Patient Access Standard Operating Procedure Manual

University Teaching Trust

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1.0 WHO SHOULD READ THIS DOCUMENT?

This operating manual is intended to be of interest to and used by all individuals working in Salford Royal NHS Foundation Trust (SRFT) services who organise patient access for hospital or community treatment, with a responsibility for:

- referring patients
- managing referrals
- adding to and maintaining waiting lists

The principles of the policy apply to both medical and administrative waiting list management.

2.0 KEY PRACTICE POINTS

2.1 This operating manual details how patients will be managed administratively at all points of contact within SRFT and should be read in conjunction with the overarching Patient Access Policy.

2.2 The operating manual has been developed to ensure SRFT provides a consistent, equitable and fair approach to the management of patient referrals and admissions that meets the requirements of the NHS Operating Framework and the commitments made to patients in the NHS Constitution.

2.3 **The NHS Constitution** states that patients can expect to start their consultant led treatment within a maximum of 18 weeks of referral for a non-urgent condition. Patients with more urgent conditions, such as cancer or heart disease, will be seen and treated more quickly.

3.0 BACKGROUND/ SCOPE/ DEFINITIONS

This operating manual details the overall expectations of SRFT for the management of referrals and admissions into and within the organisation and describes the processes to be undertaken.

4.0 WHAT IS NEW IN THIS VERSION?

Record of Changes to Document – Issue Number: 6.0 - SOP				
Changes approved in this document by - MISG				27 01 6
Section Number	Amendment ***(shown in bold italics)***	Deletion	Addition	Reason
7.12.1			DNA Urgent Referrals All clinical urgent patients will be routinely offered a further appointment if they DNA their Initial appointment. The new RTT clock will commence on the date the patient agree to the further appointment.	
6.8.1	Where no MDS has been received after a further 2 weeks despite the actions the clock start will then be recorded as /reported as the date it was received in the Trust			
6.17.1		The 18 week clock will continue to tick		
9.12		If a provider receives a referral and the patient is unable to attend any appointment within 14 days, the provider should inform the GP of the situation and advise the clock will be re-started from when the patient is available, rather than cancelling the referral and asking the GP to re-refer as in the spirit of the overarching		

		CWT rules (4.1, 4.1.1 and 4.11).		
5.1.1Sources of referral that commence a clock			Example 5 - Mr D was contacted by the hospital and a further appointment arranged [new RTT clock start on the date that the patient agreed to the new appointment (rebooking of the new appointment takes place).	Alterations to rules

5.0 POLICY/ GUIDELINE/ PROTOCOL

The successful management of patients who wait for non-urgent outpatient appointments and elective treatment is the responsibility of a number of key individuals and organisations including: NHS England, General Practitioners (GP's), Hospital doctors, Clinical Commissioning Groups (CCG's) and Trust staff. Commissioners must ensure that long-term service agreements are established with sufficient capacity to ensure that no patient waits more than the guaranteed maximum time. Failure to commission and commit resources to funding adequate capacity will lead to longer waiting lists and times.

With the introduction of "Patient Choice" the balance between patient referrals and additions to waiting lists may cause unpredicted increases or decreases in the demand for services.

Trust staff have an important role in managing waiting lists effectively. Treating patients and delivering a high quality, efficient and responsive service ensuring prompt communications with patients is a core responsibility of the Trust. Trust staff must promote a safe, clean and personal service.

The accuracy of published data is of paramount concern to the Trust. In support of data accuracy all transactions made in iSOFT Patient Centre/CRIS will be performed by staff in accordance with the training manual. This will be given to staff on completion of their relevant training course and prior to access rights being issued. An up to date document is available on the Trust's Intranet.

To ensure consistency and the standardisation of reporting, all waiting lists are to be managed within the iSOFT Patient Centre /CRIS. E-REFERRAL SYSTEM TAL slot issues will be managed on E-REFERRAL SYSTEM until capacity has been identified and the booking can be made in iSOFT Patient Centre. Manual card systems must **not** be used within the Trust.

5.1 REFERRAL TO TREATMENT GUIDANCE OVERVIEW

Since March 2008 the concept of waiting times for the different stages of treatment (outpatient, diagnostic, and inpatient) was replaced by 18-week Referral to Treatment pathway (RTT). RTT is concerned with the patient's journey from referral to first definitive treatment rather than measuring the time spent waiting at different stages of the pathway.

The 18 week standard applies to elective pathways that do or might involve medical or surgical consultant-led care. The decision as to whether or not an 18-week clock commences is dependent on who makes the referral and into what type of service.

5.1.1 Sources of referral that commence a clock

Clock Starts

An 18-week clock starts when any care professional or service make a referral to:

- 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 GP
- 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 professional or general practitioner

Note: Referrals to a consultant led service, undertaken on their behalf by Nurse Specialists / Allied Health Professionals are included in the 18-week pathway.

All aspects of the patient pathway must be concluded within 18 weeks including investigations and diagnostics. This may also include non-consultant led services as long as the patient is remaining under the care of a consultant and this is part of the patient's 18-week pathway.

The "clock" stops at the point at which the patient receives their first definitive treatment or a clinical decision is made that treatment is not required.

Upon completion of an RTT pathway a new RTT clock starts:

a) When a patient becomes fit and ready for the second of a consultant-led bilateral procedure

Example 1

⏱	*Mr A is referred to a consultant ophthalmologist and books an appointment through E-referral system [RTT clock start].* *After seeing his consultant as an outpatient it is agreed that he would benefit from operations on both eyes to remove cataracts. He is admitted for a day case procedure on his left eye to remove a cataract a few weeks later [RTT clock stop]. After a short period of recovery, Mr A contacts the hospital to arrange a time for the operation on his right eye to be performed [new RTT clock start]. The procedure is undertaken a few weeks later [RTT clock stop].*

b) Upon decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan

Example 2

⏱	*Mr B was referred to an orthopaedic consultant suffering from frozen shoulder.* *The consultant recommended a course of physiotherapy to see if this alleviated the symptoms. Following the course of physiotherapy Mr B's frozen shoulder was no better and at a follow-up outpatient appointment it*

	was agreed that surgical procedure was needed to treat this condition. In this scenario, the physiotherapy was intended to be definitive treatment and would have stopped the new RTT clock. Unfortunately the physiotherapy did not relieve Mr B's symptoms so further intervention was required. When it was agreed that surgery was necessary this would start a new RTT clock which would stop when the patient was admitted to have the surgery carried out.

c) Upon a patient being re-referred into a consultant-led service as a new referral

Example 3

	Some time ago, Mrs C was referred by her GP [RTT clock start] to a consultant physician who prescribed a course of medication and provided the GP with a treatment plan for management of her condition in primary care [RTT clock stop]. *Recently, Mrs C's condition has worsened and her GP felt it necessary to refer her back to the consultant for further opinion [new RTT clock start]. In this instance a new RTT clock would start on the date that the provider receives Mrs C's referral.*

d) When a decision to treat is made following a period of active monitoring

Example 4

	A child in a family at risk of familial breast cancer is referred to the genetics service for pre-symptomatic testing. *It is not appropriate to proceed until the child is old enough to consider the implications of having genetic test for themselves as there is no risk until they are an adult [RTT clock stop as active monitoring or alternatively treatment not required]. A new RTT clock will start at the point it becomes appropriate for the service to see the patient, or where a new referral is made by the patient's GP if the patient had been discharged back to the care of their GP.*

e) When a patient rebooks their appointment following a new appointment DNA that stopped and nullified their earlier RTT clock (see section 6.17)

Example 5

	Mr D was referred by his GP to a consultant rheumatologist, however on the day of his appointment due to unforeseen circumstances he was unable to attend [RTT clock nullified]. The consultant was concerned that if Mr D was not seen his condition could have significant detrimental consequences so he should be offered another appointment. Mr D was contacted by the hospital and a further appointment arranged [new RTT

	clock start on the date that the patient agreed to the new appointment (rebooking of the new appointment takes place).

5.1.2 Clock stops

- First definitive treatment - the clock stops on the date that the patient receives the first definitive treatment intended to manage his or her condition.
- For inpatient or day case admission, the clock stops on the day of admission (ensuring first definitive treatment is given). For treatment provided in an outpatient setting, the clock stops on the day the patient attends.
- Clinical decision that treatment is not required - the clock stops on the date that the clinical decision is communicated to the patient.
- Patient choice to decline treatment - the clock stops on the date that the patient declines treatment having been offered it.
- Active monitoring - the clock stops on the date that the clinical decision to commence active monitoring is made and is communicated to the patient.
- Decision to return the patient to primary care for non-medical/surgical consultant-led treatment in primary care. The clock stops on the date that this is communicated to the patient.

Example 6

	Mr D is seen by the Cardiologist and given a diagnosis of an aortic aneurysm. Mr D and the Consultant discuss the possibility of surgery but it is agreed that at this stage it is too small for surgery. The patient is therefore put on a period of active monitoring. During this time regular ultrasound tests will be carried out to measure the size of the aneurysm and life style changes (weight, exercise) are addressed to minimise the risk of rupture to the patient (which would then result in emergency surgery). As the risk of death from surgery is higher than the risk of death from a rupture, not all aneurysms result in surgery and this patient may be monitored and then perhaps discharged back to the GP, or if the aneurysm increases in size then surgery will be required.

Example 7

	Mrs R is referred to general medicine with undefined respiratory disease. The consultant has no clear plan of treatment and wants to monitor the patient before any intervention. There are two options; to discharge back to the GP for monitoring (clock stop) or to start a period of active monitoring, with the patient having a follow up appointment in 3 months' time, but to contact the hospital before if her condition deteriorates.

Example 8

	Mr C visited his GP suffering from a painful shoulder. The GP refers Mr C for a course of physiotherapy. The physiotherapist service is based within a

	secondary care hospital. *In this case there is no waiting time clock started as Mr C is referred direct to physiotherapy and not to a consultant-led service. Were the GP to refer Mr C to see an orthopaedic consultant who subsequently recommended physiotherapy treatment, a waiting time clock would have started at referrals and stopped when physiotherapy treatment was provided.*

5.1.3 Active Monitoring

A clinical decision is made to start a period of active monitoring i.e. in many pathways there will be times when the most clinically appropriate option is for the patient to be actively monitored over a period of time, rather than to undergo any further tests, treatments or other clinical interventions at that time. When a decision to commence period of active monitoring is made and communicated with the patient, then this stops a patient's 18 week clock.

Active Monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made. If such a decision has been made but subsequently it becomes apparent that there is a clinical reason to delay treatment/admission then an 18 week clock would usually continue.

Any instances where the clinical reason for a delay means that the patient waits over 18 weeks would constitute a clinical exception to 18 weeks, which are reflected in the tolerance for 18 weeks.
Patients may initiate the start of a period of active monitoring themselves i.e. by choosing to decline treatment or see how they cope with their symptoms. However, patient initiated active monitoring should not be applied where a patient asks for "thinking time" and wants to delay the next stage of their pathway for a short time (e.g. a few days). Only where the patient is wishing to delay their treatment for two weeks or longer should a patient initiated active monitoring be applied.

Active monitoring can only be used for a patient where there has been a diagnosis of cancer and this is recorded as a form of treatment as opposed to a patient with suspected cancer.

5.1.4 Inter Provider Transfer Administrative Dataset (IPT)

The purpose of the IPT minimum data set (MDS) is to ensure that the RTT administrative data required for a patient pathway (required by the DSCN 17/2006) is passed onto the receiving provider/service where the patient's care has been transferred to.

	Tertiary referrals cannot be rejected because of an impending or past RTT breach date.

All internal and external referrals must be accompanied with an IPT MDS.

5.2 DIRECT ACCESS - AUDIOLOGY

The national audiology clock rules apply to any direct-access referral into audiology services providers. This includes patients who have a newly diagnosed hearing loss and those who are returning for reassessment and the provision of an upgraded hearing aid. Direct access means referral into non-consultant services.

Patients referred to audiology provider services from any consultant-led service follow the RTT rules and are therefore not included in the direct-access audiology collection.

5.2.1 Clock Start (also see point 5.1.1)

When any non-consultant led health professional or service make a direct-access referral to an audiology department 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.

5.2.2 Clock Stops (also see point 5.1.2)

A direct-access audiology clock stops on the date that it is communicated to the patient and subsequently their GP and/or other referring practitioner as appropriate that first definitive non-consultant-led audiology treatment has begun.

Treatment includes:

- the fitting of a medical device
- hearing aid reprogramming
- wax removal (if it is the definitive treatment)

Non Treatment includes:

- referral to a consultant led service
- returning the patient to primary care
- active monitoring (see 5.1.4)
- patient declines treatment
- clinical decision made not to treat and this is communicated to the patient

6.0 OUTPATIENTS

6.0 RECEIPT & REGISTRATION

6.1 Pre Referral Diagnostics

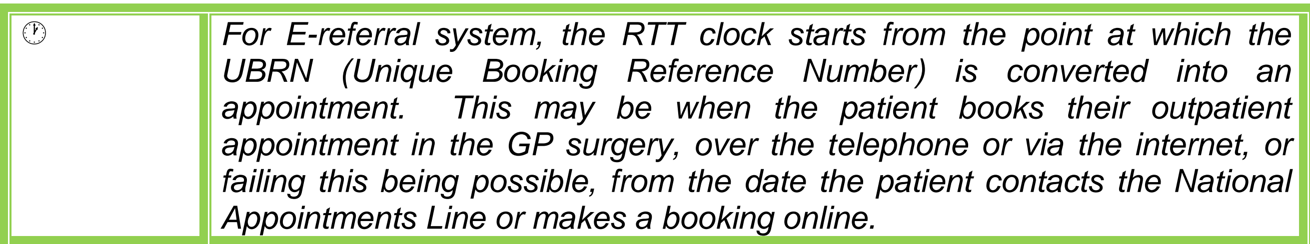
Patients who require a diagnostic investigation prior to their appointment should be seen by the consultant within an agreed date calculated from the date the original letter is received as monitored via the OP/RTT pivot. In some cases there has been a patient pathway agreed between clinicians in primary and secondary care that allows for the diagnostic investigation to be considered formally as the first consultant appointment. In these instances, the patients follow a pathway that may or may not result in a face to face consultant appointment. A consultant led decision is made on receipt of the initial referral or immediately following the initial investigation and this may result in a protocol of options such as multidisciplinary assessment and treatment, a course of physiotherapy, or possibly a consultant opinion.

6.2 E-referral system

E-referral system (E-referral system) is the national electronic solution for clinicians to refer a patient for a first outpatient appointment. The implementation of E-referral system is now mainstream within the Trust and is the preferred option for receiving referrals.

Referral letters must be electronically attached to E-referral system by the referrer within 3-5 working days of the appointment request (decision to refer) and where the appointment is more than 5 days in advance.

For **E-referral system referrals,** the referral date is the E-referral system UBRN conversion date whether referred via the national telephone appointment line (TAL) or via the internet on NHS choices. All referrals booked under a generic consultant must be altered within one working day to the named consultant under whose care the patient will remain.



For E-referral system, the RTT clock starts from the point at which the UBRN (Unique Booking Reference Number) is converted into an appointment. This may be when the patient books their outpatient appointment in the GP surgery, over the telephone or via the internet, or failing this being possible, from the date the patient contacts the National Appointments Line or makes a booking online.

6.2.1 Rejected Referrals

Where a referral has been clearly referred into a clinically inappropriate service the referral must be rejected on E-referral system with a clear reason and possible alternative action to be taken by the referrer. A letter will be sent to patient informing them of the decision and requesting that they discuss this with their GP. A referral should not be rejected if it related to a subspecialty of the existing speciality it has been attached to.

6.2.2 Redirection

Where a referral has been booked into a clinically inappropriate clinic within a service then the referral must be redirected to the appropriate clinic. A letter will be sent to patient informing them of the decision.

6.2.3 Slot Availability

It is the responsibility of the Service Management Teams to ensure that there are 'sufficient' slots available on E-referral system to ensure patients have reasonable choice of dates and times within the agreed national/local waiting times. Service Management Teams must monitor slot availability and forward plan for any identified capacity constraints.

6.2.4 Appointment Slot Issues (ASI's)

The Access, Booking & Choice Team will also alert Service Management Teams when there are ASI's. On booking an ASI the member of staff is responsible for ensure the referral date is altered to reflect the **date the first ASI** notification was received and not the date the UBRN was converted.

The patient will be advised that the Trust has a responsibility to book an appointment for the patient, depending on the urgency which is determined by the GP. The Trust will endeavour to contact the patients within three working days of the patient being added to the ASI E-REFERRAL SYSTEM worklist and must wherever possible, book the appointment via E-REFERRAL SYSTEM. Only under exceptional circumstances, should the request be cancelled and booked manually, and certainly not without consultation with the patient.
This will be monitored via the Trust's Out Patient waiting list pivot and escalated via the Divisional Access & Performance meetings.

6.2.5 Polling Range

The maximum polling ranges for slot availability on Choose & Book will managed by the Lead Manager, Access Booking and Choice with the agreement of the Service Management Team in line with national/local guidelines on waiting times.

6.2.6 Directory of Services (DOS)

The Lead Manager, Access, Booking and Choice will manage the Trust's DoS on E-referral system. Clinical Directors will be responsible for reviewing and signing off the DoS on an annual basis or when a service changes. The DoS must provide a clear description of the service and the clinics provided.

6.3 PAPER REFERRALS

All referral letters **MUST** date stamped on receipt into the organisation where possible. **All referrals should be too emailed to refertosalfordroyal@nhs.net.**

All paper referrals need to be registered on iSOFT Patient Centre within one working day of receipt to the designated registering service for each speciality to the date of receipt as designated above.

Referrals received directly by a service or Consultant/Clinician must be date stamped and sent to the designated registering service immediately e.g. the Call Centre at SRFT (hand delivered to avoid delay if possible).

Registrations of referral must be recorded as either:*

- GP with a referral source of PGP
- Tier 2 Allied Health Professional with a referral source of PHT
- Internal tertiary referrals with a referral source of TCO
- External tertiary with a referral source of OTC
  - When registering these the Trusts NAC's code should be entered into 'Referral Comments' field on iSOFT Patient Centre e.g. RM3 See section 14 appendix 2 for recording format
- A&E with a Referral source of AE
- Other with a Referral sources of OTH e.g. DVLA, Prisons
- Dentists with a referral source of GDP
- Self-Referral with a Referral Source of SR

*This list is not exhaustive

All referrals will say YES to the 18 week prompt with the exception of the following:

- Contact Dermatitis Investigation Unit (CDIU)
- Live Donors
- Heart Failure
- Ward Discharges
- Cerebral Function Unit

6.4 REFERRAL / REQUEST DATE

The referral date for patients on a new 18 week pathway is the date on which the **paper referral** is received into the organisation **not** the service.

For patients on an existing 18 week pathway the referral date is the date indicated on the 18 week minimum data set (MDS) on the **Inter Provider transfer Form (IPT) with 'Latest 18 week clock start date'**.

The original clock start date from the referring provider will continue from their existing pathway until the patient receives their first definitive treatment. This must be updated on the iSOFT Patient Centre within 2 working day of registration.

For patients **not** on an 18 week pathway the referral/request date is the date the referral/request is received into the organisation.

6.4.1 Inappropriate referrals/requests

If the referral/request is for a service not provided by the Trust then the referral/request must be returned to the original referrer with advice. The Booking office must be informed and the referral/ request closed off on iSOFT Patient Centre.

6.4.2 Mismatch of Consultant Interest and patient needs

If a referral has been made to an individual who does not have the necessary skills for the needs of the patient, the professional prioritising the referral should re-route the referral to an appropriate colleague prior to seeing the patient.

6.4.3 Insufficient/illegible clinical & demographic information

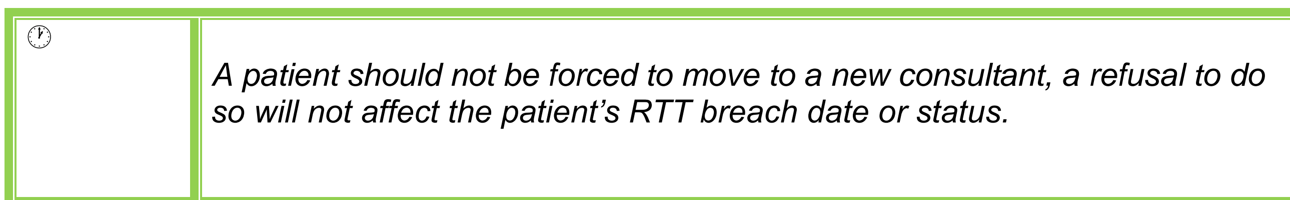
If the referral/request does not provide sufficient/illegible information for the health care professional to make a decision, the letter should be returned to the original referrer.

6.4.4 Accept and reject referrals

All referrals must be accepted or rejected by the receiving clinical team within one working day. Clinical teams have a responsibility to see any patients that are booked into the wrong clinic or service where the referral was not accepted or rejected by their clinical team on E-referral system.

6.4.5 Named Consultants

Once a patient has chosen a specific provider or consultant to treat them this can only be altered with the patient's agreement (unless the change is due to ill health, retirement or it is not clinical appropriate).



A patient should not be forced to move to a new consultant, a refusal to do so will not affect the patient's RTT breach date or status.

6.5 EPR / SCANNING OF REFERRALS

6.5.1 E-referral system

All referral letters will be moved using WINDIP (drag & drop functionality) into EPR prior to the patient's appointment date and as part of the clinic preparation.

6.5.2 Paper referral

All patients, where applicable, will have their referral letter and accompanying MDS bar coded and scanned at the point of registration onto EPR. A second scan of the letter will be added once it has been triaged and prioritised.

6.6 TRIAGE

All patients will have their referral triaged and prioritised by an appropriate clinician. This must be carried out within **one** working day. Clinical directorates must have arrangements in place for reviewing referrals to meet the timescales.

Departments managing their own referrals must ensure they adhere to the same one working day time scale.

6.7 DETERMINING PRIORITY

All patients who are added to a waiting list must be given a clinical priority of either Urgent or Routine

6.7.1 Urgent - Any urgent referrals/requests must be allocated an appointment within 4 weeks.

6.7.2 Routine - on receipt of a referral/request patients will be booked an appointment within the current waiting times target.

6.8 IPT/MDS FORMS – TERTIARY REFERRALS

The purpose of the IPT minimum data set (MDS) is to ensure that the RTT administrative data required for a patient pathway (required by the DSCN 17/2006) is passed onto the receiving provider/service when the patient's care is transferred. The responsibility for ensuring the MDS is provided with an onward referral lies with the medical secretary typing the referral letter.

For patients on an existing 18 week pathway the referral date is the date indicated on the 18 week minimum data set (MDS) on the **Inter Provider transfer Form (IPT) with 'Latest 18 week clock start date'**.

	For referrals from a GP the RTT clock starts when the referral letter is received by the secondary care provider. For tertiary referrals the patient's RTT clock status and breach date must be provided on a Minimum Data Set (MDS) form from the referring hospital. For referrals within secondary care that start a new pathway, the RTT clock starts at the point the receiving organisation receives the referral.

6.8.1 Escalation for missing MDS data for incoming referrals

All referrals to SRFT from secondary care providers or from a primary care interface service must be accompanied by an MDS. In the absence of a form the MDS administrator will follow the escalation process.

- **Stage 1**

The administrator will contact the referring organisation to request the MDS data where not provided with the referral.

- **Stage 2**

Where no MDS form is received within 2 weeks of the initial request a further request for the MDS form will be made by the administrator.

- **Stage 3**

Where no MDS has been received after a further 2 weeks despite the actions above the clock start will then be recorded as /reported as the date it was received in the Trust

	When a patient is referred onward their RTT status and breach date remain the same. If the referral is for a new condition or significantly different treatment for an existing condition a new RTT clock will start.

6.8.2 Escalation for missing MDS data for internal/subspecialty referrals

- **Stage 1**

The administrator will email the Service Management Team to request the MDS data where this is not provided with the referral.

Note: MDS forms should be printed and sent with the referral to OP Call Centre or administration responsible for registering referrals.

- **Stage 2**

Where no MDS form is received within 1 week of the initial request the Senior Manager will be informed.

6.9 BOOKING OF APPOINTMENTS

6.9.1 Booking system – to ensure "patient choice" is offered at the first outpatient appointment and ultimately all other stages of the journey the following booking systems are used:

- E-referral system
- Full Booking
- Partial Booking
- No Patient Choice (Follow up's)
- Managed Booking

	Where it has not been possible to contact the patient the RTT clock is nullified and the patient is discharged. For the purposes of reporting no pathway is deemed to have started. A new clock would start should they be re-referred by their GP.

	Where it has not been possible to contact the patient to arrange a new outpatient consultation the referral should be removed from Patient Centre. This must be done by the person or department responsible for booking for appointment.

All patients will be given the opportunity to choose the date for their appointment. It is essential that a record of the booking type offered to the patient is completed on iSOFT Patient Centre.

6.9.2 Follow Up Appointments

All specialties must move to introduce both **managed booking and direct access clinic appointments** (follow up appointments) in order to improve patient experience.

	Where it has not been possible to contact the patient to arrange a follow-up Appointment the RTT clock is stopped when the patient is referred back to their GP. A new clock would start should they be re-referred by their GP.

	Where it has not been possible to contact the patient to arrange a follow-up appointment an RTT status of 'Decision not to treat NT34' must be recorded on Patient Centre. This must be done by the person or department responsible for booking for appointment.

6.10 PATIENT CONTACT

A patient can be contacted through a number of methods:

- **By Telephone -** Within 5 working days of receipt of the referral (or earlier where clinically indicated) the patient will be telephoned a minimum of two attempts at 2 different times before aborted.

- **By Letter -** Within 5 working days of the referral will be received (or earlier if clinically indicated a letter will be sent) if staff are unable to contacted patients by telephone.

- **Contact Letters -** A letter will be sent to the patient (after a referral is received) requesting the patient to contact the relevant booking team with 5 days to arrange a suitable appointment date & time.

6.10.1 Non Response to Contact Letters

If the patient does not respond to the invite letter within the stated time frame, they will be discharge back to their GP. A letter will be sent to the patient copied to the GP. This must be carried out by the person or the department responsible for booking the appointment.

6.11 RECORDING OF BOOKING TYPE

All appointment offers must be accurately recorded whether a patient is contacted directly by telephone or by a face to face appointment booking. When they agree to the date and time of appointment, the appointment is booked as **CHOICE YES, BOOKING TYPE 2.**

When a patient is booked by the issue of a letter with no agreement to date and time then the appointment booked is **CHOICE NO, BOOKING TYPE 0.**

Patients booked in response to a contact letter need to be recorded as **CHOICE YES, BOOKING TYPE 1.**

***NOTE: E-REFERRAL SYSTEM records ALL** patients that are recorded **as CHOICE YES, BOOKING TYPE 2** so good administrative patient contact practices are essential.*

6.12 OVER BOOKING CLINIC RULES

The over booking of a clinic needs to be authorised by either the Consultant /Clinician or Service Management Team. The authoriser's name must be recorded in the appointment comments file with any requests to book a new patient into a follow up(s) slot (or vice versa).

6.13 PATIENT CORRESPONDENCE

All patients regardless of the method of booking must be sent a letter confirming the date, time and location of the appointment within 1 working day.

For paper referrals the appointment should be booked with an appointment confirmation letter being sent within 5 working days of registration onto iSOFT Patient Centre/CRIS.

For E-REFERRAL SYSTEM referrals a letter informing the patient of their referral must be sent within 1 working day of the booking/request being received.

The letter is an audit trail of the arrangements and should contain the following core details:

- Patient's name
- Date letter is sent to patient
- Date and time of appointment agreed
- Where patient is to report to on arrival
- Any response required from the patient
- Contact number and times available for queries relating to their appointment
- Information booklet(s)
- Information about any planned treatment

6.14 REASONABLE NOTICE

A reasonable offer for **a new outpatient appointment** is an offer of a time and date **two or more weeks** from the time that the offer was made. Should a patient accept an appointment earlier than two weeks, this then becomes a reasonable offer.

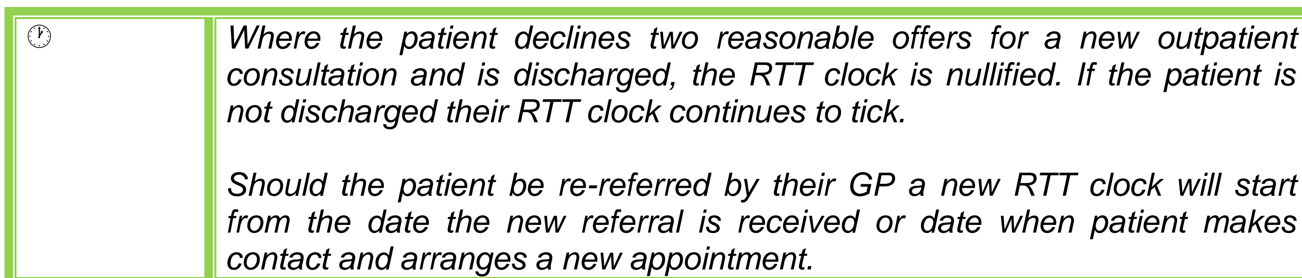
If a patient's declines two or more reasonable offers and the patient is unavailable to attend within the waiting time period then the patient must be returned to the care of their GP.

6.14.1 Patient declining two reasonable offers

Some patients will turn down reasonable appointments because they have a holiday booked or because of work commitments. A patient-initiated delay may make it unreasonable or impossible for SRFT to provide treatment within the RTT target.

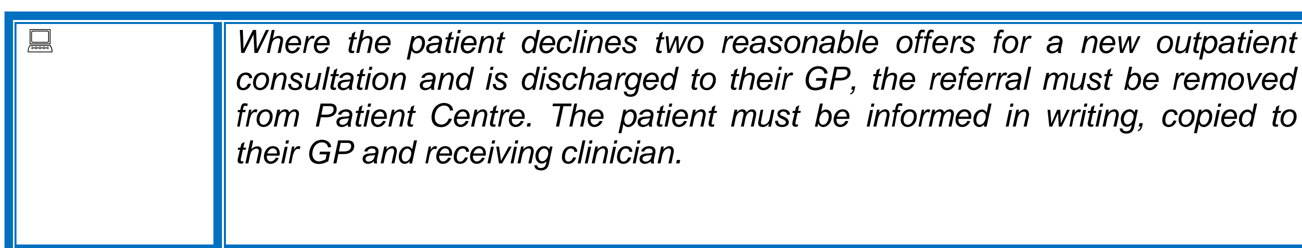
If a patient declines two reasonable offers of a date for a new appointment they will be discharged back to their GP, confirmed in a letter to the patient copied to the GP. This is responsibility of the person or department responsible for managing the referral and or booking the appointment.

***Note**: This does not relate to TWW referral please see Section 9 point 9.12 for further information*



Where the patient declines two reasonable offers for a new outpatient consultation and is discharged, the RTT clock is nullified. If the patient is not discharged their RTT clock continues to tick.

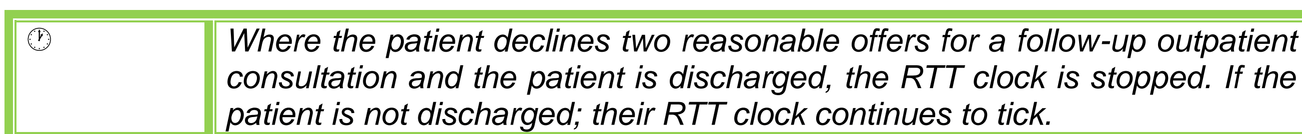
Should the patient be re-referred by their GP a new RTT clock will start from the date the new referral is received or date when patient makes contact and arranges a new appointment.



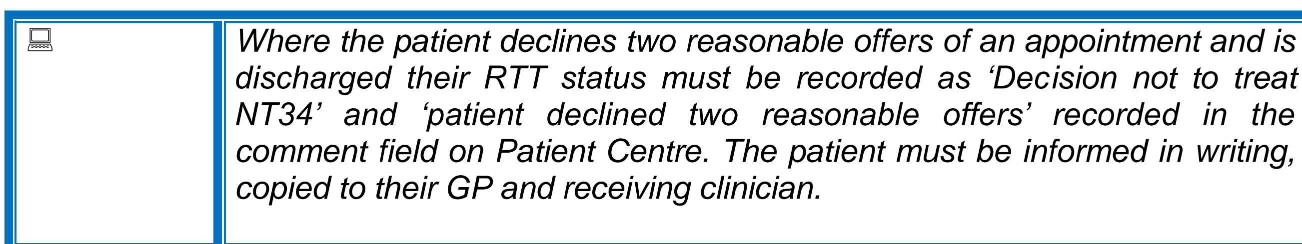
Where the patient declines two reasonable offers for a new outpatient consultation and is discharged to their GP, the referral must be removed from Patient Centre. The patient must be informed in writing, copied to their GP and receiving clinician.

6.14.2 Reasonable notice for follow up appointments

Reasonable notice does not apply to follow up appointments, however good practice would indicate that if a patient is to be given an appointment with less than a week's notice, two attempts to contact the patient by telephone to agree and inform the patient about this appointment should be made.



Where the patient declines two reasonable offers for a follow-up outpatient consultation and the patient is discharged, the RTT clock is stopped. If the patient is not discharged; their RTT clock continues to tick.



Where the patient declines two reasonable offers of an appointment and is discharged their RTT status must be recorded as 'Decision not to treat NT34' and 'patient declined two reasonable offers' recorded in the comment field on Patient Centre. The patient must be informed in writing, copied to their GP and receiving clinician.

6.15 APPOINTMENT REMINDER SERVICE

The Trust offers an appointment reminder service to patients where they will be asked if they would like to use this service at the first point they book in for their consultation. Patient consent/decline will be recorded on Patient Centre and only patients that have consented will be included in the service.

A reminder will then be issued one week prior to any further appointments and they will have the opportunity to cancel or rebook their appointment. The reminder will be delivered to either the patient's mobile telephone in the form of an SMS message or to their land line as an IVR.

A further reminder will be sent 24 hours prior to the appointment for patients with mobile telephone numbers recorded. This will **ONLY** act as a reminder, there is no facility to cancel or rebook their appointment.

6.16 ARRIVALS LATE FOR CLINIC

Patient arriving late for appointment due to unforeseen circumstances where there is clinician still in clinic must see.

For patients that arrive over 30 minutes after the allotted appointment slot the clinician should be informed of their arrival. Patients should be informed of the wait time. Patient's being brought via transport, and we are aware there are delays, must be managed in line with the agreed process attached below.

Guidance for Delays with Hospital Transport

Guidance for Delays with Hospital Transpo

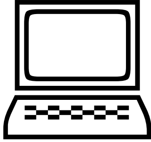
6.17 DNA's (DID NOT ATTEND)

6.17.1 New Patients*

Where a **new routine** patient has agreed an appointment/admission date with reasonable notice and this has been clearly communicated to them, then subsequently DNA's the patient will be referred back to the GP (or other referrer) and/or removed from the OP/IP/DC waiting list. Their 18 week clock will be stopped and nullified. A letter to the patient and GP will confirm this and outline the need for a re-referral if necessary.

Offer of a further appointment following a DNA may be considered by the Consultant/Clinician for urgently referred patients or patients assessed as being vulnerable.

	For DNA of a new outpatient appointment the RTT Clock is nullified. For the purposes of reporting no pathway is deemed to have started. If the patient is referred by their GP a new RTT clock will start when the new referral is received.

	*Where a patient is discharged following DNA of follow-up outpatient appointment the RTT Clock is stopped. If the patient is re-referred by their GP a new RTT clock will start when the new referral is received.*

 Paediatrics must have the following actioned as the patient is not the one responsible for not attending:

7.12.1 **DNA Urgent Referrals**
All clinical urgent patients will be routinely offered a further appointment if they DNA their Initial appointment. The new RTT clock will commence on the date the patient agree to the further Appointment.

All patients that DNA their appointment will have a DNA form completed as part of the cashing up process on the day of their appointment by the clinician they were due to see. All patients that DNA two consecutive appointments on the same registration will be discharged back to their GP/other referrer.

6.17.2 Follow-up / Review patients*

EPR will be reviewed by the Consultant/Clinician and a decision will be made as to whether the offer of a further appointment will be made. If the patient is on an 18 week pathway and offered a further appointment their 18 week clock will continue to tick.

6.17.3 Paediatrics*

A Paediatric who DNA their first appointment, their information will be reviewed by the consultant and if it is felt there is for examples no clinical risk, high need, safeguarding, then the patient will be discharged.

All other paediatric patients will be offered one further appointment

As the patient is not the one responsible for not attending the appointment, the following actions are completed:

- The GP/referrer is informed following every DNA
- Check that the demographics are correct in line with the National Spines data base
- Review to ensure the child is not subject to CPP or on the "Children in need" list prior to discharge
- Services who provide home visits also are required to follow the above in conjunction with the steps of the Unseen Child Policy

Note - All patients that DNA their appointment will have a DNA form completed as part of the cashing up process on the day of their appointment which will be reviewed by the clinician they were due to see.

All patients that DNA two consecutive appointments on the same registration will be discharged back to their GP/other referrer

	If the patient continues to DNA new appointments following a GP referral or other provider referral that starts a new clock period, and is contacted to arrange a further appointment, a new RTT clock is started each time a new appointment is arranged.

6.17.4 Pre-operative Assessment*

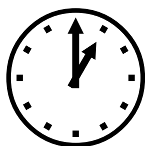
Patients who fail to attend their pre-assessment appointment will be removed from the waiting list and referred back to the care of their GP. This would stop their 18 week clock. The exception to this will be if there are compelling medical or social reasons why the patient should remain on the waiting list where a second pre-op assessment appointment will be offered (in which case, their 18 week clock would continue to tick until the patient is admitted for treatment).

* *If the patient was removed from the waiting list/pathway and the removal was later found to be a mistake, then the patient must be re-instated **without prejudice**, as if he or she has never been removed. This is achieved by deleting the incorrect cancellation on ISOFT Patient Centre.*

Any patient who DNAs a second consecutive pre-operative assessment appointment should be discharged by the responsible Clinician.

Any patient who makes contact with SRFT and cannot attend a previously agreed date for pre-operative assessment should, where possible, be given the opportunity to re-arrange.

Where re-scheduling a preoperative assessment appointment will cause a delay to a patient's agreed date for surgery this should be made clear.

	*DNA of pre-operative assessment clinic appointment does not affect RTT status or breach date; however where TCI date is known and can remain unaffected, discretion can be used in when dealing with patient DNA or non-response to contact letters.*

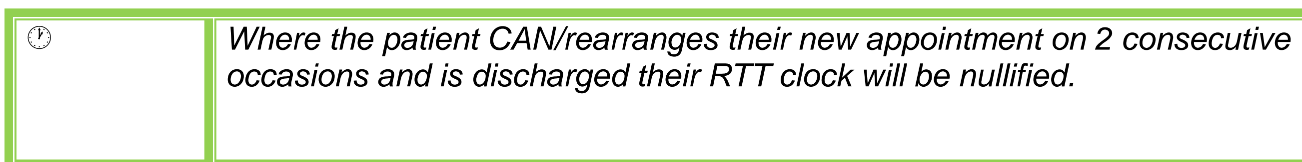
6.18 PATIENT CANCELLATIONS / REARRANGEMENTS

6.18.1 New Appointments

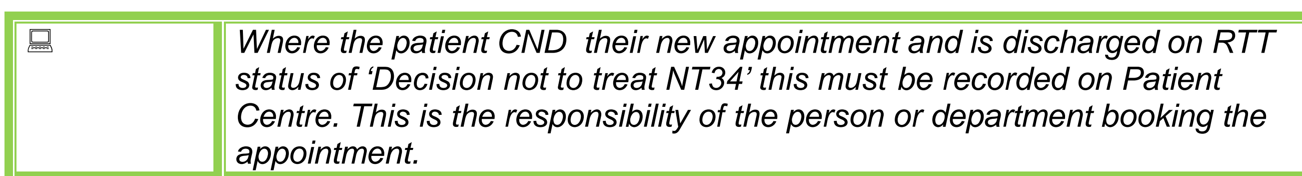
	Following a CND if a patient reschedules their appointment within their breach time this will not alter their RTT clock or breach date. *The reason for the patient cancellation must be recorded on Patient Centre.*

A patient should be warned that if declining one date only one further date can be offered. If a new patient then cancels/re-arranges their appointment on 2 consecutive occasions they will be discharged and re-referred back to their GP. A letter to the patient and GP will confirm this and outline the need for a re-referral if necessary.

If a patient cancels their new appointment and does not attempt to rebook this within 2 weeks they will be discharged and referred back to their GP. A letter to the patient and GP will confirm this and outline the need for a re-referral.



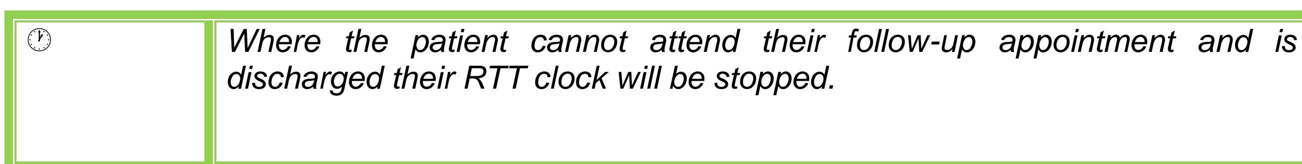
Where the patient CAN/rearranges their new appointment on 2 consecutive occasions and is discharged their RTT clock will be nullified.



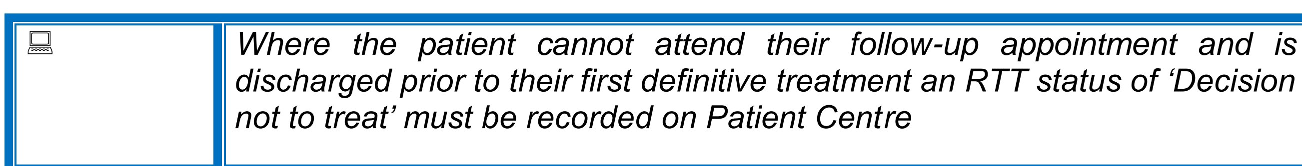
Where the patient CND their new appointment and is discharged on RTT status of 'Decision not to treat NT34' this must be recorded on Patient Centre. This is the responsibility of the person or department booking the appointment.

6.18.2 Follow up Appointments

All follow up patients who have multiple cancellations will be reviewed by the Consultant /Clinician responsible for their care. If there is a decision to discharge they will be referred back to their GP. A letter to the patient and GP will confirm this and outline the need for a re-referral if necessary.



Where the patient cannot attend their follow-up appointment and is discharged their RTT clock will be stopped.



Where the patient cannot attend their follow-up appointment and is discharged prior to their first definitive treatment an RTT status of 'Decision not to treat' must be recorded on Patient Centre

6.18.3 Paediatric appointments

As the patient is not the one responsible for not attending the appointment, the following actions are completed:

- the referrer must be informed as a result of 2 consecutive new cancellations or follow up appointments (if they are on an open 18 week pathway) following their discharge

- a follow-up appointment for patient (not subject to the 18 week rules) must have their records reviewed and a clinical decision made as to whether the offer of a further appointment is made
- check we hold the correct records
- review to ensure child is not subject to CPP or on “Child in Need” list prior to discharge
- services that provide home visits also are required to follow the above in conjunction with the steps of the Unseen Child Policy

Where patients considered being vulnerable the Consultant/Clinician responsible for their care will contact the patient’s GP/referrer to outline their concerns.

6.18.4 Appointments Cancelled on the Day by Patients

A patient that cancels their appointment on the day (prior to their appointment time) will be recorded as a patient cancellation as prior notification has been given.

The use of the Cancelled on the Day (CND) appointment outcome MUST only be used when there has been an incorrect recording added to an E-Referral system appointment that cannot be altered and this MUST only added if agreed by either a supervisor or manager.

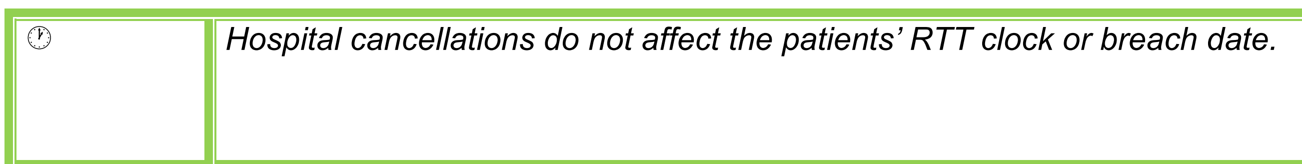
6.19 CANCELLATIONS BY HOSPITAL

Consultants/Clinicians and their clinical teams are required to provide at least six weeks’ notice before the date of commencement of the leave period (including planned study and meetings) and submit the relevant form to the relevant Clinical Director/ Service Management Team for approval.

Clinic Cancellations with less than 6 weeks’ notice can only be authorised by the appropriate Managing Director or designated Senior Manager.

All patients who have their appointment/admission cancelled by the Trust for any reason will be contacted by the Trust to rebook their appointment/admission ensuring that no waiting time is breached.

Patients should not be cancelled more than once.



Hospital cancellations do not affect the patients’ RTT clock or breach date.

6.20 SPECIAL REQUIREMENTS

6.20.1 Vulnerable Patients

It is essential that patients who have been deemed vulnerable have their specific requirements are identified at the point of referral.

This group of patients may include:

- patients with learning difficulties or mental health issues
- Children under the age of 19
- Patients' with physical disabilities or mobility problems
- patients whose first language is not English or those who use British Sign Language
- elderly patients who require community care.

All relevant information must be recorded on iSOFT Patient Centre/CRIS to ensure that when selecting a patient for admission their specific requirements needs are identified early and appropriate arrangements made. This information must be recorded in detail in the comment field of iSOFT Patient Centre relating to the listing.

6.20.2 Advocacy

Patient advocacy requests and enquires should be made to the Patient Advocacy and Liaison Service (PALS) at SRFT.

6.20.3 Patient transport

Patient transport for all first outpatient attendances must be booked by the referring GP practice. Subsequent patient transport arrangements will be booked via the Patient Transport Team.

6.20.4 War Veterans

Service personnel injured in conflict must receive priority treatment (if known) of patients of the same level of clinical need if the condition is directly attributable to injuries sustained in conflict.

6.20.5 Overseas Visitors

Patients who are identified as overseas visitors must be referred to the Overseas Patient Team for clarification of status regarding entitlement to NHS treatment before/during registration takes place (see Overseas Visitors Policy).

6.20.6 Religious/Ethnicity

The Trust is committed to providing, wherever possible, a flexible booking system to support the ethnic/religious requirements of service users.

6.20.7 Prisoners

All communication in relation to referrals received from HM Prison Services will be with the referring Medical Officer. No correspondence will be sent directly to the patient in these instances.

6.20.8 Staff Referrals

Requests from Health and Wellbeing department (only) are to receive priority treatment against patients of the same level of clinical need where staff have been assessed as the treatment needed may facilitate staff to return to work to provide care and support to patients.

We will continually work towards ensuring that individuals due to their requirements are not disadvantaged by this operational manual; we will, through the Impact Assessment process, in consultation with BME and local disability groups, identify areas of concern, and work in partnership to reduce or wherever possible eliminate these issues.

6.20.9 Home Visits

The home visiting criteria is difficult to establish and for this reason, each case must be judged in isolation and on the individual needs of the patient by the triaging clinician. In addition:

- Heart failure patients with advancing Heart Failure symptoms (NYHA III-IV) who have been reassessed and or discharged from Secondary Care for medical management or palliative care.

- Patients on anticoagulant therapy - if the patient is housebound and the GP already visits.

6.21 PLANNED OUTPATIENT APPOINTMENTS

Would include:

- Patients who have started treatment and there is a plan for the next and subsequent stages (e.g. removal of metal work).

- Patients waiting for a planned procedure as part of a course of treatment .This will include those waiting for appointments at specific intervals or tests as part of a screening programme.

6.22 PRIVATE PATIENTS

If the patient is to be seen privately, the prioritiser or Medical Secretary must inform the appropriate booking office clerks to close the patient's episode off CRIS/ iSOFT Patient Centre.

For a private outpatient appointment the referral/request source of referral will be recorded as category PAY – (full paying).

Where a patient has been seen privately but requests to revert to the NHS for listing then the patient should be referred back to their GP for discussion and choice of clinician.

(A Code of Conduct for Private Practice – Recommended Standards of Practice for NHS Consultants, 2.13 page 4)

http://www.nhsemployers.org/~/media/Employers/Documents/Pay%20and%20reward/DH_085195.pdf

Private Patient policy link below:

http://intranet/policies-resources/leaflets/tru/cs0313/?locale=en

Private Patient operational policy link below:

http://intranet/policies-resources/trust-policy-documents/trust-wide-general/op/p13011602/?locale=en

6.23 OVERSEAS VISITORS (OSV)

Patients who are identified as OSV must be referred to the OSV officer for clarification of status regarding entitlement to NHS treatment (see Oversees Visitor policy).
http://intranet/policies-resources/trust-policy-documents/trust-wide-general/fin/fp207/?locale=en

6.24 PATIENTS REQUIRING COMMISSIONER APPROVAL (PRIOR APPROVAL)

Procedures not normally funded
There are a number of procedures which require specific approval from commissioners before the Trust can proceed with treatment. In these instances, approval must be obtained from the relevant commissioner (NHS England, CCG or Wales) before the patient can be listed for treatment.

All elective activity for Scottish patients requires prior approval from the respective Scottish Board.

In addition to exclusions agreed with the Trust's main commissioners, the Welsh commissioners have a specific prior approval arrangement for

- All referrals to Pain services
- GP referrals to neurosurgery
- GP referrals to Neurology
- GP Referral to Spinal Surgery

Procedures not commissioned should not be carried out by providers and will not be paid for unless prior approval via an Individual Funding Request (IFR) has been agreed. The North West Commissioning Support Unit who should respond to all prior approval requests within 5 working days (for routine procedures) and one working day for urgent procedures.

If a GP wishes to refer a patient to secondary care for a procedure or treatment which is specifically excluded, the GP is responsible for obtaining prior approval for funding before making the referral. The Prior Approval letter should be sent / attached with the referral letter. If the provider receives a referral for a procedure or treatment which is specifically excluded that does not include evidence of prior approval, this should be requested from the GP. The GP should be asked to respond within 5 working days. If the approval is not provided within 5 working days of the request by SRFT, the referral should be returned to the GP.

If a GP refers a patient for an opinion and following the outpatient appointment the consultant decides that a restricted procedure is required then it is the responsibility of the consultant to seek approval via the commissioning team. If the procedure is carried out without commissioner approval, then the commissioner will pay for the outpatient attendance, but will not pay for the procedure.

If in any doubt as to whether a service, device or procedure is excluded, please contact the Commissioning Team at Salford Royal.

6.24.1. Identification at outpatient appointment

If it is not clear from the initial referral that the patient will require treatment or a procedure not normally funded then the patient may be seen in outpatients. If it is identified at the outpatient appointment that prior approval is required the consultant will inform the patient at the outpatient consultation stage that this is the case. A letter will then be written to the referrer, copied to the patient, requesting that the patient is re-referred if prior approval is successfully sought. The patient will be removed from the waiting list.

6.24.2. Clinical criteria

Some procedures are funded by GPs/CCGs when the patient meets certain clinical criteria. If a clinician wishes to proceed with treatment and the treatment falls into this category then the clinician must identify in the patient notes or the patient letter that they meet the criteria specified in the relevant CCGs policy. If the patient does not meet the criteria then treatment may not be given. In the latter case the patient will be removed from the waiting list.

6.24.3. Exceptional funding

Exceptional funding applies to procedures that are not currently commissioned by CCGs. Funding will not be supported by the Exceptions Committee unless there is unequivocal evidence that the case is exceptional and that the proposed intervention will be of significant clinical benefit. The commissioning of these procedures is subject to review, in the event of new research evidence and NICE guidance.

Additionally, any patient who does not meet the required criteria for criteria based access procedures or prior approval procedures will be treated as an exceptional funding case.

Examples include: non-cancer related breast surgery, pinnaplasty, complementary therapies and use of Botox.

6.25 COPY LETTER TO A PATIENT

According to the NHS Plan 2000 (paragraph 10.3) Consultants/Clinicians are required to ask patients if they would like to receive copies of correspondence written about them to another professional relating to their medical problem. Frequently this correspondence is from a Consultant/Clinician back to the referring GP. Guidelines pertaining to the content and set out of letters is available on the DoH website:

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4086054.pdf

Hospital Care - When patients 'book in' at an OP reception, they will be asked whether they would like to receive a copy of the correspondence generated as a result of their visit to the hospital and this must be recorded in the appropriate field in iSOFT Patient Centre.

Medical secretaries will send a copy of the Consultant/Clinician's letter to the patient, if indicated on MediSec, all clinical correspondence therefore, must be typed on MediSec.

Community Services will continue with their current practice until systems are in place to support the process above.

6.26 RETRIEVAL OF CASENOTES / PAPER LITE (EDMS)

Casenotes, either electronic or in hard copy, are an integral part of patient care and must be made available according to the agreed standards and targets outlined in the Health Records Management Policy.

6.27 TEMPLATE CHANGES

Consultants/Clinicians wishing to change clinic templates must do so in conjunction with the Service Management Team and or Clinical Director. To avoid patients being inconvenienced a 'go-live' commencement date for template changes must have 6 weeks' notice prior to their implementation.

6.28 CLINIC UTILISATION

All clinic slots must be utilised fully and it is the responsibility of the staff booking the outpatient appointment to ensure all appropriate slot types are filled.

6.29 CLINIC OUTCOME FORM

Following **all** outpatient attendances/DNAs the Clinic Outcome Form must be completed and returned to the appropriate reception and recorded on iSOFT Patient Centre/CRIS within 1 working day of the event.

6.30 DIRECT ACCESS CLINICS (DAC)

Consultants/Clinicians may identify individual patients appropriate to be offered direct access appointments instead of a traditional routine follow up appointment. This group of patients will be added to the appropriate DAC waiting list on Patient Centre and advised to

contact the hospital when an appointment is required, following which their request will be triaged and offered an appointment (if appropriate) within 14 days.

6.31 OPEN APPOINTMENTS

Patients may be offered an open appointment for a designated period of time. This group of patients will be added to the appropriate open appointment waiting list on Patient Centre, on contacting the hospital the patient will be triaged and offered an appointment if appropriate.

6.32 OUTPATIENT CLINIC ROOM ALLOCATION

Consultant/Clinicians or managers may wish to request additional clinical rooms in the main OP area for new staff, for the expansion of existing clinics or for some ad hoc sessions. To ensure a fair and equitable system, requests for clinical rooms should be undertaken by contacting the Clinical Outpatient Matron and a response will be given within 3 working days of the request made. Upon receipt of requests, applications will be reviewed to allocate clinical space where possible or suggest an alternative accommodation that may be available elsewhere within the hospital.

6.33 PRIVATE ROOM UTILISATION

The Renal Outpatient Department is designated to see private patients (please refer the Private Patient Coordinator for further details).

6.34 OUTPATIENT CORRESPONDENCE

All outpatient correspondence must be completed within FIVE working days.

6.35 MONITORING AND VALIDATION

It is the responsibility of the individual Divisions to validate and manage their waiting lists. Any potential or real breach of Trust or national target must be reported in advance to the responsible Managing Director.

6.36 MONITORING OF RTT ACCESS TARGETS

All Divisions undertake a standardised approach to Access & Performance where Service Management Teams review access targets and provide assurance that systems and processes are in place to manage patients throughout their pathway.

6.37 INTERNAL REFERRALS

Generally, a patient and their GP can most satisfactorily decide, at each stage, their journey the most appropriate provider.

Where a hospital consultant believes a patient would benefit from a non-urgent opinion from a specialist for a condition unrelated to the presenting complaint, this information should be provided back to the GP and patient where a decision as to whether a referral is progressed and to which provider.

This covers:

- non-urgent referrals for conditions not related to the presenting complain
- non urgent referrals from A&E

- all other non-urgent consultant to consultant referrals not covered by the exceptions below

Exceptions include:

- clinical Urgent referrals
- referral form medical specialities to surgical specialities for the same condition
- referrals from a generalist to a sub speciality
- referral for the assessment and suitability of patients for surgery or interventions
    - Thrombophilia screening
    - Transplant recipient or donor
    - Hyperglycaemia
    - Referral for anaesthetists for Cardiac or Respiratory Medicine

	For internal consultant to consultant referrals, the RTT clock will start from the original referral received date if the referral is for the same condition. For new or significantly different treatment an onward referral will start a new RTT clock on the date the referral is received by the receiving organisation.

7.0 DIAGNOSTICS

7.1 INTRODUCTION

The administration and management of waiting lists must be consistent, easily understood, patient focused and responsive to clinical decision making. Diagnostic tests are recorded on more than one computer system (iSOFT Patient Centre, CRIS and specialty-specific databases) which complicates the monitoring of patients waiting. In addition, diagnostic tests are performed as both inpatients and outpatients – so both sections 6.0 and 8.0 of the Patient Access Procedure Manual should be referred to for further guidance, in conjunction with the key principles outlined in this section.

- Diagnostic waiting list - All tests/procedures for which a patient is waiting, irrespective of the referral route (i.e. whether the patient was referred by a GP or by a hospital-based clinician or other route) and also irrespective of the setting in which they are carried out (e.g. inpatient ward, x-ray department, outpatient clinic etc.).

- Planned tests/procedures (surveillance) - A procedure or 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. Examples include a 6 month cystoscopy review or regular blood tests.

- Unscheduled tests/procedures - Diagnostic tests or procedures carried out on patients following an emergency admission, (as well as any diagnostic tests/procedures on a patient in A&E). If not carried out immediately, these should be added to the active waiting list.

7.2 DIAGNOSTIC PROCEDURES

Within the attached document is a list of all the diagnostic procedures undertaken.

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7.3 PATIENTS REFERRED FOR DIAGNOSTICS 0

When a patient is referred to a department for diagnostic investigations the responsible clinician must ensure the patient is aware of the timescales and their responsibility for attending the appointments.

7.3.1 General Principles:

- all patients must be seen in order of clinical priority
- patients should be able to negotiate their appointment dates and times
- no patient waiting for a diagnostic appointment or admission will be suspended or paused for any reason

It is acknowledged some patients require expediting due to reasons such as clinical urgency or RTT breach date, and in such cases the timescales laid out below for booking such appointments are mitigated.

7.3.2 Referrals and Referral Protocols

Will only be accepted via electronic ordering on EPR or on imaging request cards where there is not an electronic ordering solution available.

Where referral protocols exist, Consultants/Clinicians and GPs are expected to comply. If the radiologist, upon verification, feels the referral does not comply with the protocol for the investigation the request will be returned to the referrer for further information.

7.4 RECEIPT & REGISTRATION

7.4.1 Direct Access

Direct Access diagnostics are those where the GP refers for a diagnostic test only and when in receipt of the result will then make a decision whether or not to refer the patient on to secondary care.

	Direct access diagnostics are not covered by RTT rules as the patient has not yet been referred to secondary care. An RTT clock only commences if the GP has made the decision to refer following the diagnostic procedure, in which case, the RTT clock starts when the referral for treatment is received by the Trust.

7.4.2 E-referral system - See O/P section 6.2

7.4.3 Electronic Requests

Where available this media this is the preferred method be used to request diagnostics.

7.4.4 Request Cards

All request cards MUST date stamped on receipt into the organisation/department.

All diagnostic request cards need to be registered on iSOFT Patient Centre/CRIS within one working day of receipt to the designated registering service.

A diagnostic request received directly by a Service or Consultant/Clinician must be date stamped and sent to the designated registering service immediately e.g. the Radiology Booking Office at SRFT and be hand delivered to avoid delay if possible

7.5 **PRIORITISING** - For OP see Section 6.0 point 6.7, for IP Section 8 point 8.5, for TWW Section 9.0 point 9.4

7.6 **TRIAGE (VETTING)** - For OP Section 6.0 point 6.6, for IP Section 8.0 point 8.5, for TWW Section 9.0 point 9.2

Where an investigation is deemed not to be appropriate the request/referral will be returned to either the GP or responsible clinician with appropriate guidance.

7.7 BOOKING SYSTEM

All patients will be given the opportunity to choose the date for their diagnostic. It is essential that a record of the booking type offered to the patient is completed on the iSOFT Patient Centre/CRIS or other approved reporting systems authorised by Chief Information Officer.

All modalities must move to introduce both **managed bookings for all planned and surveillance patients** in order to improve patient experience and add value to appointments for patients. All bookings should be booked in order no waiting times are breached

7.8 **PATIENT / NON PATIENT CONTACT** – see OP Section 6 point 6.10

7.9 **PATIENT CORRESPONDENCE** – See OP Section 6 point 6.13

7.10 **WAITING TIMES** – See Section 10.4

7.11 **REASONABLE NOTICE** – See OP Section 6 point 6.14, IP Section 8 point 8.11 and TWW Section 9.0 point 9.9

	Where a patient declines dates for a diagnostic test or appointment their RTT clock remains the same.

A patient who declines two reasonable offers - For OP see Section 6.0 point 6.14.1, for TWW Section 9.0 point 9.12.

Patients waiting for a diagnostic appointment or admission cannot be paused or suspended for any reason.

7.12 DNA (DID NOT ATTEND)

Where a **routine** patient has agreed the date diagnostic test with reasonable notice and this has been clearly communicated to them, and then subsequently does not attend (DNA), the patient will be referred back to their GP or referring/responsible Clinician and removed from the OP/IP diagnostic waiting list. A letter confirming this is sent to the GP, copied to the patient or referrer/responsible Clinician outlining the need for a re-referral if necessary.

*If the patient was removed from the waiting list/pathway and the removal was later found to be a mistake, then the patient must be re-instated **without prejudice**, as if he or she has never been removed. This is achieved by deleting the incorrect cancellation on ISOFT Patient Centre.*

	Unless the patient is discharged to their GP (or discharged with an open appointment) their original RTT status and breach date remain the same. *The diagnostic 6 weeks wait time will reset to the date of the patient's DNA of their test if a further test is booked*

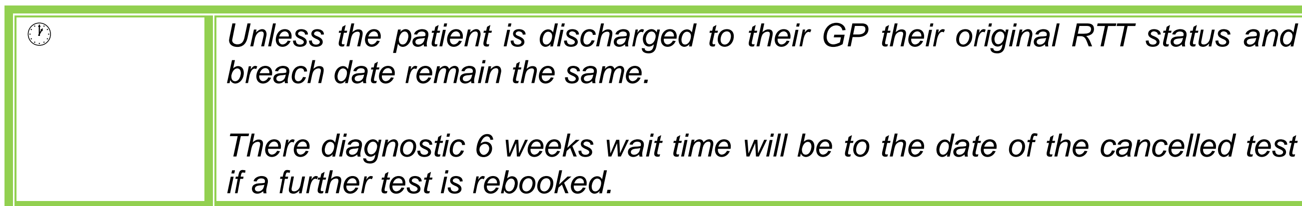
	Where a patient is to be discharged the patient's RTT clock will be stopped and an RTT status of 'decision not to treat' must be recorded on Patient Centre.

7.12.1 DNA URGENT REFERRALS

All clinical urgent patients will be routinely offered a further appointment if they DNA their initial appointment. The new RTT clock will commence on the date the patient agree to the further appointment.

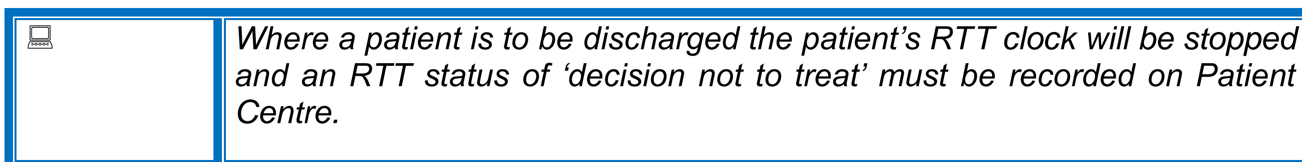
7.13 PATIENT CANCELLATIONS / REARRANGEMENTS – Also see for OP section 6.0 point 6.18, for IP/DC Section 8.0 point 8.13, for TWW 9 Point 9.12

The referring clinician/responsible clinician will be informed by the appropriate diagnostic department if the patient cannot agree a date within the agreed timescales. The responsible clinician will take the appropriate action following review of the patient's case.

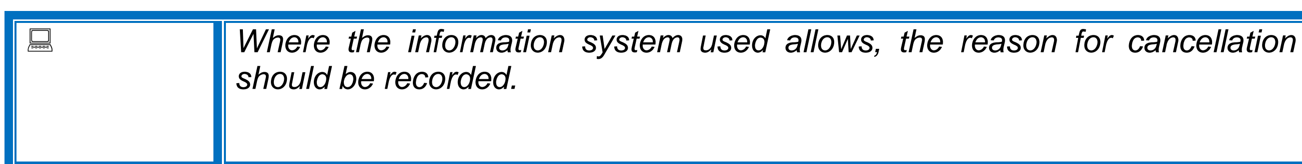


Unless the patient is discharged to their GP their original RTT status and breach date remain the same.

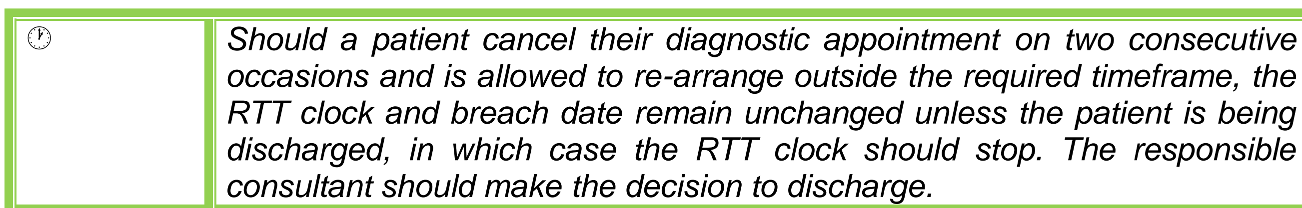
There diagnostic 6 weeks wait time will be to the date of the cancelled test if a further test is rebooked.



Where a patient is to be discharged the patient's RTT clock will be stopped and an RTT status of 'decision not to treat' must be recorded on Patient Centre.



Where the information system used allows, the reason for cancellation should be recorded.



Should a patient cancel their diagnostic appointment on two consecutive occasions and is allowed to re-arrange outside the required timeframe, the RTT clock and breach date remain unchanged unless the patient is being discharged, in which case the RTT clock should stop. The responsible consultant should make the decision to discharge.

7.13.1 Patient Cancellations – Cannot Rearrange

If a patient cancels their appointment on more than one occasion or they are unable to re-arrange their appointment within 6 weeks of the diagnostic request date, the referral will be returned to the requesting/responsible Clinician. The requesting/responsible Clinician will take appropriate action following review of the patient's case.

7.13.2 Patient appointments cancelled on the day

Patients that cancel their appointments on the day (prior to their appointment time) will be recorded as a patient cancellation as prior notice has been given.

7.14 <u>HOSPITAL CANCELLATIONS</u> – See OP Section 6 point 6.19, IP/DC Section 8.0, point 8.14

Where patient appointments are cancelled on the day, in particular urgent diagnostics such as those that fall under JAG guidance, there must be a minimum of 48 hours' notice given to the patient for a further appointment.

	Where a patient's diagnostic test is cancelled due to hospital reasons, their RTT status and breach date remain unaffected.

7.15 PLANNED PATIENTS – See OP Section 6.0 point 6.21 and for IP Section 8.0 point 8.24

7.16 PRIVATE PATIENTS – See OP Section 6.0 point 6.22

7.17 OVERSEAS VISITORS (OSV) – See OP Section 6.0 point 6.23

7.18 REPORTING AND VERIFICATION

Timeliness of diagnostic tests will be factored when considering the whole pathway and results must be available in time to allow progress through all stages of a compliant RTT pathway. Local arrangements for timely reporting of diagnostic tests will be negotiated separately:

- results will be displayed on EPR and sent in hard copy to the requesting clinician
- results for tertiary patients will be available on EPR and dispatched in hard copy to the Clinician who requested the investigation
- results for direct access patients will be available on EPR for Salford GP's and dispatched in hard copy to the requesting GP if out of Salford

7.19 PATIENTS ADMITTED FOR DIAGNOSTICS

A patient added to the waiting list must be admitted for this procedure within 6 weeks of it being requested. The request date is the date made to add the patient to the diagnostic admission waiting list.

7.20 DIAGNOSTIC RESULTS

7.20.1 Diagnostics results requiring a management plan

The patient will either be invited to attend a follow-up appointment or the Clinician will contact them via letter to give them the results of their diagnostic tests and inform them of their suggested future management.

7.20.2 Normal Diagnostics results

The patient will either be contacted by telephone or a letter will be written to the patient and their GP confirming a normal result. The RTT pathway will stop at the point the patient has been notified of a decision not treat or that no further treatment is needed.

7.22 SUBSEQUENT DIAGNOSTICS

Subsequent diagnostics will occur when a patient is already undergoing treatment for their condition and may require further diagnostics to assess and monitor a change in their condition, or consider suitability for an alternative treatment.

	Should a patient already undergoing treatment for their condition, undergo diagnostics to assess for suitability for alternative treatment, a new RTT clock would start when the decision was made to commence the new treatment, an RTT clock status of 'decision to treat following watchful wait' must be recorded at that point.

7.23 MONITORING AND VALIDATION See OP Section 6.0 point 6.36

7.24 DIAGNOSTIC TARGETS See Section 10.4

8.0 INPATIENT/DAYCASE WAITING LIST

8.1 INTRODUCTION

The administration and management of Inpatient/Daycase waiting lists must be consistent, easily understood, patient focused and responsive to clinical decision making. If a patient is waiting for treatment and are to be managed effectively it is essential that everyone involved in this function have a clear understanding of their roles and responsibilities.

	This is the final stage of the RTT pathway. On the date of admission for elective treatment the RTT clock stops. The patient should not have waited longer that the RTT target time unless they have chosen to do so.

	Some patients may have an RTT clock stop event prior to a decision to admit for intervention. In this case a new RTT clock starts when the Decision to Admit (DTA) was made and communicated to the patient.

8.2 IP/DC WAITING LIST

The attached flow sheet describes the process for booking an IP/DC admission.

APPENDIX 4 Booked Admission Flow sheet

8.2.1 Additions

- The decision to admit a patient must be made by a Consultant or a designated Clinician on their behalf.
- A patient who is added to the a waiting list must be deemed medically fit.
- A patient who requires a further OP consultation or investigation to assist in the decision making must not be placed on the waiting list until this is completed and the patient has agreed they wish to proceed.
- A patient should not be placed on a waiting list before they are ready e.g. a patient with slowly deteriorating pathologies whilst they mature.
- A patient who needs to lose weight should not be added to a waiting list if they are unfit for the procedure and therefore not ready for the surgical phase of treatment.
- At the time of adding the patient to the waiting list, if the patient is unavailable for a period of greater than 12 weeks the responsible Consultant must decide what action should be taken i.e. put the patient on active monitoring and be clinically reviewed at a later stage or discharge the back to their GP/referrer.

8.2.2 Age Restriction to Elective Admissions

No child under the **age of 3** may be listed for elective surgery

8.2.3 Decision to Admit Date (DTA)

The DTA date for a patient on an existing 18 week pathway should be recorded on iSOFT Patient Centre as the date the DTA was made and the waiting list entry must be linked to the appropriate 18 week pathway on iSOFT Patient Centre.

8.3 IPT/MDS See OP Section 6.0 point 6.8

8.4. PRE-OP ASSESSMENT SERVICE

The administration process for managing pre-operative assessment clinic appointments should be in accordance with the standards described in Section 6.0 Outpatients. To reiterate:

- 1 x DNA and refer back to the GP unless specific clinical reason
- Pre op assessment appointments should be classed as follow ups

Pre-op assessment minimises the risk of late cancellations by ensuring that the patient is as fit as possible for surgery and general anaesthetic and that the patient wishes to undergo the procedure.

8.5 DETERMINING PRIORITY

All patients who are added to a waiting list must be given a clinical priority of either Urgent or Routine.

8.5.1 TWW/Cancer

All TWW patients must be treated by day 62 or earlier if possible.

8.5.2 Urgent

Any urgent referrals/requests must be allocated an IP/DC admission as soon as possible.

8.5.3 Routine

On receipt of a referral/request a patient will be booked an appointment within the current waiting times target.

8.6 MANAGING AN IP AND DAY CASE WAITING LIST

The process of selecting patients for admission and subsequent treatment is a complex activity. It entails balancing the needs and priorities of the patient against the available resources in the operating theatres and beds where necessary.

The following key principles apply:

- All patients must be listed for admission on iSOFT Patient Centre on the day the Decision to Admit (DTA) was made.
- All patient added must be recorded within one working day of their DTA.
- Patients will be treated in a timely and effective manner.
- Clinically urgent patients will be treated as a priority and within the shortest waiting times possible.
- Non-clinically urgent patients (routine) will be treated in chronological order based upon he length of wait if there are no other factors for consideration such as choice and complexity.
- Patients who subsequently become unfit for surgery will be referred back to their GP and 18 week clock stopped, see point 8.18 in this section.
- If the patient is unable to accept a reasonable offer of two admission dates due to personal/social reasons, this needs to be recorded but **a clock pause can be no longer used** in managing the waiting time as this is allowed for in the tolerance of the 92% target.

8.7 BOOKING

Full booking is the preferred option and is undertaken at the point the Clinician decides to admit the patient and a date for their admission is agreed with the patient and a date is recorded in the Clinicians diary or equivalent.

8.7.1 Partial Booking – The patient is advised of their waiting time and is able to choose and confirm their admission date with three weeks' notice.

8.7.2 No Patient Choice – The patient is given an admission date by no consultation or choice. This method of booking or IP/DC should only be used in exceptional circumstances

8.7.3 Selecting Patients for Admission

Primary Targeting Lists (PTL/Pivots) methodology will be used to facilitate equity for non-clinically urgent patients and assist the organisation in preventing breaches of the maximum waiting times target.

	Where it has not been possible to contact the patient to arrange a date for elective admission, the patient should be removed from the elective waiting list and an RTT status of 'Decision not to treat' must be recorded on Patient Centre

8.7.4 War Veterans - See OP Section 6.0, point 6.20.4

8.8 METHOD OF ADMISSION

8.8.1 Elective Waiting List

A patient admitted electively from a waiting list having been given no date of admission at a time a decision was made to admit and does not meet the definition of planned or booked.

8.8.2 Elective Fully Booked Admission

A patient admitted having been given a date at the decision to admit was made.

8.8.3 Elective Partially Booked Admission

A patient offered a date for admission after the decision to admit was made.

8.8.4 Elective Planned

Elective planned waiting lists patients are those who are waiting for clinical reasons to be recalled to the hospital for a further stage of treatment or surgical investigation.

8.9 CONTACTING A PATIENT TO ARRANGE THE DATE

A patient should be contacted by telephone to arrange their admission. A minimum of two attempts should be made at different times of the day. Where contact cannot be made a letter will be sent to the patient requesting the patient make contact to the relevant secretary within 3 weeks to arrange a suitable admission date.

For Urgent and TWW patients a check on the contact numbers held should be carried out and if any further contact numbers are available. This is the responsibility of the medical secretary making the booking.

8.9.1 Non Response to Contact Letters

If the patient does not respond to an invitation letter, the national spine data base must be checked and staff should contact the GP in order to ensure the detail and contact numbers held are correct. One further attempt must be made by telephone

The appropriate Consultant must be informed and the patient then removed from the waiting list. Following clinical advice the patient will be discharged back to the care of their GP or where appropriate the other referrer. They must be informed in writing outlining a need to re referral should the patient still need to be seen and treated.

8.10 REASONABLE NOTICE

- A reasonable offer for an elective admission is a date with at least three weeks' notice
- Should the patient accept an offer of admission earlier than three weeks, then this becomes a reasonable offer
- Where a patient declines a second reasonable offer a pause may be applied from the earliest reasonable offer date to the date the patient is available
- If unwilling to accept a date within three weeks clinical advice must be sought as to:
    - offering a longer pause
    - discharging with/without an open appointment
    - clinical review at a later stage with Clinician and outcome of preoperative assessment

Service Management Teams will regularly review patient initiated delays and pauses for trends and appropriateness.

Note: Patients cannot be suspended for medical reasons.

8.10.1 Patient declining offer of dates

Patients who decline one reasonable offer MUST be offered at least one further reasonable date. The refusal should be recorded on iSOFT Patient Centre. The patient should be warned that where they decline one date only one further date can be offered. If the second reasonable date is declined then their clock may be paused from the date of the first reasonable offer and should restart from the date that a patient says they are available to come in.

There is no minimum time period for this pausing. The **maximum** period of pausing is 6 weeks. In the event the period of unavailability exceeds this then the patient must be removed from the waiting list and returned to the care of their GP. If the patient wishes to wait longer, clinical advice may be sought to decide whether to:

- Discharge the patient back to their GP
- Undertake a clinical review

8.11 PATIENT CORRESPONDENCE

All patients, regardless of methods of booking, must be sent a letter confirming the date, time and location of the admission within 1 working day.

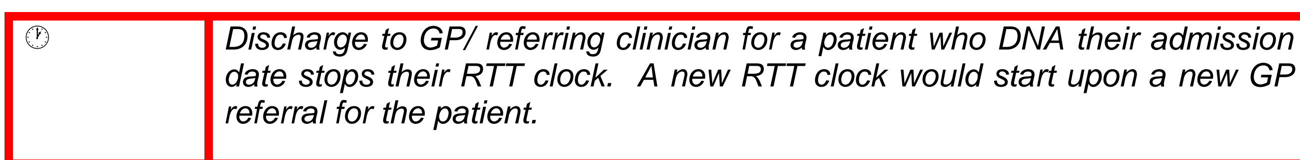
The letter is an audit trail of the arrangements and should contain the following core details:

- Patient's name
- Date letter sent to patient
- Date and time of admission agreed

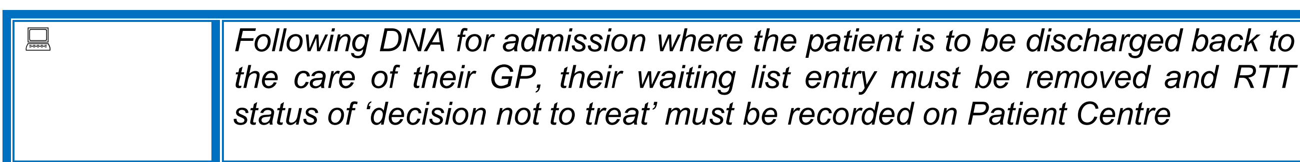
- Where to report on arrival
- Response required from the patient
- Named contact and time available for queries relating to admission
- Reference to instructions for admission and/or booklet
- Request to check bed is available on day of admission
- Reasons for checking bed availability

8.12 DNA

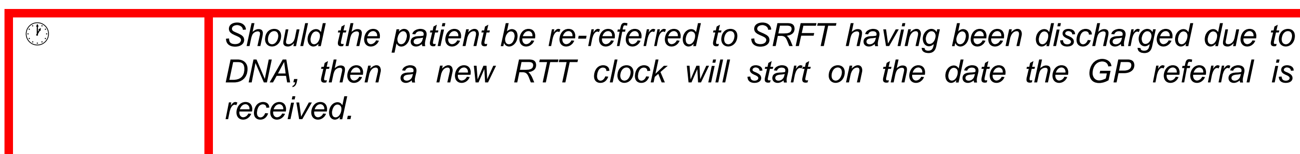
Where a routine IP/DC patient has agreed an admission date with reasonable notice and this has been clearly communicated to them, then subsequently does not attend (DNA), the patient will be referred back to the GP (or other referrer) and/or removed from the IP/DC waiting list. Their 18 week clock will be stopped. The Consultant will review the patient's casenotes/EPR record and will send a letter to the patient and GP to confirm this and outline the need for a re-referral if necessary.



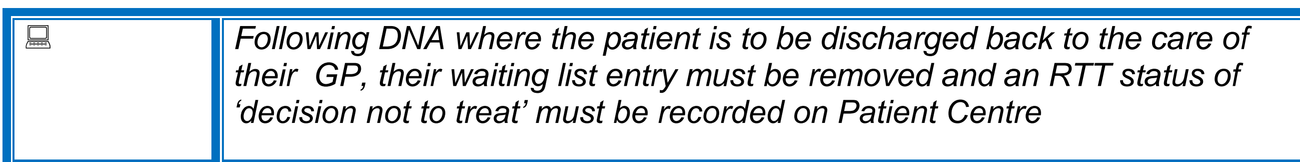
Discharge to GP/ referring clinician for a patient who DNA their admission date stops their RTT clock. A new RTT clock would start upon a new GP referral for the patient.



Following DNA for admission where the patient is to be discharged back to the care of their GP, their waiting list entry must be removed and RTT status of 'decision not to treat' must be recorded on Patient Centre



Should the patient be re-referred to SRFT having been discharged due to DNA, then a new RTT clock will start on the date the GP referral is received.



Following DNA where the patient is to be discharged back to the care of their GP, their waiting list entry must be removed and an RTT status of 'decision not to treat' must be recorded on Patient Centre

8.12.1 Vulnerable Children, Adults and Dialysis Patients

In these exceptional cases the Consultant responsible for the care of the patient will review the patient's casenotes/EPR record and decide on the most appropriate action to be taken. If at any point the Clinician feels the patient's health is being compromised then the patient must be referred to other appropriate authorities. Where a child is known to Social Services any DNA must be communicated to the appropriate department.

Renal dialysis patients who DNA, or cancel on the day, are not to be discharged due to their clinical need. Repeat DNA's will result in a meeting between the patient, clinician

and ward manager / lead nurse to discuss non-compliance with dialysis treatment and appropriate action will be taken thereafter.

8.12.2 Urgent patients will be offered a second admission date. Their 18 week clock will continue to tick.

⏱	*For any patient who DNA a date for admission and is not discharged their RTT clock and breach date remain unchanged. Should a second opportunity be given to the patient this must be given within their existing RTT breach date. If when contacted the patient wishes to delay their surgery, a patient initiated pause can only be made from the time of contact following the DNA to the point at which the patient makes themselves available for surgery.*

8.13 PATIENT CANCELLATIONS / RE -ARRANGEMENTS

8.13.1 Routine

A patient may find that once they have agreed a TCI date it becomes inconvenient for personal or social reasons. A patient pause will be added from the point the patient makes contact to the point they make themselves available for surgery and their TCI date re-arranged as requested

If a routine patient cancels their admission on 2 consecutive occasions they will be discharged and re-referred back to their GP. A letter to the patient and GP will confirm this and outline the need for a re-referral if necessary.

Note This does not apply to TWW patients - See Section 9, point 9.12

8.13.2 Admissions/Daycases that patients cancel on the Day

Patients that cancel their admission on the day (prior to their arrival time) will be recorded a patient cancellation as prior notification has been given.

8.14 CANCELLATIONS ON DAY OF SURGERY *BY THE* HOSPITAL (FOR NON-CLINICAL REASONS) including non-invasive diagnostic procedure

Following a last minute cancellation (on the day of surgery, day of admission or following admission), patients have the right to be offered a new date for treatment that is within 28 days of the cancellation, if this is not possible then they are eligible to be offered private treatment paid for by SRFT.

If a patient is rescheduled with 24 hours (this is not working days) this is classed as a postponement rather than a cancellation.

If a patient is offered a reasonable date within 28 days but prefers to be treated later this should not be recorded as a breach.

	If a patient's operation or admission was cancelled by the hospital then their RTT clock continues to tick. An alternative date must be arranged before the existing RTT breach date.

8.15 MEDICALLY UNFIT FOR TREATMENT

- Patients medically unfit at the time of decision to admit should not be added to an elective list
- For patients on an elective waiting list, if the patient is identified as not fit for surgery, they must be removed from elective waiting list
- Patients cannot be suspended for medical reasons

	Becoming medically unfit while waiting for an elective procedure does not stop a patient's RTT clock. Short-term periods of unavailability (two weeks or less) must be absorbed into the overall patient waiting time.

	Discharging the patient to their GP / referring clinician stops their RTT clock. A new RTT clock is started if the patient is re-referred back to the consultant for the identified procedure.

	At the time of removing from the waiting list, the patient's RTT status must be recorded as 'decision not to treat' on Patient Centre.

8.16 REMOVALS OTHER THAN FOR TREATMENT

A patient may wish to be removed from the waiting list before they are treated, for example a patient may wish to transfer to the private sector or decide that they no longer wish to have the procedure.

	Where a patient wishes to be removed from the elective waiting list their RTT clock will be stopped.

	Where a patient wishes to be removed from the waiting list they should be removed on Patient Centre. Their RTT clock must be stopped by recording a status of 'treatment declined by patient' on Patient Centre.

8.17 REINSTATEMENT FOR CLINICAL REASONS

A patient may have been removed from the waiting list other than for treatment. If removal was a result of following this procedure but now reinstatement is judged to be clinically appropriate then reinstatement onto the waiting list should be undertaken will be a new episode of care. In the scenario above it may not be necessary to ask the GP to re-refer or for the patient to be seen in clinic if their clinical circumstances have not changed. In this case, a patient will be put onto the waiting list as a new episode of care as the result of a telephone request. All circumstances should be recorded on iSOFT Patient Centre system to ensure a complete audit trail.

Patients will only be re-instated onto a waiting list following the clinical decision to do so as long as this is within 6 months of discharge.

8.18 REINSTATEMENT FOLLOWING AN INAPPROPRIATE REMOVAL

If the patient is removed from the waiting list and the removal was later found to be a mistake, then the patient must be re-instated **without prejudice**, as if he or she had never been removed. This is achieved by deleting the incorrect cancellation on iSOFT Patient Centre which maintains the original DTA date.

8.19 PATIENT TRANSFERS

8.19.1 Pending Admissions for Tertiary Services

All Patients referred from another provider require an MDS via the standard IPT form.

8.19.2 Clinical Transfer

Patients have the right to be treated by the consultant he/she was originally referred to or by one of his team. However, occasionally there may be need to transfer the care of a patient between consultants, this can only be undertaken with agreement by the patient with the exception of ill health or retirement or if not clinically appropriate. The original consultant and the receiving consultant must both be notified and must agree to the change.

	A patient should not be forced to move to a new consultant, a refusal to do so will not affect the patient's RTT breach date or status.

8.19.3 Transfers between Providers

Transfers out to alternative providers for treatment must always be managed with the consent of the patient. A completed 18-week IPT proforma containing the MDS must be attached to the referral letter sent to the receiving Trust.

If a patient does not wish to be transferred, the original provider must ensure the patient is admitted for treatment in compliance with the waiting time guarantee.

	Patients wishing or clinically needing to transfer their care from SRFT will not have their RTT status or breach date affected, the information on the patient's RTT status and breach date will be transferred to the new provider via a Minimum Data Set (MDS) form.

8.19.4 Transfer to Private Providers

Transfer to alternative providers will be in consultation with the patient and the Consultant.

If a patient does not wish to be transferred, the original provider must ensure the patient is admitted for treatment in compliance with the NHS Constitution. Waiting times will continue uninterrupted. The patient must not experience an extended waiting time in their 18-week pathway due to the transfer.

Where a patient is transferred to the private provider under the same SRFT consultant, the patient and the Consultant will be notified of the new venue emphasising that the surgeon will remain the same.

If a patient is transferring to a Private Provider and also a new consultant, emphasis must be made to the patient of the suitability of the new consultant.

	For patients transferred to the private sector their RTT status and breach date remains the same. For recording purposes the patient remains under SRFT reporting of compliance to the RTT target.

	For patients that decide to continue their treatment in the private provider their RTT clock will stop when they decide to transfer to be seen privately.

8.19.5 Transfer from a private provider to SRFT

A patient transferring to SRFT from a private provider must be referred to SRFT by their GP. A private outpatient who elects to have NHS treatment after an initial private consultation must join the appropriate waiting list at the same point as if their consultation has been under the NHS once their GP referral had been received.

	For patients transferred to SRFT from a private provider their RTT clock will start when SRFT receives a referral from their GP.

8.20 IMMEDIATE INPATIENT DISCHARGE SUMMARIES

All patients must have an immediate inpatient discharge summary completed within 24 hours of discharge.

8.21 PATIENTS LISTED FOR BILATERAL PROCEDURES OR MORE THAN ONE PROCEDURE

The listing of a patient for a bilateral procedure or more than one procedure must be in accordance with the following:

- A bilateral procedure is one that is performed on both sides of the body at matching anatomical sites. Examples include cataract removal and hip and knee replacements.

- Consultant led bilateral procedures are covered by 18 weeks with a separate clock for each procedure. The 18 week clock for the first consultant-led bilateral procedure will stop when the first procedure is carried out (or date of admission for the first procedure if it is an inpatient/daycase procedure). When the patient becomes fit and ready for the second consultant-led bilateral procedure, a new 18 week clock will start.

8.22 PRIVATE PATIENTS - See also Section O/P 6.0 Point 6.22

If the patient is to be seen privately, the prioritiser or Medical Secretary must inform the appropriate booking office clerks to close the patient's episode off CRIS/ iSOFT Patient Centre.

For an outpatient appointment the referral/request source of referral will be recorded as PPN. Where appropriate, an 18 week clock would start for the patient with the clock starting on the date that the patient's care is transferred to the NHS.

Where a patient has been seen privately, but requests to revert to the NHS for listing, then the patient should be referred back to their GP for discussion and choice of clinician.

If the patient is to be seen privately, the prioritiser or Medical Secretary must close the patient's episode off iSOFT Patient Centre

If the patient is admitted as a Private Patient the waiting list entry source of referral will be recorded as FULL PAYING in Patient Centre.

8.23 OVERSEAS VISITORS (OSV) – See Section O/P 6.0 Point 6.23

8.24 PLANNED WAITING LIST

It is appropriate for a patient who has started treatment with a management plan for the next and subsequent stages (e.g. removal of metal work) to be added to a planned waiting list, this will also include those waiting for tests as part of a screening programme.

Examples of planned admissions are:

- Repeat check cystoscopies / endoscopies

- Follow-up chemotherapy sessions which are necessary at regular intervals
- Admissions arising from other treatment (e.g. the planned removal of an internal fixation after three months)

	Patients on planned waiting list will have an RTT clock status of 'treatment already commenced or on-going' or 'watchful wait / active monitoring'. *Patients on planned waiting lists are not included in RTT measurement.*

8.25 MONITORING AND VALIDATION - See OP Section 6 point 6.36

8.26 RTT TARGETS - See Section 10.4

9.0 CANCER /TWO WEEK WAIT REFERRALS (inc BREAST SYMPTOMATIC & RAPID ACCESS CHEST PAIN)

9.1 TTW (IC BREAST SYMPTOMATIC & RAPID ACCESS CHEST PAIN) REFERRALS

Referrals should be made using a tumour specific cancer referral proforma accompanied, if desired, by a detailed letter that clearly highlights the referral is a suspected cancer. The proforma reflect the national guidance and indicate pre-referral test requirements. The proforma's are in each practice as electronic forms and linked to the patient information leaflet which is given to the patient at the point of referral to notify them of the process.

The procedure for requesting an appointment for a suspected cancer patient is as follows:

9.1.1 Choose & Book Referrals

- For Choose & Book referrals (preferred option) an Appointment Request must be submitted at the time of decision to refer. A Telephone Outcome Appointment made for the patient by the GP and the referral letter attached. Booking must remain in line with the DoH Cancer Guidelines.
- The Referral will be accepted by the TWW Co-ordinator and the patient contacted by telephone (twice) to make an appointment
- If the patient is unable to be contacted by telephone an appointment will be made on behalf of the patient and a confirmation letter sent to the patient.

9.1.2 Paper Referrals

- Paper referrals must be faxed to the Call Centre within 1 hour on 0161-206 1048.
- The Call Centre staff must register the referral and clearly record on iSOFT Patient Centre that it is a Two Week Wait (TWW) using the ORE function and 'Referred By' field on iSOFT Patient Centre - TWW. The Call Centre will then make an appointment for within two weeks of the date of the referral letter.

- Where ‘straight to test’ is an option, but requires clinical triage, referrals are sent to the clinical teams on receipt and these are returned to the Call Centre or GIU for UGI scope patients to allow for booking within 1 working day.

9.2 TRIAGE

9.2.1 Paper Referrals

Paper referrals must be faxed to the Call Centre within 1 working day to 0161-206 1048.

The Call Centre staff will register the referral and clearly record on iSOFT Patient Centre that it is a TWW using the ORE function and ‘referred by’ field. The Call Centre will then make an appointment for within two weeks of the date of the referral letter.

Where ‘straight to test’ is an option but requires clinical triage, referrals are sent to the clinical teams on receipt. Post triage they are returned to the Call Centre or Endoscopy Unit for Upper Gastrointestinal patients to allow for booking within 1 working day.

All departments managing their own referral e.g. Colposcopy will manage these referral in line with this guidance.

9.3 EPR/SCANNING – see OP Section 6 Point 6.5

9.4 DETERMINING PRIORITY

All patients referred under the TWW rule will be added to Patient Centre/CRIS must be given a of a TWW status priority.

9.4.1 Downgrading a TWW referral request - only a GP can withdraw the TWW status and if a Consultant thinks the TWW referral is inappropriate this should be discussed with the GP and the GP asked to withdraw the two week wait referral status. Then any appropriate changes can be made on iSOFT Patient Centre/CRIS.

9.4.2 Upgrades

The starting point for this 62 day period is the date on which the consultant (or an authorised member of the consultant team, as defined by local policy) decides to upgrade the patient. This is recorded as the Consultant Upgrade Date.

9.5 BOOKING OF APPOINTMENTS

All patients TWW/Breast Symptomatic and Rapid Access Chest Pain patients **must** be seen within a maximum **14 days of receipt** of the GP referral.

However the **internal target is 5 working days** for first OP appointment.

- Book the patients in as early as possible whilst continuing to liaise with the service team to try and arrange an appointment for as close to the 14 days as possible (additional slots/overbookings etc.)
- Add a comment in the appointment that this is patient choice if over 5 working days
- Alert both Cancer services and the Specialty Service Team of the patients unavailability to be seen within 14 days

9.6 **BOOKING SYSTEM** - see Section 6 point 6.9

9.7 **OVERBOOKING RULES** - see Section 6 point 6.12

9.8 PATIENT CONTACT

By Telephone: Within 1 working day of receipt of the referral patient will be telephoned, where contact cannot be made by telephone (after a minimum of two attempts at 2 different times) will be attempted.

An appointment confirmation letter will be posted if staff are unable to contacted patients by telephone.

9.9 REASONABLE NOTICE

Reasonable notice does not apply to this group.

9.10 **PATIENT CORRESPONDENCE** - See OP Section 6.0 point 6.13

9.11 DNA's

9.11.1 First OP appointment

If a patient DNA's their initial outpatient appointment i.e. does not turn up and gives no notice, this would allow the clock to effectively be re-set from the receipt of the referral (recorded as the CANCER REFERRAL TO TREATMENT PERIOD START DATE) to the date upon which the patient rebooks their appointment. The Trust shall endeavour to arrange the second appointment within the original 14 days of date of referral but should this not be feasible an appointment shall be made following national guidance.

Should the patient subsequently DNA a second consecutive appointment the patient will be discharged back to their GP (other referrer). The patient's records will be reviewed by the lead clinician and the GP (other referrer) will be sent either a management plan or information on the need for the patient to be referred.
There is only one pause (clock stop) allowed for the TWW (i/c symptomatic breast and RACP) standard.

9.12 PATIENT CANCELLATIONS/RE-ARRANGEMENTS

If a provider receives a referral and the patient is unable to attend any appointment within 14 days, the provider should inform the GP of the situation and advise the clock will be re-started from when the patient is available, rather than cancelling the referral and asking the GP to re-refer as in the spirit of the overarching CWT rules (4.1, 4.1.1 and 4.11).

9.12.1 Appointments Cancelled on the Day

Patients that cancel their appointments on the day (prior to their arrival time) will be recorded as a cancellation as prior notification was received.

9.13 HOSPITAL CANCELLATIONS – See OP section 6 point 6.19

9.14 DIAGNOSTIC FLAG SYSTEM

Patients with suspected cancer who require a diagnostic procedure will be tracked using the cancer tracking system. Individual tumour pathways identify the turnaround times for tests and reporting. Departmental systems CRIS – Radiology etc. will identify the patient as requiring rapid reporting, in some cases this is hot reporting and linked to clinics/lists.

If following a TWW outpatient appointment the consultant decides a patient requires any diagnostic tests, the radiology request cards should be marked with TWW to highlight they are a suspected cancer patient. The pathways agreed should enable direct booking for patients with allocated slots associated with the pathways.

A wait time adjustment cannot be added whilst the patient does not have a cancer diagnosis.

If the patient requires several diagnostic tests, these must be managed within the pathway and tracked using the tracking system.

9.15 CANCER TRACKING – See Cancer Service Standard Operating Procedure

http://intranet/policies-resources/trust-policy-documents/trust-wide-clinical/gen/twcg212/?locale=en/

9.16 COMMUNICATIONS AND REFERRAL PROFORMAS (CaRP)

Communication and Referral Proformas are the official administrative process that transfers the cancer pathway from one organisation to another.

9.16.1 E-CaRPing

A CaRP is required when a patient physically attends another hospital. Even if a patient is just attending for an outpatient appointment they must be CaRP'd. Patients purely for MDT/SMDTS'S discussion don't need CaRP's (diagnostic exclusions apply). See Cancer Service Standard Operating Procedure Manual.

9.17 MULTIDISCIPLINARY TEAM (MDT) MEETINGS

MDT meetings are held weekly, some specialities have fortnightly or monthly meetings.

9.18 IP/DC ADMISSIONS

9.18.1 REASONABLE NOTICE - does not apply to this group of patients

9.18.2 DNA - see Section 8 point 8.12

9.18.3 Patient Cancellation/Re-Arrangements - See Section 8 point 8.13

9.19 PATIENT TRANSFERS FOR IP/DC PROCEDURES - see section 8 point 8.19

9.19.1 Pending Admissions for Tertiary Services

9.19.2 Transfers between Clinicians & Providers - See Section 8, point 8.19

9.19.3 Clinical Transfer - See Section 8, point 8.19.2

9.19.4 Transfer from the Private Sector to SRFT - see section 8, point 8.19.5

9.20 PRIVATE PATIENTS – See Op Section 6 Point 6.20

(A Code of Conduct for Private Practice – Recommended Standards of Practice for NHS Consultants, 2.13 page 4)

Private Patient policy link below:

http://intranet/policies-resources/leaflets/tru/cs0313/?locale=en

Private Patient operational policy link below:

http://intranet/policies-resources/trust-policy-documents/trust-wide-general/op/p13011602/?locale=en

- *Private patients are not included in the CWT tracking process*

9.21 OVERSEAS VISITORS (OSV)

Patients who are identified as OSV must be referred to the OSV officer for clarification of status regarding entitlement to NHS treatment. (Please see the Oversees Visitor policy).

http://intranet/policies-resources/trust-policy-documents/trust-wide-general/fin/fp207/?locale=en

9.22 MONITORING AND VALIDATION

See Cancer Service Standard Operating Procedure.

9.23 CANCER TARGETS - see section 10 point 10.4

9.23.1 62 day decision pathway guidance

In order to meet the Greater Manchester and national standards cancer patients on a 62 day pathway, please see Cancer Services Standard Operating Procedure for further details.

Pathway	First Trust	Second Trust	Third Trust	Breach allocation
2 trust	CaRP'd before day 42	Treated after day 62	N/A	Second Trust
2 trust	CaRP'd after day 42	Treated after day 62	N/A	First Trust
3 trust	CaRP'd before day 19	CaRP'd before day 38	Treated after day 62	Third Trust
3 trust	CaRP'd after day 19	CaRP'd after day 38	Treated after day 62	First Trust
3 trust	CaRP'd before day 19	CaRP'd after day 38	Treated after day 62	Depends on whether Second Trust was for diagnostics or treatment option

10.0 Standards

10.1 ENTITLEMENT TO NHS TREATMENT

Patients are eligible for free NHS treatment at Salford Royal NHS Foundation Trust if they are:
1. Ordinarily resident in the UK
or:
2. Overseas visitors, but entitled to free NHS services under the National Health Service (Charges to Overseas Visitors) Regulations.

See section for Prior Approval

- For referrals from Wales prior approval is needed for referrals to the following specialties
- All Pain Referrals
- GP referrals to Neurology,
- GP referrals to Neurosurgery
- GP referrals to Spinal Surgery

10.2 NHS CONSTITUTION

Since 1st April 2010, NHS Constitution states patients have the right to access services within the maximum waiting times, or for the provider to have taken all reasonable steps to offer a range of alternative providers if this is not possible. This relates to:

- The 18 week standard from referral to consultant led service to the start of their treatment for non-urgent conditions

- The two week standard from referral to seeing a specialist for those who have suspected cancer or, where this is not possible, for the NHS to take all reasonable steps to offer the patient a quicker appointment at a range of alternative providers if the patient makes such a request.

10.3 LOCAL TARGETS

Locally agreed stages of treatment targets will be used for **ALL** patients (including those that are not on an RTT pathway) patient pathway and will be specialty specific for example a pathway:

- 4 weeks to 1st OP appointment
- 4 weeks for diagnostic
- 10 weeks to IP TCI date

10.4 NATIONAL TARGETS

Patients must be treated within the following national waiting time targets. Failure to achieve these targets and thresholds will put them at risk of breaching its terms of authorization as a Foundation Trust and will risk financial penalties within the NHS standard agreed with its commissioner:

- Maximum waiting times from referral to start of treatment are shown below
- Maximum waiting times for cancer as shown below

Referral to Treatment Wait time Targets	
Commitment	**Operational Standard**
Open	92%
Direct Access Audiology	95%
Diagnostic Target	
Less than 6 weeks	99%
Cancer Wait time Targets	
Commitment	**Operational Standard**
62-Day (Urgent GP Referral to Treatment) Wait for: All Cancers	85%
62-Day For First Treatment from First Screening Service Referral for: All Cancers	90%
31-Day (Diagnosis To Treatment) Wait for First Treatment: All Cancers	96%
31-Day (Diagnosis To Treatment) Wait for First Treatment: All Cancers	98%
31- Day Wait for Second or Subsequent Treatment: Anti-Cancer Drug	94%
31- Day Wait for Second or Subsequent Treatment: Surgery	94%
31- Day Wait for Second or Subsequent Treatment: Radiotherapy Treatments	94%
All Cancer Two Week Wait	93%
Two Week Wait for Symptomatic Breast Patients (Cancer not Suspected initially)	93%

11.0 REFERENCES AND SUPPORTING DOCUMENTS (inc Glossary of terms)

- 18 week rules and definitions

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198930/Referal_to_treatment_Rules_Suite.pdf

- Tackling hospital waiting: the 18 week patient pathway - an implementation framework and delivery resource pack

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4134668

- Department of Health (2004) A code of conduct for private practice: recommended standards of practice for NHS consultants http://www.nhsemployers.org/SiteCollectionDocuments/DH_085195.pdf
- Department of Health (2007) '18 Weeks - Defining Success' presentation (Source: Martin Clayton, Salford CCG)
- Department of Health (2007) Choice at Referral – Guidance Framework May. Gateway Reference 20227 http://webarchive.nationalarchives.gov.uk/20080107205405/dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_075116
- Department of Health (2008) Going Further for on Cancer Waits. http://www.nwlcn.nhs.uk/Downloads/Cancer%20Intelligence/Going%20Forward%20on%20Cancer%20Waits%20A%20Guide%20Version%206.8.pdf
- Department of Health (2010) NHS Constitution for England. https://www.gov.uk/government/publications/the-nhs-constitution-for-england
- Department of Health (2010) Operating framework for the NHS for England 2012/13 https://www.gov.uk/government/publications/the-operating-framework-for-the-nhs-in-england-2012-13
- Department of Health (*Updated 18 Clock rules suite)*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198930/Referal_to_treatment_Rules_Suite.pdf
- Department of Health National Direct Access Audiology Clock rules April 2011 https://www.gov.uk/government/publications/allied-health-professional-referral-to-treatment-revised-guide-2011
- Department of Health www.doh.gov.uk/patientlettersissues.htm.
- DSCN Notice 07/2003 Reasonable Notice to Patients

http://www.isb.nhs.uk/documents/dscn/dscn2003/072003.pdf

- DSCN Notice 09/2007 Earliest Reasonable Offer Date

  http://www.isb.nhs.uk/documents/dscn/dscn2007/092007.pd

  http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance

- All waiting list and scheduling procedures
- Health Records Management Policy,

  http://intranet.srht.nhs.uk/policies-resources/trust-policy-documents/trust-wide-general/dcrm/hre106/?locale=en

- Overseas Visitor Policy,

  http://intranet.srht.nhs.uk/policies-resources/trust-policy-documents/trust-wide-general/fin/fp207/?locale=en

EXPLANATION OF TERMS & DEFINITIONS

Active Waiting List	Patients awaiting elective admission for treatment and are currently available to be called for admission.
Active Monitoring	An 18 week clock may be stopped where it is clinical appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage.
Admitted Pathway	A pathway that ends in a clock stop for admission for treatment (day case or inpatient).
Clinical Commissioning Group (CCG)	Are groups of GP practices that are responsible for commissioning most health and care services for patients
Could Not Attend (CNA)	Patients who notify the hospital that they are unable to attend a previously agreed appointment regardless of notice period.

E-referral system	Electronic system by which GPs can refer patients directly to a service and can either book the appointment with the patient or the patient can book at their own convenience via Health space on the Internet or the National Telephone appointment line.
Clock Pause	A clock pause for patient wait time (Oct 15) can be no longer used as these delays have been accounted for in the tolerance of the 92% target.
Day Cases (DC)	Patients who require admission to the hospital for treatment and will need the use of a bed/trolley/recliner but who are not intended to stay in hospital overnight.
Decision to Treat	Where a clinical decision is taken to treat the patient. This could be treatment as an IP or DC, but can also include treatments performed in other setting e.g. OP
Department of Health (DOH)	The Department of Health works to improve the quality and convenience of care provided by the NHS and social services.
Did Not Attend (DNA)	Patients, who have been informed or agreed their admission date (inpatients/day cases) or appointment date (outpatients) and who, without notifying the hospital, did not attend for admission/OP appointment.
Elective Admissions	Where a decision to admit a patient for treatment is made that is not an emergency. The patient will be placed on an elective admission waiting list.
First definitive Treatment	An intervention intended to manage patient's disease, condition or injury and avoid further intervention. First definitive treatment is a matter

	of clinical judgement
Fully Booking	Patients awaiting an elective admission/appointment who have been given an opportunity to agree an appointment/admission date over the telephone following an outbound calling. These patients form part of the active waiting list. This process should be used with all patients booking, where possible.
Hospital Initiated Cancellation	A cancellation of admission by the hospital
Independent Booking Service (IBS)	A telephone appointments service that makes the link between the referral sent using the E-referral system but there is no IT interface with the provider units booking system.
Non Admitted pathway	A pathway that ends in treatment that does not require an admission or a clock stop for 'non treatment'.
Non Consultant led	Where a consultant does not take overall clinical responsibility for the patient.
NCEOPD	National Confidential Enquiry into Patient Outcome & Death.
Outpatients (OP)	Patients referred by a general practitioner or another clinical professional i.e. another Consultant/Dental Practitioner for clinical advice or treatment not requiring admission.
Partial Booking	Where admission/appointment the patients will be placed on the appropriate Consultant/Clinicians waiting list. An appointment will be agreed with the patient a minimum of 3 weeks in advance of the expected due date.

Primary Targeting List	A list of all patients whose treatment needs to be planned to meet target wait times.
Planned Admissions	Patients who are to be admitted as part of a planned sequence of treatment or investigation. They may or may not have been given a firm date.
Unfit For Surgery	A list of patients awaiting elective admission who are currently unsuitable for admission due to some underlying medical reason.
TCI	To come in, the date of a patient's admission to hospital
	The tolerances take into account delays in patient care for other patient initiated delay and clinical exceptions. For open pathways the standards for compliance is 92%.

12.0 ROLES AND RESPONSIBILITIES

This section outlines the key responsibilities of key groups of staff within the Trust in relation to this Operating Procedure Manual.

12.1 Director of Strategy and Development - will be responsible to the Board of Directors for ensuring the Operating Procedure Manual is implemented and adhered to and will performance manage the implementation of the Manual via the Trust Executive Finance & Information Committee.

12.2 Director of Finance - will ensure the Trust is maximising its clinic and theatre capacity whilst adhering to the NHS Executive guidelines regarding:

- Total number on waiting list
- Cancelled operations/clinic
- Waiting times targets
- Planned Waiting List

12.3 Chief Information Officer - will ensure robust and timely information is produced and made available to Trust management as appropriate. Data entry is accurate and complies with national and local data standards and will ensure:

- Consistent waiting list reporting is achieved internally and externally
- System changes are actioned in liaison with suppliers
- Software and process changes are implemented in liaison with users
- Information feeds through Prodocapo reliability on a daily basis

12.4 Managing Directors via their Service Management Teams - will be responsible for ensuring all patients receive treatment within national and locally agreed targets, and that all staff adhere to the Trust's Patient Access Policy and Patient Access Operational Manual.

12.5 Consultants/Clinicians - Each Clinician/ Consultant will decide which patients require adding to a waiting list and their clinical priority. Consultants/Clinicians will be responsible for the care of all patients listed on their waiting list they receive their treatment within national and locally agreed targets.

All clinicians and their clinical teams are required to provide at least six weeks' notice before the date for commencement of the leave period (i.e. planned study leave and meetings), and submit the relevant form to the relevant Clinical Director/ADNS for approval.

Clinicians will be responsible for reviewing patient's records for those requiring re-scheduling following a hospital clinic cancellation to ensure patient care is not compromised.

Clinicians and their clinical teams will be responsible for ensuring all E-referral system referrals and paper referrals are reviewed within one working day of receipt into the organisation.

12.6 Health Records - Clerks will be responsible for locating case-notes, preparing either in an electronic or paper format and delivering notes to the appropriate clinic/reception area prior to the clinic/patient appointment.

12.7 Lead Manager ABC - Will be responsible for maintaining the Directory of Services (Dos) and ensuring outpatient referral processes are reviewed in line with the evolvement of E-referral system.

12.8 Waiting List Coordinators/Medical Secretaries - Will be responsible for adding and the administration of patients to the OP/IP/DC/Diagnostic waiting list(s) on iSOFT Patient Centre /CRIS/IPM as appropriate to their role.

Medical Secretaries must ensure all patients/GP correspondence is typed and dispatched within five working days of the patient event and that the hospital IT system is updated accordingly.

Medical Secretaries must also complete a minimum data set (MDS) on an Inter Provider Transfer (IPT) form for all patients being referred either internally or to another provider.

12.9 Wards & Departments – Must ensure patients are admitted and discharged on iSOFT Patient Centre; recording out-comes against pre-admissions if patients DNA or CANCEL. Ensure all case-notes are available for admission date and all patient movements within the hospital are accurately recorded on iSOFT Patient Centre i.e. ward transfers, hospital transfers, admitting consultant changes or discharged.

12.10 Bed Managers/Theatre Staff - must contact the Senior Manager or SMOC (out of hours) before cancelling a patient due to lack of bed availability, advising on the patient's length of wait, relevant circumstances and also inform the Consultant's Secretary/Service Management Team of the hospital cancellation in order to facilitate a new TCI date that is within 28 days.

12.11 MDT Coordinators – Will be responsible for monitoring of all patients on the cancer tracking system and to monitor that their treatment is within national and locally agreed targets.

12.12 Patient Access Clerks/Receptionists - Must ensure all patients are registered within one working day and are added to an 18 week pathway, ensuring that all appointment/admissions are accurately recorded on iSOFT Patient Centre.

12.13 Clinical Commissioning Groups/Commissioning Support Unit /General Practitioners Play a pivotal role in ensuring the following:

- Robust communication pathways are in place to feed back to GP's
- Patient referrals are managed via the national E-referral system electronic booking system
- Patients are 'ready' to start their treatment and progress if necessary without any unnecessary delay during consultation
- Management of patients on receipt of the unfit for surgery proforma from SRFT and be responsible for addressing medical reasons
- Management of patients as appropriate, when informed by SRFT, that the patient has DNA'd their admission/appointment and has been removed from the waiting list
- Management of patients as appropriate, when informed by SRFT that the patient has cancelled their admission on two occasions and has been removed from the waiting list

APPENDIX 1 INTER PROVIDER TRANSFER FORM

Salford Royal NHS
NHS Foundation Trust
University Teaching Hospital
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Inter-Provider Transfer Minimum Data Set

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

Referring Organisation Details:	
Referring Organisation Name: Salford Royal NHS Foundation Trust	Referring Organisation Code: RM3
Referring Clinician:	Referring Clinician Registration Code:
Referring Treatment Function Code:	Contact Name:
Contact Phone:	E-mail:

Patient Details:	
Patient's Family Name:	Patient's Forename:
Title:	Date of Birth:
NHS Number: 6109101001	Local Patient Identifier:
Correspondence Address: Post code:	Contact Details: Patient is lead contact: Lead contact name if not the patient: Home: Work : Mobile: E-mail:

GP Details:	
GP Code/Name:	GP Practice Code/Name:

Referral To Treatment Information:	
Patient Pathway Identifier:	Allocated By (organisation code):
Is the patient on an 18 Weeks RTT pathway?:	YES
Is the referral the: - Start of a new pathway (new condition or change of treatment) Y/N - Continuation of an active pathway (1st definitive treatment not given) Y/N - Continuing treatment for a stopped pathway (1st definitive treatment given) Y/	
Is this referral for: - Diagnostic tests only Y/ N - Opinion only Y/N	
Date of decision to refer to receiving organisation:	Clock start date *(Date the patient started on the existing pathway or the date of this referral if it starts a new pathway):*
List all organisation involved in the 18 Weeks pathway:	

Receiving Organisation Details:	
Receiving Organisation Name:	Receiving Organisation Code:
Receiving Clinician:	Receiving Treatment Function Code:
Date and time MDS sent:	

For Receiving Organisation:
Date/time received:

APPENDIX 2 EXTERNAL NAC's PROVIDER CODES

Abbreviations/format to be used when recording external outpatient referrals in the referral free test comment field on iSOFT Patient Centre:

TRUST	CODE
Aintree University Hospitals NHS Trust	REM
Ashton, Leigh & Wigan	5HG
Blackpool Fylde & Wyre NHS Trust	RXL
Bolton Hospitals NHS Trust	RMC
Bury	RW6
Central Manchester & Manchester Children's	RW3
Central Manchester & Manchester Children's	RW3
Christie Hospital NHS Foundation Trust	RBV
Countess of Chester NHS Foundation Trust	RJR
East Cheshire NHS Trust	RJN
Lancashire Teaching Hospitals	RXN
Liverpool Women's NHS Foundation Trust	REP
Mid Cheshire NHS Foundation Trust	RBT
North Cheshire NHS Trust	RWW
North Pennine Acute	RW6
Salford Royal Foundation Trust	RM3
Southport & Ormskirk NHS Trust	RVY
St Helens & Knowsley	RBN
Stockport Acute NHS Foundation Trust	RWJ
Tameside Hospital NHS Foundation Trust	RMP
Trafford Healthcare NHS Trust	RM4
University of Morcombe Bay NHS Trust	RTX
University of South Manchester	RM2
Walton Centre	RET
Wrigtington Wigan & Leigh NHS Trust	RRF

APPENDIX 3 DATA QULITY REPORTS

PAP Data Quality reports.docx