

REFERRAL TO TREATMENT ACCESS POLICY

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1. INTRODUCTION

1.1 Key Principles

- Patients should wherever possible be offered a choice of provider for their care
- Patients are treated , in order, according to clinical need;
- Pathways should be delivered to ensure that everyone who chooses to be treated within 18 weeks and for whom it is clinically relevant, will be. ([Annex A - 18 Week Key milestones](#))
- Patients must receive information at each step of their pathway advising them of their responsibilities
- Patients should only be referred for consultant led services if they are fit, ready and willing to access services within a maximum of 18 weeks. The exception being overriding urgent pathways
- Consultant to consultant referrals should only be made in urgent cases (e.g. cancer, life, limb or sight-threatening conditions) or where there is an agreed clinical pathway. All other referrals should be made via the GP (or GDP).
- All patients on an 18 week pathway that are referred on to another service or another provider before treatment has commenced must be received by the new service/provider within 4 weeks of the clock start date.
- Systems for arranging appointments/admissions for patients will:
 - Offer choice of dates and provision
 - Minimise the risk of cancellation;
 - Reduce the risk of Did Not Attends (DNAs).
- Systems should ensure accurate information is collected about inpatient, diagnostic and outpatient services and recorded on the appropriate system in a timely manner, and in line with national information standards;
- Systems should ensure effective two-way communication with patients and their GP;
- Systems should ensure robust communication between Managers, Administrative staff and Clinicians;
- Clinicians, Managers and Administrative staff should have clear roles and responsibilities with regard to referral management, outpatient and diagnostic booking, and the treatment process.
- Referrals for named consultants should only be accepted in cases where only that clinician can provide the expertise.
- Every Patient admitted electively from a waiting list should have been pre-operatively assessed to ensure that the Patient is fit, willing and able to undergo the procedure for which he/she was listed.

- Day surgery should be the default management intent for elective procedures.
- Patients admitted for an elective procedure should be admitted on the day of surgery wherever possible unless the patient's clinical pathway determines otherwise
- All elective patients should have an agreed discharge plan
- Elective procedures will only be cancelled for medical reasons
- Provider, referral management and commissioning organisations will have procedures in place for 18 week PTL tracking and monitoring in accordance with the LHC policy.
- No patient will be inequitably affected by this policy or the practices it promotes on the basis of their race, gender or a disability

1.2 Scope of the Policy

The Referral to Treatment Access policy should be used in all areas where patients' pathways include consultant-led care.

The policy relates to all clinical and administrative operational services across the Leeds Healthcare community including:

- Referral Management;
- Consultant-led Outpatient Appointments;
- Diagnostic Services;
- Inpatient / Day Case Admissions

1.3 Policy Statement

The purpose of this policy is to set out the standards that must be adhered to when managing a patient's referral to treatment pathway

This document should be read in conjunction with the Handbook of Administrative Practice (To be updated once policy has been approved).

1.4 Policy Effect

All consultant-led services are subject to the Department of Health guidance on 'Delivering the 18 week pathway'. The Leeds Healthcare Community will take actions as necessary to comply with the obligations set out NHS Improvement Plan (June 2004) and subsequent requirements.

The statements set out in the Referral to Treatment Access policy must be adhered to by all Local Health Community staff involved in 18 week pathways. Only where there are justifiable reasons for doing so will the standards set out in the policies be deviated from. In such cases, the Designated Service Manager must seek advice and agreement from the appropriate authority before proceeding. A record will be kept as to the reasoning behind the deviation from the standard in the Patient's health record.

Failure to follow the Referral to Treatment Access policy could result in the instigation of disciplinary procedures.

1.6 Referral to Treatment – Key Concepts

1.6.1 Definitions

18 Week referral to treatment (RTT) period - The part of a patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other 18 week clock stop point.

Active monitoring - An 18 week clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care, before any clinical treatment.

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

Admitted pathway - A pathway that ends in a clock stop for admission (day case or inpatient)

Non-admitted pathway - A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment'

Pause - The act of pausing a patients' 18-week clock. Clocks may only be paused for non-clinical reasons and only where a patient chooses to wait longer for admission than two *reasonable offers* made by the provider

1.6.2 18 Week Clock Start Definition

An 18-week clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to:

- a) A consultant led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner. The clock starts when a confirmed booking is made through the Choose and Book system or when the referral is received by the service provider;
- b) An interface or referral management or assessment service, which may result in an onward referral to a consultant led service, before responsibility is transferred back to the referring health professional or general practitioner. The clock starts when the referral is received by the referral management or assessment service.

1.6.3 18 Week Clock Stop Definition

An 18-week clock stops when:

- a) First definitive treatment starts.

- b) It is clinically appropriate to return the patient to primary care for any non consultant-led treatment in primary care;
- c) Clinical decision is made to start a period of active monitoring;
- d) A patient declines treatment having been offered it, with reasonable notice (see section 3.5);
- e) A clinical decision is made not to treat;
- f) A patient DNAs their first appointment made with reasonable notice, following the initial referral that started their 18 week
- g) A patient DNAs any other appointment made with reasonable notice, and is subsequently discharged back to the care of their GP

2. CAPACITY MANAGEMENT

2.1 General Principles

The Leeds Health Community will ensure that there is a shared approach to capacity management.

The PCT (Primary Care Trust) will ensure that patients are offered a full range of choices for providers of treatment. If a patient chooses to wait longer than 18 weeks for treatment the provider will be made aware.

Where the current capacity available in a service is not adequate to meet the numbers of patients to it within the pre-agreed timescales, the relevant service manager should ensure that senior managers are aware so that further steps can be taken to treat patients according to the RTT standard.

Provider units must manage the available capacity and link these to clinical job plans.

2.2 Outpatient Clinic Booking Rules

Clinic booking rules must, as part of the capacity planning process, be agreed with each consultant for his/her clinical team and reviewed at least annually. PAS should accurately reflect the agreed clinic rules.

Changes to clinic booking rules for consecutive clinic sessions must be agreed with the appropriate Directorate Manager in order to take account of the impact of the change on service delivery. Any clinic changes should be assessed against the Directory of Service and a plan to manage the impact should be agreed.

2.3 Directory of Service (DOS) Management

The DOS must be developed in conjunction with the relevant clinical leads of the service. DOS should be kept under continuous review to ensure that they reflect services provided.

Any new DOS entry must be agreed by the Head of Service before publication on the Choose and Book system.

Clinics attached to the DOS should not be cancelled or reduced within 6 weeks of the clinic date (except for unpredictable sickness or compassionate leave).

If a clinic has been cancelled the Service Manager/Directorate Manager must be notified in order to assess impact on the lost capacity.

It is not acceptable to reschedule a patient more than twice. Systems must be in place to ensure that patients are seen within the 18-week target.

The rescheduled date for new patients, who have already been notified of their original clinic date, should be within 2 weeks of that original date and soon enough to achieve the 18 weeks guarantee.

If re-scheduling does occur this should still allow patients to be seen in chronological order, in line with their RTT start date.

The efficient delivery of services is dependent upon robust planning. The LTHT Trust has a Consultant Leave policy for consultant medical staff which requires at least 6 weeks notice of absence.

3. MANAGEMENT OF OUTPATIENT BOOKING

3.1 Direct Booking

The national Choose and Book (C&B) system will be the primary referral and booking method. The start of the waiting period is at the point of conversion of the Unique Booking reference Number (UBRN). This may be in the clinician's practice or through the internet. The waiting for booking requests received through the Telephone Appointment Line (TAL) will commence at the time the booking request is received.

LTHT Clinical Services will be published on the Directory of Services (DOS). Appointments will be made available far enough ahead, to support delivery of the 18 week RTT commitment.

A self referral should only be accepted if the patient had a previous referral for that specialty/condition and the discharge date of that referral was within the last 6 months and this is a pre-agreed condition pathway. The 18 week clock start date will be when the patient contacts the service to arrange the booking.

Note: For any referral that comes via a Referral Management Services (RMS) or Clinical Assessment Centre (CAS) the 18 week clock start date will be the date of receipt of referral in those services (this includes any that are subsequently directly booked from the RMS/CAS). These referrals should all be accompanied by the national minimum data set for Inter-provider transfers (See Annex 3 - IPT MDS)

Where referrals are being clinically triaged prior to onward referral to a secondary care provider, the referral should be received by the provider no more than 3 days after the 18 week clock start date.

3.2 Acceptance of Booking

Where clinicians want to review referrals for appointments that have been directly booked, this should be completed within 2 working days of receipt. After this time period the referral must be accepted automatically.

3.3 Non-Directly Booked Appointment Processes

Where Choose and Book is not yet in place:

- If the referral is sent via a Referral Management or Clinical Assessment Service, the 18 week clock starts at the point at which the service receives the referral letter

- If the referral is sent directly to the care provider the 18 week clock starts at the point at which the provider receives the referral letter.

All referrals must be sent to a centralised referral and booking service within the provider organisation and must be date stamped on receipt.

All accepted referrals will be registered on the provider system within 1 working day of receipt and open ('Dear Doctor') referrals should be assigned to the consultant with the shortest waiting list. The process should take account, where possible, of specific clinical special interests.

Where patients have not been appointed using the Choose and Book system for Direct Booking the following standards also apply;

3.4 Prioritisation

All referral should be prioritised within 2 working days of receipt in to the hospital by the clinician or their authorised deputy. The clinician should clearly indicate on the referral letter the priority that has been allocated.

The only exceptions to the above are if the referrer had completed an agreed referral protocol thus indicating a particular care pathway to be followed eg. Direct access clinics, "two-week cancer" referrals and where the receiving clinicians do not need to prioritise referrals. .

3.5 Booking Processes for Non Directly Booked Appointments

Patients will be contacted either by post or telephone when they have been selected for an appointment offer and asked to agree a date for their outpatient consultation. For the offer to be deemed "reasonable" the patient should be given a minimum of two weeks notice. There may be instances where patients are prepared to accept an offer with less than two weeks notice, when their acceptance makes the offer "reasonable".

Patients should be asked to contact the department within 7 days of receipt of the offer and indicate whether they wish to accept or decline the offer.

PAS will be updated immediately a patient is given an appointment date.

Each patient should be allocated an individual outpatient appointment time. New patients should be booked into 'new' slots and follow-up patients should be booked into 'follow-up' slots.

When the appointment is booked staff should also book any necessary supporting services, such as lip readers, interpreter and transport, in line with patient's needs.

3.6 Patients unable to start their pathway

If a patient is unable to accept two separate offers with reasonable notice the patient should be discharged and referred back to the care of their GP. This action will stop the 18 week clock.

3.7 Patient cancellations

If a patient accepts and then cancels their appointment for a second time they should be discharged and returned back to referrer. This will stop the 18 week clock.

Patients who telephone to cancel their appointment should be offered another appointment date at the time of their telephone call.

For new appointments, agreement should be sought from the consultant whether the referral back to the GP can be performed as an administrative task with the consultant being notified of the outcome.

For follow-up appointments the consultant will refer the patient back to the GP based on their clinical assessment.

With all the above, discretion should be exercised if there are exceptional circumstances behind the patient's reason for cancellation.

Any subsequent cancellation if re-appointed will not stop the clock at any other point in the 18 week pathway

3.8 Patient DNA

When a patient does not attend for an appointment without giving prior notice, this is classed as a Did Not Attend (DNA). The patient must then be referred back to their GP provided:

- The provider can demonstrate that the appointment was clearly communicated to the patient;
- Discharging the patient is not contrary to their best clinical interests;
- The clinical interests of vulnerable patients (e.g. children) are protected and are agreed with clinicians, commissioners, patients and other relevant stakeholders.

If a patient DNA's the first appointment of the 18 week pathway and the patient had accepted the offer or it was a reasonable offer then the 18 week clock will be nullified. If a clinician requests that the appointment is re-booked then a new clock start will commence from date of the re-booking of the next appointment.

Any subsequent DNA will not affect the clock at any other point in the 18 week pathway unless the patient is discharged.

3.9 Arranging subsequent appointments

All subsequent appointments should be booked as soon as firm dates can be agreed. These should be agreed within the clinic planning horizon, to minimise any risk of the provider cancelling the booking.

Patients who need a follow-up appointment within 6 weeks of their first appointment should be able to choose a convenient date and time before they leave the hospital.

At the point of making the follow-up appointment any special support requirements such as lip readers, interpreter and transport should also be booked.

Self Referrals - A self referral should only be accepted if the patient had a previous referral for that specialty/condition and the discharge date of that referral was within the last 6 months.

3.10 War Pensioners

The term 'war pensioner' refers to people who are receiving a pension for wartime injuries. Priority should be given to 'war pensioners' when they are attending hospital for either examination or treatment which relates to a condition for which they receive a pension.

The referral should make it clear that the patient is a war pensioner and requires treatment for a condition or conditions for which they receive a pension or gratuity. When such a referral is received the patient should be treated as 'urgent'.

3.8 Private Patients and Overseas Visitors

Private Patients and Overseas Visitors should be clearly identified as such on patient management systems. Consultants have a responsibility to ensure that their private patients are identified as such and should inform administration staff as soon as possible^{1,2}. For potential Overseas Visitors, staff should conduct the necessary brief interviews with patients to ascertain the patient's status.

Where a Patient has been seen privately by a Clinician but now requires a follow up appointment in the NHS, the referral must be treated as a new referral to LTHT and seen in chronological order (unless clinical priority dictates) within the guaranteed waiting times. A new Referral to treatment time clock will start at the point the patient is referred into the NHS. Where the patient has already had treatment in the private sector and the NHS care is for post-operative follow up or active monitoring only, this referral will not start a new RTT period.

3.11 Transport

Transport should only be booked where a patient's medical condition or impairment warrants the use of patient transport services.

¹ For further advice on Private Patients contact the Trust's Service Agreement Department
Private Patients Office

² The 'Green Book', HC (86)4, Private Practice in Health Service Hospitals
The BMA Consultant Handbook, 2000

A clinical practitioner capable of assessing the patient's medical condition must determine the need for transport as well as the type of transport required.

4. MANAGEMENT OF DIAGNOSTIC BOOKINGS

4.1 Defining Diagnostic Tests

A "Diagnostic" test is defined as a test or procedure used to identify a person's disease or condition and which allows a medical diagnosis to be made. A patient's wait for a diagnostic test/procedure begins when the request for the test or procedure is made. The wait ends when the patient receives the test/procedure.

For the purpose of RTT recording this does not include waits for diagnostic tests/procedures where:

- The patient is waiting for a planned (or surveillance) diagnostic test/procedure, i.e. a procedure or series of procedures as part of a treatment plan which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency, e.g. 6 month check cystoscopy;
- The patient is waiting for a procedure as part of a screening programme (e.g. routine repeat smear test etc.);
- The patient is an expectant mother booked for confinement;
- The patient is currently admitted to a hospital bed and is waiting for an emergency or unscheduled diagnostic/test procedure as part of their inpatient treatment.

4.2 Booking Diagnostic Tests

It is good practice that patients book their diagnostic test at their outpatient attendance or have it undertaken before attending the outpatient appointment. The same rules for reasonable notice apply as for Outpatient appointments.

Patients will be contacted either by post or telephone when they have been selected for an appointment offer and asked to agree a date for their outpatient consultation. For the offer to be considered "reasonable" the patient should be given a minimum of two weeks notice. There may be instances where patients are prepared to accept an offer with less than two weeks notice.

4.3 Patient unable to continue their pathway

If a patient is unable to accept two separate offers, each with reasonable notice the patient should be discharged and referred back to the care of their GP.

This action will stop the 18 week clock. The consultant referring the patient for the diagnostic test should also be informed that the patient has been discharged so that they can refer back if the patient is clinically urgent. This action will start a new 18 week clock

4.4 Patient Cancellations

The same rules apply as for Outpatient booking please refer to section 3.6.

For new appointments, consultants should be asked whether the referral back to the GP can be performed as an administrative task with the consultant being notified of the outcome. If the GP feels the test is still necessary they should refer back to the test department. This will start a new 18 week clock.

For follow-up appointments the diagnostic team will refer the patient back to the GP based on their clinical assessment.

With all the above, discretion is required for exceptional circumstances and the reasons given for cancellation.

4.5 Patient DNA

The same rules apply as for Outpatient booking please refer to section 3.7.

If the GP feels the test is still necessary they should refer back to the test department. This will start a new 18 week clock.

5. MANAGEMENT OF ADMISSION BOOKING

The consultant will normally make the decision to treat a Patient. If the decision is made by a senior trainee this must be reviewed by the consultant. This ensures that the consultant agrees that an operation and/or admission are necessary and that they intend to call the patient for treatment. Patients must not be listed unless the consultant has agreed to undertake the treatment.

A decision will be made in clinic regarding the type of admission (In-patient or daycase) and the procedure or treatment to be undertaken. This will then be ratified at pre-operative assessment. The Patient should be given an indication of the waiting time for their treatment.

If, a Patient does not meet locally agreed criteria to proceed for an operation or admission at the point that a decision is made that treatment is required and if the medical condition is likely to persist, the patient should be referred back to primary care for treatment or referred to the appropriate specialty to be seen. A date should not be agreed and the patient should not be added to a waiting list e.g. Patients who are required to lose weight or for age-related surgery.

The date on waiting list for patients will be the date the decision to treat has been made unless the patient is due to be seen in pre-operative assessment within 5 days of the decision to treat. In these circumstances if the patient is declared fit at pre-operative assessment the date on list will be the date of the pre-operative assessment appointment.

The patient and GP have a responsibility to make contact when the medical condition is resolved and the patient may be reviewed again as an Out-patient or referred directly

back to the Pre-operative assessment team if the patient is fit again within 3 months at which point a new RTT journey would commence.

5.1 Changes in the Patient's Status whilst waiting for proposed Admission

The Patient will be asked to communicate with their GP in the event of any alteration in clinical or symptomatic state while waiting for admission to hospital.

If the Patient informs the Trust that they no longer require treatment, the GP and consultant should be informed and their removal from the waiting list should be confirmed to the Patient in writing.

If a patient becomes unfit whilst on the waiting list they should be removed from the waiting list and either be managed within the outpatient setting or referred back to the referrer, whichever is deemed to be clinically appropriate.

5.2 Agreeing a Date for an Admission

When a patient has been selected for admission and thereby asked to agree a date for their admission date, they will be contacted either by;

- post
- or telephone
- or at the pre-operative assessment/re-assessment appointment
- Email (with patient consent)
- SMS text messaging (with patient consent)

For an offer to be considered "reasonable" the patient should be given a minimum of three weeks notice. Patients should be asked to contact the department within 7 days of receipt of the offer and indicate whether they wish to accept or decline the offer.

There may be instances where patients are prepared to accept an offer with less than three weeks notice. It is important in these cases that the patient is made aware that they do not have to accept the short-notice offer made.

For patients with suspected cancer where treatment must occur within 31 days, 48 hours notice is considered to be "reasonable". Verbal offers of admission should be followed by written confirmation. If the appointment is not fully booked at outpatient or pre-assessment clinic, special arrangements may be required to ensure patients receive essential information or medication in advance of their admission given the short timescales involved.

5.3 Processing Admission Data

Waiting lists should be structured to indicate priority of admission.

Children (up to the age of 14 and discretionally up to 16) should be managed on a separate waiting list from adults.

Patients' details for new waiting list entries will be registered on the Provider Waiting List within 3 working days of the decision to admit.

5.4 Active Waiting Lists

The 'active' waiting list will consist of those Patients who are fit, ready and available for admission. This will include Patients whose admission was 'booked' and those waiting without an admission date.

5.5 Patients Waiting for Planned Treatment

Planned waiters should be accurately recorded as such on a waiting list³. These are patients waiting for a sequence of In-patient or daycase treatments or investigations, *after* their initial waiting list or emergency admission e.g. check cystoscopy and removal of metal work. Note: these patients will be deemed to be outside the scope of 18 weeks and will not have an RTT start date.

5.6 Patients Waiting for Bilateral Treatment

If a Patient is waiting for a bilateral operation or 'staged' surgery where the second procedure cannot be completed before the patient has had the first procedure, the patient should be placed on the active list for the first stage. Once the first stage has been completed and the patient becomes fit and ready for the subsequent stage then a new 18 week clock should start.

5.7 Patients Who Choose to Delay Admission

If a patient chooses to delay treatment longer than the two reasonable offers made, their 18 week clock may be paused. The clock is paused from the date of the first reasonable offer and restarted when the patient informs the Trust they are available for admission.

If a patient chooses to delay treatment for longer than 3 months then they should be removed from the waiting list, the RTT period closed and returned to the referrer.

5.8 Patient Cancellation

If a patient cancels an offer that they had accepted (or with reasonable notice) for a second time then they should be discharged and returned back to the care of their GP. This action will stop the 18 week clock.

The referrer should also be advised of the action taken.

5.9 Patient DNA

The same rules apply as with Outpatient booking (refer to section 3.7). However in this circumstance a reasonable offer is defined as 3 weeks notice.

5.10 Cancellations on day of Surgery

No patient should normally be cancelled by the hospital on day of surgery. If this course of action is deemed necessary it must be authorised by the Directorate Manager. When this happens patients must be booked a new date either within 28 days (as per the national standard) or before their 18 week breach date, if this is shorter than 28 days.

6. TERTIARY/INTERPROVIDER REFERRALS

If the patient needs to be referred to another provider for the same condition, the 18 week clock is still running until their first definitive treatment, irrespective of where that treatment takes place.

All clinical transfer information (including the mandatory national Inter-Provider Transfer Minimum Data Set) must be forwarded to the receiving provider within 48 hours of the decision to refer.

If this dataset is incomplete or inaccurate, the receiving care provider will contact the referring organisation to get the correct data items. If there is no data on the original RTT start date, this will be recorded as unknown, but the 18 weeks performance reports will clarify that this data was not provided by the referring provider.

7. TRANSFERS OF PATIENTS BETWEEN PROVIDERS FOR CAPACITY REASONS

Transfers to alternative healthcare providers must always be with the consent of the patient, the GP (or commissioner, if they are acting on behalf of the GP) and the receiving Consultant. The transferring consultant should be informed of this decision by the commissioner as a matter of courtesy. The original provider should provide the national Interprovider dataset within 48 hours of the agreement to transfer the patient.

Where a patient has been transferred from one care provider to another, e.g. when there are capacity shortages, the patient must not return to the original provider for follow-up care. In these cases, a 'full package of care' has been commissioned externally by the PCT which includes any follow up care.

8. PRIORITISATION OF WORK

This Policy ensures compliance with DH guidance on the management of the 18 weeks Referral to Treatment target.

9. RESPONSIBILITY FOR DOCUMENT DEVELOPMENT

Lead Director: Matt Walsh/ Helen Barker

Local Specialists:

10.EQUALITY IMPACT ASSESSMENT

This Policy has been assessed for its impact upon equality. The Leeds Teaching Hospitals Trust is committed to ensuring that the way that we provide services and the way we recruit and treat staff reflect individual needs, promote equality and does not discriminate unfairly against any particular individual or group.

The development of Trust policies must comply with equalities legislation which is to promote equality and eliminate unlawful discrimination. Guidance on Equality Impact Assessment of policies is available on the Trust intranet.

1. Screening			
How relevant is this policy and its associated procedures to promoting equality and human rights and to eliminating discrimination? (indicate in boxes below)			
	Not relevant	Partly relevant (say which parts)	Very relevant
Race/ethnic group:		Yes (Rules for booking appointment and calculating waiting times)	
Disability ⁴ :			
Gender including transsexuals:			
Age:			
Sexual Orientation:			
Religion:			
Human Rights ⁵			
Carers or other group (please state)			
2. Assessing Impact (To be completed where the policy and associated procedures has been determined as relevant in the screening process)			
Please specify, in the rows below, anything that you have included in this policy and its associated procedures to ensure that equality is promoted and that no one will be unlawfully disadvantaged (discriminated against) as a result of this policy			
Race/ethnic group:	Within the Handbook staff are offered ad <ul style="list-style-type: none"> ▪ Take all steps to identify in advance any barriers to attendance or full participation ▪ Meet the communications needs of patients who do not speak English or who have visual problems ▪ Make full use of aids, services and facilities available in the Health Community. ▪ Ensure that alternative means of communication are utilised (e.g. 		
Disability:			
Gender:			
Age:			
Sexual Orientation:			
Religion:			
Human Rights			

⁴ To comply with human rights legislation a policy or function must, where possible, promote (in addition to equality), dignity, respect, fairness and autonomy

⁵ How relevant is this policy and its associated procedures to promoting equality and human rights and to eliminating discrimination? (indicate in boxes below)

Carers or other group (please state):	telephone instead of letter, minicom instead of telephone, translated information, large print, audio tape or Braille) <ul style="list-style-type: none"> ▪ Ensure additional personal assistance is offered and available.
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11 IDENTIFICATION OF STAKEHOLDERS

The Access Policy has Leeds Health Community wide implications. Staff, including contractors, volunteers and employees of other organisations who are for the time being, subject to the direction and management control of the Trust, are the main stakeholders as they are bound by policy and required to comply with it. Stakeholders also include patients as they are required to understand the rules around access and their responsibilities.

12 CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

The Policy has been circulated across the Healthcare Community for consultation including a range of Patient groups.

13 POLICY APPROVAL AND RATIFICATION

The final draft of the Policy will be agreed by the pan Leeds 18 Week Programme Board and endorsed by the Trust Board.

14 PROCESS FOR REVIEW/REVISION

The Policy will be reviewed on a 3 month rolling basis from the date of approval by the Programme Board to ensure any new guidance and operational feedback is incorporated.

15 COMMUNICATION AND DISSEMINATION

Following approval, the policy will be notified to the target groups named on the front page of this policy in the reference box as follows:
Directors – communication directly by e-mail and discussion at TMB.
Senior operational and corporate managers – communication directly by e-mail and to be notified by Directors through line management briefing.
All staff and members of the public – Trust communication channels including the Trust internet and intranet sites, e-Bulletin, staff workshops.

16 IMPLEMENTATION

The effective date will be immediate and implementation will be supported across the Health Community.

17 MONITORING COMPLIANCE AND EFFECTIVENESS

KEY PERFORMANCE INDICATORS

Regular monitoring of services should be undertaken to ensure that this policy is being adhered to, particularly the following:

- Patients are being seen in chronological order;
- Clinics and Operating Areas are being fully and appropriately utilised;
- Patients being offered two weeks notice of an appointment for outpatients and diagnostics
- Patient being offered three weeks notice for admission
- Did Not Attend (DNA) rates.
- Active monitoring rates
- RTT “pause” rates
- Audit of the use of ‘tolerances’ – ie whether the reason for a patients’ pathway being longer than 18 weeks is due to clinical need or patient choice, or whether due to other factors
- Patients are being treated within 18 weeks of the referral date
- Compliance with the Disability Discrimination Act (DDA) and Race Relations ACT.

18 REFERENCES/ASSOCIATED DOCUMENTATION

www.18weeks.nhs.uk

19. CONFIDENTIALITY (COMMON LAW DUTY OF CONFIDENTIALITY)

Personal health data is classed as ‘sensitive’ under the Data Protection Act 1998. This data is to be protected with even more vigour than other types of personal data. Both paper-based records and computerised records must only be used for caring for patients or for administrative purposes connected with that care.

A patient’s explicit consent must be obtained if their personal health data is to be used for purposes other than patient care. Exceptions to this are when the Trust is legally required to disclose information for public health reasons or because it is served with a court order.

All employees handling patient data are bound by a ‘common law duty of confidence’ in addition to being bound to their contract of employment, which contains a confidentiality clause.

18 Week Key Milestones

The 18 week maximum patient pathway becomes fully operational by December 2008.

December 2008 (National Standard)

- 90% of patients admitted (whose treatment requires a stay in hospital) should have a 'referral to treatment' pathway period shorter than 18 weeks
- 95% for non-admitted patients (whose treatment is completed without a hospital stay) should have a 'referral to treatment' pathway period shorter than 18 weeks

The standard applies to all patients who choose to be treated within 18 weeks and where it is clinically appropriate to do so. The 'tolerances' are to allow for

- i. Patient choice (patients choosing not to accept earliest offered appointments or choosing to delay treatment)
- ii. Cooperation – patients who do not attend appointments along their pathway
- iii. Clinical exceptions – those patients with clinically complex conditions and/or co morbidities unsuitable to be treated within 18 weeks