Title		**Patient Access policy**	**Policy Identifier**	LC:QA:27
Policy Area		Quality	**Policy Version**	2
Policy Author	**Name**	Donna McDonald	**Issue Date (DD/MM/YY)**	22/02/2024
	Job title	Head of Patient Services		
Policy Approved by	**Name**	Governance Committee	**Review Timescale (yrs)**	2
	Position	Governance Committee	**Expiry Date**	22/02/2026
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Introduction

The purpose of this policy is to document LivingCare Group (LCG) responsibilities for managing patient access in line with the National and Local RTT standards. The policy covers all stages of the 6 week and 18 week referral to treatment (RTT) pathway from referral through to discharge back to primary care.

This policy should be read in conjunction with the guidance from NICE on suspected cancer; recognition and referral, Safeguarding Children and Safeguarding Adults policies.

We will ensure that the management of patient access to services is transparent, fair, equitable and managed according to clinical priority. This policy applies to all administration and clinical prioritisation processes relating to patient access managed by LivingCare Group, including outpatient, inpatient, day case and diagnostic services.

This policy should be adhered to by all staff within the organisation who are responsible for referring patients, managing referrals and adding to and maintaining waiting lists for the purpose of progressing a patient through their 6 week and 18 week RTT pathway.

The accountability for effective implementation and adherence to this policy is the responsibility of the Head of Patient Services.

Head of Patient Services and Head of Clinical Services are responsible for ensuring their staff comply with the policy and are fully trained by receiving the appropriate annual training and to keep records of staff training.

Head of Patient Services and Analytics and Data Team will provide advice and support to all staff in the effective implementation of this policy.

There are Standard Operating Procedures stating how to deliver the Patient Access Policy and Key Performance Indicators to measure and report the delivery.

1.1 National Performance Standards

The following national performance standard applies to 18 Week RTT patients:

- 99% of incomplete patients will receive their first definitive treatment within 18 weeks (126 days) of their referral.

The following National Performance Standards also apply:

- No patient will wait longer than six weeks for a diagnostic test or image;
- All patients with suspected cancer, who are referred urgently by their General Practitioner (GP), must be seen within 14 calendar days from the receipt of referral;
- All patients diagnosed with any form of cancer will receive their first treatment within 31 days from the decision to treat consultation;
- All patients referred through the urgent 14 day cancer referral route and subsequently diagnosed with cancer will receive their first treatment within 62 days of the date of referral received;
- Patients who are not referred through the urgent 14 day pathway, but who have highly suspicious symptoms, may be added to the 62 day pathway at the request of a hospital specialist, as will any patients referred from screening services.

1.2 National Health Service (NHS) Constitution

This NHS Operating Framework sets out the planning, performance and financial requirements for NHS organisations. One of the key areas is maintaining a strong grip on service and financial performance, including ensuring that the NHS Constitutional right to treatment within 18 weeks is met. The NHS Constitution was revised in March 2013 and details the legal rights of patients in regards to their care. The NHS Handbook to the Constitution (March 2013) states that patients will have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible.

The Constitutional rights are to:

- Start Consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions;
- Be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.

Exceptions to this are:

- Where the patient chooses to wait longer;
- Delaying the start of treatment is in the patient's best clinical interest;
- It is clinically appropriate for the patient's condition to be monitored in secondary care **without** clinical intervention or diagnostic procedures at the particular stage;
- The patient fails to attend appointments, which had been chosen from a reasonable set of options;
- The treatment is no longer necessary.

The following services are not covered by the Constitution:

- Non-medical Consultant-led mental health services;
- Maternity services;
- Public Health services provided or commissioned by local authorities.

1.3 Principles

The 18 week referral to treatment pathway

The referral to treatment pathway includes all the stages that lead up to treatment, including outpatient consultations, diagnostic tests and procedures.

Benefits for patients and the NHS

- Patients will receive the most appropriate treatment with far shorter waits;
- Commissioners will be accountable for the performance of Providers through their contracts;
- Providers will be managing an integrated patient pathway;
- Working collaboratively with other healthcare providers.

The 18 week referral to treatment pathway does not replace other waiting times, targets or standards where these are shorter than the median waiting times. This includes waiting times for patients with suspected cancer or waiting times for Rapid Access Clinics.

1.4 Key Elements of the 18 week RTT Pathway

The following points summarise the key elements of the standard:

- All patients should be fit, willing and able to commit to treatment and managed according to their clinical urgency within the 18 week RTT waiting times;
- A non-admitted pathway refers to patients that do not require admission to hospital to receive their first definitive treatment, i.e. that treatment is given or prescribed in outpatients;
- An admitted pathway refers to patients who require admission to hospital, as either a day case or an inpatient, to receive their first definitive treatment;
- An incomplete pathway refers to patients who have not yet received their definitive treatment, therefore, their 18 week RTT period is still open, the patient may be in the non-admitted, diagnostic or admitted part of their pathway;
- Patients will be managed and measured on a non-admitted pathway until the point at which they require admission for treatment, as either a day case or inpatient, at which point they are managed and measured within the admitted pathway;
- The 18 week RTT pathway begins on the date that a paper referral is received by the LivingCare, or when a Unique Booking Reference Number (UBRN) is converted from an e- Referral (formerly known as Choose and Book) request to an appointment. The clock then continues to tick until either the first definitive treatment is given, or another event occurs which stops the clock;
- An 18 week RTT pathway can also be started within another healthcare provider setting and then the patient can be transferred to the LivingCare, where the clock will continue to tick from the original referral start date;
- The 18 week RTT pathway can be started by a large number of referrers when they refer the patient into a Consultant led service. These include GP's;
- Patients may have more than one 18 week RTT pathway if they have been referred to and, are under the care of, more than one Clinician at any point in time; however, a

clinical decision will be taken whether a patient may be on more than one admitted pathway at any point in time;

- Each 18 week RTT pathway must be measured and monitored separately and will have a unique pathway identifier in the LivingCare patient administration system (SYSTMONE).

Every step along the 18 week RTT pathway (outpatient, diagnostic, pre-assessment, admission, discharge, decisions made) must be recorded in SYSTMONE using a set of RTT status codes. These steps are referred to as clock starts and clock stops. If every step is not captured and recorded correctly, the LivingCare will build up a database of patients with incorrect open RTT periods, which will lead to difficulties in managing demand and capacity and recognising 'true' patients.

It is, therefore, imperative that Clinic Outcome Forms are completed at the end of every clinic session to enable the patient pathway to be updated according to the decision made in clinic with the patient and the Clinician.

1.5 Management of Urgent Suspected Cancer Patients (2ww)

A GP should, in accordance with NICE guidance 2015, explain to people, who are being referred with suspected cancer, that they are being referred to a cancer service. Reassure them, as appropriate, that most people referred will not have a diagnosis of cancer and discuss alternative diagnoses with them. They should discuss that the patient should be available to attend for appointments over a 62 day period.

Step Down at receipt of referral

Only GPs are able to downgrade referrals from the USC 2ww referral pathway, at the point of receipt. Where a Consultant believes that a referral does not meet the criteria for USC, 2ww referral prior to first appointment, the Consultant **must** discuss the referral with the referring GP/GDP and the GP/GDP **must** agree to downgrade the referral. The Consultant must inform the outpatient schedulers they have spoken to the GP. Without this confirmation, the downgrade will not take place.

For patients who cancel appointments:

- Patients should not be referred back to their GP after a single appointment cancellation;
- Patients should not be referred back to their GP after multiple (two or more) appointment cancellations **unless this has been agreed with the patient** – by cancelling an appointment a patient has shown a willingness to engage with the NHS.

1.6 Exclusions from the RTT Pathway

The following activity is excluded from the 18 week RTT standard:

- Elective patients undergoing planned procedures (check cystoscopies etc);
- Patients receiving ongoing care for a condition whose first definitive treatment for that condition has already occurred;
- Referrals to non-Consultant led services.

2. RTT Pathway

2.1 Clock Starts

A clock start is when a referral is received into a Consultant led service for diagnosis and treatment of a patient's condition, by receipt of paper referral or conversion of UBRN. It is of the utmost importance that there is no delay in the processing of the referral once it has been received in the LivingCare.

The most common clock starts are detailed as follows:

2.1.1 Referral received from Primary Care

The date that the LivingCare receives the referral is the date the clock starts. 18 week RTT Pathways start with referrals from Primary Care to the following services:

- Medical or surgical Consultant-led services - irrespective of setting;
- Cancer services, for which a 62 day cancer target clock also starts;
- When a patient is seen in clinic and a diagnosis of cancer is confirmed and their treatment plan discussed (decision to treat). The GP must be notified within 24 hours of diagnosis;
- Diagnostic services, provided the patient will be assessed and, if appropriate, treated by a medical or surgical Consultant-led service before responsibility is transferred back to the referring health professional;
- Practitioners with special interests if they are part of a referral management arrangement as defined;
- Where a patient has been seen privately and then is referred by the GP to an NHS LivingCare after being offered choice.

Referrals from Primary Care to the following services will not start the clock:

- Therapy, healthcare science or mental health services that are not medical or surgical

Consultant-led, including multi-disciplinary teams and community teams, irrespective of setting;
- Diagnostic services if the referral is a straight-to-test arrangement;
- Primary dental services provided by dental students in hospital settings.

2.1.2 Upgrading Referrals

A Consultant may choose to upgrade a referral from “routine” to either “urgent” or “Cancer” when this is clinically appropriate. In the case of “Cancer”, the Consultant will also inform the MDT Co-ordinator to ensure appropriate tracking of their pathway. Where any upgrade has taken place, this will be advised to the referrer through the clinic letter.

2.1.3 Consultant to Consultant referrals

Consultant to Consultant referrals are acceptable if the referral is with regards to the condition that the patient was originally referred to LivingCare for. If a condition can be managed in primary care then the patient should be discharged back to their GP practice.

If the onward referral to a Consultant-led service is for a different/separate condition, the patient must be referred back to their GP in order for the patient to be offered choice.

Unless any of the following circumstances apply;

For investigation, management or treatment of cancer, or a suspected cancer;
A life threatening or urgent condition;
For patients with pre-existing complex medical problems for specialist assessment in relation to anaesthetic risk.

For Ophthalmology patients only:

- Diabetic Retinopathy Screening (DRS) patients, whose screening results show non DRS pathology to be referred direct to an ophthalmology Consultant;
- Patient is being treated for a chronic eye condition e.g. Glaucoma, ARMD and then develops other eye conditions, not related to their original referrals, to be referred to the appropriate ophthalmology Consultant for treatment.

2.1.4 End of active monitoring

If, after a period of active monitoring, the patient or the Care Professional then decides that treatment is now appropriate, a new 18 week RTT period starts. This new clock starts at 0 weeks; it does not restart at the point at which the previous clock was stopped. There is then a new 18 week RTT period in which the patient must receive their first definitive

treatment.

2.1.5 Bilateral Procedures

If a decision to treat involves bilateral procedures e.g. both cataracts, both knees, as part of a single pathway of care, the patient should be listed on the waiting list for the initial procedure (first side) with a comment noting that a second 'bilateral' procedure is to take place when the patient has recovered from the first. After surgery, for the first procedure, the 18 week RTT clock stops. When the Consultant deems the patient fit from the first procedure, they should then be placed on the waiting list with a new RTT period and clock start for the second procedure.

2.2 Ongoing Clocks

A patient's clock is ongoing clock until:

- first definitive treatment has been given;
- a decision not to treat has been made;
- a patient is placed on active monitoring;
- the patient is discharged back to primary care.

2.2.1 Activity within an RTT period which does not stop the Clock

This might be a follow up appointment, request for a diagnostic test/image or adding a patient to a waiting list for admission.

2.2.2 Transfer to another healthcare provider

If a patient is referred from one provider to another as part of their RTT period, their original 18 week RTT clock should keep ticking until the first definitive treatment. The originating provider should ensure that the patient's initial RTT start date forms part of the onward referral information; this information is known as minimum data set (MDS). An Inter Provider Transfer (IPT) form is required. The RTT is the responsibility of the originating provider. If the referral arrives without an IPT, LivingCare must add a minimum of eight weeks to the referral date until the IPT form arrives. In some instances, these patients will be returning to the originating referrer with the clock continuing to tick

2.2.3 Flight Restrictions

There is no clinical evidence to substantiate flight restrictions for surgical patents. If, during consultation, a clinical decision is made that a patient must not have surgery before or after a long haul flight, any periods of time must be taken into account within the patient's 18 week RTT pathway. The RTT clock will continue to tick, therefore, when planning surgery for such patients. This must be taken into account to prevent the patient from breaching the standard.

2.3 Clock Stops for Treatment

A clock stops when the first definitive treatment starts.

First definitive treatment is defined as being an intervention intended to manage a patient's disease, condition or injury and avoid further intervention. The date that the first definitive treatment starts will stop the clock. This may be either in an interface service or a Consultant-led service.

2.4 Clock Stops for Non-treatment

There are a number of different of different ways a clock could stop for non-treatment.

2.4.1 Start of a period of active monitoring

This is where it is clinically appropriate to monitor the patient in secondary care without clinical intervention or further diagnostic procedures. Active monitoring can be initiated by either the patient or the Clinician. The start of a period of active monitoring stops the RTT waiting time clock. If a new form of treatment is required at the end of the active monitoring period, a new clock starts from zero weeks and the LivingCare has a further 18 weeks to treat the patient.

2.4.2 Patient does not attend (DNA's) their first activity following referral

When a patient fails to attend the first activity (appointment or diagnostic test) in their pathway, their RTT pathway is nullified.

Where the clinician feels it appropriate to offer the patient a new appointment, then a new clock would start on the date that the patient agrees the new appointment date (not the date of the rescheduled appointment itself).

Where this is not the case, the patient may be referred back to primary care, providing it can be demonstrated that:

- The appointment was clearly communicated;
- Discharging the patient is not contrary to their best clinical interest.

Particular care should be made to protect the interests of vulnerable patients eg children.

2.4.3 Patient DNA's subsequent activity on pathway

When a patient DNA's a subsequent appointment, diagnostic test or image, pre-assessment appointment or To Come In date (TCI) for elective admission; where it is appropriate to continue to retain clinical responsibility for the patient at LivingCare Group, a further appointment should be offered and the patient's waiting time clock should continue ticking.

The patient may be discharged back to primary care, and their 18 week RTT clock will be stopped providing that you can prove that:

- The appointment was clearly communicated and reasonable notice of the appointment was given;
- Discharging the patient is not contrary to their best clinical interest.

Should the patient wish to receive treatment, then they can be re-referred by their GP – a new RTT pathway and period would start on receipt of the re-referral to the LivingCare Group.

This ruling applies to children unless there is concern raised as part of the 'Safeguarding Children Policy', further appointments may be given, however the clock continues from the date of referral, you may not start a new 18 week clock.

2.4.4 Patient cancels care activity

If a patient cancels, rearranges or postpones their appointment, this has no effect on the RTT clock, which should continue to tick. 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.

Where a decision is made to return a patient to primary care, their 18 week RTT clock will be stopped. Should the patient wish to receive treatment, they then can be re-referred by their GP – a new RTT pathway would start on receipt of the re-referral to LivingCare Group.

2.4.5 Decision not to treat / no treatment required

When the Clinician and the patient decide that treatment is not required or a decision made that no treatment is to occur; the patient's clock is stopped.

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

2.4.6 Patient declines offered treatment

Patients may choose not to proceed with the treatment offered and, therefore, their 18 week RTT clock is stopped and the patient referred back to primary care.

2.4.7 Patient dies before treatment

When a patient dies before they receive treatment, their 18 week RTT clock will be stopped and their RTT pathway ended.

3. Approach to management of patients pathways

3.1 Management Rules

This section covers the general principles that govern progressing patients through their 18 week RTT pathways.

It is the responsibility of the Head of Clinical Services and Head of Patient Services, in partnership, to provide the agreed capacity to ensure that demand is met. This should be done through weekly 'Activity and Performance' meetings. They should ensure that the allocation and availability of new and follow up slots are spread between two week wait,

urgent and routine appointments is robust enough to meet all performance standards.

3.1.1 Entitlement to NHS Treatment

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

3.1.2 Patients transferring from private Independent Service Providers (ISP) to the NHS

Patients can choose to convert between NHS and private status at any point during their treatment without prejudice. Further guidance can be sought in the LivingCare Group Private Patient Policy located on the Intranet.

3.1.3 Patients transferring from the NHS to Private Independent Service Provider

NHS Patients opting to have a private procedure must be removed from the NHS waiting list, their 18 week RTT clock stopped, and the pathway ended.

3.1.4 Listing patients for more than one admitted RTT pathway

Where it is clinically acceptable, patients may be on more than one admitted RTT pathway at any given time.

3.1.5 Patients requiring commissioner approval

Clock stops can only be made to a patient's RTT pathway when treatment occurs or a decision not to treat is made. No adjustments or clock stops can be made to a pathway whilst a panel or approval board assesses commissioner approval requests. Patients who require treatment, which must have commissioner approval prior to commencement, must not be disadvantaged by having their referral returned to primary care. Therefore, the referrer to LivingCare Group must seek prior approval before referring the patient. The approval must accompany the referral.

In some instances it will not be apparent until the outpatient consultation or on completion of diagnostic testing, that the patient requires an excluded procedure. Commissioners should hold approval panels in line with the 18 week timeframes for any patient referred for assessment who has already commenced an RTT pathway. Please refer to the Individual Funding Request (IFR) Policy from the patients CCG.

3.1.6 Reasonable Notice

Prior to referral, patients should be made familiar with their obligations to the RTT pathway and that recurrent cancellations of their appointments could delay their treatment. Further guidance can be found within the NHS Constitution

Our aim will always be to offer a date appropriate for a patient‘s clinical priority and convenience.

For decisions to admit for treatment and appointments, reasonable notice is the offer of two appointments with at least three weeks notice. If the patient accepts an offer at shorter notice, this also represents a reasonable offer in respect to management of cancellations or DNA's

3.1.7 Booking

Patients have the right, as part of the NHS Constitution, to make choices about their NHS care and to have information to support these choices. The patient has the right to choose the organisation that provides their NHS care.

3.1.8 Cancellation of Appointments or TCI date

3.1.8.1 Patient Cancellations

Patients who give prior notice, however small, are classed as "Patient Cancellations".

Excluding cancer and urgent patients as well as considering the Safeguarding Policy, if a patient cancels their first appointment or TCI date anywhere in an RTT pathway, another appointment or TCI date must be re-arranged at that contact, within two weeks of the original appointment or TCI date. If an appointment is not available within two weeks, this must be escalated and exception reported.

If a patient cancels, rearranges or postpones their appointment, this has no effect on the RTT clock, which should continue to tick. 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.

Where a decision is made to return a patient to primary care, their 18 week RTT clock will be stopped. Should the patient wish to receive treatment, they then can be re-referred by their GP – a new RTT pathway would start on receipt of the re-referral to LivingCare.

If a patient cancels their appointment via e-Referral (formerly Choose and Book) and does not rebook following the receipt of the reminder letter, it will be assumed that the referral is not required and the UBRN will be cancelled, and the patient referred back to primary care.

Where the patient has a different condition, which may be resolved in Primary Care and is preventing treatment of the condition they were referred for (patient not fit, willing and able), in these cases the 18 week RTT clock must be stopped and the pathway ended. In the case of a different condition, LivingCare Group will write to the GP explaining that if the patient is fit, willing and able within 12 weeks, they should contact LivingCare Group to place the patient back on the waiting list.

If a patient cancels their appointment and does not require further appointments, the 18 week RTT clock will be stopped, the RTT pathway ended and the patient referred back to primary care.

Patients with a minor ailment, such as a cold or cough, which would be resolved in a short period of time, should be added to the waiting list. The RTT clock will continue to tick.

For 2ww referrals:

- Patients should not be referred back to their GP after a single appointment cancellation;
- Patients should not be referred back to their GP after multiple (two or more) appointment cancellations **unless this has been agreed with the patient** – by cancelling an appointment a patient has shown a willingness to engage with the NHS.

3.1.8.2 LivingCare Cancellations

If we cancel an appointment or TCI date anywhere on an RTT pathway, the clock continues to tick.

For an Outpatient or Diagnostic appointment, the patient should be re-dated within two weeks.

3.1.9 Did Not Attends (DNA's)

Excluding cancer and urgent patients as well as considering the Safeguarding Policy, if a patient DNA's a first activity following referral (the very first outpatient appointment or first diagnostic appointment) the patients clock will be nullified.

Where the clinician feels it appropriate to offer the patient a new appointment, then a new clock would start on the date that the patient agrees the new appointment date (not the date of the rescheduled appointment itself).

Where patients who attend their first appointment but then DNA any subsequent appointment in their pathway, where it is appropriate to continue to retain clinical responsibility for the patient at LIVINGCARE GROUP, a further appointment should be offered and the patient's waiting time clock should continue ticking.

In all other cases the patient may be discharged back to primary care, the patient's 18 week RTT clock will be stopped, the RTT pathway ended.

For patients referred on the cancer 2ww referral pathway who DNA two appointments, the patients 18 week RTT clock will be stopped, the RTT pathway ended and the patient returned to primary care.

In all instances if a patient is then re-referred back to LivingCare, this will be a new referral which starts a new 18 week RTT pathway and clock.

In all instances the LivingCare must be able to prove that:

- The appointment was clearly communicated;
- Discharging the patient is not contrary to their best clinical interest.

3.1.10 Patient initiated delays

Patients may choose to delay their treatment for social reasons e.g. a holiday. Clinicians have provided 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, the LivingCare should allow the delay, regardless of the length of wait reported. This will have no effect on the RTT clock, which will continue to tick.

Patient initiated delays will be recorded in the interests of good waiting list management.

In the diagnostic phase of the pathway, if a patient chooses to delay their treatment for a period longer than six weeks, the clinician may refer the patient back to primary care until they are fit, ready and able to begin their treatment.

3.1.11 Patient Thinking Time

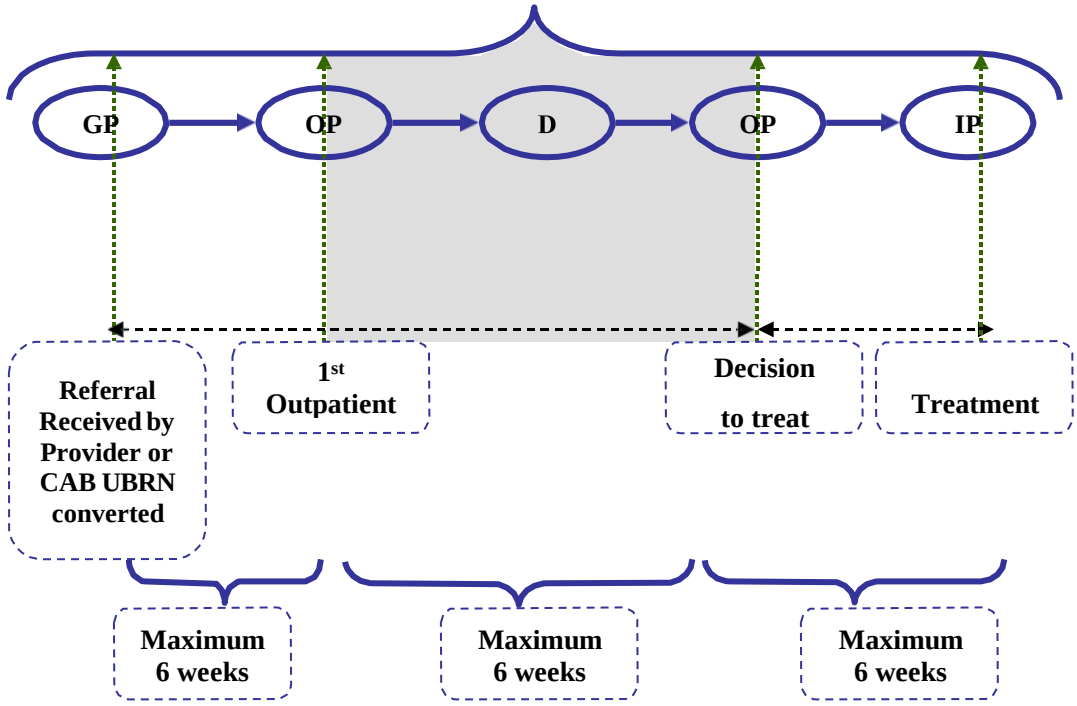
It might be appropriate, both clinically and from a patient's perspective, to stop a waiting time clock and refer back to primary care where a patient asks to think about their options for several months, to see how they cope with their symptoms over that period. If the patient asks for a brief period to consider the treatment being offered, this should have no effect on the waiting time clock.

3.1.12 Active Monitoring

This is where it is clinically appropriate to monitor the patient in secondary care without clinical intervention or further diagnostic procedures. Active monitoring can be initiated by either the patient or the clinician. The start of a period of active monitoring stops the RTT waiting time clock. If a new form of treatment is required at the end of the active monitoring period, a new clock starts from zero weeks and the LivingCare has a further 18 weeks to treat the patient.

3.2 Outpatients

3.2.1 General Principles



This is the '**ideal patient pathway**'; LivingCare aim for, and achieve, shorter pathways. If the patient can be seen in outpatients within six weeks from receipt of referral, and requires a diagnostic test, and then requires surgery – this denotes the ideal waits. If, however, the patient has been referred for example to Dermatology and the patients within this service are usually treated at their first outpatient appointment, then their pathway would not mirror this; Dermatology patients may wait 17 weeks for their outpatient appointments as they will be treated within 18 weeks. Each pathway must be dealt with according to the complexities and clinical decisions for the patient.

- Waiting Lists and admission schedules will be managed according to clinical priority and then in 18 week RTT chronological order.
- Patients are kept fully informed and have a single point of contact at the LivingCare.
- Referrals should be accepted or rejected, as appropriate, by timely triage.
- There must be a new referral for a patient with an existing condition if the request for further consultation is three months after the discharge of the original referral.
- When contacting patients to arrange an appointment, three attempts to contact the patient by telephone must be made. If the patient cannot be contacted by telephone, then a letter must be sent to the patient advising them to contact the Patient Services Team within seven days to arrange their appointment or they will be removed from the waiting list. Should the patient fail to contact the Patient Services Team, their 18 week RTT clock will be stopped, the RTT pathway ended and the patient returned to primary

care.

- The patient will be sent a confirmation letter regarding their booked appointment. The letter must be clear and informative and should include a point of contact and telephone number to call if they have any queries. The letter should explain clearly the consequences, should the patient cancel the appointment or fail to attend the clinic at the designated time.

3.2.2 Referrals Letters

- The aim of LivingCare is to receive the majority of referrals using the NHS e-Referral Service (formerly Choose & Book).
- The referrer must ensure that the referral letter is attached within an acceptable time to enable triage to take place:
    - 2WW - Same Day;
    - Urgent - One Working Day;
    - Routine - Three working days.
- The triage of referrals received electronically should be done in a timely manner and either accepted, rejected or redirected.
- The LivingCare and Primary Care Organisations will continue to work together to ensure all referrals are relevant to the Directory of Services published by the LivingCare.
- Paper referrals must be addressed and sent to The Patient Services Team, 4215 Park Approach, Thorpe Park, Leeds LS15 8GB for specialties not using the e-Referral (formerly Choose & Book) system.
- Referrals in the majority of cases should be addressed to ‘Dear Doctor’ to ensure that they will be allocated to the appropriate Consultant with the shortest waiting time.
- At the point of Triage, the Consultant may upgrade a referral from “Routine” to either “Urgent” or “Cancer”

3.2.3 Referral Letters through Primary Care Services

Referrals received, from primary care providers, will be classified as GP/AHP referrals. The waiting time accrued in the service forms part of the patient’s 18 week RTT pathway and is demonstrated as part of the IPT process. Failure to complete an IPT form will result in an inappropriate clock start and may prolong the patient‘s journey. If a referral is received without the IPT form, the LivingCare must add a period of eight weeks to the date of receipt until an IPT form is received. If the patient was treated in primary care, but now the patient requires a substantially different or new treatment, a new 18 week clock starts when the referral is received.

3.2.4 Referral Audit Trail

In order to establish that the Policy is appropriately carried out and reflects current standards, an audit of the processes will be undertaken on a quarterly basis. This process will be led by the Data Quality Lead and compliance will be assessed against national standards. In order to keep SYSTMONE accurate and up to date, it is the responsibility of all staff to make sure all activity is recorded accurately. SYSTMONE and the data therein must be constantly amended or updated accordingly and reviewed regularly.

3.2.5 Referral Expedite Letters

To avoid duplicate referrals, if a GP writes to the LivingCare requesting an appointment be expedited; the letter should be clearly marked "**Request to Expedite - this is not a referral**" and attach a copy of the original referral quoting the Unique Booking Reference Number (UBRN).

3.2.6 Referrals - Written Advice from Consultant

If a Consultant feels that written advice can be given to avoid the need for a face to face appointment, including the patient being managed more effectively on an alternative treatment pathway within primary care, advice will be given to the GP and the patients 18 week RTT clock will stop, the RTT pathway ended and the patient will be returned to primary care.

Any written documentation or e-consultation from GPs for advice only should be clearly marked in the letter that —"**this is not a referral".** This type of referral is not applicable to 18 week RTT; and therefore a clock will not start.

3.2.7 Cancellation of clinic sessions/part sessions

A minimum of six weeks notice of annual or study leave is required for clinic cancellation, authorised only by the appropriate Head of Clinical Services. Clinics should not coincide with other known commitments. The only acceptable reason for a clinic to be cancelled within six weeks is unplanned absence of medical staff e.g. sickness. However, it is expected that all efforts will have been made to replace the clinician before this action is taken. Clinics will not be cancelled for any other purpose, unless exceptional circumstances arise.

All clinics should be monitored closely and a complete and comprehensive analysis of clinic cancellations should be made available for performance monitoring at LivingCare daily communications meeting this should include:

- those with less than six weeks notice;
- those clinics added at short notice;
- those clinics cancelled with no patients;
- number of patients previously cancelled;
- number of first and follow up appointments.

3.2.8 Annual and Study Leave

All requests for annual and study leave by Consultant and Doctors written approval

from the Head of Clinical Services and PSM within a minimum of six weeks before leave is to be taken.

3.2.9 Contents of the Appointment Letter

All appointment letters should follow the LivingCare set format. A Patient Information Leaflet will be sent with the appointment letter for a first outpatient appointment.

3.3 Diagnostics

Many patients require diagnostics to determine the appropriate diagnosis and, therefore, subsequent treatment required to treat the patient. Diagnostic tests can be in many forms, including blood tests, endoscopy or an X-ray etc. Diagnostic tests must be performed within six weeks of request for the test, to ensure delivery of the national standard. In many instances, they will also form part of the patient's 18 week RTT pathway.

If a patient cancels or misses an appointment for a diagnostic test/procedure, then the **diagnostic waiting time** for that test/procedure is set to zero and the waiting time starts again from the date of the appointment that the patient cancelled/missed. Where this presents a significant technical challenge, and doing so does not adversely affect wait times, the same clock can continue, if there is still an intention to carry out a diagnostic test.

Similarly, if a patient turns down reasonable appointments, i.e 2 separate dates and 3 weeks notice, then the **diagnostic waiting time** for that test/procedure can be set to zero from the first date offered.

3.3.1 Straight to test diagnostics

Where a GP/AHP requests a diagnostic test to determine whether onward referral to secondary care or management in primary care is appropriate, then the patient is not on an 18 week RTT pathway and the RTT clock does not start.

The patient must have the diagnostic procedure within six weeks of referral. If the patient is subsequently referred to secondary care, then an RTT pathway will commence on the date the referral is received.

Where a GP refers a patient for a diagnostic procedure prior to an outpatient appointment with a Consultant, as part of an agreed pathway, then the patient is on an 18 week RTT pathway, and the clock starts on receipt of the referral. A patient must wait no longer than six weeks for their diagnostic procedure.

3.4 Pre-Operative Assessment

Where pre-operative assessment is required, patients should be pre-operatively assessed within one week after the decision to admit is made to ensure the patient is fit for procedure.

If, during the p re-operative assessment, an anaesthetist is requested to assess the patient, the patient will be booked into an anaesthetist led pre-operative assessment clinic within two weeks of the pre-operative assessment date.

If, at the pre-operative assessment appointment, it is found that the patient is not fit for their surgery where the patient has an unrelated condition, which may be resolved in primary care and is preventing treatment of the condition they were referred for (patient not fit, willing and able), they will be discharged back to their GP to be managed in primary care.

Communication to the GP should be within 7 working days and will clearly outline:

The reasons why the patient is not fit for surgery;

- Specify what needs to be done, who by, and the timescales;
- LivingCare contact details to assist the GP with the referral back to the appropriate pre- operative assessment service, as soon as the patient becomes fit for surgery.

If the patient becomes fit for surgery within three months:

- The GP will provide the LivingCare with a written update on their patient‘s clinical condition prior to them being booked back into the pre-operative clinic. This will start a new 18 week RTT pathway
- Pre-assessment clinic staff will keep a record of those patients who have the option to return within 3 months.

4. Patients not on a RTT pathway

4.1 Activity which is not part of an RTT pathway

Once a patient has received their first definitive treatment, which stops their 18 week RTT clock, they may continue to receive ongoing care for the condition that they were referred to the LivingCare for. Once the 18 week RTT clock has stopped, and the pathway ended, any treatment received that was discussed with the patient and is in the original plan of care, is not part of an 18 week pathway. This ongoing treatment is classed as 'not applicable to 18 weeks'.

However, when a patient has previously received their first definitive treatment, and a substantially different or new treatment is required for the patient, then this will start a new 18 week RTT period. For example, a patient has tried physiotherapy to treat their condition, but now requires surgery.

4.1.2 Planned Procedures

The definition of a 'planned procedure' is:

Where clinically a patient needs to wait for a period of time.

This includes planned diagnostic tests which are not subject to the six week rule, treatments, or a series of procedures carried out as part of a treatment plan – which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Patients on planned lists should be booked in for an appointment at the clinically appropriate time and they should not have to wait a further period after this time has elapsed. For example, a patient due to have a retest in six months time should be booked in around six months later and they should not get to six months, then have to wait again for non-clinical reasons. This is not an acceptable use of a planned list.

Where patients are waiting for a planned diagnostic test or procedure, the diagnostic waiting time guidance would apply in relation to cancellations and DNA's. **See section 3.3 Diagnostics**

If a patient reaches the date that the planned procedure was due and is still waiting, an 18 week RTT clock should start from the date that the procedure was due.

There should be no patients on a planned waiting list for social reasons – RTT rules should be applied to these patients.

4.2 Patients who DNA or cancel

The same rules apply to patients who are not on an 18 week RTT pathway as those that are, and they are recorded on SYSTMONE using Status codes that reflect this.

5. Prisoners

All elements of the Access policy are relevant to the population of Her Majesty Prison Services. However, all appointments will need to be managed within the prison regime and the LivingCare Patient Access Standard Operating Procedures.

6. Access to Health Services for Military Veterans

A Veteran is someone who has served in the armed forces for at least one day. When servicemen and women leave the armed forces, their healthcare is the responsibility of the NHS. All veterans are entitled to priority access to NHS hospital care for any condition as long as it is related to their service, regardless of whether or not they receive a war pension. GPs should notify the LivingCare of the patient's condition and its relation to military service when they refer the patient, so that the LivingCare can ensure that it meets the current guidance for priority service over other patients with the same level of clinical need. In line with clinical policy, patients with more urgent clinical needs will continue to receive priority.

7. Vulnerable Patients

It is essential that all staff within their roles ensure that patients, who are vulnerable for whatever reason, are identified as early as possible in the referral pathway. Patients are provided with whatever additional help and support is required. Patients are provided with communications in the appropriate format to access services. The referrer should make clear what needs have been identified, and this should be recorded on LivingCare systems, reviewing and updating on subsequent visits. When safeguarding issues are identified, LivingCare procedures should be followed in the normal way.

8. Delivery of Policy & Support

8.1 Responsibilities and Accountabilities

The accountability for effective implementation and adherence to this policy is the responsibility of the Commercial Director.

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

8.2 Training

18 week RTT training will be available for all staff in the local health community, to ensure accurate and timely data collection, to enable the LivingCare to meet the RTT standards. Staff groups should include all those who have dealings with patients throughout their pathway e.g. Receptionists, Booking Staff, Medical Secretaries, Nurses, Doctors, Clinicians and Managers.

To ensure high quality waiting list administration and continual maintenance of data quality, all staff involved in waiting list management will be trained to a standard level, tailored to the individual's responsibilities. Each year, all relevant staff will undergo compulsory refresher training or when systems are altered or operational practice changes.

8.3 Adherence to Policy

The LivingCare will routinely monitor the appropriate application of this policy for 18 week RTT pathways. This will be achieved by:

- RTT Spot Check Programme;
- Validation of RTT pathways for monthly performance reporting purposes;
- Ad hoc spot checks on themes or specialties;
- Weekly validation of monitoring lists to deliver >99% of diagnostics to target reportable through the DM01.

Where issues arise with compliance of the policy, the issue will be highlighted by the relevant Team with the appropriate Patient Service Manager. Failure to reach agreement, at this stage, will be referred to the Commercial Director

8.4 Information for Internal Hospital Management

Detailed information on 18 week RTT performance and the waiting lists are published on a daily and monthly basis. Internally, this information includes:

- Incomplete performance by specialty;
- Incomplete waiting list size and volume over 18 weeks;
- Data quality reports;
- Completed patient information.

This information is reviewed on a weekly basis at specialty level through the LivingCare Access and Performance meeting.

Monthly reports are provided to the LivingCare Board.

Revisions/Reviews

Revision/ Review No	Date	Revised/ Reviewed by:	Detail of Revision
001	22/02/2024	Lauren Walton/Donna McDonald	*Amendments to Job positions and roles within the business and accountability.*