Essex Partnership University
NHS Foundation Trust

PROCEDURAL GUIDELINES ON EPUT18 WEEK REFERRAL TO TREATMENT ACCESS FOR MENTAL HEALTH AND COMMUNITY SERVICES

POLICY/PROCEDURE NUMBER:	CLPG69
VERSION NUMBER:	1
AUTHOR:	Associate Director Business Development and Service Improvement.
CONSULTATION:	2 month consultation - Patients, Carers, CCGs, Social Care Organisations, GPs, Staff
IMPLEMENTATION DATE:	April 2018
AMENDMENT DATE(S):	NA
LAST REVIEW DATE:	NA
NEXT REVIEW DATE:	April 2021
APPROVAL BY EXECUTIVE OPERATIONAL SUB-COMMITTEE	17th April 2018
RATIFICATION BY FINANCE & PERFORMANCE COMMITTEE:	19th April 2018

SCOPE

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this policy is The Executive Director of Community Services and Partnerships

PROCEDURAL GUIDELINES ON EPUT 18 WEEK REFERRAL TO TREATMENT ACCESS

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Assurance Statement

Delivering high quality clinical are at the heart of all EPUT clinical services. This procedural guideline is to ensure that the objectives set out in its equivalent policy are detailed in a way that is understood by all staff thereby ensuring that the policy can be fully implemented, monitored and reviewed within the organisation. The policy and procedural guideline aims to ensure that the Trust has a sound framework for delivering clinical services in a timely, accessible and high quality patient centred way.

1.0 GUIDING PRINCIPLES

1.1 EPUT 18 Week Referral to Treatment (RTT) principles are to ensure timely, safe and appropriate services are provided. Timely and safe services for EPUT include the early screening/triage of cases to ensure urgent clinical conditions and risks are identified and are managed along the right care pathway. Clear procedures for dealing with all aspects of a patients care pathway are addressed making services more efficient, and also ensure that other care pathway and service policies and procedures are in line with these principles.

1.2 Equity of access for all EPUT Patients both in Mental Health and Community Services is paramount and this guiding principle underpins all policies and procedures regarding access to services.

1.3 As a general principle, referrers should only refer patients when it is appropriate to start treatment and patients should commit to keeping appointments set with them. EPUT in turn is committed to commence treatment within 18 Weeks.

1.4 This procedure uses the term ‘Patients’ to encompass all patients and service users within Mental Health and Community Services.

1.5 Vulnerable patient groups such as older people with dementia and children who may be at risk, are treated differently, specific legislation and good practice will apply and must be adhered to, with procedures in place to ensure they are not disadvantaged because of their condition or situation, and that any known or suspected risk is managed effectively.
Clinical cases where there is a known or suspected mental capacity issue need to be considered carefully to ensure they are not disadvantaged due to their condition. Appropriate MH advocacy and reference to the Mental Capacity Act should be referred to.

1.6 This procedure and the associated policy apply to all age groups.

1.7 In the event of any current or future contractual agreements to introduce tighter time based milestones along a care pathway, that contractual agreement will have priority over this 18 week RTT Policy and Procedure.

1.8 For Mental Health patients this procedure must be considered closely with the Trusts Disengagement Policy and Procedure which provides specific safeguards in managing care pathways relating to disengaging patients, including those at risk, vulnerable and that have capacity issues.

1.9 EPUT provides integrated services with Social Care in partnership and the principles regarding access to care apply equally to social care and health care referrals.

2.0 INTRODUCTION

2.1 Providing high quality services is a high priority for EPUT.

2.2 The time it takes for a patient to start treatment is central to providing a high quality service, with waiting times consistently being in the top few priorities stated by patients in national surveys and locally in the form of complaints when delays occur.

2.3 The accompanying policy defines the roles and responsibilities that every member of staff must take into account when working with patients and their associated care pathway.

2.4 This procedure impacts on other Trust policies which relate to care pathways. Each service will need to review local protocols and procedures for managing care pathways to ensure they are in line with this policy.

2.5 This procedure sets out the expected standards of behaviors expected by the Trust and patients, so that each is aware of its responsibilities to communicate effectively, keep to appointments, and act in a reasonable and fair way when cancellations have to be made.

National Institute for Clinical Excellence (NICE) guidelines lay down recommendations for a number of condition specific pathways. Clinical services should continue to aspire to work to these recommendations. This procedure and the accompanying policy lay down maximum waiting times, and services are encouraged to strive for the shortest patient journey times possible.

2.6 This procedure reinforces commitment to avoid service cancellations, wherever possible.

2.7 Clinical decisions need to be made in reference to a particular clinical presentation and any risks, to ensure the Trust delivers timely and good quality services at all times.

2.8 Patients will have access to this procedure and will be made aware of their role in ensuring the Trust's waiting list processes are efficient. They are expected to attend their appointments and to notify the Trust of any unavailability or changes to their personal circumstances so that wastage is kept to a minimum.

3.0 18 WEEK REFERRAL TO TREATMENT (RTT) PRINCIPLES

3.1 To manage an effective referral to treatment care pathway, information systems need to record the time and date a referral comes to the Trust, when a patient is seen, the reason why they are seen, discharges or any further appointments made.

3.2 In RTT terms this means the starting, nullifying, pausing and stopping of clocks which accurately record a care pathway.

3.3 Patients can cancel an appointment for personal and social reasons and delay the setting of a new one for the same reasons.

3.4 A breach tolerance of 8% is set to account for breaches due to patient choice.

3.5 A cancellation made on the day of the appointment cannot be registered as a DNA and these cancellations cannot be recorded as a DNA

3.6 Blanket policies allowing a discharge following a set number of cancellations and/or DNA's is no longer permissible unless the following criteria are met;

- The provider can demonstrate that the appointment was clearly communicated to the patient
- Discharging the patient is not contrary to their best clinical interests
- Discharging the patient is carried out according to local publically available policies on DNA's
- These policies are clearly defined and specifically protect the clinical interests of vulnerable patients (for example children, patients with dementia and those with a Learning Disability), and are agreed with clinicians, commissioners, patients and other relevant stakeholders.

Notes

1. It should be noted then that the above criteria should be considered when the defaults of discharges after two missed DNAs or cancellations as described in this policy occur. This also applies to the discharging of patients after a first DNA and discharging after a failure to take advantage of an opt-in period, which are permissible under the national rules and in this procedure.
2. It should be noted that the guidance states that patients should not be discharged back to their GP simply because they have cancelled or rearranged appointments, and that referral back to the GP should always be a clinical decision. The Trust takes the view that holding cases that have not been seen for long periods of time may hold more clinical risk than giving continuous appointments. **Two** cancelled or DNA consecutive appointments will trigger a clinical decision making point.
   - Discharge will occur for clinical and safety reasons unless there are greater clinical reasons why this should not occur or discharge is prevented by law. This ensures that the safest decision has been taken.
   - If there are clinical reasons why discharge should not occur, the Trust must manage that situation robustly by ensuring that the patient is supported to attend for an assessment and/or treatment at the earliest opportunity and not just give further appointments without dialogue in the

hope an attendance occurs.
- Decisions should be recorded to aid audit and case review

3.7 A patient may need and should be given thinking time to decide if they want to proceed with the treatment plan. A discussion between the clinician and patient will identify the reasonable time needed to think about whether to go ahead or not and during this time the clock will continue to run. There is no defined set time period this should take but as a guide two to three weeks should be set and according to patient need. In some circumstances after the initial thinking time has elapsed or as a first thinking time period the patient can enter a period of active monitoring to consider if to proceed with treatment. In this case the clock stops while the period of active monitoring runs. In all cases where thinking time and active monitoring has been agreed a date to review must be made. It may be appropriate to discharge back to the referrer rather than hold inactive cases potentially in the wrong place and unsafely for prolonged periods of time.

3.8 After the first DNA a patient can be discharged and the clock nullified. The referrer will be written to advise of the discharge and invite a new referral if required.

Under new guidance from 2015 a patient can ask for a new appointment directly and in this case a new clock start will start at the date the patient agrees a new appointment.

3.9 Clock pauses were withdrawn in 2015.

4.0 CLOCK STARTS, IDENTIFYING REFERRAL DATE

4.1 The Trust will establish the clock start date for each patient, according to the following criteria:

4.1.1 For appointments that are booked though the Choose and Book (C&B) system, the clock start date will be the date that the patient books the appointment. This will be when they convert their Unique Booking Reference Number (UBRN) by booking an appointment through any of the Trusts Single Points of Referral.

4.1.2. For referrals made by letter or phone, the clock start date is the date that the referral letter is **received** by the Trust, i.e. the date the letter or phone call was received. Referral forms or where used, referral templates need to be sufficiently complete to start a clock. Where the referral in not complete the referral must (apart from in 4.1.3 below) be returned to the referrer and therefore the clock not started. Where a clock is not started the referral must be returned to the referrer making clear that the referral was not accepted and the reasons why. Referrers need to know when cases have been rejected as soon as possible to prevent cases falling through the net in managing risks and clinical conditions. Therefore for all routine cases the GP must be informed within 7 working days where a case has been rejected, and 24 hours for Urgent cases, which will therefore require a phone call or FAX and can be followed up by a letter later. For electronic

referrals under Choose and Book, the rejection can be sent back through the referral portal, usually on the same day of the referral.

4.1.3. Where there are clinical and risk issues apparent in a poorly drafted referral letter or template, whether the case was referred as an urgent case or not, the referral should be dealt with immediately. The RTT clock will continue ticking. Actions may include;

- Contacting the referrer to obtain more information to proceed
- Responding to the referral by contacting the patient in the usual way to ensure clinical and risk issues are dealt with.

4.1.4. Any referrals received locally, for example a letter received directly by a consultant instead of through the formal referral routes, the referral must be dated to ensure the clock start is later entered on the system correctly. These referrals must be handed to the local administration hub immediately to ensure the referral enters the correct care pathway and is registered properly.

4.1.5. For all other MH and community services referrals must be registered with a relevant local administration service or system correctly ensuring the date the letter, FAX, or phone call received is accurately recorded. System One may start a clock when a task is sent or information is scanned in, where in this case the person doing so must start an 18 week clock by ticking the 18 Week Referral box in the ‘Record referral in’ screen

4.1.6. For drop ins (where they apply) the clock starts on the time and date of the drop in, even if the assessment does not take place that day. Local arrangements must be in place to ensure that where a drop in is a legitimate self-referral, there are registration forms available to record enough information to start a clock

4.1.7. When a patient DNA’s their first appointment and where the provider can demonstrate the appointment was clearly communicated to the patient, the clock is stopped and nullified, that is, it is treated as if the clock was never started.

A clock start can occur following a nullified clock in two ways:

4.1.8 The patient can ask for a new appointment. A new clock starts on the date the new appointment is requested.

4.1.9 The provider can offer a new appointment. In this case the clock starts on the date the patient agrees the new appointment date, or the date the Trust rebooks the appointment.

4.2 All letters, Faxes and Registration forms must be date stamped, to ensure the correct date can be entered on the system later.

4.3 For all services: As a matter of procedure, all referrals must be entered onto the relevant system for a clock start to occur, but note it is the date the referral was received by the trust that starts the clock and not the act of putting the case on the system.

4.4 In the event of a referral for bilateral treatment, (e.g. podiatry, both feet), the clock will start at the point of referral as described above, however the treating clinician will, in discussion with the patient as appropriate in the circumstances agree which part of the body is treated first. The Trust will start a new clock for the other body part when the clinician and patient agree it is appropriate to continue treatment to the other body part.

5.0 CLOCK STOPS

5.1 The end of a referral to treatment pathway and its clock stop will usually be at the start of treatment.

5.2 Following receipt of a referral and a decision that the case needs an assessment after any clinical screening required, the patient will receive an assessment appointment. Some services may refer to the first appointment as a referral for treatment and not assessment where local treatment protocols allow.

At assessment a patient will be either discharged if no treatment is appropriate, will start treatment immediately or will be referred into EPUT for treatment.

Treatment can start at assessment where the patient clearly perceives the intervention as the start of treatment and there is no significant delay in the continuation of that treatment where this is necessary. What constitutes treatment and if this is appropriate to start at assessment is defined locally by each individual service. Clock stops are audited independently and externally and application of local protocols must be fair and robust.

As a general principle assessment does not constitute the commencement of treatment unless it is clear from the nature of the assessment that;

The content of the assessment clearly identifies a need, diagnosis, disease, injury or condition and treatment is commenced to meet that need, diagnosis, disease, injury or condition;

and the perception of the patient is that they have started treatment

and it is clear from the setting of further appointments that a normal course of treatment has progressed from the assessment, i.e. there are no unreasonable or unexplainable delays to the next appointment that demonstrate a waiting list for treatment. Data validation exercises are carried out from time to time to compare actual and expected pathway milestones.

and there is a local treatment protocol in place that permits the commencement of treatment at assessment. The 18 Week Project Team can assist local teams in developing local protocols where this is required.

5.3 Diagnostic procedures are excluded from constituting treatment.

5.4 Clock stopping includes the following actions:

5.4.1 Admitting the patient for treatment as an inpatient or to an Assessment Unit.

5.4.2 Treatment in an Outpatient Clinic. Treatment may be any activity, e.g. advice giving, counselling, support, prescription etc., where the original need or care plan identified at assessment is met, or started, as agreed locally. The patient may be discharged after a single treatment session or offered a further appointment as clinically appropriate in each case.

5.4.3 Treatment from a Psychological Service, e.g. Psychology, Psychotherapy. The commencement of a single (if it is a standalone and complete treatment) or series of therapeutic interventions will stop a clock. Assessment may need to continue, which is permitted, as long as treatment for the original need, or care plan is started and the patient does not perceive themselves as waiting for treatment, otherwise the clock must run until treatment is started. Continuous assessment should be avoided where possible without commencing treatment. Any interventions that are considered diagnostic e.g. aptitude testing and psychological profiling are not treatment, and this type of intervention cannot stop a clock.

5.4.4 Treatment from an Allied Health Professional e.g. Occupational Therapy, Physiotherapy, Speech and Language Therapy. Some specialist services may carry out their own assessments instead of using an assessment service. In these cases the clock can only stop when the first clear and distinct treatment commences. Many of these services will be able to start treatment at the first assessment due to the nature of the assessment particularly where psychological care is provided to patients and carers. Allied Health Professionals working in Community Services will often be able to stop a clock on the giving of advice e.g. regarding mobility. Services need to be clear through the development of local protocols what constitutes treatment and which referrals they receive are a referral for treatment or for advice. Referrals for advice are tracked on a Trust Waiting List rather than a Patient Tracking List and neither start or stop RTT clocks.

5.4.5 Treatment for patient appliances and wheelchair services starts with the supply of a medical device, with the clock stopping on the date on which definitive fitting, or where appropriate trial fitting, begins and there is no undue delay in subsequent fitting sessions thereafter; (Ref DH AHP RTT Revised Guide 2011).

5.4.6 Active monitoring stops a clock and is clinically appropriate in some cases. Active Monitoring can only be applied in a small number of circumstances where the treating clinician is unable to commence treatment because they do not know how to treat due to the signs and symptoms being inconclusive at that time. The purpose of active monitoring is to give the clinician time to see how a condition progresses allowing the right treatment to be applied. When the clinician later identifies the condition

and the right treatment a new clock is started and will run until that treatment is started.

5.4.7 The patient is referred back to Primary Care after screening or assessment.

5.4.8 The patient declines further intervention, either before or after assessment or treatment and is discharged from the service.

5.4.9 The patient did not attend a first appointment. The original clock is nullified. (only when the provider can demonstrate the appointment was clearly communicated to the patient).

5.4.10 A decision is taken to discharge the patient following one or more DNAs' or on the second cancellation. (provided discharging the patient is not contrary to their best clinical interests)

5.4.11 The patient dies.

6.0 CLOCKS NULLIFIED

6.1 When a clock is nullified the care pathway is not reported, and treated as if it never occurred.

6.2 Where a first appointment is DNA'd, and there are risk and clinical factors that prevent discharge the first clock is nullified, and a new RTT period commences from the date a new appointment is agreed with the patient.

6.3 Note that where a patient DNA's a subsequent appointment, if further appointments are given, the clock does not stop. Therefore the practice of giving appointments towards the end of a referral to treatment period is not advised for if the patient cancels, or DNA's and is given another appointment the service will probably breach.

7.0 MANAGING WAITING LISTS AND CARE PATHWAYS - GENERAL RULES

7.1 Note that many EPUT services use an 'opt in' function that gives a patient information regarding access to services either for an assessment or post assessment and the start of treatment. 'Opt in' is supported by the Trust as long as instructions are clear and fair regarding contact and consequences of failure to contact. Different services will operate different opt in periods depending on the specific patient group. Local protocols need to be set locally to manage patient and carer expectations in the event of a dispute. Local capacity and demand profiles will determine the setting of 'opt in' time periods. A clock continues to run during the 'opt in' period.

7.2 All Mental Health and Community Services must have in place procedures to screen/triage cases that identify clinical need and risk, so that patients are managed in the appropriate care pathway. Patients who have urgent clinical need and or carry risk/safeguarding issues will be fast tracked along urgent care pathways.

7.3 The referrer must be informed in a timely way, when cases are discharged back to them following DNA's and cancellations. When a referrer has made an urgent referral, and is therefore concerned about a clinical condition or risk, the GP must be informed as soon as practicably possible if the case has been rejected for any reason. Consider contact by telephone or FAX if the postal system is going to delay an update later than 24 hours. Note that GPs have, and will commonly complain if they do not know the outcome of an urgent referral and they expect timely communications and updates.

7.4 Cases that carry risk or involve safeguarding or come from vulnerable groups must be reviewed by a clinician prior to discharge. Consider the use of an advocate where it is in the interests of the patient to have one. This protects patients from vulnerable groups being administratively discharged.

7.5 Regarding assessments, all referrals must be registered through central booking services where they are in place or with local teams where there is no central booking service. Accuracy regarding the time and date a referral is received is essential and the routine stamping of referrals supports and provides evidence of the accurate starting of an RTT clock.

7.6 Once received, cases that need screening/triage (where this has not happened already) will be sent to a clinician in the relevant area, with urgent cases usually sent by fax or email. Services that process urgent referrals are not permitted to batch referrals beyond a reasonable time that allows the urgency to be safely dealt with. The screener will confirm the designation of the case so that it is correctly booked in within the correct time scales as Urgent or Routine.

7.7 Assessment times will be carried out by different teams, systems and processes according to local protocol, national guidance, local agreements and contract. Waiting times for screening, assessment, diagnostics and treatment, along emergency, urgent and routine pathways must be adhered to maintain 18 Week RTT requirements.

7.8 After assessment, any referral made into an EPUT care pathway is usually a referral for treatment. Continuous assessment is generally undesirable and any further assessment after a first face to face appointment should be part of a care plan delivering treatment.

Treatment is defined by EPUT as;

'**The first intervention intended to manage a patient's disease, condition or injury'**

7.9 Initial assessment can be considered treatment only where the patient perceives themselves as starting treatment, and are no longer waiting for a service to start. Letters, information leaflets and explanations of the intervention any service offers need to make clear when that treatment is being offered.

7.10 All treatment services will be provided with an accurate and up to date waiting list, based on information from Trust information systems, showing all patients who are waiting for an appointment, and the time they have been waiting to be seen. This list will be produced by the Information Directorate using an 18 week

tool called a Patient Tracking List (PTL). The PTL will give all services an accurate tracking of cases from week 1 to week 18. The patient Tracking List is available on the Intranet.

7.11 Once treatment is completed, the patient should be discharged. Routine follow up appointments when treatment is completed should be avoided where possible with the GP, patient and carers being given the appropriate management advice.

7.12 The use of 'open case' and 'patient to contact' outcome codes are no longer supported by the Trust. This is because;

- Large numbers of patients can then remain unaccounted for on Trust information systems for long periods of time.
- The Trust is responsible but not in control of emerging clinical condition changes and risks
- It causes databases to become clogged and inaccurate over time
- It causes reporting to over represent the size and degree of clinical demand and leads to poor outlier profiling.
- It is not consistent with a PbR financial contracting framework which demands clear Primary and Secondary care boundaries.

7.13 The effective use of the Trust's 18 Week RTT policy and Procedure will lead to quick access to clinical services and therefore it is now reasonable to discharge patients to Primary Care in the knowledge for both clinician and patient that emerging clinical and risk issues will be picked up in a timely manner.

8.0 BOOKINGS AND CANCELLATIONS - GENERAL RULES

8.1 Booking Targets and Best Practice Guidelines

No patient can be booked in for an appointment past their treatment deadline. Where this is not possible the local and/or a senior manager and in the case of outpatients the Clinical Director must be involved in creating capacity to make the appointment. It is high risk practice to offer appointments for treatment towards the end of an RTT period, because breaching may be inevitable in the event of a patient cancelling.

All services should aim to provide a first appointment to commence treatment (unless required to commence earlier) within 8 weeks of a clock start. This ensures that in the event of DNA's and cancellations the service can aim to achieve the start of treatment before 18 Weeks.

Where appropriate and where confidentiality issues and capacity allows, services should provide reminders to patients to improve the uptake of appointments. This may be in the form of letters, phone calls, texts, email etc.

8.2 Service Cancellations

Within 6 weeks of the clinic date, cancellation of appointments and clinics, particularly due to short notice annual leave is not permitted without considering the needs of the patient and organising a replacement member of staff where necessary. Requests for cancellation of clinics and appointments will usually be refused by the relevant manager.

Where a service has to cancel an appointment, a new appointment should be given within 28 days or sooner if the RTT care pathway goal will be compromised.

8.3 Specialist Opinions

Where a specialist opinion is required prior to commencing treatment the clock cannot stop. Requests for second opinions should only be made where it is absolutely necessary, and should remain within EPUT wherever possible. The involvement of expertise available within the service is encouraged.

8.4 Patient Initiated Delays

Where a patient is not ready or fit for treatment at the point of referral, services may refuse a referral within the confines of the following provisions.

The definition of 'fit' needs to considered in relation to mental health and social care referrals, where being considered unfit should not generally be extended to the condition being referred for treatment.

In 2015 guidance changed to allow Patients the right to wait longer than 18 weeks and should have their wishes accommodated without being penalised. Patient may choose to wait because of;

- Social reasons
- Personal Reasons

Decisions about a patients waiting time should be made with the patients best clinical interests in mind and with the referrer agree how best to manage a condition that has been referred for treatment that will be significantly delayed, e.g. the GP managing the condition with advice.

8.5 Patient Medically Unfit to Attend

If a patient is unfit to attend an appointment and this is likely to persist for more than two weeks, the patient should be discharged back to their GP and a new referral made when the patient is available to attend. In some cases this may require a referral to another service, within or external to EPUT to support and treat a condition or need. Where discharge back to the GP occurs there should be clear communication with the patient and GP, and must be timely in accordance with guidelines laid down elsewhere in this procedure, confirming the reason for discharge and that another referral can be made when the patient is fit to attend another appointment. The GP may need more guidance on the condition of the patient that is expected prior to re referral.

When provisions within this section are applied, mental capacity issues, Mental Health Act referrals and the use of advocates must be considered.

8.6 Thinking Time.

Thinking time is defined as a short but unspecified period where the patient is given time to consider if they wish to proceed with the proposed treatment plan. In these cases the clock will continue to tick.
In other cases where the patient needs more time to consider if a particular treatment is right for them, e.g. they may decide their symptoms are manageable after a trial period, and then starting a period of active monitoring is more appropriate while the patient makes a decision.

A letter must be sent to the patient confirming they have the agreed time to decide if they wish to take up the offer of an appointment and that automatic discharge will follow in the event of no further contact from the patient unless other arrangements are made

8.7 Choosing to wait for a particular location for treatment

Patients cannot be penalised for choosing to be treated at a specific location, nor due to difficulties in accessing transport.
Services must be prepared to ensure that where treatment is offered at another location, the time to start treatment is no more than the original or usual place of treatment.

8.8 Special Considerations to Manage Risk and Patient Safety

This procedure seeks to strike a balance between choice and flexibility and managing risk. The way DNA's and cancellations are managed must be consistent and robust to prevent patients remaining untreated for long periods of time without feedback to GP's etc.

8.9 DNA and cancellation management and good communication with referrers including GP's is essential to;

- Prevent the hiding of abuse in vulnerable patients,
- Prevent patients who are unwell and in need of treatment being left on waiting lists.
- Ensure referrer expectations are not being met due to factors they are not aware of.

8.10 Patient Cancellations

Under 18 week RTT rules, a patient can cancel a first appointment, and the original clock will still run. At the point of a cancellation, the patient must be informed that they can rebook at the point of the cancellation, or make contact later and re book. In this case the patient must be informed that they will be discharged if they do not make contact within a reasonable time, to be determined by each service locally according to the requirements of the service, with the default being 21 days. The application of this default is important to ensure that conditions, needs and injuries are not left untreated without a plan for long periods of time. It is important that the referrer is aware and has the opportunity to have a discussion with their patient and decide on the appropriate course of action, which may include alternative treatment options within Primary Care.

8.11 Clock Breaches Due to Patient Choice

Patients should be encouraged to have an appointment at the earliest opportunity to treat the condition need or diagnosis in a timely way, and prevent further deterioration. However a patient can extend the rebooked appointment past an 18 week breach date. The length of time that the extension can occur is not specified, and instead a policy of common sense and fairness is introduced by national guidance. The following guidance should be followed;

8.11.1 Blanket policies to penalise patients are not permitted.

8.11.2 Patients may delay an appointment to account for school holidays and other social and personal reasons.

8.11.3 A discussion needs to take place with the patient and consider factors including;

8.11.3.1 The clinical condition and its clinical complexity

8.11.3.2 Any risks to self and others with delays in treatment

8.11.3.3 Personal factors to the patient and their family, e.g. carers availability, safeguarding issues, the age of the patient etc.

8.11.3.4 The point at which the patient agrees that it is reasonable to discharge because of non-availability and the arrangements to agree a timely appointment should they re-refer later.

8.11.3.5 If a delay to commence treatment is proposed after 6 months from the clock start date, a senior manager representing the service may review that case and discharge having had a discussion with the patient if the senior manager deems the delay is unreasonable. Otherwise the appointment will stand, with the proviso that discharge will occur in the event of cancellation or a DNA unless there are clear clinical and risk reasons not to do so.

8.12 In the case of new referrals into the Trust, a patient must be given up to two appointments when they initiate a cancellation. This means that a patient can cancel a **first** appointment for any reason within the parameters in the above section. However on the second cancellation the service should discharge the patient, where there are no clinical or risk reasons to prevent this.
A letter must be written to the referrer and copied to the GP where appropriate, confirming the discharge and the reason for it. Where further appointments are given the referrer and GP need to be informed. The referrer must be informed in a timely manner and in accordance with guidelines laid down elsewhere in this procedure, and patient safety will be protected by ensuring that cases carrying risk are clinically reviewed prior to discharge.

8.13 A cancellation on the day of the appointment can no longer be considered a DNA.

8.14 Patient DNA's

This procedure introduces a joint responsibility for patients and EPUT to keep to appointments. The facility to discharge to a referrer following a DNA is an essential component of managing the RTT care pathway. Discharge must be carried out safely within the terms of the guidelines below. Patient safety is protected through the practice of a clinician reviewing all cases identified as carrying clinical risks prior to discharge.

In all cases where a patient does not attend an appointment, the case must be followed up or discharged so that ongoing management and shared care responsibilities are clear to Primary and Secondary services. This is good clinical and risk management practice.

In the event of discharge, the service must have procedures in place to ensure a clinician reviews the decision in cases that carry risk, are from vulnerable groups or the condition referred is clinically significant, and the referrer must be informed in a timely manner in line with guidance laid down elsewhere in this document according to the situation.

A DNA is defined as where a patient fails to attend a booked appointment. When making decisions on how to deal with a DNA the factors taken into consideration must reflect the individual patient and the service in question. A Zero Tolerance policy is not permitted.

The rules are different for DNA of a first appointment and DNA of subsequent appointments.

Where there is a DNA of a first appointment, the service may decide to discharge the Patient and this is permitted where:

8.14.1 The appointment was clearly communicated to the Patient.
8.14.2 There are no significant clinical or risk factors preventing discharge (this may be evidenced by the referral material)

Vulnerable groups such as children, confused elderly, learning disability conditions, those relying on carers and are agreed with clinicians, commissioners, patients and other relevant stakeholders, are specifically considered to protect their clinical interests.

8.15 Where there is a significant clinical or risk issue, or a patient subsequently contacts the service for a new appointment and a new appointment is given, the original RTT clock is nullified and a new clock start occurs on the date the new appointment is communicated to the patient, or the date the patient called respectively.

8.16 Where there is a DNA of a subsequent appointment the patient should be discharged when the following apply:

8.16.1 The appointment was clearly communicated to the Patient.
8.16.2 There are no clinical risks preventing discharge.
8.16.3 Vulnerable groups such as children, confused elderly, learning disability conditions, those relying on carers and are agreed with clinicians, commissioners, patients and other relevant stakeholders are specifically considered to protect their clinical interests

8.17 The clock does not stop if a further appointment is given following a DNA of a subsequent appointment. Therefore breaches may occur if capacity is not built in to deal with subsequent DNA’s or cancellations, or if further appointments are given routinely.

9.0 VULNERABLE PATIENTS AND CHILDREN

9.1 There are special rules for the non-attendance of vulnerable patients e.g. Children. Specialist directorates e.g. paediatric services and Learning Disability, and general directorates where appropriate, need to manage non-attendance reflecting the evidence based knowledge and national guidelines of the particular client group. Legal issues and the Mental Health Act in particular may apply and must be considered.

9.2 The identification of vulnerable patients and those subject to safeguarding and high risks enables these patients to receive treatment in a timely manner as well

as ensuring that all pathway issues including discharge are managed appropriately to the circumstances.

9.3 Nonattendance may be due to a carer's vulnerability, or the hiding of abuse or neglect. Some patient groups may not be aware of the referral, e.g. those with dementia that live alone, and others may rely on carers to deal with letters and opt in times where these are used may have to be adjusted to take these factors into consideration

9.4 In cases where there are identified risk, vulnerability and safeguarding issues, the service must make attempts to communicate with the patient and or parents/carer, and where indicated the Protection of Vulnerable Adults, and Safeguarding policies and procedures followed. These cases must always be actively managed in the appropriate way, and all relevant authorities and parties involved in the case kept up to date in a timely manner.

9.5 With paediatric services if non-attendance is due to a child being removed into care or a care placement breaking down, immediate liaison with Social Services should be undertaken to establish if the child will remain in the EPUT area and continues to need a service, or will move out of area, in which case the 18 week clock status will continue, and should be communicated to the other provider.

9.6 It is not good practice to discharge patients from these groups before the appropriate investigations have been carried out. Advice from the Safeguarding Leads may be appropriate.

9.7 Cases that have or suspected Mental Capacity issues need special consideration to ensure this patient group are not disadvantaged (see Mental Capacity Act Policy on the intranet)

10.0 SUPPORT AND IMPLEMENTATION STAFF

To support the entire service in the transition to a Referral to Treatment case management system, staff are available to support and can be contacted for more information and support in the implementation of RTT principles which can include site visits where necessary.

- Mark Travella — Associate Director Business Development and Service Improvement
- Nikki Jones — Associate Director of Business Reporting and Analysis
- Robin Thornton — Senior Information Analyst
- Carl Wilson — Senior Information Analyst

11.0 REFERENCES

- Recording and Reporting referral to treatment waiting times for consultant-led elective care NHS England 2015
- Recording and Reporting referral to treatment waiting times for consultant-led elective care FAQs NHS England 2015
- Referral to treatment consultant-led waiting times – Rules Suite DOH October 2015
- NHS Charter DOH
- Clinical Risk Assessment Policy and Procedures
- Safeguarding Adults Policy & Procedures
- Disengagement Policy & Procedure (Mental Health)
- Safeguarding Children Policy & Procedure
- CAS Operational Policies and Local Protocols
- FRT Clinical Guidelines
- Duty Team Operational Policies & Local Protocols
- DH AHP RTT Revised Guide 2011
- Mental Capacity Act Policy
- S.117 Procedure

END