Bolton Clinical Commissioning Group

Royal Bolton Hospital
NHS Foundation Trust

BOLTON HEALTH ECONOMY

ACCESS POLICY

For ELECTIVE SERVICES

Bolton Health Economy includes:
NHS Bolton CCG
Bolton NHS Foundation Trust
BMI The Beaumont Hospital

For distribution to:
All other service providers treating NHS Bolton patients

Document Control

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Has an Equality & Diversity Impact Assessment been completed?	This policy relates to waiting times for all patients from Bolton and as such assessment is not considered necessary at this stage.

Consultation History

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FD 02	9/5/12		Approval from NHS Bolton PIT team
FD03	18/5/12		To be tabled at Bolton CCG Board for approval
FD05	25.05.12	Amended following comments from national IST team	To be tabled at RBHFT and Bolton CCG Board for approval
FD06	Jul 12	Addition to 5.7 DNA	Following comments at LMC
FD07	Aug 12	Removal of "NHS Bolton" from pg 9	Request from RBHFT
FD08	15/9/12	Change to sample DNA letter	Bolton LMC
FD09	Nov 12	Addition of screening services	Request from Bolton CCG Board
FD10	Nov 12	Amendment to screening DNAs	Discussions between PCT and RBH
FD 11	May 14	18 weeks standards included	Request from Bolton CCG
FD 12	Dec 14	Review of full document by CCG	Bolton CCG
FD 13	Jul 15	Review of full document by BFT	Bolton NHS FT
FD14	Sept 15	Review of document in line with new national guidance	Bolton CCG / Bolton NHS FT / BMI Beaumont
FD15	Feb 16	Review of document for fitness for surgery criteria	Bolton CCG

Bolton is the name used to refer to Bolton Clinical Commissioning Group. The legal identity of the organisation remains unchanged.

CONTENTS

1. EXECUTIVE SUMMARY

The length of time a patient needs to wait for hospital treatment is a visible and public indicator of the quality of hospital services provided. It is the responsibility of all members of staff including GPs, hospital clinicians, commissioners and NHS managers to ensure successful management of patient waiting times by having a clear understanding of roles, responsibilities and the policies affecting delivery of patient care.

The purpose of this policy is to ensure that all patients requiring access to outpatient appointments, planned inpatient or day case treatment and diagnostic tests are managed consistently and equitably, according to national and local frameworks and definitions. This policy provides good practice guidelines to assist staff with the effective management of elective patients supported by reference to national and local policy documents.

The NHS Constitution brings together in one place details of what staff, patients and the public can expect from the NHS. It also sets out patients' rights. These rights cover how patients access health services, the quality of care they should expect to receive, the treatments and programmes available, confidentiality, information and their right to complain if things go wrong. It includes the right ***"to access treatment within maximum waiting times, or for the NHS to take reasonable steps to offer you a range of alternative providers if this is not possible"***[1].

This means that patients have the right to start consultant-led treatment within 18 weeks from referral; and to be seen by a specialist within 2 weeks of GP referral for suspected cancer. Where this is not possible the NHS should take all reasonable steps to offer the patient a quicker appointment at a range of alternative providers, if the patient makes such a request. This policy provides the framework, rules and definitions to enable that right to be delivered fairly and equitably to all patients.

Since 2008 patients referred by their GP for hospital treatment have had the right, with few exceptions, to be treated by any hospital, including many in the independent sector that meets the standards set by the NHS. Patients have the right to information to help them make that choice. The NHS Choices website provides support to patients to help them make those choices

The NHS does not provide unlimited access to healthcare. There are national restrictions applied to non-UK residents and local restrictions to certain procedures which are deemed to be of limited clinical value. Local policies are managed under the Greater Manchester Effective Use of Resources programme, details of which can be found on NHS Bolton CCG's website at http://www.boltonccg.nhs.uk/about-the-ccg/what-we-do/effective-use-of-resources.

The guiding principle of providing excellent care to patients without unnecessary delay should always be followed, together with those of kindness, reasonableness, honesty and good communication.

For further details relating to The NHS Constitution including the transfer process see Pages 21 and 22

1 As stated in the NHS Constitution: https://www.gov.uk/government/publications/the-nhs-constitution-for-england

All services commissioned by NHS Bolton should comply with the following best practice. ***It is the responsibility of the referring clinician at the time of referral to ensure all patients are ready and available to receive treatment within these timeframes:***

- **Choice** – when referring a patient, the referring clinician should ensure that the patient is offered choice of provider, where this is clinically appropriate.
- **Routine referrals** – patients should commence treatment within 18 weeks of referral
- **Urgent referrals** – patients should be seen within a maximum of 4 weeks from referral
- **Cancer 2-week referrals** – patients should be seen in a first outpatient appointment within 2 weeks from referral.
- **Cancer treatment** - the maximum wait for all cancer patients from date of decision to treat to first definitive treatment should be no more than 31 days (including diagnostics), where clinically appropriate. In total no cancer patient should wait longer than 62 days from urgent GP referral to first treatment.
- **Clinical Assessment & Treatment Services (CATS)** – patients should have completed their CATS episode within a maximum of eight weeks including any diagnostics and follow up
- **Diagnostic test referrals** – patients should undergo their diagnostic test within a maximum of 6 weeks from referral
- **Rapid access clinic referrals** – patients should be seen within a maximum of 2 weeks from referral.
- **Screening Programmes** – patients are invited to undergo screening with reminder letters sent. Patients who DNA will be reappointed and this is communicated back to General Practitioners. Patients remain within the screening protocol as per the programme.
- **Military personnel –** providers should give priority to military personnel and veterans (and their families and dependents where appropriate – see reference on page 19) and ensure services provide ease of access and timely health or dental care. It is the responsibility of GPs to ensure clear identification on referral letters of such patients.
- **Consultant leave** - all providers should be committed to offering certainty to patients as well as choice in arranging their care. A minimum of **6 weeks formal notice of planned annual, study or professional leave** must be given when a doctor requires a clinic to be cancelled or reduced and must be authorised by the appropriate line manager.
- **Communication plan** – It is the responsibility of Bolton Health Economy to ensure all staff involved realise the importance of this Access Policy and 18 week pathway to ensure patients are receiving high quality elective care without any undue delays. This policy should also be displayed on the intranet for staff use.

Patients should always be managed in chronological order unless clinical urgency dictates otherwise

Patients should be asked at every stage of their pathway about the information they would like to be provided to them and shared if appropriate with their carer's and provided with information appropriate to their care pathway in accordance with those wishes

2. 18 WEEKS OVERVIEW

The 18 week referral to treatment (RTT) standard applies to elective pathways (except Genito-urinary medicine and maternity services) that do or might involve medical or surgical consultant-led care. The start of an 18 week pathway is dependent on who makes the referral and into what type of service.

The target sets a maximum time of 18 weeks from the point of initial referral up to the start of any treatment necessary for all patients who want it, and for whom it is clinically appropriate.

This section provides further definition of the 18 week target and includes information on referrals that commence an 18 week clock and those that do not.

The following national operating standards apply to all patients:

Rule	Operating Standard
Patients will receive their first definitive treatment within 18 weeks of referral	92% of patients on incomplete pathways to be waiting less than 18 weeks
Patients will receive diagnostic tests or images within 6 weeks of request	1% or less of patients to wait more than 6 weeks
No patient will wait more than 52 weeks for treatment	Zero tolerance
Patients with suspected cancer who are referred urgently by their GP must be seen within 14 days of the GP decision to refer	93% of patients to be seen in 14 days or less
Patients diagnosed with any form of cancer will receive their first treatment within 31 days of diagnosis (decision to treat)	96% of patients to receive first treatment within 31 days
Patients referred through the urgent 14 day suspected cancer referral route and subsequently diagnosed with cancer will receive their first treatment within 62 days of the date of referral.	85% of patients to receive first treatment within 62 days
Patients urgently referred from NHS Cancer Screening Programmes (breast, cervical and bowel) will receive their first treatment within 62 days	85% of patients to receive first treatment within 62 days
Patients who are not referred through the urgent 14 day suspected cancer referral route, but have a consultant decision to upgrade the urgency of the patient due to suspected cancer symptoms and are subsequently diagnosed with cancer, will be treated within 62 days	No operational standard

There are important reasons why not everyone can or should be treated within the operating standards:

- Patients who choose to wait longer for personal or social reasons
- Patients for whom it is clinically appropriate to wait longer (this does not include clinically complex patients who can and should start treatment within 18 weeks)
- Patients who fail to attend appointments they have agreed

These patients are taken into account in the tolerances set as part of the delivery standard.

An 18 week clock...

1. Starts when a patient is referred to a consultant-led service
2. Stops when a patient is discharged with or without treatment, or is being actively monitored without treatment
3. May be exceeded only when either it is not in a patient's best clinical interest to proceed to treatment within the maximum waiting time, or where a patient chooses to delay their treatment beyond this time

More detailed definitions are provided in the glossary on page 16

3. REFERRALS

3.1 Sources of referral that start an 18-week clock.	Referrals **<u>from</u>** the following to a consultant-led service may start an 18-week clock: ▪ General practitioners (GPs) ▪ General dental practitioners (GDPs) ▪ General practitioners (and other practitioners) with a special interest (GPSIs) ▪ Hospital consultants ▪ Optometrists and Orthoptists ▪ Accident & Emergency (A&E) or Minor Injuries Units (MIU) ▪ Walk-in Centres (WIC) ▪ Genito-urinary Medicine clinics (GUM) ▪ National screening programmes ▪ Specialist nurses or allied health professionals where commissioners have approved these ▪ Prison Health Services A referral from the healthcare professionals outlined above starts an 18-week clock when it is expected that: 1. The patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional. 2. Any treatment will or might be carried out by a medical or surgical consultant-led service irrespective of setting.
3.2 Referrals to services which start an 18-week clock	Referrals from primary care **<u>to</u>** the following services start 18-week clocks: 1. Medical or surgical consultant-led services irrespective of setting including: • Referral-management centres (this covers arrangements known as clinical advisory centres, integrated clinical assessment and treatment services, interface services etc.) • Cancer services (for which a 62-day cancer-target clock also starts) • Rapid Access Clinics (for which a 14 day waiting time target for first outpatient/assessment also applies) 2. 'Straight to Test' diagnostic services – whereby patients are referred for tests e.g. scope, as part of a local agreement between primary and secondary care. This refers to circumstances where - if a GP is referring a patient to see an outpatient consultant - the GP can at the same time book the patient in for a diagnostic test at the provider. This means that by the time the patient attends their first OP appointment, they will have already had the test and the results can then be discussed at the OP appointment. 3. GPs with special interests (GPSI's) if they are part of a referral-management arrangement.

3.3 Referrals to services from Secondary Care which start an 18-week clock	In some circumstances an 18-week clock will start in a secondary care setting. Consultant to consultant (or consultant-led services) referrals specifically for: 1. A different condition newly identified by the consultant and unrelated to the original condition for which the patient was referred (e.g. cardiology problem identified at assessment following orthopaedic referral). This may cause a second clock to start (and a 31-day clock if cancer is the new condition) with any first clock still ticking. *NB 1 – Consultant to Consultant referrals for a new condition are not allowed under NHS Bolton contractual arrangements. Patients should be referred back to GP for choice and referral to be made if deemed appropriate.* *NB 2 - A consultant to consultant referral for the same condition continues the original 18 week clock (e.g. clinician refers to a colleague who may sub specialise in the management of specific conditions).*  2015/16 Cons to Cons Policy 2. A patient may attend A&E and it is identified that they require to commence an elective pathway within a medical or surgical specialty (this does not apply to fracture or to anti-coagulant clinics since this a continuation of a non-elective pathway). 3. In cases where a patient has been initially admitted as non-elective and it is identified that they require further treatment as an elective patient. (e.g. patient admitted with acute cholecystitis who is listed for cholecystectomy at a future date). 4. Separate conditions or complications developed with pregnancy, or if a new-born baby is suspected of having a condition for which they are referred to medical or surgical consultant-led service for elective treatment. 5. New conditions identified as a result of a genetic test. 6. In cases where a patient has not been on an 18 week pathway (e.g. after a period of active monitoring), a new decision to treat within a medical or surgical consultant-led service is made.
3.4 Referrals that *do not* commence an 18-week clock.	Referrals from primary care to the following services do not start the clock: 1. Allied Healthcare Professionals (e.g. physiotherapy) healthcare science (e.g. audiology) 2. Mental health services that are <u>not</u> medical or surgical consultant-led (including multi-disciplinary teams and community teams run by mental health trusts) irrespective of setting 3. Diagnostic services if the referral is not part of a 'straight-to-test' arrangement. 4. Primary dental services provided by dental students in hospital settings 5. Obstetric services. 6. Referrals to Genito-urinary services

	7. Private patients or patients under the care of a non-English commissioner. 8. GPs with special interests (GPSI's) if they are not part of a referral-management arrangement However, the expectation remains that these patients will be treated in a timely manner, in accordance with their clinical need.
3.5 Referral review	Hospital clinicians and the CCG will undertake regular reviews and audit of referrals to check compliance with protocols and guidance and provide feedback to primary care as part of their training and development to ensure the most appropriate use of resources.

4 CLOCK STARTS AND STOPS

This section describes at which point an 18 week clock should be commenced and when it can be stopped. It is important to note that a patient's clinical care will often continue although an 18 week clock has been stopped.

4.1 The point at which the 18-week clock starts	1. The RTT clock start date is defined as the date that the provider receives notice of the referral. 2. For NHS e-Referral Service (Choose and Book) referrals, this will be the date that the patient converts their UBRN (Unique Booking Reference Number), (including where the referral is rejected by the chosen provider and the patient is subsequently re-referred – noting that the GP has responsibility for referring into the correct service for the patient's condition). 3. Where no appointments are available at the patient's chosen provider at the time they convert their UBRN, and their referral is deferred to the provider, the UBRN will immediately appear on that provider's Appointment Slot Issue (ASI) work list. The date on which the UBRN appears on this work list is the consultant-led RTT clock start. If there has been any previous activity against the UBRN (for example, a booking into a Clinical Assessment Service) it is the earlier date that starts the consultant-led RTT clock. 4. If a patient is booked via Referral Management and Booking Service RMBS or Telephone Appointment Line (TAL) the clock start is recorded as the date the patient made contact with RMBS/TAL. 5. If the referral is from an interface service or another acute provider, then clock start details must be obtained from the referring organisation. It is important that clock starts can be accurately identified for all patients on an RTT pathway, including pathways that involve more than one provider organisation. Providers will need to ensure that they identify all inter-provider referrals clearly, as the clock start date for these referrals will **NOT** be the date subsequent providers receive the referral 6. For RTT pathways that start within an interface service (all arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care), the correct clock start date will be the date that the interface service received the original GP referral and **not** the date that the onward referral from the interface service was received by the secondary care provider. 7. If the referral is from a clinician in A&E to a consultant-led speciality for the patient to be reviewed on an elective basis. *NB: this is the date that the consultant decides to refer and not the date when the referral is received.* 8. In cases where a patient has been initially admitted on a non-elective pathway and it is identified that they require further treatment as an elective patient. (e.g. patient admitted with acute cholecystitis who is listed for cholecystectomy at a future date), the start of the 18 week clock would be recorded as the date that a decision to list was made. In those circumstances where a decision to list cannot be made during the non-elective episode (e.g. the team caring for the patient need to refer to another specialty for further advice or to carry out the procedure) the

	18 week clock would start on the date of referral to the other consultant led clinical team. 9. If a patient has been on active monitoring and a decision is made that medical or surgical consultant led intervention is required then a new 18 week clock would start at the time the clinician identifies further intervention is required.

4.2 Bilateral procedures	A bilateral procedure is a procedure that is performed on both sides of the body at matching anatomical sites. Examples include cataract removals and hip or knee replacements. Consultant-led bilateral procedures are covered by RTT measurement with a separate clock for each procedure. The RTT clock for the first consultant-led bilateral procedure will stop when the first procedure is carried out (or the date of admission for the first procedure if it is an inpatient/day case procedure). When the patient becomes fit and ready for the second consultant-led bilateral procedure, a new RTT clock will start.
4.3 When to stop the 18 week clock	1. First definitive treatment: the clock stops on the date that the patient receives the first definitive treatment intended to manage their condition. 2. For inpatient or day case admission, the clock stops on the date that the admission occurs. It is recognised that in some cases treatment may not start until the day after admission (or possibly later). However for simplicity and pragmatism, the clock stop should be recorded as the admission date. 3. For treatment provided in an outpatient setting, the clock stops at the appointment where that treatment is provided. 4. Clinical decision that treatment is not required - the clock stops on the date that the clinical decision is communicated to the patient. 5. Patient choice to decline treatment - the clock stops on the date that the patient declines treatment, having been offered it. 6. Active monitoring - the clock stops on the date that the clinical decision to commence active monitoring is agreed with the patient 7. Decision to return the patient to primary care for non-medical/surgical consultant-led treatment in primary care - the clock stops on the date that this is communicated to the patient. 8. Where a clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list. 9. A patient who becomes pregnant and the waiting time is such that an offer could be made before the gestation time is complete should be removed from the waiting list and referred back to their GP, unless the procedure is clinically advisable during pregnancy. The GP should make arrangements to re-refer the patient back when they are no longer pregnant and are medically fit to undergo treatment.

4.4 Examples of first definitive treatment	First definitive treatment is defined as 'an intervention intended to manage a patient's disease, condition or injury and avoid further intervention'. **First definitive treatment** could be: • treatment provided by an interface service; • treatment provided by a consultant-led service; • therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions This can include: 1. Outpatient treatment (or medical or surgical consultant-led treatment irrespective of setting) if no subsequent inpatient or day-case admission is expected. 2. Prescribing of medication or advice given if no subsequent inpatient or day-case admission is expected. 3. Fitting of a medical device. 4. Inpatient or day-case treatments 5. Diagnostic tests turned into therapeutic procedures during the investigation. 6. Therapy (for example physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science interventions (e.g. hearing-aid fitting) to manage the patient's condition and avoid further intervention.
4.5 Interventions that do not stop an 18-week clock.	The following examples do <u>not</u> stop the clock: 1. Administration of pain relief <u>before</u> a surgical procedure takes place, or other steps to manage a patient's condition in advance of definitive treatment. 2. Consultant-to-consultant referrals where the underlying condition remains unchanged. For example, for a patient who may require assessment by consultants in more than one specialty for development of their treatment plan, for the same condition for which they were originally referred. 3. Where a provider rejects a referral stating their service is not appropriate for this patient, the referrer must re-refer the patient to an appropriate service without delay. 4. If the referral is from one consultant-led service to another for the same condition (e.g. clinician refers to a colleague who may sub-specialise in the management of a specific condition), the clock start is the date the initial referral was received from primary care. Consultant to Consultant referral for the same condition does not start a new 18 week clock but continue the existing clock.

4.6 Cancellation of Appointments and Procedures

A cancelled or rearranged appointment, either patient-initiated or provider-initiated will not in itself stop an RTT clock.

1. Cancelled by Patient

Those patients who choose to cancel and rearrange their appointment should be given an alternative date within the next 14 days at the time of cancellation, so a convenient date and time can be discussed with them.

Patients should not be discharged back to their GP simply because they have cancelled or rearranged appointments; referral back to the GP should always be a clinical decision, based on the individual patient's best clinical interest.

Any subsequent cancellations may result in discharge back to GP but this must be communicated to the patient in all patient correspondence and telephone conversations**.**

2. **Cancelled by Provider**

a. ***Outpatient appointments*** - Clinics should not be cancelled or reduced within **six weeks** of the clinic date, except where there are exceptional circumstances. If a clinic has to be cancelled within six weeks of the clinic date, patients should be offered another appointment within **two weeks** of their original appointment, or arrangements should be made for that clinic to be covered by another consultant. Where a clinic is cancelled more than six weeks in advance, the appointment will be rearranged for the earliest opportunity.

b. ***Inpatient or day case procedures*** – 18 week clocks do not stop for those patients whose procedures have been cancelled following admission as an inpatient or day case for non- clinical reasons (for example, lack of theatre time due to emergency procedures being carried out).

Their rearranged admission should be within **28 days,** or earlier if the RTT or cancer breach date falls prior to the date of the 28 day breach.

If the treatment is cancelled by the provider after admission for clinical reasons (for example, patient deemed temporarily unfit for surgery due to chest infection), then the RTT clock should continue to tick unless a clinical decision is made that the patient is unsuitable for surgery/treatment and they are discharged back to primary care or a decision not to treat is made.

Patient appointments and procedures that have been previously cancelled by the provider should not be cancelled a second time. This will be subject to regular provider review and audit, with action plans to be put in place as required.

5 DELAYS

The management of patient initiated delays or failure to attend for treatment is detailed within this section.

5.1 Patient availability	Some patients will turn down reasonable appointments due to social or work commitments. A reasonable offer of an appointment is one for a time and date three or more weeks from the time that the offer was made. ***Prior to referral onto an 18 week pathway GPs should ensure that patients are ready and available to receive treatment within this 18 week timeframe.***
5.2 Patients who choose to delay treatment due to work or social commitments	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 are taken account of in the tolerance of 8% set for achievement of the incomplete pathway waiting time operational standard. With effect from October 2015, the RTT Rules Suite has been updated to reflect the removal of the provision to apply adjustments to RTT pathways for patient-initiated delays. Providers will, however, wish to maintain local records of: 1. All patient initiated delays; and 2. Patients who chose to start treatment after 18 weeks, that is, those who were offered a reasonable appointment within 18 weeks of referral but chose to wait longer, for personal or social reasons. No blanket rules will be applied that apply a maximum length to patient-initiated delays that does not take account of individual patient circumstances. Providers should have mechanisms in place to protect patients who may come to harm by choosing to delay their treatment. Clinicians should provide booking staff with guidelines as to how long (in general) patients should be allowed to defer their treatment without further clinical review. Patients requesting a delay longer than this should have a clinical review to decide if this delay is appropriate. If the clinician is satisfied that the proposed delay is appropriate then the provider should allow the delay, regardless of the length of wait reported. If the clinician is not satisfied that the proposed delay is appropriate then the clinical risks should be clearly communicated to the patient and a clinically appropriate TCI date agreed. If the patient refuses to accept the advice of the clinician then the responsible clinician must act in the best interest of the patient. If the clinician feels that it is in the best clinical interest of the patient to discharge the patient back to the care of their GP and inform them that treatment is not progressing then this must be made clear to the patient. This must be a clinical decision, taking the healthcare needs of each individual patient into account. **It is not acceptable to refer patients back to their GP simply because they wish to delay their appointment or treatment. However, it would be acceptable where referring patients back to their GP is in their best clinical interests. Such decisions should be made by the treating clinician on a case by case basis.**
5.3 Patients who choose to delay	Stopping a patient's clock for a period of active monitoring requires careful consideration on a case by case basis and its use needs to be consistent

treatment for "thinking time"	with the patient's perception of their wait. Where a patient is given 'thinking time' by the consultant, the effect on the RTT clock will depend on the individual scenario. If the agreed 'thinking time' is short, then the RTT clock should continue to tick. An example is where invasive surgery is offered as the proposed first definitive treatment but the patient would like a few days to consider this before confirming they wish to go ahead with the surgery. If a longer period of 'thinking time' is agreed, then active monitoring is more appropriate. An example is where the clinician offers a surgical intervention but the patient is not keen on invasive surgery at this stage, as they view their symptoms as manageable. A review appointment is agreed for three months' time and the patient is placed on active monitoring. The RTT clock would stop at the point that the decision is made to commence active monitoring.
5.4 Reasonable offer of appointment	A reasonable offer of an appointment is one for a time and date three or more weeks from the time that the offer was made.
5.5 Patients who are unfit for surgery	Patients should only be referred for inpatient or day case procedures if they are ***fit and available*** for surgery. If at any point in the patient pathway, it is evident that the patient is unfit for surgery then the provider should discuss this with the patient, and – if it is agreed that the procedure is not to be carried out - the patient should be discharged back to primary care. In this scenario, this is a non-admitted clock stop when a clinical decision not to treat is made and communicated to the patient. **However, this guidance should be interpreted with discretion following discussion with clinician involved to ensure the action is reasonable. In certain circumstances where clinically appropriate, the clinician may choose to commence a period of active monitoring, where the patient's condition is regularly assessed until such time as they are suitable for treatment.** If a patient is colonised with MRSA, this does not affect their RTT clock. There are patients referred on to RTT pathways for whom it is clinically appropriate to undertake treatment even if they are colonised with MRSA, and these cases just need to be managed correctly. Since April 2009, all relevant elective patients have been screened for MRSA, and positive patients will have to be decolonised and treated within the RTT pathway. If the consultant makes a clinical decision that it is in the interest of the patient to refer them back to primary care, then the patient's RTT clock may be stopped, on the date that this decision is made and communicated to the patient. **It is not expected that patients will be referred back to primary care just because they are MRSA positive, and exceptional reasons will be needed to support such clinical decisions.**
5.6 Recording pauses	As per section 5.2, any pauses should be clearly documented on the patient electronic record.

5.7 DNA (Did Not Attend)	A DNA (sometimes known as FTA or Failed to Attend) is defined as where a patient fails to attend an appointment/admission without prior notice. Patients who rearrange their appointments in advance (irrespective of how short the period of notice they give) should not be classed as a DNA. Where any patient referred routinely DNAs their **first** appointment, provided that the provider can demonstrate that the appointment was clearly communicated to the patient via eRS, this will nullify the RTT clock (in other words, it is removed from the numerator and denominator for RTT measurement purposes). Where any **adult** patient referred routinely (unless identified as clinically / socially vulnerable, or otherwise at risk adults) DNAs their first appointment after initial referral, they may be discharged back to the GP (or other referrer) at the discretion of the clinician and their clock nullified, in line with local DNA policies. This must be communicated in the correspondence to the GP and patient with details of how to resurrect the referral within 2 weeks or re-refer if the period of contact is greater than 2 weeks (see sample letter on page 26). Patient DNAs at any other point on the RTT pathway will not stop the RTT clock, unless the patient is being discharged back to the care of their GP. The action of discharging the patient will stop the clock provided that: • the provider can demonstrate that the appointment was clearly communicated to the patient; • discharging the patient is not contrary to their best clinical interests, which may only be determined by a clinician; • discharging the patient is carried out according to local policies on DNAs, which specifically protect the clinical interests of vulnerable patients Further patient DNAs along the pathway may result in the patient being discharged back to their GP and their clock stopped **except for children, vulnerable adults and urgent referrals.** However, the provider must be able to demonstrate that the appointment offer was reasonable and clearly communicated to the patient. NB – Patients on a screening programme will be reappointed and this will be communicated to the GP. All return to screening protocol as per the programme. In line with national guidance, there are no blanket rules that do not take account of the circumstances of individual patients, therefore, it is for clinicians to determine whether discharging a patient is or is not contrary to the patient's healthcare needs.

5.8 What if it isn't clinically appropriate to treat within 18 weeks?	In some cases, treatment within 18 weeks may not possible for clinical reasons. For instance: 1. If a series of tests must be done in sequence; 2. When a second condition presents itself that needs to be treated before the first; 3. Where the patient and consultant have agreed that the patient needs a second opinion which despite best efforts adds a delay; 4. For patients for whom there is genuine clinical uncertainty about the diagnosis but where active monitoring (and clock stop) is inappropriate. 5. Where the patient is medically unfit to be treated; Patients who are unfit for surgery and are likely to remain unfit for surgery for at least **3** weeks should be discharged back to their GP for further management and their clock stopped. A new clock will start once the patient is medically fit for re-referral. However, this is not a hard and fast rule. With this exception all the other examples should be included in 18 week recording as they are allowed for in the 18 week target tolerance, along with patients who choose to delay their pathway. The provider will need to be able to demonstrate that cases that take longer than 18 weeks to reach first definitive treatment are legitimate i.e. fit into the category of either patient choice or clinical exception.
5.9 Communication and documentation	If the clock is stopped because of a clinical decision not to treat then the clock stops on the date that the clinical decision is communicated to the patient. A key principle for 18-weeks is that any decision to pause or adjust a patient's clock or to accept that a patient will not receive their treatment in 18 weeks, however legitimate this is, should be explicitly communicated to the patient and subsequently to their GP, and the original referrer if not the GP.

6. Electronic Management of Referrals and Appointments

A national electronic system exists to which GP referrals are added and initial appointments subsequently booked. Where possible, each provider should publish it's services to the electronic system and where services are published in this way, manual referrals should not be sent or accepted. This will support referring clinicians in ensuring that choice of provider is offered to patients at the point of referral.

The electronic referral and booking guidance below is to be followed by referring clinicians and provider organisations. Of note, although this guidance relates primarily to electronic referrals, the principles and timescales are applicable to manual referrals too:

6.11 Choice	Where a provider service is published to the referral and booking system, the referring clinician should ensure that referrals to this service are submitted electronically. Such referral requests should include the shortlist of appropriate providers discussed with the patient.
6.12 Clinical Information	The referring clinician will ensure that the clinical referral information is uploaded in the following timescales: • **Two Week Wait / Urgent**: Within 24 hours / 1 working day of referral creation. • **Routine**: Within 72 hours / 3 working days of referral creation. Upon receipt of a new referral the provider will review and either accept or reject it in the following timescales: • **Two Week Wait / Urgent**: Within 48 hours / 2 working days of referral letter being uploaded to system. • **Routine**: Within 72 hours / 3 working days of referral letter being uploaded to system. The timeline below sets out the expected timescale from referral to treatment  Referral Timeline

6.13 Booking an Appointment	An appointment may be classed as directly or indirectly bookable. Directly bookable means that the provider's available appointment slots are visible within the electronic system. Where a service is indirectly bookable, the referral can be raised through the electronic system though the clinic slots will not be visible and a conversation is then usually required between the patient and the provider to arrange the appointment. Where a service is directly bookable, the patient may book into an appointment slot in any of the following ways: • By ringing NHS Bolton CCG's Referral Management and Booking Service. • By ringing the national Telephone Appointment Line. • By accessing the online appointment booking service. • GP practice staff may book an appointment for the patient (the patient must be involved in decision regarding date, time and venue) of appointment). The provider should ensure there is sufficient capacity available via Choose and Book for a patient to be able to book an appointment directly. Where there are no slots available for a directly bookable clinic, the referral will be 'deferred to provider'. This means that the patient's referral joins an Appointment Slots Issue list that the provider will work through. In these circumstances the provider will contact the patient to book the appointment. Patients added to a provider's Appointment Slots Issue list should be contacted by the provider within 5 working days of the referral letter being uploaded to the system. Where a service is classed as indirectly bookable, the patient will be provided with instructions for booking an appointment with that service.
6.14 Rejecting a Referral	Where a referral is rejected and / or the appointment cancelled, the provider should give feedback in writing to the referring clinician. The feedback should be clear and avoid the use of abbreviations and should indicate whether the patient has been informed of the cancellation. Such communication should take place within the time frames outlined in section 6.12 above. Where the referral needs to be directed to a different clinic within the same specialty, the original referral can be updated by the referring clinician or provider and a new appointment issued. Where the initial referral has been created for the wrong specialty and clinic type, the provider should cancel the request and advise the referring clinician of the correct specialty/clinic type. The referring clinician should then create a new referral to the correct specialty. Please refer to the Consultant to Consultant policy in section 3.3 of this document for further information.

6.15 Cancelling an Appointment (Patient)	The guidance below should be followed when a patient contacts either the provider or NHS Bolton's Referral Management and Booking Service to cancel/rebook an appointment: • An appointment should be rebooked at the time it is cancelled and should be no more than 14 days after the original appointment time. Under no circumstances should the rebooking of an appointment be allowed to compromise the provider's commitment to commence a treatment episode within the timeframes set out in Section 1 of this policy. • When rebooking an appointment, the patient should be advised that further rebooks are not allowed and a comment should be added to the electronic referral indicating that the patient has been advised of this. If a referral is not updated as described then the patient may rebook again in the future. • If a patient is unable to accept an appointment within the following 14 days then they should be advised that the referral will be cancelled and they will need to return to their GP if re-referral is required. A 'Contact' should be added to the referral to indicate that the patient has been given this advice. If unable to rebook because the provider has little or no capacity, the call handler should cancel the appointment and add a 'Contact' to the referral to indicate this. An email should also be sent to the provider's booking office to highlight this.
6.6 Cancelling an Appointment (Provider)	Clinics should not be cancelled or reduced within **six weeks** of the clinic date, except where there are exceptional circumstances (this does not include attendance at meetings). If a clinic has to be cancelled, patients should be offered another appointment within **two weeks** or arrangements made for that clinic to be covered by another consultant. Where a provider does cancel or rearrange a patient's appointment, it is the responsibility of the provider to communicate this clearly to the patient.
6.7 DNA (Did Not Attend)	Any **adult** patient referred routinely (unless clinically/socially vulnerable adults) who did not attend their **first** appointment after initial referral should be discharged back to the GP (or other referrer) at the discretion of the clinician. This must be communicated in the correspondence to the GP and patient with details of how to resurrect the referral within 2 weeks or re-refer if the period of contact is greater than 2 weeks (see sample letter on page 26). Any DNAs along the pathway will result in the patient being discharged back to their GP **except for children, vulnerable adults and urgent referrals.** However, the provider must be able to demonstrate that the appointment offer was reasonable and clearly communicated to the patient.

7 DEFINITIONS

This section aims to provide clear definitions of the terms used where they have a particular meaning within the context of 18-weeks.

18-week referral to treatment period	The part of a patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other 18 week clock stop point.
A	
Active monitoring	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. A new 18-week clock would start when a decision to treat is made following a period of watchful waiting/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. In those instances where the patient's original condition is deemed to be clinically urgent and the hospital consultant needs to seek the advice/intervention of another consultant, the 18 week clock will continue until such time as the patient receives the first definitive treatment or they are returned to the care of the GP. 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.
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, performed as separate procedures. For example,

	removal of cataracts from both eyes.
C	
Clinical decision	A decision taken by a clinician or other qualified care professional, in consultation with the patient.
Clinical exception	One of 2 reasons that a patient's pathway may exceed 18 weeks. Clinical exception is not the same as clinical complexity (see 5.8)
Consultant-led service	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.
Converting a Unique Booking Reference Number (UBRN)	When an appointment has been booked via Choose and Book, the UBRN is converted.
D	
DNA – Did Not Attend	When a patient fails to attend an appointment or admission without prior notice.
Decision to admit	Where a clinical decision is taken to admit the patient for either a day case or inpatient.
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.
Direct access	See "Straight to test"
E	
Electronic Referral Service (eRS)	A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic
F	
First definitive treatment	An intervention intended to manage a patient's condition.
Fit (and ready)	A new 18-week 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.
H	
Healthcare science intervention	See "Therapy or Healthcare science intervention"
L	
Low priority procedure	Procedures covered by Effective Use of Resources policies, commissioned only under certain criteria or following defined commissioner approval process. 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 follow the defined approval process. There will be no effect to the patients 18 week clock, as clock stops can only be applied 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 for exceptional funding. See Appendix 3 for full Effective Use of Resource information pack.
N	
NHS Bolton CCG	GPs, the public and any other providers commissioned to provide services for Bolton patients.
Non-admitted pathway	A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment'.
Non consultant-led	Where a consultant does not take overall clinical responsibility for the patient.
Nullified clock	When a patient DNAs their first appointment the referral is erased from the numerator and denominator in national reporting
O	
Overseas visitors	The NHS is first and foremost for the benefit of people who live in this country. People who are not ordinarily resident here are not automatically entitled to access free NHS hospital treatment. Those people who are not 'ordinarily resident' in the UK (living here lawfully and on a settled basis) are subject to the *NHS (Charges to Overseas Visitors) Regulations 1989*, as amended, and will have to pay for any hospital treatment they receive unless an exemption from charge applies to them.
P	
Pause - clock pause for patients on an admitted/day case pathway	The act of pausing a patients' 18-week clock. Clocks may only be paused for non-clinical reasons and only where a patient chooses to wait longer for admission than two reasonable offers made by the provider
Patient choice	One of only 2 reasons that a patient's pathway may exceed 18 weeks
Planned lists	Patients who require structured follow-up at appropriate intervals to detect the need for further treatment. It includes patients waiting for a planned diagnostic test or series of tests undertaken as part of a treatment plan which are required for clinical reasons to be carried out at a specific time or at a specific frequency. Patients should only be added to a planned list when it is clinically appropriate for them to wait for a period of time
Providers	Directorate and Departmental Managers, clinicians and administrative staff
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 defined an offer of a time and date: 2 weeks for outpatient or diagnostic patients 3 or more weeks for admitted patients 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. This only applies to inpatient/daycase treatment
Referral Management and Booking Service (RMBS)	RMBS provide a referral management and booking service for the local health community of Bolton. Majority of GPs are able to refer by using an Electronic booking system "Choose & Book." Patients are offered a choice of provider and in most cases they will agree a convenient date and time with their chosen provider. In some cases this may not be possible and the patient will be advised on when to expect to be contacted with an appointment date. Any queries from either the patient or the GP will be handled by the RMBS, in particular if an appointment can't be arranged straight away.
S	
Straight to test or direct access	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 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 patients' 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: Where less invasive or intensive forms of treatment have been unsuccessful and more aggressive or 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 consultation with the patient.
T	
Therapy or Healthcare Science Intervention	E.g. Physiotherapy, Speech and Language Therapy, Podiatry, Counselling etc.) or healthcare science (e.g. hearing aid fitting)
Tolerance	NHS Bolton will define success by what patients tell us, but patients' views need to be underpinned by measures of delivery that organisations can report and monitor progress on operationally. The measure of delivery for organisations that we will continue to judge progress against will be the monthly referral to treatment data for admitted and non-admitted patients.
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.

7 REFERENCES

The NHS Constitution (2015)
https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

NHS Choices – Find a hospital
http://www.nhs.uk/ServiceDirectories/Pages/ServiceSearch.aspx?ServiceType=Hospital&InputError=Default

Department of Health, Access to treatment for overseas visitors
http://www.dh.gov.uk/en/MediaCentre/Factsheets/DH_123858

Bolton CCG Effective Use of Resources Information
http://www.boltonccg.nhs.uk/about-the-ccg/what-we-do/effective-use-of-resources

Department of Health (2015) Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting-RTT-guidance-v24-2-PDF-703K.pdf

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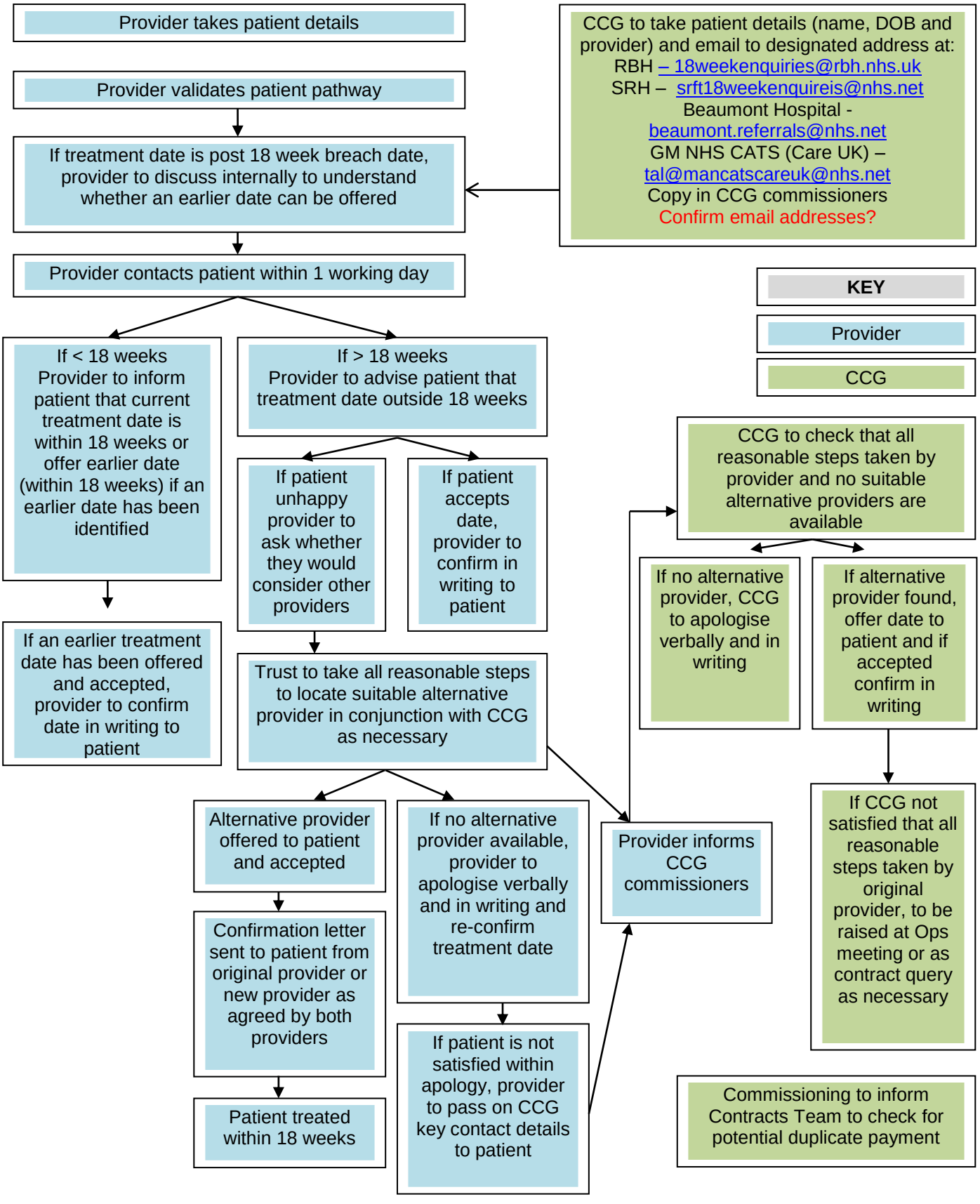
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting-RTT-guidance-FAQs-v6-2-PDF-164K.pdf

Department of Health (2015) Referral to Treatment consultant-led waiting times: Rules suite
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464956/RTT_Rules_Suite_October_2015.pdf

Appendix 1

NHS Constitution – Process for enquiries or complaints made under the right to access services within maximum waiting times



Appendix 2

NHS

The NHS Constitution gives you the right to start your non-emergency treatment within a maximum of 18 weeks.

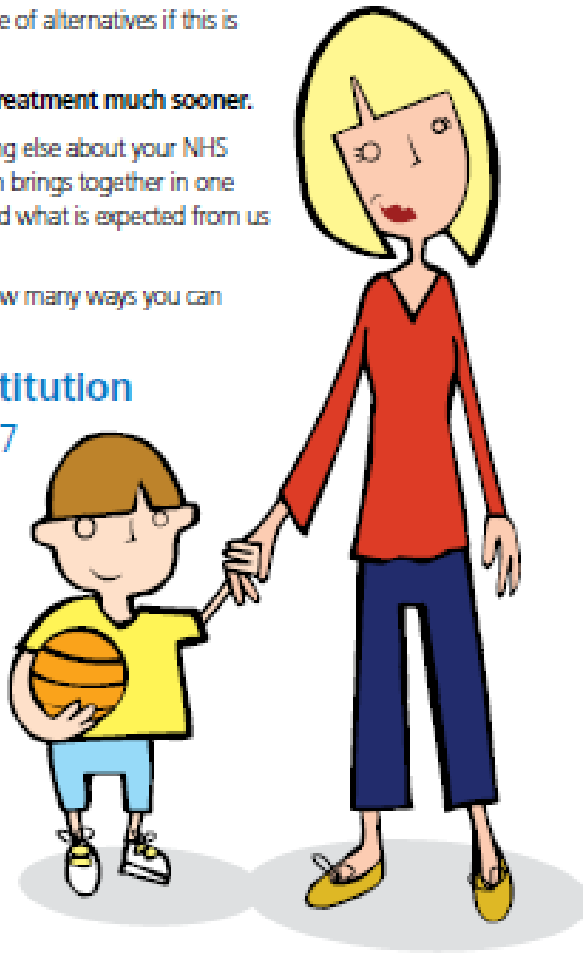
As long as you choose it and it is appropriate for you, **you have the right to start your non-emergency treatment within a maximum of 18 weeks** from when you are referred by your GP, or to ask the NHS to take all reasonable steps to offer you a range of alternatives if this is not possible.

In fact, most patients can expect to start treatment much sooner.

Your rights around waiting times and everything else about your NHS care are set out in the NHS Constitution, which brings together in one place what we can all expect from the NHS and what is expected from us in return.

To read the NHS Constitution or to find out how many ways you can access the NHS, please:

visit **www.nhs.uk/nhsconstitution**
call NHS Direct on 0845 4647
or ask your GP.



THE NHS CONSTITUTION
the NHS belongs to us all