Access, Booking and Choice Policy and Operational Procedures

Date Approved	
Ratifying Body	Access Improvement Task Force
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1.0 Introduction

The Royal National Orthopaedic NHS Trust (RNOH) is committed to ensuring that patient access to services is transparent, fair and equitable and is managed according to clinical priority, the NHS Constitution and national and local guidelines.

The purpose of this policy and its associated documents is to ensure that patients are treated in a timely and efficient manner. Providing both clarity on national and local guidelines in place for managing patient access to elective services, eliminating any unnecessary waiting, thus supporting a maximum wait of 18 weeks from referral to first definitive treatment.

- Patients receive treatment according to their clinical priority.

- Routine patients and those with the same clinical priority are treated in chronological order.

The policy aims to provide assurance of embedding requirements of the NHS Planning Guidance and the commitments made to patients in the NHS Constitution throughout the patient pathway at RNOH.

https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

This policy covers key elements that support the patient access process. This policy should be read in conjunction with:

- Cancer Access Policy - the London Sarcoma Service Operational Policy.
- DOH Referral to Treatment Consultant Led Waiting Time Rules Suite
- RNOH Therapies Booking SOP
- RNOH Booking First and Follow up Appointments SOP
- RNOH Partial Booking SOP
- RNOH DNA SOP
- RNOH Cancellations SOP
- RNOH Theatre Scheduling Policy SOP
- RNOH Staff Customer Service SOP

This policy applies to all administration and clinical prioritisation processes relating to patient access managed by The Royal National Orthopaedic NHS Trust, including outpatient, inpatient, day case, therapies and diagnostic services.

This policy and associated documents have been formally approved by the Senior Management Team and will be applied consistently without exception across the Trust. This will ensure that all patients are treated in accordance to their clinical need. Cancer patients will be prioritised according to national

guidance (Cancer Access Policy). The administration of non NHS patients including overseas visitors is not covered by this policy and should be managed according to the Overseas Visitors Policy. However, should these patients be accepted by the Trust they will be treated in accordance to the guidelines set out in this policy.

This policy must be adhered to by all staff within the Trust who are responsible for referring patients, managing referrals, adding to and maintaining waiting lists for the purpose of taking a patient through their treatment pathway.

The Head of Operations and Clinical Director(s) have the overall responsibility for implementing and ensuring adherence to the policy within their area. Adherence to this policy will be routinely monitored by the Operational Management and Access, Booking and Choice (ABC) groups.

2.0 Objectives

2.1 This policy sets out the way in which RNOH will manage patients who are waiting for treatment on admitted, non-admitted or diagnostic pathways. It covers the management of patients at all sites where RNOH operates.

2.2 Every process in the management of patients who are waiting for treatment must be clear and transparent to the patients and to partner organisations and must be open to inspection, monitoring and audit.

2.3 RNOH will work to meet and improve on the maximum waiting times set by the Department of Health for all groups of patients.

2.4 RNOH will aim to negotiate appointment and admission dates and times with patients.

2.5 RNOH will work to ensure fair and equal access to services for all patients in accordance with the Equalities Act 2000.

2.6 In accordance with training needs analysis, staff involved in the implementation of this policy, both clinical and clerical, will undertake training provided by RNOH and regular annual updates. Policy adherence will form part of the staff appraisal process.

2.7 RNOH will ensure that management information on all waiting lists and activity is recorded on an appropriate system.

2.8 RNOH will give priority to clinically urgent patients and treat everyone else in turn. War pensioners and service personnel injured in conflict must receive priority treatment if the condition is directly attributable to injuries sustained in conflict.

3.0 Scope

3.1 This policy sets out or advises on the overall expectations of RNOH and local Commissioners on the management of referrals and admissions into and within the organisation, and defines the principles on which the policy is based.

3.2 A separate Booking and Scheduling User Manual reflects the processes by which the Policy expectations are activated.

3.3 This policy and the User Manual are intended to be of interest to and used by all those individuals within RNOH, who are responsible for referring patients, managing referrals, adding to, and maintaining waiting lists for the purpose of organising patient access to hospital treatment. The principals of the policy apply to both medical and administrative waiting list management.

4.0 National Access Standards

4.1 The national standards as set out in the NHS Planning Guidance

- 92% of patients on an incomplete pathway (admitted and non-admitted pathways) should have been waiting no longer than 18 weeks.
- 99% of patients requiring a diagnostic test should have been waiting no longer than 6 weeks from referral.

4.2 These measures include the various stages of the outpatient consultation, any diagnostic procedures and inpatient treatment. These are maximum waits and not a target. The Trust will challenge itself to ensure that the majority of patients are seen in a much shorter timeframe.

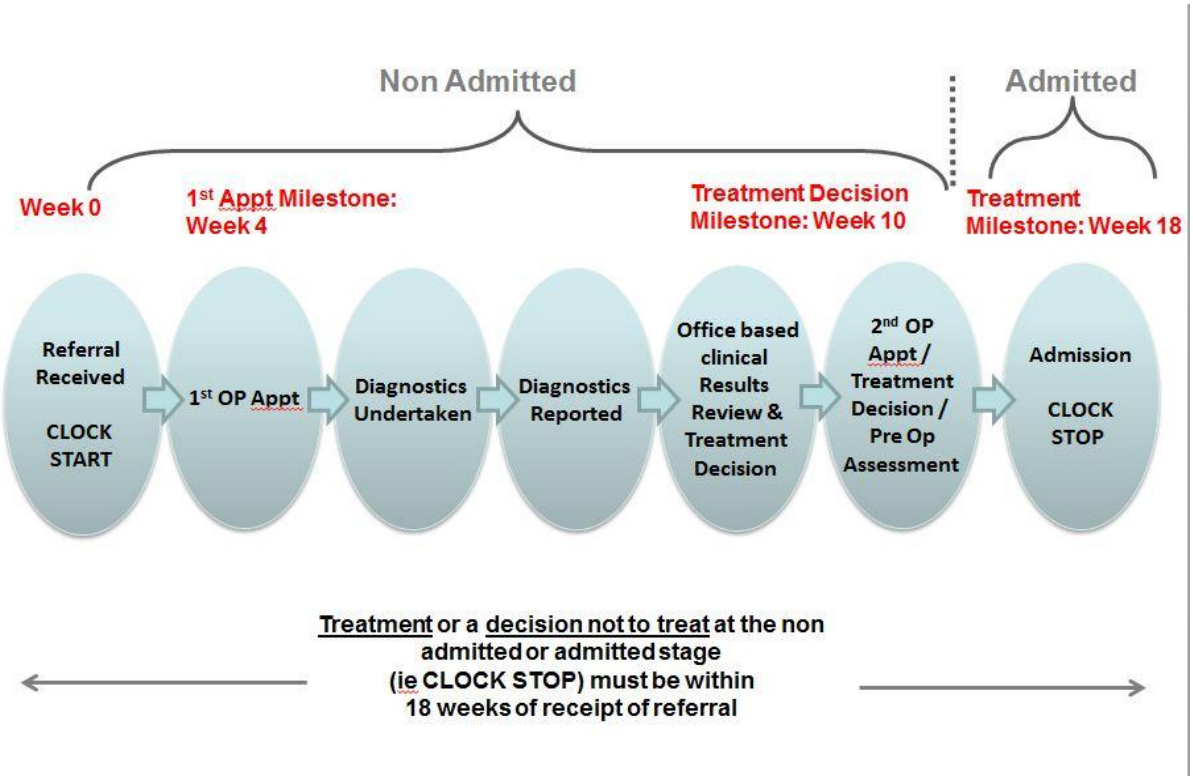
4.3 As set out above, the national standard is for all non-emergency patients to be treated within 18 weeks, where clinically appropriate and the patient chooses to do so, and this is what the trust is committed to delivering. However the Trust will continually challenge itself with the aim being to reduce all maximum waits.

4.4 To assist with the deliverance a maximum wait of 18 weeks the Trust's current aim is to deliver a maximum wait for first outpatient appointment of 4 weeks from the receipt of referral, 6 weeks for all diagnostic procedures and 8 weeks from the date of decision to treat to first definitive treatment.

4.5 For urgent referrals the Trust will aim to deliver a maximum wait of 2 weeks for first outpatient appointment, from receipt of referral, 2 weeks for all diagnostic procedures and 3 weeks from date of decision to treat to first definitive treatment.

5.0 Referral Management Process

Referrals to RNOH are managed through central and decentralised teams. For details of the referral process please refer to the RNOH Booking first and follow up appointments SOP, the diagram on the following page provides a graphical overview of waiting times and steps in the patient pathway.



Pathway milestones will be managed according to individual specialties.

See Appendix 1

6.0 Cancer Waiting Times

The headline performance measures for 2015/16 are against a minimum threshold of:

- 93% of patients referred as an urgent cancer referral will be seen within two weeks.
- 85% of patients receiving their first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.
- 96% of patients receiving first definitive treatment within one month of a cancer diagnosis.

- 94% of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery or radiotherapy.

http://www.ncin.org.uk/collecting_and_using_data/data_collection/gfocw

7.0 Exclusions from 18 week RTT reporting

7.1 The following activity is excluded from the 18 week RTT standard. However, the principles set out in this document must be followed for all patients:

- Emergency admissions.
- Elective patients undergoing planned procedures (removal of metalwork, procedures related to age/growth, check cystoscopies etc.)
- Patients receiving ongoing care for a condition where the first definitive treatment for that condition has already occurred.
- Patients whose 18 week clock has stopped for active monitoring, even though they may still be followed up by their consultant.

8.0 Private Patients

8.1 The Trust will neither advantage nor disadvantage Private patients. Private patients may transfer to the NHS for treatment; they are treated in chronological order relevant to their pathway.

8.2 Patients seen privately for diagnostic assessment must be referred (usually by Consultants to themselves) and attend an outpatient / pre-admission appointment.

8.3 Private patients may join or leave the NHS system at any stage, but may not 'bounce' between the two systems.

8.4 Some Private Providers offer consultation and treatment under NHS arrangements for commissioning and payment. They must offer similar services to NHS providers and, again patients must be neither advantaged nor disadvantaged. The Trust will treat NHS patients with a Private Provider in exactly the same way as those with NHS providers, regardless of the clinician involved.

8.5 The Trust will cooperate with commissioners and others to ensure the principle of equity for all patients is maintained and, if necessary, enforced.

9.0 Responsibilities

9.1 The accountability for effective implementation and adherence to this policy sits with the Chief Operating Officer and Medical Director (s).

9.2 The Trust will ensure all staff (both administrative and clinical) have access to the Access Booking and Choice Policy and associated documents and have received appropriate role based training to ensure competency and adherence to the policy.

9.3 All staff are responsible for ensuring that any data created, edited, used or recorded in all Trust systems is done so accurately and in accordance to this and other Trust policies relating to the collection, storage and use of data held by the Trust to maintain the highest standards of data quality and patient confidentiality in accordance with Trust Information Governance policy.

9.4 Head of Operations and Clinical Director (s)

The Head of Operations and Clinical Director(s) have overall responsibility for implementing and ensuring adherence to the Elective Access Policy within their area. This includes:

- Ensuring effective processes are in place to manage patient care and treatment that meets national, local and NHS constitution targets and standards.
- Managing allocated resources with the aim of achieving access targets. This includes having the staff and other resources available to provide scheduled outpatient clinics, treatment and theatre sessions and to avoid the need to cancel a patients agreed date of admission/appointment.
- Working with and be supported by General Managers and Clinical Leads to provide a joined-up approach to implementing this policy and delivering patient care in line with national, local and NHS constitution targets.
- Ensure appropriate escalation mechanisms are in place to support prompt intervention of any difficulties.

9.5 Divisional General Manager

The Divisional General Manager must work in conjunction with the Head of Operations and clinical teams and will have day to day responsibility for:

- Reviewing demand and capacity of the service and forward plan appropriately.

- Implementing effective local monitoring systems to ensure compliance with this policy and avoid breaches of the targets.
- Ensuring any deviation from policy or occurrence of target breaches are reported on Safeguard in line with the Trust incident reporting procedure.
- Implementing systems and processes that support data quality, ensuring that any validation is accurate and completed within agreed timescales.
- Escalating any difficulties which are not being resolved in the timescale required.
- Ensuring the staff that need to operate this policy are aware of the policy and have received the necessary training.

9.6 Consultant

Each consultant is responsible for ensuring:

- All patient referrals are vetted within 3 working days from the date of scanning.
- Any inappropriate referrals are returned to the referrer within 5 working days with a documented explanation as to why.
- Working with the management team to manage medical staff's leave to ensure that scheduled outpatient clinics, patient treatments or theatre sessions are not cancelled.
- Waiting times are accurately communicated to patients and/or their carers.
- With the support of the management team ensure that robust processes are in place to make sure patient care and treatment plans are delivered in line with clinical need and within timescales set out in national, local and NHS constitution targets.

9.7 Scheduler and Clerical Staff

The role of Schedulers and Clerical Staff with waiting list responsibility includes:

- Maintaining accurate and up to date waiting list data on the relevant patient administration system.
- Maintaining accurate demographic details for patients, ensuring contact details are confirmed with the patient at every appropriate opportunity.
- Ensuring appropriate referral to treatment status is recorded on ICS.

- Ensuring all appointment/admission dates are fully agreed with the patient, as set out in this policy.

- Ensuring the administration of patients on the waiting list is carried out in line with this policy and other relevant policies/standard operating procedures.

- Escalating any potential issues or areas of concern to the appropriate manager and consider the need to report as clinical incident on safeguard.

10.0 Details of the Policy

10.1 Management of New and Follow Up Outpatient Appointments (Booking & Scheduling User Manual Section 3)

10.2 Outpatient Referrals

- Referrals must be registered and scanned onto RNOH systems within 24 hours.

- Clinical review must take place within 2 working days of receipt of referral.

- Patient contact must be made within 4 working days of receipt of referral.

- Where patients cannot be contacted their care will be transferred back to their GP, with both patient and GP being informed in writing.

10.3 General Principles for Booking

- All patients must be seen in order of clinical priority and length of wait.

- Patients have an opportunity to negotiate their appointment time and date.

- No adjustments can be made for patients waiting for an outpatient appointment.

- No adjustments can be made for patients waiting for a diagnostic appointment.

- A decision to add an outpatient, diagnostic or elective waiting list must be recorded on an approved information system within one working day.

- Patients will only be added to the waiting list if there is a real expectation that they will be treated, and that given reasonable notice the patient is willing to make themselves available for treatment.

- All communication with patients (or parents/carers) will be timely, informative, clear and concise.

10.4 Reasonable Offer

- A reasonable offer is a date that is at least three weeks from the time of the offer being made.
- Patients who decline one reasonable offer must be offered one further reasonable date.
- If two reasonable offers are declined for either a new or follow up consultation, a clinical review will be conducted and if deemed to be in the patient's best clinical interest, the patient's care will be transferred back to their GP.
- All appointments will be confirmed in writing.

10.5 Clinic Cancellation or Reduction

Every effort is made NOT to cancel clinic appointments:

- A minimum of six weeks' notice of planned clinic cancellation, reduction or additional capacity must be given by all clinical staff, together with the reason. Any changes to clinic configuration, including reduction or cancellation which are within the six weeks' notice period must be authorised by the Operational Manager and will only be approved in emergency or in exceptional circumstances.
- All proposed clinic reductions and cancellations should be discussed with Clinical Director for the service and all possible cover arrangements explored to prevent clinic cancellations taking place. CNS clinic cancellations should be discussed and managed by the relevant Matrons.
- Only in exceptional circumstances, when all possible cover arrangements have been explored, should patients be cancelled. In these instances it may be appropriate for medical staff to review the case notes.
- The clinic appointments will be reviewed initially by the Inpatient or Outpatient scheduler to ensure that no patients breach the waiting time targets as a result of cancellation/reduction. Any potential RTT breaches caused as a result of clinic cancellation will be brought to the attention of the Head of Operations for advice or direction. **(Refer to Clinic Cancellation SOP)**

10.6 Patient Did Not Attend (DNA)

A DNA occurs when:

- The patient (with the exception of paediatrics and vulnerable adults) does not attend their hospital appointment.
- No contact between the patient and the RNOH has been made up to the appointment time to justify the reason for not attending.
- The Trust policy is that a patient who has failed to attend their first outpatient appointment will have their care transferred back to their GP having first ensured that:
    - The patient's case notes have been discussed with the clinical team.
    - We have confirmation the appointment has been communicated to the patient.
    - Discharging the patient is not contrary to their best clinical practice.

Where the responsible clinician believes that one of these criteria applies, the patient can be offered a second appointment date. All patients should be transferred back to the care of their GP following a second consecutive DNA. Patient GP will be notified in writing.

If a patient has failed to attend a diagnostic test or pre-operative assessment appointment the patient will be transferred back to the clinical team with a view to discharge.

If a patient fails to attend a follow up outpatient appointment they will be transferred back to the care of their GP in line with the DNA criteria outlined above, providing it is not contrary to their best clinical interest. **(Refer to Patient DNA SOP)**

10.7 Cannot Attend (CNA)

- Patients are able to cancel their outpatient appointment before their agreed time and date without on two occasions before their care is transferred back to the referring Trust/ GP. This will only be done following a clinical review and if deemed in the patients best interests.

10.8 Paediatric or vulnerable adult DNA

On first DNA for paediatric patients at the discretion of the responsible clinician a further appointment or admission can be offered. Factors which could suggest a second appointment or admission date being offered are:

a) Severity of referring medical condition.

b) Vulnerability of the child **(refer to Child Protection Policy.)**

c) Existing Social Care or child protection issues.

Whilst it is preferred that the responsible clinician review the case notes of those paediatric patients that DNA, it is acceptable that this is undertaken by the designated paediatric outpatient nurse where present. For follow up patients the responsible clinician should make the decision taking into account the patient's previous management and diagnosis.

In line with the Trust's Child Protection Policy it may be appropriate to contact the Child Protection team after the first DNA. A referral should be made to the Trust's Social Work department for ongoing monitoring and investigation.

If it is decided to reappoint, the department responsible for booking this appointment should first check the patient's contact details with the GP before calling/ letters being sent.

All patients that DNA on a second appointment should be referred to the Trust's Child Protection Team **(refer to Child Protection Policy).**

Should a referral be made to the Child Protection Team, the management of the patient's condition remains the responsibility of the consultant to which the child was originally referred.

On first DNA of a vulnerable adult, the clinical team and Social work team lead must be informed and patient given a second appointment. The operational management team will:

- Discuss the patient with clinical team.
- Inform the Trust's Social Work team that DNA has occurred.
- Attempt to contact the patient and establish reason for DNA.
- Agree a second date and inform the patient by phone.
- Inform the GP of the second appointment.

10.9 Letter following DNA

Where the patient is discharged, both the GP and referring clinician, if different, shall be informed by letter.

Where the patient is re-appointed, the automatic PAS generated letter states that they have failed to attend a booked appointment, and that failure to do so on a second occasion (without prior contact) will lead to the Trust's Child Protection Team being alerted.

For more detail on the paediatric DNA process please refer to **Booking & Scheduling User Manual section 3**

10.10 Inappropriate referrals

If a consultant deems a referral to be inappropriate, it must be sent back, and the decision communicated to the referring GP with an explanation of why and the 18 week clock stopped. The referral decision must be updated and discharged accordingly on the system. This can happen at any point in the pathway, but the Trust aims to identify these before the first appointment is allocated.

If a referral has been made and the special interest of the consultant does not match the needs of the patient, the consultant should cross-refer the patient to the appropriate colleague where such a service is provided by the Trust and the referral amended accordingly on the system.

11.0 All Trust Cancellations

The Royal National Orthopaedic Hospital will ensure that Trust-initiated cancellations are kept to a minimum and patients will be re-booked for the appointment/procedure as close to the original date as possible and in line with the NHS Constitution. Cancellations will be rebooked within 24 hours.

12.0 Management of Diagnostic Appointments and Admissions (Booking and Scheduling User Manual section 3)

12.2.1 Patients Referred on for Diagnostics

- Referring clinicians are responsible for informing patients of the likely waiting time for diagnostic tests.
- Where treatment has not been given, subsequent appointments must be given within in the RTT breach date.

12.2.2 Diagnostic Referrals

All Access policy rules apply equally to diagnostics appointments and admissions.

Patients could be referred for diagnostic investigations via the following scenarios:

- Direct Access – whereby the patient's care remains with the GP / referrer. The GP / referrer will review the results to decide if the patient needs to be referred for consultant led treatment.

- Straight to Test – whereby there are locally agreed pathways where the patient is being referred for consultant led treatment but will have relevant diagnostic tests undertaken prior to their first outpatient appointment.
- Part way along an RTT pathway.

Diagnostic departments should have mechanisms in place to ensure that they know the patient's RTT status and their current wait time.

https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/

12.2.3 Arranging Diagnostic Appointments and Admissions

- For diagnostic appointments and admissions a 'reasonable offer' is considered to be a date with at least two weeks' notice.
- At least one attempt will be made to telephone the patient to make a reasonable offer, then the patient can be sent an appointment / admission date, including a clear offer to the patient to call to negotiate a date.
- Should a patient be unable to accept a date within two weeks, one further date with at least three weeks' notice will be offered.
- An RTT adjustment cannot be applied for any patient waiting for an outpatient or inpatient diagnostic procedure.

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- Should a patient be unable to accept a date within two weeks, one further date with at least two weeks' notice will be offered.
- An RTT adjustment cannot be applied for any patient waiting for an outpatient or inpatient diagnostic procedure.

12.2.5 DNA Diagnostic Appointments

Patients who DNA a first diagnostic appointment can have a second appointment booked within 2 weeks.

A second DNA will result in a letter to the referrer, who will transfer the patient's care back to the GP with advice.

12.2.6 Results Reporting

Reporting of results must be made available in time to allow progress through all likely stages of the RTT pathway.

13.0 Management of Elective Admissions (Booking and Scheduling User Manual section 3)

13.1 Adding Patients to an Inpatient Waiting List

On the date of admission for treatment, the clock stops for that pathway period. The decision to add patients to the waiting list must be made by the consultant or designate (eg SpR).

The patient must have accepted the clinician's advice on elective treatment prior to being added to the waiting list.

Additions to the waiting list must be made within one working day of the decision to admit.

Patients must not be added if:

- They are unfit for procedure.
- Further investigations are required first.
- Not ready for the surgical phase of treatment.
- They need to lose weight.
- There is no funding available for the intended treatment.

13.2 Use of Planned Waiting List

Planned waiting list patients are those who are waiting to be recalled to hospital for a known further stage in their course of treatment or investigation/intervention. These patients are not waiting for a first treatment date - they have commenced their treatment and there is a plan for the subsequent stages of that treatment. Examples include:

- Removal of metalwork
- APD Infusion
- Fluoro Guided Intervention
- Facet Injection
- Magnetic Imaging
- Rehabilitation of shoulder

.

Patients should only be on a planned list if there are clinical reasons why the patient cannot have the procedure or treatment until a specified time. Patients on planned waiting lists should not be on open 18 week pathways. There should be no patients on a planned waiting list for social reasons.

If planned patients are not treated when planned they will be transferred to an RTT pathway and the clock will stop once they have received treatment. Planned patients should have a treat by date entered onto PAS.

13.3 Selecting Patients for Admission

- Clinically urgent patients will be prioritised according to need
- All routine elective patients must be managed chronologically in order of RTT waiting time.

13.4 Contacting Patients to Arrange a Date for Elective Admission

Patients will be contacted by telephone to arrange their admission date and this date confirmed in writing. Where patients cannot be contacted via telephone or in writing, they will be transferred back to their referrer.

13.5 Reasonable Offer

- A reasonable offer for an elective admission is a date with at least three weeks' notice.

- Where a patient declines a second reasonable offer, please consider clinical advice to:
  - Transfer the patient care back to referring Trust/GP
  - Offer a telephone clinic for advice where possible
  - Escalate to operational managers

All early reasonable offer dates (EROD) and reasons for declining offer must be recorded in the PAS system.

All periods where patients are not available for surgery must be recorded onto the PAS system.

13.6 Patients 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 their surgery, they must be removed from elective waiting list.
- Patients cannot be suspended for medical reasons.

13.7 Did Not Attend (DNA)

- Patients (with the exception of paediatrics and vulnerable adults) who do not attend their date for elective admission will be transferred back to the referrer.
- Clinically urgent patients can be offered one further admission date

13.8 Cancellations on Day of Surgery

- Following a "last minute cancellation" (on the day of surgery, day of admission or following admission), patients have a right to be offered a new date for treatment that is both within 28 days of the cancellation and within their RTT breach date.
- Where a patient cannot be re-booked within 28-days following a cancellation by RNOH, they will be offered the choice to have the procedure in the private sector funded by RNOH.

13.9 Tertiary/Inter-Provider Referrals

A tertiary referral received by the Trust will be expected to include the 18 week national mandatory Inter Provider Transfer Administrative Minimum Data Set (IPT MDS) which includes the date the original Trust received the referral. The Central Booking Office must:

- Check if the patient is already registered on iCS and if so, check all details on iCS are the same as those on the referral.
- If not already on iCS, register the patient (look up any missing data on the NHS Portal).
- Write the patient's hospital number on the referral.
- The RTT team checks all new and opinion only tertiary referrals for the MDS. If the original clock start information is missing the RTT team will chase the referrer for it. If the referrer does not respond within 48 hours a new clock start date is given.
- Patient Pathway Tracker must be updated.

Consultants referring patients to other providers are required to use the mandatory national 18 week IPT MDS template for each referral (see Appendix B). If the IPT MDS form is not received, contact should be made with the referrer to request this information. This should be provided within 3 working days or the referral should be returned to the sender.

14.0 Monitoring Compliance with the Policy

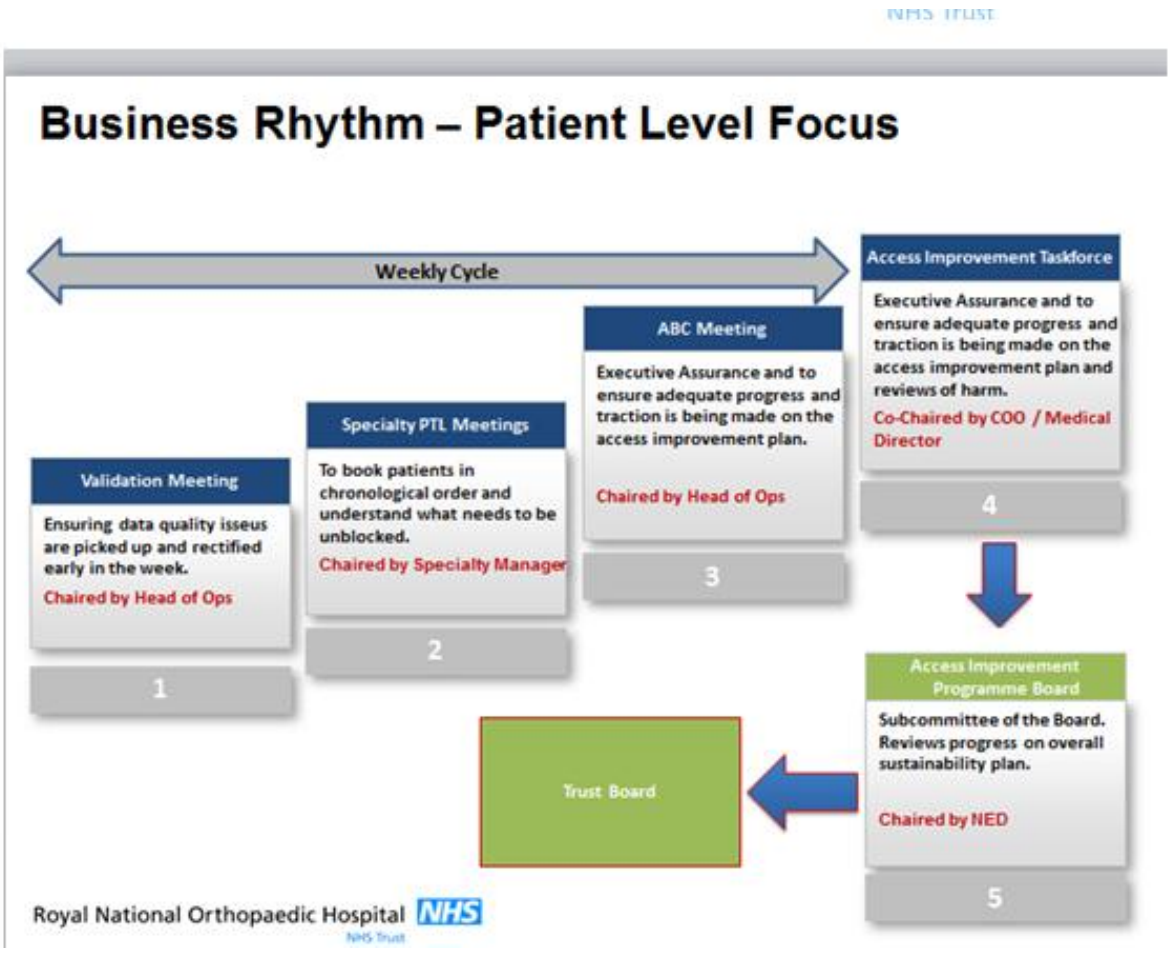
14.1 The Trust Board monitors performance against patient access targets on a monthly basis.

14.2 Weekly Validation meeting ensures that data quality issues are picked up and rectified early on every week. This meeting is chaired by the Head of Operations.

14.4 Weekly Specialty PTL Meetings ensure that patients are booked chronologically and any challenges are managed. This meeting is chaired by specialty managers.

14.5 Weekly ABC Meetings provide executive assurance and ensure adequate progress and traction is being made. This meeting is chaired by the Head of Operations.

14.6 The following structure is in place:



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APPENDIX 1 - 18 Week Clock Starts and Stops

Introduction

This appendix sets out the detailed rules which govern when 18 Week clocks start and stop. It has been developed in accordance with the national rules for 18 Weeks contained in the DH guidance Referral to treatment: consultant-led waiting times rules suite.

An 18-week clock starts with:

- Referral from a GP to a consultant-led service – the clock starts on the date that the referral is received by the provider
- CAB referrals – the clock starts on the date that the patient converts their Unique Booking Reference Number (UBRN)
- Other primary care referrals including
- Nurse Practitioners
- GPs with specialist interest
- AHPs
- General Dental Practitioner
- An interface or referral management service which may result in an onward referral to a consultant led service before responsibility is transferred back to the referring health professional or GP. If a referral is received from a referral management service (RMS) the clock will have been started when the RMS received the referral
- When a patient needs surgery on both sides of their body, for example both hips is fit and ready to proceed with their second operation. When a new treatment plan is started which is not already part of the existing care plan
- A re-referral to a consultant-led service having previously been discharged with a clock stop event
- When a decision is made to treat following a period of active monitoring e.g. at a follow-up OPA
- When a patient rebooks their OPA following a first appointment DNA that stopped and nullified their earlier clock

An 18-week clock stops when first definitive treatment starts, which could be:

- Treatment provided by an interface service

- Treatment provided by a consultant-led service
- Date of admission as a day case or as an inpatient for an elective procedure
- Date treatment given or started in outpatients

Treatment from an 18-week pathway perspective is defined as "the start of the first treatment intended to manage the patient's disease, condition or injury and includes:

- Drug therapy
- Advice and guidance to the patient
- Minor procedure undertaken in outpatients
- Inpatient/day case admission for a treatment procedure
- Physiotherapy
- Fitting of medical device
- Therapy or health-care science intervention provided in secondary or interface service. Decision to add patient to a transplant list. Patient referred back to primary care for treatment. Starting a period of active monitoring. Patient receives treatment following an attendance for a diagnostic test – for example starting medication following an endoscopy; have a polyp removed at colonoscopy

The clock also stops if:

- There is a decision not to treat
- The patient declines treatment
- The patient DNAs their first appointment and is subsequently discharged back to the GP (the clock is nullified and removed completely from the denominator)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464956/RTT_Rules_Suite_October_2015.pdf

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

Appendix 2 - Glossary of Terms

Active Monitoring An 18 week clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures.

A new 18 week clock would start when a decision to treat is made following a period of active monitoring.

Active Waiting List Patients awaiting elective admission for treatment and are currently available to be called for admission.

Can Not Attend (CNA) Patients who, on receipt of reasonable offer(s) of admission, notify the hospital that they are unable to attend.

Choose and Book A method of electronically booking a patient into the hospital of their choice.

Date Referral Received (DRR) The date on which a hospital receives a referral letter from a GP. The waiting time for outpatients should be calculated from this date.

Day cases Patients who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.

Decision to Admit date (DTA) The date on which a consultant decides a patient needs to be admitted for an operation. This date should be recorded in the case-notes and used to calculate the total waiting time.

Did Not Attend (DNA) Patients who have been informed of their date of admission or pre-assessment (inpatients/day cases) or appointment date (outpatients) and who without notifying the hospital did not attend for admission/ pre-assessment or OP appointment.

First Definitive Treatment An intervention intended to manage a patient's disease, condition or injury and avoid further invention. What constitutes First Definitive Treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.

Indirectly Bookable Services Some provider services are not directly bookable through Choose and Book so patients cannot book directly into clinics from a GP practice. Instead they contact the hospital by phone and choose an appointment date. This is defined as an Indirectly Bookable Service.

Inpatients Patients who require admission to hospital for treatment and are intended to remain in hospital for at least one night.

Open Appointments Open appointments clinically unsafe and are no longer used within this Trust.

Outpatients Patients referred by a GP or another health care professional for clinical advice or treatment.

Planned Patients An appointment/procedure or series of appointments/procedures as part of an agreed programme of care which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Planned activity is sometimes referred to as “surveillance” or “follow up”.

Patient Tracking List (PTL) The PTL is a list of patients (inpatients and outpatients) whose waiting time is approaching the guarantee date, who should be offered an admission/appointment before the guarantee date is reached.

Reasonable Offer For an offer of an appointment to be deemed reasonable, the patient must be offered a choice of dates within the timescales referred to for outpatient, diagnostics and inpatients.

Referral to Treatment (RTT) The 18 week pathway focuses and address on the whole patient pathway from referral to start of treatment.

To Come In Date (TCI) The offer of admission, or TCI date, is a formal offer in writing of a date of admission. A telephone offer of admission should be recorded as a formal offer. Telephone offers should be confirmed by a formal written offer.