clinicians must ensure that any decision to refer back to the GP/Referrer is in the best interest of the patient.

9.11.6 If a cancer patient DNAs a diagnostic test appointment twice the diagnostic department will contact the patients' clinician and the administration team to inform them of the DNAs, the clinician or administration team will then make contact with the patient and discuss the need for the tests before informing the GP that they have been unable to progress the pathway and need to consider their view on discharging back to the care of the general practitioner.

9.12 Patients Who Do Not Attend a Follow Up Appointment

9.12.1 Patients who DNA a follow up appointment, will be given two calendar weeks to rebook the missed appointment. The SMS Reminder Service reminds the patient of future appointments, two days in advance and provides them with the opportunity to change or cancel their appointment before it becomes a DNA.

Patients with cancer or suspected cancer should not be discharged back to the GP/Referrer after two or more cancellations unless this has been agreed with the patient following discussion with the clinician to whom the patient has been referred. Clinicians must ensure that any decision to refer back to the GP/Referrer is in the best interest of the patient.

9.13 Prior Approvals Policy

9.13.1 The ICB has a Prior Approvals Policy, incorporating its Low Priority Policy and Policy on Limited Clinical Effectiveness. This identifies treatments that may not be routinely funded and describes for each example what process to follow. Where it is clear at the point of referral that the referral is for a 'restricted' condition it is the responsibility of the referrer to follow the policy and ensure authorisation is gained prior to making a referral to secondary care.

9.13.2 However, any referral being received in secondary care that is clearly covered by the Prior Approval Policy should be rejected (and the 18-week clock nullified) and returned to the referrer with advice for them to follow the Prior Approval Policy.

9.13.3 In many cases it is not possible to determine whether the treatment is covered by the Prior Approval Policy until after initial assessment. The 18-week clock will continue to 'tick' during the time taken to gain funding approval. For cases referred to the Exceptional Treatments Panel they will seek to confirm within 1 week of receipt if the request, providing full supporting information has been received with the request. Referrals going to the Restricted Treatments Panel are currently only reviewed on a monthly basis, however it is expected that these will be identified prior to referral, i.e. before a clock has been started. For cases that require a significant review of evidence before a funding decision can be made it is expected that the tolerance for clinical complexity will be sufficient to ensure targets are not breached.

9.13.4 The list of procedures that requires prior approval is not a fixed list and will be added to over time as NICE recommendations and local decommissioning develop further.

10. Daycase Surgery

10.1 Waiting Lists

10.1.1 A patient should only be placed on a waiting list for surgery if they are not fit for surgery and cannot be booked in for a daycase surgery appointment immediately.

10.1.2 Accurate data recording is essential to ensure that waiting list entries are linked to the correct RTT pathway to enable the effective monitoring of patients.

10.1.3 Patients who are considered as short-term medically unfit for surgery, e.g. patient has a cold but expects to be medically fit within 14 days, will be booked at a time when they are likely to be fit. The RTT clock will remain ticking.

10.1.4 Long term medically unfit patients are those suffering from a condition which prevents the continuation of treatment and unlikely to be resolved in less than 14 days. If deemed appropriate by the clinician, the patient will be discharged back to Primary Care and re-referred when clinically ready. A new RTT clock would start at the point of re-referral.

10.1.5 If a patient is undecided whether to proceed with treatment, they are given up to 14 days to make that decision during which time the RTT clock will still tick. If after 14 days the patient has not decided whether to proceed with treatment this starts a period of patient initiated active monitoring, which is a clock stop event.
Patients on active monitoring will be reviewed within 3 months when the decision will be made on whether they are to proceed with treatment. Dependent upon the clinical circumstances of the individual patient they may be discharged to GP care.

10.2 Reasonable Offer of Notice for Surgery

10.2.1 A reasonable offer is defined to be an offer of a time and date 1 or more weeks from the time that the offer was made two dates should be offered to the patient with any appointment agreed between SCDS and the patient within this definition automatically considered to be reasonable.

10.2.2 If the patient declines the offer of two reasonable dates, within three weeks', but they are able to accept an appointment within six weeks of contact, the patient is to be dated at that time. If the patient is near to their 18 weeks Treat by Date, this may result in them becoming a breach, which SCDS will need to accept.

10.2.3 If the patient is not willing or able to accept any dates and declines any further treatment they will be discharged on clinical grounds and their GP/Referrer informed.

10.2.4 Patients may be offered same-day surgery if clinically appropriate and it is the patient's decision to accept this.

10.2.5 If a cancer patient does not accept the first reasonable choice of date the clock will be suspended during the period of patients' unavailability and restarted again when the patient becomes available. For patients under the 31-day or 62-day standard, 'reasonable' is classed as any offered appointment between the start and end point of 31 or 62-day standards.

10.3 **Patient Initiated Delays**

10.3.1 Many patients will choose to be seen at the earliest opportunity. However, patients are entitled to wait longer for their treatment if they wish. Patients must be allowed to plan their treatment around their personal circumstances. Delays as a result of patient choice and complexity are taken account of in the tolerance of 8% set for achievement of the incomplete pathway waiting time operational standard.

10.3.2 If the patient wishes to delay surgery, i.e. schoolteacher, the patient will have their surgery date booked into a time when they are more likely to be able to attend, otherwise they will be added to a waiting list. The period of delay may differ from patient to patient but in choosing the length of delay, the patient is in effect initiating their own active monitoring against their condition. There is no blanket rule against the length of delay, but good practice and clinical decision will guide this.

10.4 Multiple Procedures

10.4.1 Patients who require bilateral procedures relating to the same reason for referral, i.e. two lesions, should be offered a date for the second procedure at follow up or when clinically appropriate (when they are fit and ready) and a new 18-week pathway will commence.

10.4.2 If the need for the second treatment is identified separately from the first, a new 18-week clock starts for the second.

10.5 Cancelled Surgery

10.5.1 SCDS will only cancel a patient's surgery when it is not possible to carry out the procedure with consideration being given to patients who have been previously cancelled.

10.5.2 Patients cancelled on the day of their operation for non-medical reasons must be given a new surgery date within 28 days of cancellation. EPRS is to be updated at the time of the patient being notified of the cancellation and not at a later date. The patient will normally be given a new surgery date on the day of cancellation or breach date, whichever is sooner. Where this is not possible, patients should be contacted within three working days of their cancellation date to agree a further suitable date.

10.6 Patient Cancellations

10.6.1 Patients who cancel two agreed surgery dates will be removed from the clinic list and their GP/Referrer informed, provided that reasonable offer of surgery date was agreed with the patient and not detrimental to the patients care. The 18-week pathway will be updated to stop the clock as the patient has declined treatment.

10.7 Patients Who Do Not Attend (DNA)

10.7.1 All patients should be offered two reasonable dates with a minimum of 1 weeks' notice. Patients who fail to attend on the day of surgery will be given the opportunity to rebook their missed appointments within two calendar weeks.

10.7.2 The 18-week pathway will be updated to stop the clock as the patient has declined treatment. The 18-week rules for DNAs do not differentiate between adults and children. However, consideration should be given to allocating a second date, before discharging children, some vulnerable adults, and cases of clinical urgency. In this circumstance the 18-week clock will still be ticking. If it is deemed appropriate to offer a second surgery date and the patient again fails to attend, no further dates will be offered. The GP/Referrer will be informed and the 18-week RTT clock will stop as the patient has declined treatment. The reason for allocating a further surgery date must be recorded. The rebooking of patients that DNA on two or more occasions should be considered on a case by case basis.

10.7.3 Where a cancer patient DNAs their surgical appointment, they will be offered a further date within two weeks of the DNA. If the patient DNAs an admission twice in a row they will be referred back to the care of their GP/Referrer and the clinician/Cancer Nurse Specialist will be informed.

10.8 Cancer Waiting Times

The current national standards relating to cancer are as follows:

- 2-weeks from General Practitioner (GP) referral for suspected cancer to first outpatient attendance.
- 31-days from decision to treat to first definitive treatment for cancer.
- 31-days from decision to treat or earliest clinically appropriate date to subsequent treatment (surgery, drug or radiotherapy) for all cancer patients including those with a recurrence.
- 62-days from urgent GP referral for suspected cancer to first definitive treatment for cancer (31 days for suspected Children's cancers).
- 62-days from a Consultant's decision to upgrade the urgency of a patient (e.g. following a non- urgent referral) to first treatment for cancer
- 28-days target for all patients who are referred for the investigation of suspected **cancer** and find out, within **28 days**, if they do or do not have a **cancer** diagnosis.

11. Private Patients

11.1 The DH Code of Conduct for Private Practice (Jan 2004) states that:

- Any patient seen privately is entitled to subsequently change his or her status and seek treatment as an NHS patient;
- Any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status;
- Patients referred for an NHS service following consultation or private treatment should join any NHS service at the same point as if the consultation or treatment were an NHS service;
- Their priority on the waiting list should be determined by the same criteria applied to other NHS patients

11.2 An RTT clock will start on the day the provider of NHS care accepts clinical responsibility for the patient. ~~Paper referrals are to be date stamped with the date of receipt, as this is the date the RTT clock commences.~~ When this transfer takes place between providers the referral letter should be accompanied by an Inter Provider Transfer. When the transfer takes place within a provider (a provider who provides both NHS and private care) the date of the transfer needs to be clearly documented in the patient's medical record.

11.3 Patients who have been seen privately and subsequently transfer to the NHS for daycase treatment will have their 18-week clock start at the point at which clinical responsibility for the patient's care transfers to the NHS.

11.4 The date of decision to admit is recorded as the date the letter is received and date stamped on receipt. An Inter-Provider Transfer form should be received with the referral letter.

12. Overseas Visitors

12.1 All patients referred to SCDS without a valid NHS number will be rejected back to the GP/Referrer and this information will be requested.

13. Interprovider Transfers

13.1 All referring organisations must provide a minimum dataset to the receiving organisation to allow the monitoring of a patient's progress along an 18 weeks pathway where care has been transferred between providers.

13.2 An inter-provider form is to be completed and sent with the referral letter via an NHS.net account or on e-RS, to the receiving organisation within 2 working days of decision to refer.

13.3 When an inter-provider transfer is received into an organisation, the RTT clock is updated to the date that the original healthcare organisation received the referral. Data must be provided between organisations and recorded on the relevant electronic systems as the clock remains ticking until the start of definitive treatment.

13.4 Transfers to alternative providers, in order to meet waiting times requirements, must always be with the consent of the patient. The original date of referral is passed to the receiving provider as the clock remains ticking until such time as the start of definitive treatment.

13.5 If the patient does not wish to be transferred to another provider, SCDS must ensure the patient is scheduled for treatment in compliance with their 18 Week pathway. If the organisation does not provide the treatment required and the patient doesn't wish to be transferred, the patient is referred back to the care of their GP/Referrer.

13.6 For suspected cancer patients on the 31 or 62-day pathway the referral letter should be highlighted '2 week wait' where appropriate, and the breach date given.

14. Armed Forces Community

14.1 In line with the Armed Forces Covenant, SCDS will ensure that members of the Armed Forces Community (including those serving, reservists, their families and veterans) are supported, treated equally and receive the same standard of and access to healthcare as any other UK citizen in the area they live.

14.2 Referrers should make it clear that the patient is a member of the Armed Forces Community.

14.3 Armed Forces Community should retain their relative position within the NHS service, if moved around the UK due to the Service person being posted, however they should not be given priority over other patients with more urgent clinical needs.

14.4 Veterans receive their healthcare from the NHS and should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need.

15. Process For Monitoring Compliance And Accountability And The Effectiveness Of The Policy

15.1 SCDS will maintain effective performance monitoring systems to ensure implementation of the policy.

15.1.1 It is expected that each service will develop internal monitoring to ensure that the policy is adhered to. This will include the monitoring of waiting times for follow up appointments.

15.1.2 In order to manage Key Performance Indicators, the ~~Information Technology Department~~ Data Team will provide Operations/Service Managers with regular reports including Incomplete Pathways, Cancer Performance Dashboard and Diagnostic Waits. In addition, compliance monitoring data will be provided for the following areas:

- DNAs, for both new and follow-up appointments, where further appointments have been allocated
- Clinic appointments where the outcome has been left as 'Open'
- Outpatient cancellations

15.1.3 Further data may be required, as agreed with the ~~Information Technology Manager~~ Head of Data, to assist Operations/Service Managers in achieving the required standards of this Policy.

15.1.4 The ~~Information Department~~ Data Team will be responsible for providing timely, consistent and relevant information to manage effective waiting lists and highlight any concerns about waiting times directly with the nominated Operations/Service Manager for each service.

15.1.5 Teams/departments are expected to review and act upon the information provided to ensure that patients are treated in order of clinical priority and then in chronological order.

15.1.6 ~~Monthly~~ weekly validation of incomplete pathways, i.e., where a clock has started, and the patient has not yet received treatment, will be undertaken. The accurate recording of data within a pathway will support this and enable SCDS to provide assurance that, where clinically appropriate, all patients receive treatment within national waiting time standards.

15.1.8 SCDS will ensure governance processes are in place to enable continued delivery of Waiting Times Standards.

15.2 Frequency

In each financial year, the Operations/Service Managers will review the measures listed above to ensure that this policy has been adhered to.

15.3 **Recommendations/ Action Plans**

Implementation of the recommendations and action plans will be monitored by the Management Team, which meets on a fortnightly basis.

15.3.1 Any barriers to implementation will be risk assessed.