Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Patient Access Policy

Key Points

The Trust strives to ensure equality of opportunity for all, both as a major employer and as a provider of health care. This Patient Access Policy has therefore been equality impact assessed to ensure fairness and consistency for all those covered by it, regardless of their individual differences, and the results are shown in Appendix 1.

Version:	1.2
Lead Author:	Head of Performance
Executive Lead:	Director of Operational Performance and Information
Date Approved by Policy Approval Group/Responsible Committee:	January 2017
Policy Category:	Clinical
Review Date:	January 2020
Target Audience:	All Trust staff involved in patient booking and waiting list management for elective patients

Document Control	
Previous Version Information:	
Previous Title:	Patient Access Policy
Previous Approval Date:	31/12/15
Relevant to CQC requirements:	Yes
Relevant to Information Governance Toolkit:	Yes
Other External Assessments	
Individual(s) Consulted:	*Commissioners (CCG), Intensive Support Team (NHS Improvement), Clinicians in primary & secondary care, staff directly involved in waiting list management, patient representative(s)*
Department(s) Consulted:	All divisions
Committee / Group(s) Consulted:	Policy Approval Group, Access Improvement Board
Amendments Made:	
Keywords:	*Referral to Treatment (RTT), Access, 18 weeks, Outpatients, Inpatients, Waiting List, Was not Brought, Cancellation, Active monitoring*
Related Trust Documents:	
• Safeguarding Children and Young People Policy • Management of Cancelled Operations	

Executive summary 4

Section 1 – Policy Statement
1.1 Introduction 4
1.2 Scope and Purpose 4
1.3 Responsibility and Accountability 6
1.4 Data Quality 6
1.5 Supporting Tools, Monitoring Systems 7

Section 2 – Operating Procedures
2.1 Standards and Expectations 7
2.2 Exceptions of RTT 8
2.3 Different types of pathway 8
2.4 18 Weeks Referral-to-Treatment (RTT) 9
2.5 Electronic Clinic Outcome Form (eCOF) 9
2.6 Clock starts 9
2.7 Clock Restarts 10
2.8 Internal Consultant to Consultant Referrals 10
2.9 Reasonable offer/notice 11
2.10 Clock stops 12
- For treatment 12
- Additional Activities / Administrative Events 13
- For non-treatment 13
- For organ donor / transplant 15
- Transfer to another NHS provider for Treatment 15
- Patient Deceased 15

Section 3 – Monitoring and Compliance
3.1 Active monitoring 15
- Clinician initiated 15
- Patient initiated 16
- School holidays 16
- Clinical initiated delays 17
3.2 Does Not Attend (DNA) (Was not brought) 17
3.3 Cancellations – Outpatients and Inpatients 19
3.4 Diagnostics 20
3.5 Inter-provider transfer/MDS process 21
3.6 Planned procedures 22

Section 4 – Approach to management of patients' pathways

4.1 Management rules 22
4.2 Patient entitlement to NHS treatment 22
4.3 Patients requiring commissioner approval 23
- Procedure of limited clinical effectiveness (POLCE) 23
4.4 Patients transferring from the private sector to the NHS 24
4.5 Patients transferring from the NHS to the private sector 24
4.6 NHS Provider Commissioning Private Sector Services 24
4.7 Overseas patients – wishing to access NHS Services 24
4.8 Managing referral letters 25
4.9 Pre-operative assessment 25
4.10 Adherence to Policy 25

Section 5 – References and Glossary

5.1 References 26
5.2 Glossary 27

Appendices

1 Equality Impact Assessment 31
2 Inter-provider Administration Transfer Minimum Dataset 32
3 Contact letter 34
4 Clinical Review Process 35
5 Cancer Access Policy 38

Executive Summary

This document sets out the management of elective patient pathways at Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) in line with national elective care standards and is based on the Department of Health Referral to Treatment Rules Suite (October 2015).

In order for GOSH to deliver performance against the national standards it is essential that elective patient pathways are managed as outlined throughout this document.

This policy will form the reference for all other guidelines and subsequent documents for the management of elective patient pathways. All GOSH staff must ensure that they are open, honest and transparent with patients at all times on the content of this policy and how national and local waiting time guidance and rules will apply to their waiting time and elective care experience.

Section 1 – Policy statement

1.1 Introduction

The Patient Access Policy is the policy by which patients' wait times and treatment should be governed, this is to include all types of elective pathways:

- Outpatient
- Elective Inpatient / Day Case
- Diagnostics
- Cancer (see the appended "Cancer Services Access Policy" to this document)

As set out in the NHS Operating Framework and NHS Constitution, everyone has the right (by law since 2010) to access certain services commissioned by NHS bodies 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 waiting times are described in the Handbook to the NHS Constitution (2013). This document has been produced with reference to the 'Department of Health, Referral to treatment, consultant-led waiting times, Rules suite, October 2015'. It sets out rules and definitions to ensure that each patient's RTT clock starts and stops fairly and consistently and provides the Trust with a framework and autonomy to work within. Therefore enabling the Trust to make clinically sound decisions locally in applying them, with consultation between clinicians, providers, commissioners and of course, patients and their families. They also ensure that waiting times are recorded and reported consistently across the NHS in England.

For all other Elective Care pathways, Diagnostic and Cancer pathways, this policy provides guidance for the management of these patients care.

1.2 Scope and Purpose

The policy covers the processes for booking, notice requirements, patient choice and waiting list management for all stages of a referral to treatment pathway for elective patients (including outpatient, inpatient, day case and diagnostic services), and the management of pathways outside of referral to treatment waiting times (such as those that are clinically planned – refer to later sections). All of these processes are to be clear and transparent to patients, families and carers; partner organisations and open to inspection, monitoring and audit, thus promoting compliance and effective use of resources.

This policy should be read alongside the Trust's Standard Operating Procedures for the management of patient pathways. The following link provides access to these, which will be continually reviewed and updated:

http://goshweb.pangosh.nhs.uk/corporate/information_services/information_reporting/Reports/Pages/waiting-list-report.aspx

http://goshweb.pangosh.nhs.uk/document_library/SOPs/Pages/default.aspx

The aim of this policy is to guarantee that the best interests of patients by ensuring services are managed efficiently in line with national waiting time standards and the NHS Constitution (2013). It will outline the Trust and Commissioner Requirements and operating standards (Operating Framework for the NHS 2014/15) for managing timely patient access to secondary care services from referral to treatment, as well as discharge to primary care. The Trust will not tolerate any form of discrimination on grounds of age, disability, race, gender, sexual orientation, religion or belief.

This policy outlines the internal operating standards and processes which must be adhered to, to ensure that patients gain access to elective treatment within the required national timeframes.

- The Trust will ensure all rules and definitions which regulate access to elective services (including cancer services) are interpreted and applied consistently and fairly

- The Trust, through the Divisional management teams, will ensure all staff responsible for managing referrals, adding to and maintaining waiting lists for the purpose of progressing a patient through their treatment pathway understand access standards and offer appointments within nationally agreed timescales.

Attendances of young persons over the age of 16

The patients who are primarily covered by this access policy are children and young people under the age of 16 years. This policy expects the following:

- Young people over the age of 12 years should be started on the GOSH Growing Up, Gaining Independence programme (GUGI) Newly referred young people over the age of 12 years should be started on GUGI as soon as possible in order to encourage their developing independence
- New referrals for young people over the age of 16 will not be accepted. If there are clinical and/or social reasons why the referral should be accepted, this can be discussed and approved by the Medical Director or, in their absence, the Chief Nurse
- In-patient care should not be routine for young people over the age of 16 and in all cases will require approval from the Medical Director or, in their absence, the Chief Nurse
- Transfer to appropriate adolescent services could occur between the ages of 12-16 years
- Transfer to appropriate adult services could occur between the ages of 16-18 years

- In some cases, long-term follow-up is required and will need to be approved by the Medical Director e.g. cancer or cardiac surgery survivors

Those services which are exceptions to the above (due to the commissioning process) I,e, to see and / or treat patients over 16 are:

- Foetal Cardiology
- Adult MRI for Cardiology
- Genetics
- Cleft lip and palate
- Antenatal diagnosed upper limb deformities
- Epilepsy

[Note – where it is deemed appropriate there can be arrangements in place for Clinical Divisional Chairs to have devolved responsibility for approval as agreed with the Medical Director]

Attendances of young persons over the age of 18

Anyone who is seen or treated at GOSH as an inpatient or outpatient beyond their 18th birthday must be treated as an adult. All staff will need to be trained in adult safeguarding. If procedures are undertaken staff will require the appropriate skills and have access to the relevant equipment i.e. ability to resuscitate adults

For further information regarding the above please refer to the Transition to Adult Care Policy.

1.3 Responsibility and Accountability

The Deputy Chief Executive has overall responsibility for the delivery of operational standards. On their behalf the Divisional Directors of Operations, and Clinical Divisional Chairs, will provide advice and support to all staff in the effective implementation of this policy.

The Director of Operational Performance & Information and/ or the Head of Performance will assure the Trust of the implementation of the policy, track progress via the weekly Waiting Times meetings and will be responsible for the annual review of this policy.

The accountability for effective implementation and adherence to this policy sits with the Divisional Directors of Operations and Clinical Divisional Chairs.

General Managers, Service Managers and Heads of Clinical Service are responsible for local implementation of the policy and ensuring all staff (clinical and non-clinical) comply with the policy and are fully trained (by receiving the appropriate PIMS, data quality and elective access training across all pathways). Staff must participate in annual training updates, and policy adherence will also form part of the staff appraisal process.

All staff who book and schedule patient care are responsible for the day-to-day adherence to this policy and for using the supporting standard operating procedures in doing so. Staff are accountable to their management teams for the application of this policy.

The Head of Information and Data Assurance is responsible for the provision of operational information to support delivery of patient pathways and for the reporting of information within and external to the organisation.

1.4 Data Quality

To support the delivery of high quality patient care, ensuring that internal processes work effectively and that external partners have their requirements met, it is therefore necessary to ensure the Trust maintains high levels of valid, complete, consistent, accurate and timely data.

Data Quality is everyone's responsibility (both clinical and non-clinical teams), both for those staff collecting data, and for those staff who enter it, either into the patient notes, Patient Administration System (PIMS) or EDM. Therefore it is important that staff get it right first time to reduce the incidence of data quality issues. The Trust needs high quality information to support a broad range of clinical and administrative functions, for example, for internal reporting for various departments and external reporting to NHS Improvement, NHS England, Care Quality Commission (CQC) and, Commissioners.

1.5 Supporting Tools, Monitoring Systems

All future activity requirements must be recorded within the Trust's Patient Administration System (PIMS) as this is the primary source of waiting list information.

Under no circumstances should records outside PIMS be the sole source of future contact requirements. Any manual records that may be kept in addition to the PIMS record must be consistent with PIMS. Where there are any differences these must be highlighted to the relevant senior management team, with approval sought that it is appropriate to do so. Any doubt must be deferred to the Trust's PIMS Committee.

The Trust provides web based (Qlikview reports) patient tracking & booking lists (PTLs) for the management of patient pathways; these include non-admitted, admitted, diagnostic and non-RTT PTLs. The PTLs are based on activity entries made on the PIMS system and then processed in line with RTT rules. All activities such as referrals, requests for admission and clinic outcome forms must be entered onto PIMS in a timely manner and in accordance with this policy and standard operating procedures. Failure to add patient activities to the waiting lists and in a timely manner is a serious matter that can put patient care at risk and non-compliance with this policy may result in disciplinary action being taken against individuals concerned.

Section 2 - Operating Procedures for Elective (non-cancer) pathways

(Use Cancer Access Policy Appendix for Cancer pathways)

2.1 Standards and Expectations

RTT consultant-led waiting times apply to English commissioned services and for those patients that English commissioners are responsible for; however the Trust is committed to treat all patients equitably and in line with their clinical needs. The points below outline this:

Referral to Treatment

- For patients on a RTT consultant led pathway, the national standard requires the Trust to have 92% of its patients waiting under 18 weeks. This is referred to as the "incomplete" waiting times standard i.e. how many patients have not yet received their treatment (and are as such "incomplete"), and for how long have they been waiting (which should be no longer than 18 weeks in most circumstances).
- Patients will only be added to the waiting list when they are fit, ready and able for treatment
- Patients with the same clinical need (as determined by the responsible clinician) will be treated in chronological order from the date of their clock start (see the

definition for clock starts in section 2.6) whilst acknowledging the right of the individual to agree a date to suit their personal circumstances

Diagnostic pathway

- No patient should wait longer than 6 weeks for a diagnostic test or image (Where applicable, the 6 week diagnostic standard occurs within the 18 week pathway)

Cancer Pathways

- All patients referred via a GP due to an urgent suspicion of cancer will receive their first treatment within 31 days of receipt of GP referral (at the secondary provider)
- Cancer patients who have not been referred via a GP but have been 'upgraded' onto a cancer pathway due to a suspicion of cancer will receive their first treatment within 62 days of the date of consultant upgrade (please refer to the Cancer Access Policy appended to this document)

Clinical Review Process

In the unfortunate circumstance that a patient may wait longer than they should (as defined above) it is the responsibility of those managing the patient's care to formally review each case from a clinical harm perspective (that is appropriate to their wait). Appendix Five provides an overview of the process that needs to be followed.

2.2 Exceptions to RTT

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

- Clinical: Patients for whom it is not clinically appropriate to be treated in 18 weeks (i.e. clinical reasons)
- Choice: Patients who choose to wait longer for one or more elements of their care (i.e. patient choice)
- Co-operation: Patients who choose not to attend their appointments

These patients are taken into account in the 8% tolerance set as part of the incomplete delivery standard.

2.3 Different types of pathway

18 Weeks – all patients who are eligible for 18 week treatment with consultant led acute hospital services

Diagnostic – for patients who require a test, scan or diagnostic procedure to inform their onward treatment should be undertaken within 6 weeks of the request being made.

Non RTT – for patients where the care being offered is not covered by the 18 week wait commitment:

- International and Private patient pathways
- Overseas patients
- Non-English commissioned patients (e.g. Scottish, Irish, Welsh)
- Pathways received from other providers marked (in the Inter-Provider Transfer MDS provided) as a non-consultant led pathway or not applicable
- Referral to non-consultant-led service
- Planned patients

- Emergency admissions
- Research (i.e. when a patient is referred to the Trust to solely participate in research. If a patient is referred for treatment / management at GOSH, and then subsequently participates in research, this remains RTT applicable until treatment or a clock stopping event occurs)

All patients of the same clinical priority and pathway must be treated equitably regardless of the type of pathway that they are on i.e. the length of wait for treatment must be considered prior to any differentiation between the pathway types.

Cancer - for further information refer to the appended Cancer Access Policy. To note that for referrals where an initial suspicion of cancer has been excluded and the diagnosis is not cancer; the pathway will revert to a standard 18 week RTT pathway.

Second Opinion - For further detail on the management of second opinions, please refer to the second opinion referral document, which is part of the training and guidance documentation (follow the link below)

http://goshweb.pangosh.nhs.uk/corporate/information_services/information_reporting/Reports/Pages/waiting-list-report.aspx

2.4 18 Weeks Referral-to-Treatment (RTT)

The majority of referrals to GOSH come from other hospital providers (i.e. not typically direct from GPs) and therefore the patient may:

- Have been waiting already (if treatment has not been given) and their pathway clock (wait time) will be "ticking" when referred in, or,
- Maybe referred to GOSH for a new or subsequent treatment, in which case the clock start (wait time) will commence following receipt of the referral into GOSH.

Patients referred in from another NHS provider must have an Inter Provider Minimum dataset provided, if this is not received at the same time as the referral then it should be within a maximum of seven days. (see section 3.6).

Each pathway has to be measured and monitored separately and will have a unique pathway ID number. Each step along the patients' pathway **must** be recorded in PIMS. These steps include outpatient appointments, diagnostic appointments, pre-assessment, admission, administrative events (e.g. a telephone call after a MDT discussion), discharge or any decision by the patient or clinician to delay further treatment at any stage should be recorded as either:

- a clock start
- ongoing activity of an already ticking clock
- a clock stop
- an activity which is not part of an RTT period.

2.5 Electronic Clinic Outcome Form (eCOF)

The Clinic Outcome Form is key to recording RTT time points and outcomes. The process to determine whether a clock continues or stops or whether a new clock should be started is based on the clinical decision made each time a patient's condition is reviewed.

It is the Consultant's responsibility to ensure this decision is captured and recorded accurately.

The clinical decision will determine whether a patient needs to remain on, or start a new RTT period, commence a period of active monitoring, or be discharged back to the referrer. Consultants should ensure that the accompanying written communication includes clear comments about the decision made in the clinic appointment and details of any next steps.

The clinician must tick the relevant clinic and RTT outcome box on the electronic clinical outcome form (eCOF) at the end of each outpatient appointment. Administrative staff should not assume responsibility to complete the clinical outcome form on a clinician's behalf. It needs to be accurately filled in with all necessary information and if not should be returned to the consultant for completion. Clinics should be outcomed at the time of the clinic or within one working day of the clinic, as a maximum.

2.6 Clock starts

An RTT waiting time clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to:

a) A consultant led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner. A consultant led service is one where a consultant retains overall clinical responsibility for the service and treatment but may not be physically present for each of the patients' appointments but he/she adopts clinical responsibility for the patients care

b) An interface or referral management or assessment service, which may result in an onward referral to a consultant-led service before responsibility is transferred back to the referring health practitioner or GP

Upon completion of a consultant-led referral, a new waiting time clock only starts:

- when a patient becomes fit and ready for the second of a consultant-led bilateral procedure
- upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care pathway
- upon a patient being re-referred in to a consultant-led, interface or referral management or assessment service as a new referral
- when a decision to treat is made following a period of active monitoring
- when a patient rebooks their appointment following a first appointment was not brought / Did Not Attend (DNA) that stopped and nullified their earlier clock (refer to Section 3.2)

The clock starts at the date the initial GP referral is received by a provider (whether that is an interface service or Trust). Please refer to section 4.9 for full details.

Very often due to the complex nature of the children and young people seen at GOSH, more than one specialty / consultant will be involved in a particular patient's care. This is often as a consequence of a referral from one specialty to another within the hospital. The later section (2.8) outlines these in more detail.

2.7 New Clock Starts

New clocks starts can be applied following the completion of a RTT period in certain circumstances:

- Bilateral procedures **-** Where patients are undergoing a bilateral procedure i.e. a procedure that is performed on both sides of the body, at matching anatomical sites then the initial waiting time clock will stop at first definitive treatment for the first procedure. Once the patient is fit and ready for the second procedure then the new waiting time 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 (not from the date that the provider has the capacity to admit/treat them).

- On Decision to start substantively new or different treatment
- Decision to treat following Active Monitoring
- When patient rebooks after DNA following initial referral (please section on clock stops below)
- Where the admit by date for a planned waiting list entry has breached (e.g. for capacity reasons) and is not clinically appropriate to adjust (please refer see the standard operating procedure for Transferring from Planned to Elective Waiting List)

2.8 Internal Consultant to Consultant Referrals

If a referral is accepted internally from one team to another for the same condition, the RTT clock will continue to tick. The team accepting the referral will assume responsibility for that patient's RTT waiting time. At this stage PIMS will need to be updated to reflect the linkage to ensure that the waiting times are accurately reflected across the pathway.
Internal consultant to consultant referrals are only appropriate in the following scenarios:

a) The referral relates directly to the primary condition for which the patient is attending hospital.

   For example (these are illustrative and not exhaustive)

   - multi-system disease where input from another clinician is an essential part of the treatment pathway
   - a patient referred with cystic fibrosis (CF) but presents with CF related diabetes or liver disease
   - a patient with nutritional problems develops bradycardia and requires a cardiology assessment

b) The referral relates to an evolving diagnosis of a worsening chronic disease, which would be better managed by another GOSH clinician

   For example (these are illustrative and not exhaustive)

   - a patient presenting with undifferentiated symptoms, which are investigated and a diagnosis made which is unrelated to the original receiving speciality e.g. a patient is referred to Dermatology with a skin lesion, which over time increases in size and needs surgical incision; this is subsequently referred onto Plastic Surgery

c) where the referral is urgent

   For example (these are illustrative and not exhaustive)

   - suspected cancer
   - where a short delay may be life threatening or is likely to impact on the long term prognosis
   - where the delay would contravene established NICE Guidelines i.e. presentation after second seizure, acute severe asthma or anaphylaxis
   - any safeguarding concerns

2.8 Reasonable offer/notice

For an outpatient appointment, diagnostic appointment and an inpatient admission date, a reasonable offer is:

- For outpatient appointments, an offer of two dates that are at least two weeks from the time that the offer was made. This does not prevent the offer of earlier dates where they are available but these cannot be counted as reasonable offers until they have been accepted (by the patient / family / carer) and evidence of this is recorded.

  Or

- For diagnostics and inpatient admissions an offer of two dates that are at least three weeks from the time that the offer was made. This does not prevent the offer of earlier dates where they are available but these cannot be counted as reasonable offers until they have been accepted (by the patient / family / carer) and evidence of this is recorded.

  Or

- The patient accepts the offer (further in this document there is guidance on restarting clocks associated with cancellations). If the patient accepts a date which is less than three weeks' notice then this becomes reasonable

All verbal offers and acceptances/refusals must be recorded on PIMS in the dedicated offer screen, as proof of acceptance and offer.

Refusal of reasonable offers

Should a patient / family decline the offer of reasonable dates, in accordance with the above, then then the following may occur:

- These need to be clinically reviewed to understand that an alternate date (should one be requested) is appropriate for that patient's condition. See later section regarding management of school holidays etc.

- For Diagnostic services (as identified in section 2.3), the diagnostic waiting time can be re-set to the date of the first reasonable offer, and be rebooked within 6 weeks (by day 41 day)

2.9 Clock stops

2.9.1 Clock stops for treatment

The term first definitive treatment is defined as an intervention intended to manage a patient's symptoms, which could be a specific disease, condition or injury and to avoid further intervention. This may occur following a consultation, receipt of results from a diagnostic test, MDT discussion or following surgery. What constitutes first definitive treatment is a matter of clinical judgement, in consultation with others as appropriate, including the patient.

The clock stops when the patient receives their first definitive treatment. This can be in an outpatient or inpatient setting (whichever comes first) for the condition for which they have been referred.

For inpatients the clock stops when the first definitive treatment is given as part of an admission (this does not include admissions for diagnostic reasons). The clock is stopped on the date of the patient's admission (as long as a procedure code has been added to the waiting list entry prior to admission – without this the clock will continue until clinically coded.

In cases where inpatient treatment does not involve a procedure this must be captured via recording an administrative event (additional activity) on the same pathway on which the admission takes place (see the following section).

For outpatients the clock will stop when the appropriate RTT outcome has selected on PIMS and been confirmed on the eCOF.

Clock Stop examples (these are illustrative and not exhaustive):

- The patient is prescribed hydrocortisone cream for a skin condition in an outpatient setting (Clock stop)
- The patient is admitted for cataract surgery (Clock stops)

Events that would not constitute a clock stop are (these are illustrative and not exhaustive):

- Pain relief prescribed in an outpatient setting (Not a clock stop – this is symptom control)
- Admission for biopsy under general anaesthetic in theatre (Not a clock stop – this is a diagnostic procedure)

2.9.2 Additional Activities / Administrative Events:

Not all appointments take place in a face to face setting, such as the outpatient clinic, as patients may be contacted by telephone or by letter e.g. communicating test results. If verbal or written contact is made to inform a patient that treatment is not required, or their condition can be actively monitored, then this decision itself will trigger a clock stop.

In the absence of a clinic visit, this clock stop decision will need to be entered onto PIMS manually by the service. Comments must be recorded within the comments field of verbal decisions which stop the clock and the Consultant correspondence to the patient, GP and / or referring clinician must be saved on to EDM.

An example of this is the patient who may have had a biopsy to determine their diagnosis and treatment. The biopsy may be normal at this stage but clinically appropriate for the patient's condition to be monitored at a later outpatient appointment. Active monitoring would commence and the RTT 18 week clock stopped, based on whichever date occurs first:

- On the date the result is communicated to the patient, or
- On the date a letter is sent informing the patient and copied to their GP and / or referring clinician

2.9.3 Clock stops for 'non-treatment'

There can also be clock stops for non-treatment. A waiting time clock stops when it is communicated to the patient, and subsequently their GP and/or referring clinician without undue delay that:

A. It is clinically appropriate to return the patient to primary care for any non-consultant led treatment in primary care (discharge)

If the clinical decision, in agreement with the patient (and/or family), is not to treat then it is appropriate to discharge the patient back to the referring organisation. The clock will stop when this information has been appropriately communicated to the patient (and/or family) and the referring organisation.

B. A clinical or patient decision is made to start a period of active monitoring

It is a clock stop, please refer to 3.1

C. A clinical decision is made not to treat

Where a decision not to treat is made then this decision (and communication with the patient (and/or family) stops the clock. Usually this will be a decision not to treat, which results in the patient being discharged back to the care of their GP and/or referring clinician.

Where there is a decision made not to treat but to retain clinical responsibility for the patient (for regular outpatient follow-ups etc) then it may be more appropriate to record this as active monitoring (although both have the same effect of stopping the clock). This again, needs to be made clear to the patient (and/or family) and the GP and / or referring clinician.

D. A patient declines treatment having been offered it

The clock will stop when a patient, having been offered treatment, declines the treatment offered. This does not include situations where a patient (and/or family) wants to delay the treatment.

If it is clinically appropriate the consultant will refer back to the referring organisation, if further monitoring is required the patient should be placed on patient initiated active monitoring as a result of declining treatment. Very often this will be a decision that has needed to involve the parents, family or carers.

E. A patient was not brought / DNA their first appointment following the initial referral that started their waiting time clock, provided that the Trust can demonstrate that the appointment was clearly communicated to the patient.

The act of a patient failing to attend their first appointment following referral for treatment, which started their waiting time clock, will nullify the waiting time clock, in the following circumstances:

- Where a direct referral is received from a GP and the patient DNAs the first appointment
- Where there is an internal referral for a different condition and the patient DNAs the first appointment
- Where the referral is received from an independent sector healthcare provider and the referral reason is not private patient referral and the patient DNAs the first appointment
- Where an inter-provider MDS is received by the Trust with an RTT status code indicating first activity for different condition.

In these DNA scenarios, where the GOSH clinician feels it is more appropriate to offer the patient (and/or family) a new appointment, then a new clock would start on the date the appointment is booked (not the date of the rescheduled appointment itself).

Where the GOSH clinician feels it is appropriate to discharge the patient the clock would stop. The clock would restart if the patient is referred back to the service.

If a patient was not brought / DNA any further appointments, the clinician can discharge back to the referring organisation provided discharging the patient is not contrary to their best clinical interests and that the service can demonstrate that the appointment was clearly communicated to the patient (and/or family). If there is an active RTT clock this would stop the clock.

Should a patient not be brought / DNA on two consecutive occasions, the patient's case must be reviewed by the responsible GOSH clinician. Upon review the service must:

- Decide if the patient's condition is such that it requires a further (3rd) appointment to be booked to be seen at GOSH. Should the condition not present any potential clinical harm by not being seen, the patient is referred back to the originating referrer (if not the GP, they must be copied into the correspondence), and the referral and pathway closed on the system

- if a 3rd appointment is to be offered, contact must also be made with the referrer to ascertain if they have recently had contact with the patient / family and that the contact details remain accurate. In this instance, "recently" is since the date of the referral to GOSH

- If there is no confirmation from the patient or family, of the 3rd appointment received and the referrer has not been in contact with the patient / family since the referral was made, the case will be referred to the safeguarding team for review and action (see section on safeguarding).

2.9.4 Clock stops for organ donor/transplant patients

The clock stops when the patient is added to a transplant list (not applicable for tissue transplants). Once the donor matching process is completed a new clock will start, and the transplant is undertaken within 18 weeks

2.9.5 Transfer to another NHS Provider for treatment

Where a patient is transferred to another provider for treatment the clock will continue ticking with that provider and will be nullified for GOSH reporting purposes.

2.9.6 Patient Deceased

The RTT clock will be stopped when a date of death is entered on PIMS.

Section 3 – Monitoring and Compliance

3.1.1 Active monitoring - Clinician initiated

Active Monitoring (previously known as watchful waiting) stops the clock when a decision is made (and agreed with the patient / family) that it is clinically appropriate to monitor the patient in GOSH without clinical intervention. Active monitoring must be agreed with the patient / family. Patients who are on active monitoring must have a future outpatient appointment (which may include future diagnostic procedures or tests).

For both forms of Active Monitoring (clinician and patient initiated) the patient will remain under the care of a consultant-led service. The GP and / or referring organisation will be updated with the progress of their patient.

Examples of clinician initiated active monitoring include:

- MRI shows some changes to the knee but the patient does not yet require surgery, so will review in outpatients in four months' time
- Regular review of patients where treatment cannot be carried out until they reach a pre-determined weight or size that cannot be defined by time

Active monitoring may apply at any point in the patient's pathway but only in exceptional circumstances after a decision to treat has been made. If such a decision has been made but subsequently it becomes apparent that there is not a clinical reason to delay treatment/admission, the waiting time clock would continue.

Future activity must be booked when a patient is placed on active monitoring. A period of active monitoring stops at the point when the patient is fit, willing and able to receive treatment, their condition changes, or they decline treatment (see later section on active monitoring).

If after a period of active monitoring, the patient (and/or family) or the clinician then decides to proceed with treatment, the period of active monitoring will end and a new clock starts and the patient must receive their first definitive treatment within 18 weeks.

3.1.2 Active Monitoring - Patient initiated

When a patient (and/or family) has been informed about their proposed treatment, particularly in the case of invasive surgery, it is not unusual for them to seek thinking time of **up to two weeks.** No clock stop is applied in this instance, and this does not constitute patient initiated active monitoring.

It may be appropriate for the patient to be entered onto active monitoring (and the RTT clock stopped) where they state they do not anticipate making a decision for a matter of months. This decision can only be made by a clinician and on an individual patient basis with their best clinical interests in mind.

In this scenario, a follow-up appointment must be arranged around the time the patient would be in a position to make a decision. A new RTT clock should start from the date of the decision to admit if the patient (and/or family) decides to proceed with the treatment option offered (typically surgery).

All communications and decisions must be clearly recorded and included on the patient record (and up loaded onto EDM).

Active monitoring ends and a new clock will start when:

- A decision to treat is made, whether in an outpatient or inpatient setting (e.g. patient added to an admitted waiting list for knee surgery after four monthly reviews). This could also be made virtually, so long as it is discussed and agreed with the patient / family, typically over the telephone.

- A patient is referred for diagnostics or specialist opinion with the intention of commencing treatment. (This does not include tests or opinions required to routinely monitor a patient's condition)

- a patient becomes fit and ready for a second bilateral procedure (e.g. cataracts, hips, knees)

All of these instances must be recorded / captured using the eCOF form.

Example:

Child X is referred to medicine with undefined respiratory disease. The consultant has no clear plan of treatment and wants to monitor the child before any intervention. There are two options: to discharge back to the referrer for monitoring (clock stop) or to start a period of active monitoring, with the patient having a follow up appointment in three months but to contact the hospital before if their condition deteriorates. The follow up appointment must be booked straight away, and the referring clinician and GP are written to confirming this care plan.

3.1.3 School holidays

As stated in the introduction of the document and in line with national guidance in support of elective referral to treatment within 18 weeks, patients (and families) need to be ready, willing and able to proceed with treatment at the point they are referred. This very often is challenging within a paediatric hospital with a high proportion of its patients being of school age, and there maybe a request that treatment be deferred until school holidays.

Should this mean deferral for a couple of weeks, and operationally possible this may be acceptable. However, anything longer will need to be clinically reviewed and assessed. At this stage it may be more appropriate that the patient is discharged back to the referrer and asked that they be re-referred when ready, willing and able. Once the patient (and/or family) has agreed to a treatment plan, treatment should not be delayed for social reasons, such as school holidays. The clock will continue to tick until treatment is delivered. Unfortunately, a clock stop cannot be applied for reasons of patient choice, once a treatment plan has been agreed. This should also be reviewed in accordance with the previous guidance on active monitoring.

If the assessment suggests that treatment is clinically urgent, this must be discussed with the patient / family and treatment dates confirmed, as per any clinical pathway.

3.1.4 Clinically initiated delays (patient unfit for treatment)

Major / significant co-morbidities

Patients who are not clinically fit to undergo treatment should not be added to the waiting list. If a patient is unfit for surgery the clinician will ascertain the likely nature and duration of their symptoms / condition. If a patient becomes unfit for their intended procedure but the responsible clinician considers it necessary to monitor the patient's condition, the patient will be removed from the waiting list and commence a period of active monitoring (with a follow-up date booked into the future, at a clinically appropriate point).

Minor ailments

If the reason is transitory, such as a cold, then the patient (and/or family) will be offered a further date within three weeks. This will allow patients with minor illness to recover and the clock will continue to run during this time. If the patient is not fit after this time, then it maybe clinically appropriate to discharge them back to their GP or local hospital for the management of their ongoing condition. Re-referrals should then be made when the patient is fit for surgery, which would start a new pathway and 18 week clock, although the Trust would try to see the patient.

When the patient is deemed ready, fit and able to proceed with their treatment a new RTT clock will be started from the date the decision is communicated to the patient (and/or family).

3.2 Did not attend (DNA) (or Was Not Brought –which includes children / young people who were not brought)

Further to section 2.9.3 part E, a DNA is when a patient fails to attend (or be brought) to an appointment / admission without prior notice or could not be seen on the day. Patients who cancel their appointments in advance should not be classed as DNA and therefore this will have no effect on their waiting time.

The Trust recognises that non-attendance may be due to several factors. However, the responsible clinicians need also to consider whether there is the potential for a safeguarding concern and act accordingly.

Should a patient not present / DNAs on 2 occurrences, the matter should be reviewed by the responsible clinician and if appropriate to do so, discharge the patient back to their referring, outlining the reasons for doing so.

Consultant staff are ultimately accountable for the safety of patients in their care and as such all staff must adhere to the policy. Consultants must identify whether safeguarding issues are a factor and whether the DNA / cancellation or refusal constitutes potential neglect of medical needs. The Trust safeguarding policy should be followed and advice sought.

If in the consultant's opinion the child's repeated failure to be brought to appointments or admissions and that DNA, cancellations or refusals are could be detrimental to their health and wellbeing, a referral to the child's Local Authority Social Care Service may be required in cases where there is likely to be a risk of harm to the child. This should be sent within 2 working days and an electronic Social Work Referral Form completed notifying them and the Safeguarding Team.

Support is available from the GOSH Social Work Service, Safeguarding Team or out of hours Clinical Site Practitioners. A letter is available on PIMS to send to parents outlining their responsibilities towards the health needs of their children.

Individual child protection plans (ICPP)

Where the threshold for Child Protection has been met and the child is subject to an ICPP, the consultant must inform in writing the child's Social Worker in the Local Authority where the child resides of any appointments or admissions where the child was not brought. This should be sent within 2 working days. Further information can be found in the GOSH Safeguarding Children & Young People Policy available in the document library.

Following a patient who was not brought the consultant or member of the clinical team will review the referral and clinical record. Where there are specific concerns relating to safeguarding, it may be necessary to take rapid action. Where this is the case, please refer to the Safeguarding Policy.

Further appointment is offered

The consultant or member of the clinical team will complete the eCOF to advise of the timescale for the appointment to be made based on clinical urgency. The appointment letter must be sent to the parents/carers within 10 working days of the missed appointment, with a copy to the GP and/or referring clinician.

Further appointment not offered
The referral should be closed by completing the eCOF appropriately. The consultant or member of the clinical team must write to the GP or referring clinician within 10 working days informing them the patient was not brought. The referrer will be asked to review the child/young person and inform the consultant in writing within 6 weeks whether the child/young person still needs to be seen at GOSH. If yes, a new referral must be initiated.

The consultant or member of the clinical team will write to the parents/carers within 10 working days of the missed appointment advising them that no further appointment has been arranged and provide contact details for the Central Booking Office should they wish to book another appointment.

The Trust recognises that some children have rare or chronic diseases for which GOSH is essential. However, if a child was not brought on two consecutive appointments, the consultant must consider concerns relating to safeguarding and whether action needs to be undertaken. See previous point above about considering discharging back to the referrer.

A letter must be sent to the GP or referring clinician within 10 working days informing them of the consecutive DNA and a request to review the child/young person. A response will be requested in writing within 6 weeks to determine whether the child is stable and to emphasise the need for the child to be brought to the next appointment, which should initiate a new referral/pathway. Consultants and their secretaries should initiate a system whereby a reminder is forwarded to those who fail to respond within 6 weeks.

3.3 Cancellations – Outpatients and Inpatients

The cancellation or change of an appointment or To Come In (TCI) date can be made by the patient (and/or family), referring organisation / GP or hospital. The impact of each will vary how the pathway is subsequently managed.

Outpatients

Patient initiated cancellations
It is important that all confirmed appointments are kept and attended. There will however be circumstances when patients / families cancel for unavoidable reasons. In these instances GOSH will cancel and rebook the appointment in order of clinical priority and waiting time.

Should there be 2 recurring instances where the patient / family cancel their appointment, this will need to be reviewed by the local consultant / clinical lead with a view to discharging the patient back to their referrer and / or if required follow the Trust safeguarding policy. Please refer to the section 3.2 above.

Hospital initiated cancellations
Outpatient cancellations initiated by GOSH must be kept to a minimum and short term cancellations should only be for unforeseen reasons. To minimise this risk all clinical staff must book annual leave / study leave at least 8 weeks in advance. Please refer to the Trust annual leave policy.

For those patients on 18 week / RTT pathways these will continue to “tick”. It is expected that all patients are managed appropriately dependant on their clinical need and wait time.

Patients affected by this must have a new appointment rescheduled on the day of cancellation, within a maximum of 14 days and in all cases within the 6 week deadline for outpatient appointments, as long as clinically appropriate.

Inpatients

Patient initiated cancellations
Patients (and/or families) who cancel an agreed admission date / TCI date will be offered a second reasonable date. The patient (and/or family) must be informed that if this second agreed admission date is cancelled by the family / patient, no further offers will be made and they will be reviewed by the responsible clinician for appropriate management, with a view to remove them from the waiting list and discharged back to the referring clinician / organisation, and / or the Trust safeguarding policy followed.

Hospital initiated cancellations – clinical and non-clinical reasons

Clinical – There will be instances on the day of admission (or pre-admission) where the Trust will need to cancel the patient's treatment / procedure for very valid clinical reasons, in the best interests of the patient. Examples include (this is illustrative and not exhaustive):

- Patient has not been nil by mouth on arrival for admission (despite having this information explained in the pre-operative material)
- Upon anaesthetic assessment, patient deemed unfit / not well enough for surgery
- Patient's clinical circumstance / condition has changed since pre-assessment and it is not safe at this time to proceed with treatment

In these situations it maybe straight forward to rebook an alternate TCI in the future, or the patient may require being followed up in outpatients to assess the next course of action for their care / treatment.

Non-clinical - It is the Trust's aim not to cancel any patients on non-clinical grounds at last minute. However, in exceptional circumstances, when this is unavoidable, patients (and/or families) should be offered a new date on the same day that they were cancelled and the new date must be within 28 days of their original TCI date or before their RTT breach date (if this is the earlier of the two dates). Priority should be given to patients who may have been cancelled more than once.

Patients who cannot be offered a date within 28 days should be escalated without delay to the Divisional Director of Operations and an alternative arrangement or provider agreed.

3.4 Diagnostics

Elective diagnostic tests and procedures are performed as either part of a pathway OR may be conducted as a planned procedure. Please see section 3.7 for guidance of planned procedures. The guidance below relates to diagnostic tests and procedures being conducted as part of an active elective pathway.

As stated in section 2.3 diagnostic tests must be performed within a maximum of 6 weeks from the date of referral / test request to the diagnostic service. Clinical urgency will determine how quickly within the 6 week wait time the patient is seen. If the patient has been sent for diagnostic testing to inform their treatment plan on an 18 week / RTT pathway, the clock continues to tick (there is no pause whilst diagnostic tests are conducted)..

If an external referral is received by the Trust for a diagnostic only, this will still need to be carried out within 6 weeks of receipt. However for 18 weeks / RTT this would be excluded from GOSH recording and reporting. The reports / scan would then be sent to the referrer to allow that provider to continue / commence treatment.

For internal diagnostic requests, should the clinical information supporting the request be insufficient the relevant diagnostic team will contact the internal referring clinician within one

week requesting the missing information. If this is not provided within two weeks, the referral will be rejected and a new referral required.

Patient initiated cancellation / DNA

For the diagnostic tests previously listed in section 2.3, if a patient cancels or DNAs a diagnostic test/procedure appointment that has been offered reasonably (as per section 2.8), 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 or DNA'd.

If the diagnostic test/procedure was booked without the reasonable offer criteria being fulfilled then the clock is not reset and the test/procedure should be booked within six weeks from the date of request. Please refer to section 2.8 on reasonable offers for what is applicable and what is not.

Please note that the 18 week clock will continue to tick despite the resetting the six week clock.

It is expected that reasonable offers should be applied to all diagnostics. If it is possible and a patient (and/or family) is willing to come in sooner than three weeks and the service can provide this, then the patient will offered this earlier time.

For patients that DNA on two occasions or those who have declined two reasonable offers, the diagnostic department will discharge the patient back to the care of the internal referring clinician who should then follow section 3.2 on DNAs. A new referral will be required from the service if the diagnostic test needs to be conducted.

3.5 Inter-provider transfer/MDS process

Inter-Provider Transfers (IPTs) refer to patients transferred from one secondary care provider to another or a tertiary referral. Upon receipt of the transfer GOSH will accept clinical and administrative responsibility for the patient.

Please refer to appended cancer access policy for separate guidance for Minimum Data Set (MDS) process for patients with suspected cancer.

An IPT MDS must be completed when:

- The care of a patient on an RTT pathway transfers between healthcare providers. This includes transfer to and from independent sector providers where this transfer is part of National Health Service (NHS) commissioned care.
- Request for a clinical opinion that results in the patient's care being transferred to an alternative provider.
- RTT pathways commissioned by English NHS commissioners independent of location.

Referring Trusts will use the agreed Inter-Provider Transfer Minimum Data Set (IPT MDS) form (Appendix 2) to communicate the relevant information about the patients' treatment status.

If a patient is referred from one provider to another as part of their RTT period, their patient pathway will continue and clock may continue to tick if treatment was not provided at the referring organisation.

The originating provider must provide an IPT MDS stating the relevant RTT status code and the patients' initial RTT clock start date (if the patient is on a ticking pathway). The IPT MDS must clearly state if the clock has already stopped or no treatment is required,

GOSH will adopt the following process for managing IPTs when the referring Trust fails to provide the IPT MDS:

- GOSH will contact the referring Trust within seven days of receipt of the referral and request the information required within seven days. Detailed comments must be left on PIMS to explain when and from whom the information was received for audit purposes.
- If that approach fails to elicit the information requested, GOSH will contact the referring trust for a second time advising them that they have a further seven days from the date of the second contact to provide the information
- If the information is still not forthcoming after the second contact, a third and final request will be made.
- Where the referring Trust is unable to provide a valid MDS after three requests, the Data Assurance team will attempt to validate the patient's IPT status from the referral letter. If sufficient evidence can be found within the referral letter to determine the patients clock status and clock start date this information will be recorded on PIMS and a detailed comment left to justify the decision.
- If the above methods do not provide a valid MDS, the patient will remain registered from the date of referral to GOSH on PIMS and managed as a new pathway. However, the patient's pathway should be reported as an UNKNOWN CLOCK START in relation to any Unify submissions.
- Where Trusts repeatedly fail to provide MDS information the Director of Operational Performance and Information will contact the COO of the referring Trust directly to discuss this matter further.

Patients referred on a ticking clock may have a previous waiting time. If the wait at the referring Trust is over 18 weeks this information must be escalated by the CBO to the receiving specialty's service manager immediately to minimise the risk of the patient breaching.

Patients with previous waits of over 30 weeks must be escalated also to the General Manager for the receiving specialty and to the Director of Operational Performance & Information and the Head of Performance.

3.6 Planned procedures

The definition of a planned procedure is:

'An appointment/procedure or a series of appointments/procedures as part of an agreed programme of care, which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency' (paraphrased from the NHS Data Dictionary)

Examples include:

- Gastroenterology – 6 month repeat endoscopy
- Pain management – injections (not first in the sequence)
- Neurology – MRIs (not first in the sequence)
- Dental – teeth extraction (not first in the sequence)
- Orthopaedics – removal of metal work following surgery
- Any procedure that can only be performed at a specific age

Patients must only be added to a planned waiting list when it is clinically appropriate for them to wait for a period of time or where treatment is for a planned sequence of interventions / procedures (as per the examples above) where the first intervention / procedure is definitive and must have an 'admit by date' to facilitate the correct management of their treatment. Procedures must be undertaken by the specified admit by date.

If a patient is unable to have their procedure before their admit by date, this must be reviewed by the responsible clinician and if clinically appropriate to do so the admit by date can be altered. If this is not the case, and this date cannot be met (i.e. for non-clinical reasons, such as capacity) the patient needs to be moved to a RTT pathway with a new clock start date and treated in-line with their clinical priority. This is additionally the case of planned patients requiring diagnostic tests and being moved to elective diagnostic waiting lists (and seen within 6 weeks).

Section 4 - Approach to the management of patients' pathways

4.1 Management rules

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

4.2 Patient eligibility to NHS treatment

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

All NHS Organisations have a legal obligation to:

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

The Human Rights Act 1998 prohibits discrimination against a person on any ground such as race, colour, language or religion. The way to avoid accusations of discrimination is to ensure that everybody is treated the same way.

This Trust needs to check every patient's eligibility. An NHS card or number does not give automatic entitlement to free NHS treatment. Therefore, every time a patient begins a new course of treatment at the hospital, **all** frontline staff must ask the following two questions, known as Stage 1 questions:

- Are you a UK/EEA/Swiss National or do you have a valid visa or leave to enter/remain in the UK?
- Which country/countries have you lived in for the last 12 months?

An additional question at this time to help identify private patients should also be asked:

- Are you attending for an NHS or a private appointment?

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

4.3 Patients requiring commissioner approval

No referral for an excluded procedure should be accepted without an exceptional treatment approval form. If the referral does not have the relevant approval, the referral should be rejected and returned to the GP for them to request exceptional treatment funding via the relevant CCG panel.

If the patient is already under the care of GOSH for their defined condition when a need to seek Commissioner Approval is identified, the patient will not be discharged from GOSH care. In this case approval will be sought. This will be completed through the relevant process within five working days, with a further five working days if panel approval is required. If no response is received within 10 working days, then this should be flagged to the Contracts Team, who will advise the Division whether treatment should proceed. Whilst approval is being sought the pathway will remain open and the clock will continue to tick. Should funding be declined, the pathway should be closed and the referral returned to the GP.

Procedures of limited clinical effectiveness (POLCE)

POLCE are treatments for which there is limited evidence of clinical effectiveness, which commissioners will not fund e.g. tonsillectomy, circumcisions. However, there may be situations in which these procedures are appropriate for children with complex illness.

Referrals can still be made for these treatments as along as the clinical criteria are met. However, either the GP or the consultant will need to complete the POLCE referral form and ensure this is sent to the commissioners before proceeding. Consultants are responsible for ensuring that referrals are not accepted for treatment until the commissioner has confirmed funding approval.

A list of POLCE procedures is available from
http://www.barnetccg.nhs.uk/Downloads/Publications/Policies/NCL-CCGs-Procedures-of-limited-clinical-effectiveness-policy-2015-16-2016-17.pdf

4.4 Patients transferring from the private sector to the NHS

Patients wishing to transfer from private healthcare to the NHS, must be returned to their GP to be offered choice and onwards referral to an NHS provider. Consultants are not permitted to make routine onward referrals from the private sector to GOSH either to themselves or to other consultants. Patients can choose to convert between the private sector and the NHS (and vice versa) without prejudice. However this cannot occur during a single episode of care (e.g. a patient undergoing a cataract operation as an NHS patient cannot choose to pay an additional private fee to have a multi-focal lens inserted during his or her NHS surgery instead of the standard single focus lens inserted as part of NHS commissioned surgery).

For patients who have been seen privately but then request a transfer to the NHS, a new RTT clock should start at the point at which clinical responsibility for the patients' care transfers to the NHS i.e. the date when the Trust accepts the referral for the patient in line with the above process.

Administrative processes should not get in the way of urgent or cancer treatment if diagnosed whilst being seen within private healthcare.

It is imperative that NHS capacity is utilised for NHS patients. Although private patient are important to GOSH, the Trust must be transparent in relation to the use of NHS resources and access to NHS treatment.

4.5 Patients transferring from the NHS to the private sector

NHS patients already on NHS waiting lists opting to have a private procedure must be removed from the NHS waiting list and the RTT clock stops on the date that the patient informs the provider of this decision.

Where a patient has chosen to attend a private consultation with their NHS consultant in order to gain more information about their condition, but wishes to remain on the NHS Waiting List, this is acceptable and does not stop the RTT clock.

4.6 NHS Provider Commissioning Private Sector Service

There may be circumstances where the Trust chooses to commission services provided by the private sector if on an RTT pathway. In this situation the RTT Pathway waiting time would continue with GOSH remaining accountable for the delivery of the RTT pathway standards.

4.7 Overseas patients – wishing to access NHS Services

Patients who are identified as overseas visitors must be referred to the Overseas Visitors Manager ext: 8859 for clarification of status, regarding entitlement to NHS treatment. This must be done as early as possible after referral and in every case before the patient is seen.

Appointments can be made if the following apply:

- They are resident in the UK on a legal, settled and permanent basis for the time being and can provide evidence to prove it.
- They are from an EU country and have sought permission from their local social insurance to access NHS treatment via the E112 or S2 route.
- Appointment is consider immediate or urgent by the consultant who will need to complete the advice from doctor tick box form (patient will be invoiced afterwards).
- Payment is made up-front for non-urgent appointments

Appointments MUST NOT be made in the following circumstances:

- Appointment is non-urgent (unless payment is made up-front)

4.8 Managing referral letters

The Trust and Primary Care Organisations will continue to work together to ensure all referrals are appropriate for the services the Trust provides. Referrals should be made to a service rather than a named clinician wherever possible and be aligned with the national agenda regarding patient choice.

As GOSH is a specialist tertiary centre, it is critical that its capacity is utilised for this purpose. As a result, all services MUST develop clear and concise referral criteria and rigorously apply these criteria at the time of grading. All referrals which do NOT fit within these criteria must be sent back to the referrer, together with a copy of the referral criteria upon which the decision has been made.

Post should be opened daily and all referrals should be date stamped immediately and registered onto PiMS within **24 hours (one working day)** of receipt of referral.

Clinical grading and completion of the Referral Monitoring Form (RMF) by the clinician must take place within **48 hours (two working days)** of receipt of referral.

If a patient has been referred to the incorrect service, the patient must be transferred to the correct consultant/team within **72 hours (3 working days)** of receipt by the hospital.

The Central Booking Office (CBO) will call the patient/family within **five working days** of receipt of the RMF to confirm the date of the appointment, providing two reasonable offers.

Consultant annual leave, study leave or sickness must not delay the review of referral letters; Divisions must work with the consultants to ensure there are contingency arrangements to cover periods of leave.

4.9 Pre-Operative assessment

Where Pre-Operative Assessment is required patients should be pre-operatively assessed as soon as possible after the decision to admit (DTA) is made to ensure the patient is fit for the procedure.

Patients will only be added to the waiting list if there is an expectation of treating them and the patient is **fit, ready and able** to receive their treatment.

The length of time that a pre-operative assessment can be completed in advance of the TCI will be service specific and set at local level. If a patient cancels or was not brought to a pre-operative assessment the same rules apply as for inpatient was not brought /cancellations.

4.10 Adherence to policy

It is the responsibility of all managers/supervisors working in elective care and also clinicians who hold a waiting list to apply the principles detailed in this policy in all decision making.

If any clinician considers that the application of this policy compromises an individual patient's care, then that clinician can appeal to the Clinical Access Group. The groups' decision is final. This right of appeal only extends to individual patient circumstances and cannot be used as a blanket appeal against the sections of this policy.

The Performance Monitoring team will routinely monitor the appropriate application of this policy. This will be achieved by an audit programme, which will see a sample of 100 patients reviewed each quarter with the results being reported to the Director of Operational Performance and Information.

Where issues arise with any member of staff in complying with the policy, the issue will be resolved between the Service Manager and the individual concerned. Any failure to reach agreement will be referred to the appropriate Divisional Director of Operations and Director of Operational Performance and Information. Failure to reach agreement at this stage will be referred to the Deputy Chief Executive Officer.

Section 5

5.1 References

Department of Health - Referral to treatment consultant-led waiting times - Rules suite (October 2015)
NHS Improvement - 2017/18 and 2018/19 National Tariff Payment system guidance
NHS Improvement - Single Oversight Framework guidance
Was Not Brought Policy
Department of Health Guidance on Implementing the Overseas Visitors Hospital Charging Regulations

The NHS Data Dictionary

http://www.datadictionary.nhs.uk

The NHS Constitution

http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf

Diagnostic FAQ's
http://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/

GLOSSARY

A

Active monitoring	A patient's RTT clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage. A new clock would start when a decision to treat is made following a period of active monitoring (in previous guidance also known as watchful waiting). This would not be a new referral – it will be a continuation of the initial referral. Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to refer the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such and also stops a clock. If a patient is subsequently referred back to a consultant-led service, then this referral starts a new clock.
Admission	The act of admitting a patient for a day case or inpatient procedure
Admitted pathway	A pathway that ends in a clock stop for admission (day case or inpatient)

B

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

C

Care Professional	A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
Clinical decision	A decision taken by a clinician or other qualified care professional, in consultation with the patient and with reference to local access policies and commissioning arrangements.
Consultant	A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. The operating standards for Referral to Treatment exclude non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.
Consultant-led	A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.

D

Decision to admit	Where a clinical decision is taken to admit the patient for either a day case or inpatient treatment
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

F

First definitive treatment	Any intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.
Fit, willing and able	A new patient pathway and clock should start only once the patient is fit, willing and able, which 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.

I

Incomplete pathway	Patients on an incomplete pathway, meaning they have not yet had a clock stop
Interface service (non consultant-led interface service)	The operating standard/right relates to hospital/consultant-led care. Therefore, the definition of the term 'interface service' within the context of the operating standards does not apply to similar 'interface' arrangements established to deliver traditionally primary care or community provided services, outside of their traditional (practice or community based) setting. The definition of the term does not also apply to: • Non consultant-led mental health services run by Mental Health Trusts. • referrals to 'practitioners with a special interest' for triage, assessment and possible treatment, except where they are working as part of a wider interface service type arrangements as described above.

N

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 <u>not</u> take overall clinical responsibility for the patient.

P

PiMS	Patient Information Management System

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 A reasonable offer is an offer of a time and date three or more weeks from the time that the offer was made. If patients decline two such offers and decides to wait longer for their treatment, then they will be discharged back to the referring clinician
Referral to Treatment period	The part of a patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other clock stop.
Referral Management or assessment Service	Referral management or assessment services are those that do not provide treatment, but accept GP (or other) referrals and provide advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient. Referral Management and Assessment Services should only be in place where they carry clinical support and abide by clear protocols that provide benefits to patients. They must not be devices either to delay treatment or to avoid having clinical discussions with GP practices about good referral practice. In the context of the operational standards, a clock only starts on referral to a referral management and assessment service where that service may onward-refer the patient to a surgical or medical consultant-led service before responsibility is transferred back to the referring health professional.

S

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

T

TCI Date	To Come In Date, planned admission date.
Therapy or Healthcare science intervention	Where a consultant-led or interface service decides that therapy (for example physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science (e.g. hearing aid fitting) is the best way to manage the patient's disease, condition or injury and avoid further interventions.

U

UBRN (Unique Booking Reference Number)	The reference number that a patient receives on their appointment request letter when generated by the referrer through Choose and Book.

	The UBRN is used in conjunction with the patient password to make or change an appointment.

W

Was Not Brought	Refers to DNA of children up to 18 years of age and vulnerable adults.

Appendix 1 – Equality Impact Assessment

Title of Document:	Patient Access Policy: Elective Care
Completed By:	Head of Performance
Date Completed:	2017
Summary of Stakeholder Feedback:	Feedback received from a range of stakeholders (both internal and external) and not specific issues raised

Potential Equality Impacts and Issues Identified		
Protected Group	**Potential Issues Identified**	**Actions to Mitigate / Opportunities to Promote**
Age	Section 1.2 addresses the age of patients this is applicable to	Section 1.2 provides guidance via the Medical Director / Chief nurse
Disability (Including Learning Disability)	The policy may not be easily understood.	Develop a version that is more accessible during 2018
Gender Re-Assignment	No specific equality issues identified for this group	-
Marriage or Civil Partnership	No specific equality issues identified for this group	-
Pregnancy and Maternity	No specific equality issues identified for this group	-
Race	No specific equality issues identified for this group	-
Religion or Belief	No specific equality issues identified for this group	-
Sex	No specific equality issues identified for this group	-
Sexual Orientation	No specific equality issues identified for this group	-

Appendix 2

INTER-PROVIDER ADMINISTRATIVE DATA TRANSFER MINIMUM DATA SET:

Completion **mandatory** for all patients where there has been a transfer of clinical responsibility to an alternative provider.

Referring organisation to complete and send within 48 hours of decision to refer.

FOR REFERRING ORGANISATION	
Referring organisation name: 1	Referring organisation code: 2
Referring clinician:	Referring clinician registration code: 4
• Contact name: 5	• Contact phone: • E-mail: • 6
• **Patient details**	
Patient's family name: 7	Patient's fore name: 8
Title: 9	Date of Birth: 10
NHS number: 11	Local patient identifier: 12
Correspondence address: Post code: 13	Contact details (optional): Patient □ Name of lead contact if not the patient: **1.** Home: Work Mobile: E-mail 14
GP details	
GP name: 15	GP practice code: 16
Is the patient eligible under the definition of an 18 Weeks RTT pathway? Yes □ No □ (if no - do not complete items 18 - 21) If yes - is this referral part of an existing pathway or the start of a new pathway? Existing □ New □ 17	

<table>
<tr><td>Unique pathway identifier (where available):

2. Allocated by (organisational code):
3.
4.
5. (Organisation that received the original referral that started the clock)
6. 18</td><td>Clock start date:

(Date the patient started on the existing pathway or the date of this referral if it starts a new pathway)
19</td></tr>
<tr><td>Date of decision to refer to other organisation:

(Required for existing pathways only)
20</td><td>For existing pathways only:

Not yet treated □
Treated □
Active monitoring □
21</td></tr>
<tr><td colspan="2">• Receiving Organisation details</td></tr>
<tr><td colspan="2">Receiving Organisation Name:
22</td></tr>
<tr><td>Receiving Clinician:
23</td><td>Receiving treatment function (speciality/department):
24</td></tr>
<tr><td colspan="2">Date and time MDS sent:
25</td></tr>
<tr><td colspan="2">FOR RECEIVING ORGANISATION</td></tr>
<tr><td colspan="2">Date/time received:

26</td></tr>
</table>

Appendix 3

<Insert date>

Dear <Insert Patient Name>,

<Insert Patient Name> has been referred to Great Ormond Street Hospital to be seen by <insert specialty>, We have been trying to contact you <Insert Patients telephone number> to book an appointment for<Insert Patients name>. Unfortunately, we have been unable unable to make contact.

If you would like <Insert Patients name> to be seen in the <insert department/clinic> please call us on <Department contact details/booking team> so we can arrange an appointment.

If we do not hear from you within two weeks of the date of this letter, we will assume that you no longer wish <Insert Patients name> to be seen and we will discharge them from the <insert department/clinic>

Yours sincerely,

< insert department/clinic>

Appendix 4

Prospective Clinical Review Process

This paper outlines the processes being undertaken at Great Ormond Street Hospital for Children (GOSH) in relation to those pathways (patients) that exceed: the national 18 week referral to treatment waiting time for elective treatment; diagnostic tests / scans wait times standard; cancer pathway standards and planned treatment pathways with admit by dates.

In order for the review to be completed, the clinician will require the following information (if required):

- Patients medical records
- Correspondence from the most recent patient activity
- Completed CHR form (for patients waiting over 40 weeks or where the clinician completing the review does not know the patient)

Referral to Treatment

Pathways 18 – 39 weeks

1. For pathways that exceed 18 weeks, these pathways are reviewed by the local Consultant responsible for the patient's care (in conjunction with the Service Manager) to ensure that there is to be no clinical consequences as to the delay in their care, and that there is a care plan in place to ensure they are seen and treated as promptly as possible.

2. At the Divisional PTL meetings, on reviewing the pathway level PTL, the Divisional Management Team will ensure all pathways over 18 weeks have been reviewed.

3. In the Trust-wide PTL meeting, the Divisional Management Teams will report by exception any pathways that have not been reviewed and actions being taken to address, or where a review has been undertaken and action is required to expedited a particular pathway which is waiting over 18 weeks.

Pathways > 40 weeks

4. For any pathways that exceed 40 weeks, these are escalated to the Divisional Clinical Chairs to review, and are reported via Datix. Action plans are then agreed to ensure that the pathway is expedited and treatment initiated as soon as possible (with dates confirmed no later than 4 weeks hence).

5. The Clinical Review Group (CRG) will oversee the outcomes of those pathways reported on Datix, which exceed 40 weeks, and where necessary intervene / act as a point of escalation for where a pathway will not be completed within 52 weeks.

Pathways > 52 weeks

6. All confirmed patients waiting over 52 weeks will be clinically reviewed by the Divisional Chairs, and referred to the CRG for review which will be chaired by the Medical Director.

Diagnostic Waits

7. Where patients are additionally on a six week diagnostic pathway, and this wait time is exceeded, then these are reviewed at a local level, and the diagnostic test / scan is undertaken as expediently as possible

Cancer Pathways

8. Any patients that exceeds the requisite waiting time for treatment (which typically for GOSH are 31 day pathways for decision to treat to first treatment, or subsequent treatment pathways), will have been escalated to the Divisional Chair, and will have a Root Cause Analysis (RCA) completed which is submitted to the CRG (in conjunction with these being entered onto Datix).

9. Once this process is completed, the RCA together with the outputs of the discussion will be shared at the Clinical Quality Review Group (CQRG).

10. As matter of routine via the local and Trust-wide Cancer PTL, all pathways are tracked weekly, in addition to the condition specific clinical Multi-Disciplinary Team reviews.

Planned Pathways

11. Patients that are on planned pathways that exceed their "admit by date (ABD)" are reviewed locally by the Consultant to ensure the planned ABD is clinically appropriate. Potentially and if clinically appropriate, this could be altered to reflect the patient's needs (in line with the Access Policy). If not, the patient is placed on an active elective RTT pathway. At this time the patient is reviewed to ensure that there are no clinical consequences due to the delay (this will include the patient's current clinical priority).

Outpatient Appointments passed their 'required appointment date' (RAD)

12. Patients that are identified on the outpatient booking list as requiring a follow up appointment who have exceeded their 'required appointment date' (RAD) will be reviewed locally by the Consultant to ensure that the RAD is clinically appropriate. If not and if clinically appropriate to do so, it could be altered to reflect the patients clinical needs.

13. If the patient waits longer than 18 weeks after their RAD, the local Consultant responsible for the patient's care (in conjunction with the Service Manager) will ensure that there are to be no clinical consequences as to the delay in their appointment, and that there is a care plan in place to ensure they are seen as expediently as possible.

14. For any pathways that exceed 40 weeks beyond their RAD, then these are escalated to the Divisional Clinical Chairs to review, and are reported via Datix. Action plans are then agreed to ensure that the pathway is expedited and treatment initiated as soon as possible.

15. All confirmed patients waiting longer than 52 weeks from their RAD will be clinically reviewed by the Divisional Chairs, and referred to the CRG for review for review which will be chaired by the Medical Director.

Quality assurance / Consistent review of outputs

16. Although the clinical review process requires input from a large number clinicians across the organisation, the Trust is committed to ensure a consistent approach to clinical review is completed across the Trust. As such the following actions will be completed to ensure consistency across all areas.

17. Divisional teams will be required to collate and record details of the clinical reviews completed at all levels of the process and feedback details to the Elective Care Steering Group on a monthly basis, detailing volumes and any themes that have been highlighted as a result of the exercise.

18. As part of a peer to peer assurance process, each Divisional Chair (or nominated deputy) will undertake a sample review of the outputs of the clinical harm reviews completed within each group for the other Division to ensure consistency. This will initially be based on a 5% sample of reviews completed, however should any inconsistency be found, the sample volume will be

increased as necessary. The outputs of these will be presented back to the Medical Director as part of the CRG on a monthly basis.

Inter-provider referrals into GOSH

19. The Trust will triage referrals in line with the Access Policy. In circumstances where a patient has been referred late, or beyond breach, it will be the responsibility of the clinician seeing the patient to determine any clinical harm that may have occurred as a consequence of a delay in management from the referring organisation. Any deemed to have had their care / condition affected as a consequence of the delay will be escalated to the CRG and this will then be escalated to the referring Hospital.

20. As a matter of routine, GOSH will share with NHS England (as lead commissioner) any patients that are referred in excess of 18 weeks, and will escalate any that are received >52 weeks.

Appendix 5

Cancer Services Access Policy

[being updated – will be refreshed in January 2018]