Dorset County Hospital NHS Foundation Trust

Elective Care: Patient Access Policy for Outpatients, Elective Surgery and Diagnostics

Policy Title	*Elective Care: Patient Access Policy for Outpatients, Elective Surgery and Diagnostics*		
Policy Number	**0059**	**Policy Version Number**	**6**
Applicable to	*All administrative / clerical / managerial staff involved in the administration of patient pathways.* *All medical and clinic staff seeing patients in outpatient settings and those with admission rights.*		
Aim of the Policy	*The aim of the policy is to ensure all patients requiring access to outpatient appointments (new and follow up), diagnostics and elective inpatient or day-case treatment are managed equitably and consistently, in line with national waiting time standards, the NHS Constitution and the Policy and Guidance for the Management of Planned Care for Dorset.*		
Next Review Due Date	*December 2023*		
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Approved by	*Finance and Performance Committee*		
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Previous Policy Number	0059	Previous Version Number	5
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Description of Changes Since Last Version	Amendments to reflect changes in local and national policy changes		

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1. Notable changes from the previous policy

1.1 Sections of this policy that are significantly different to the previous version are listed below. All changes have been made to move the trust to a 100% compliant position with the national RTT and Diagnostic rule suite.

- 2.15 Patients moving between NHS and private care
- 2.16 Evidence based access criterial protocols
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- 5.0 Diagnostics overview
- 6.0 Pre-operative assessment (POA)
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2.0 General Principles: Referral to treatment and diagnostic pathways

2.1 Introduction

2.1.1 The trust is committed to delivering high quality and timely elective care to patients. This policy:

- Sets out the rules and principles under which the trust manages elective access to outpatients appointments (new and follow up), diagnostics and elective inpatient or day case treatment
- Gives staff clear direction on the application of the NHS Constitution in relation to elective waiting times (excluding cancer). Cancer standards are covered within the Dorset Cancer Partnership Access Policy.
- Demonstrates how elective access rules should be applied consistently, fairly and equitably.

2.1.2 The policy therefore details how patients will be managed administratively at all points of contact with Dorset County Hospital NHS Foundation Trust (DCH NHS FT) while on an elective pathway and should be read in conjunction with the Patient Access Procedure Manual. It should not be used in isolation as a training tool.

2.1.2 The trust's elective access policy has been developed to support and reflect the Policy and Guidance for the Management of Planned Care for Dorset, the Referral to Treatment Consultant-led waiting times rule suite updated by the Department of Health in October 2015, NHS Improvements Elective Care Model Access Policy, published January 2019, Clinical guide to surgical prioritisation during the coronavirus pandemic, first published in April 2020, Clinical validation of surgical waiting lists: framework and support tools, published in October 2020 and the Diagnostics waiting times and activity guidance which was updated in March 2015.

2.1.3 The access policy is underpinned by a comprehensive suite of detailed standard operating procedures (SOPs). All clinical and non-clinical staff must ensure they comply with both the principles within this policy and the specific instructions within the relevant SOPs.

2.1.3 The trust is committed to promoting and providing services which meet the needs of individuals and does not discriminate against any employee, patient or visitors.

2.2 Aim and Objectives of the Policy

2.2.1 The aim of the policy is to ensure all patients requiring access to outpatient appointments (new and follow up), diagnostics and elective inpatient or day-case treatment are managed equitably and consistently, in line with national waiting time standards, the NHS Constitution and the Policy and Guidance for the Management of Planned Care for Dorset.

2.2.2 The policy:

- Is designed to ensure the management of elective patient access to services is transparent, fair, equitable and managed according to clinical priorities
- Sets out the principles and rules for managing patients through their elective care pathways (excluding cancer).
- Applies to all clinical and administrative staff and services relating to elective patient access at the trust.

2.2.3 The objective of this Policy is to provide guidance to all staff in the management of patients' access to elective hospital treatment.

2.3 Who is the Policy for

2.3.1 This Policy (and corresponding Patient Access Procedure Manual) is intended to be of interest to and used by all those individuals within DCH NHS FT who are responsible for referring patients, managing referrals, adding to and managing waiting and tracking lists, and booking any other elective treatment, for the purpose of organising patient access to hospital treatment.

2.3.2 This Policy is also intended to be a reference for patients, their families and carers, providing information regarding how their referrals and elective treatment plans will be managed by DCH NHS FT.

2.4 Definitions, Legislation, Policies, Guidelines and References

2.4.1 Explanations of the terms used in the policy.

Active Monitoring (Also known as 'watchful waiting'): 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 who are currently available to be called for admission.

Bilateral procedures: Where a procedure is required on both the right and left side of the body.

Breach: When a patient has not had a clock closing event within the required 18 weeks target for elective treatment and 6 weeks for a diagnostic procedure.

Chronological booking: Refers to the process of booking patients for appointments, diagnostic procedures and admission in date order of their clock start date.

Consultant-led service: A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse-led clinics which come under the umbrella of consultant-led services.

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

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.

Daycases: 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 Treat date (DTT): The date on which a consultant decides a patient needs to be admitted for a procedure. 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.

Did not bring (DNB): The same definition as DNA but is to be used for paediatric patients and patients who are reliant on another to bring them to an appointment due to lack of mental capacity.

Direct access: Where a GP refer patients to hospital for diagnostic tests only. These patients will not be on an open 18 week RTT pathway.

Elective care: Any pre-scheduled care which doesn't come under the scope of emergency care.

E-Referral Service (ERS): A method of electronically booking a patient into the hospital of their choice.

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.

Fixed appointments: Where an appointment or admission date is sent in the post or via email to the patient without the opportunity to agree a date.

Full booking: Where an appointment or admission date is agreed by the patient, either over the phone or when the appointment date has been selected by the patient via ERS. A confirmation letter or email is sent to the patient after the date is confirmed.

Incomplete pathway: Patients who are waiting for treatment on an open RTT pathway, either at the no decision to treat or decision to treat stage.

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

Nullified: Where the RTT clock is discounted from any reporting of RTT performance.

Outpatients: Patients referred by a General Practitioner or another health care professional for clinical advice or treatment.

Partial booking: Where an appointment or admission date is agreed with the patient near to the time it is due.

Patient-initiated delay: Where the patient cancels, declines offers or requests to delay appointments or admission for social reasons i.e. a holiday.

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

Planned waiting list: Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment at the clinically appropriate time.

Reasonable Offer: A choice of two appointments or admission dates with three weeks' notice.

Referral to Treatment (RTT): Instead of focusing upon a single stage of treatment (such as outpatients, diagnostic or inpatients) the 18 week pathway addresses the whole patient pathway from referral to the start of treatment.

Straight to test: Arrangements where patients can be referred straight for diagnostics as the first appointment as part of their RTT pathway.

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 not normally be recorded as a formal offer. Usually telephoned offers are confirmed by a formal written offer.

2.4.2 Guidelines

- Referral to Treatment Consultant-led waiting times rules suite: October 2015.https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks

- Recording and reporting RTT guidance: October 2015. https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting-RTT-guidance-v24-2-PDF-703K.pdf

- Recording and reporting RTT guidance FAQ: August 2017. https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2017/10/Accompanying-FAQs-v7.32-ASI-FAQ-update.pdf

- Policy and guidance for the management of planned care for Dorset: June 2019. https://www.dorsetccg.nhs.uk/wp-content/uploads/2020/10/Management-of-Planned-Care-Policy.pdf

- The NHS Constitution: July 2015. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf

- Diagnostics waiting times and activity Guidance on completing the 'diagnostic waiting times & activity' monthly data collection: March 2015. https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01-guidance-v-5.32.pdf

- Diagnostics FAQ's on completing the 'diagnostic waiting times & activity' monthly data collect. February 2015. https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01-FAQs-v-3.0.pdf

- Equality act 2010: June 2015. https://www.gov.uk/guidance/equality-act-2010-guidance

- Overseas visitors guidance: Sept 2020. https://www.gov.uk/government/publications/overseas-nhs-visitors-implementing-the-charging-regulations

- Armed Forces Covenant: July 2015. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/49469/the_armed_forces_covenant.pdf

- Elective care model access policy: January 2019. https://improvement.nhs.uk/documents/1583/Elective_care_model_access_policy__1.1_January_2019.pdf

- Policy for Individual Patient Treatment: November 2019. https://www.dorsetccg.nhs.uk/wp-content/uploads/2020/03/Individual-Patient-Treatments.pdf

- Clinical validation of surgical waiting lists: framework and support tools: October 2020. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/10/C0760-Clinical-validation-of-surgical-waiting-lists-1-2.pdf

- Clinical guide to surgical prioritisation during the coronavirus pandemic: November 2020. https://www.rcseng.ac.uk/coronavirus/surgical-prioritisation-guidance/

2.5 Equality Impact Assessment

2.5.1 This policy is based on accepted national guidance. This policy does not have any impact upon equality or employment rights. The completed assessment for the policy is attached as Appendix A.

2.6 Data Protection Impact Assessment

2.6.1 This policy does not signify any significant changes in the management of patient information The Data Protection Impact Assessment (DPIA) screening questionnaire can be found in appendix B.

2.7 Stakeholders and Consultation

2.7.1 This policy has been written to reflect both national and local guidance and contains no significant variation to either.

2.7.2 The local policy, the 'Policy and guidance for the management of planned care for Dorset June 2019' was written by the CCG in consultation with the following stakeholders:

- Operational leads from Royal Bournemouth, Poole and Dorset County Hospitals
- Operational leads from Dorset Healthcare
- Primary care leads
- Dorset CCG elective care leads
- NHS Digital
- Dorset MSK task and finish group, including Primary and Secondary Clinical and Operational leads.

2.7.3 The following stakeholders have been consulted with for this policy:

- Divisional Managers
- Service Managers
- Clinical Leads
- Patient Access Department
- Dorset CCG
- Primary Care Leads
- Associate Medical Director

2.8 Roles and Responsibilities

2.8.1 Whilst responsibility for achieving targets lies with the Operational Divisions and ultimately the trust board, all staff with access to and a duty to maintain, referral, and waiting list information systems are accountable for their accurate upkeep.

2.8.2 The Head of Patient Access is responsible for implementing, monitoring and ensuring compliance with the policy throughout the trust.

2.8.3 The Chief Information Officer is accountable for the timely production of patient tracking lists (PTLs) which support the divisions in managing waiting lists and RTT standards.

2.8.4 Waiting list administrators, including clinic staff, secretaries and booking clerks, are responsible to Service/ Patient Access managers for compliance with all aspects of the trust's elective access policy.

2.8.5 Waiting list administrators for outpatients, diagnostics and elective inpatient or day care services are responsible for the day-to-day management of their lists and are supported in this function by the Service/Patient Access managers and Divisional Managers who are responsible for achieving access standards.

2.8.6 The Head of Patient Access is responsible for ensuring data is accurate and services are compliant with the policy.

2.8.7 Service managers and speciality Clinical Leads are responsible for ensuring the NHS e-referral service directory of services (DOS) is accurate and up to date.

2.8.8 The Information team is responsible for producing and maintaining regular reports to enable Care Groups to accurately manage elective pathways and ensure compliance with this policy.

2.8.9 General practitioners (GPs) and other referrers play a pivotal role in ensuring patients are fully informed during their consultation of the likely waiting times

for a new outpatient consultation and of the need to be contactable and available when referred.

2.8.10 CCGs are responsible for ensuring all patients are aware of their right to treatment at an alternative provider in the event that their RTT wait goes beyond 18 weeks or if it is likely to do so.

2.8.11 In the event that patients' RTT waits go beyond 18 weeks, CCGs must take all reasonable steps to offer a suitable alternative provider, or if there is more than one, a range of suitable alternative providers, able to see or treat patients more quickly than the provider to which they were referred. A suitable alternative provider is one that can provide clinically appropriate treatment and is commissioned by a clinical commissioning group or NHS England.

2.8.12 The CCGs are responsible for ensuring there are robust communication links for feeding back information to GPs. GPs should ensure quality referrals are submitted to the appropriate provider first time.

2.8.13 The PAS Development Manager is accountable for the maintenance of PAS (Patient Administration System) on which all waiting lists are managed.

2.8.14 All clinical staff are responsible, through their Clinical Director to the Medical Director, for ensuring they comply with their responsibilities as outlined in this Policy.

2.8.15 Staff involved in managing patients' pathways for elective care must not carry out any action about which they feel uncertain or which may contradict this policy. If in doubt seek the advice of your line manager in the first instance.

2.8.16 The NHS Constitution recommends the following actions patients can take to help in the management of their condition:

- Patients can make a significant contribution to their own, and their families, good health and wellbeing, and should take personal responsibility for it.
- Patients should be registered with a GP practice as this is the main point of access to NHS care as commissioned by NHS bodies.
- Patients should provide accurate information about their health, condition and status.
- Patients should keep appointments or cancel within a reasonable time frame. Patients should be ready, willing and able before seeking a referral to secondary care.

2.9 Dissemination

2.9.1 Following approval from the policies sponsor and the sub-board committees, the policy has been uploaded on the Trusts external website.

2.9.2 This policy is uploaded to the Trust Policies and Clinical Guidance database and published via the Trust StaffNet.

2.9.3 The policy has been sent to all Divisional Management Teams, Care Group Teams, clinical leads and the Patient Access Department.

2.9.4 The link to the policy has been sent by email to all employees via the trusts weekly update.

2.10 Training and Implementation

2.10.1 As a key part of their induction programme, all new starters to the trust will undergo mandatory contextual elective care training applicable to their role.

2.10.2 All existing staff will undergo mandatory contextual elective care training on at least an annual basis where it is applicate to their role.

2.10.3 All staff will carry out competency tests relevant to their role that are clearly documented to provide evidence that they have the required level of knowledge and ability.

2.10.4 This policy, along with the supporting suite of SOPs, will form the basis of contextual training programmes.

2.10.5 Audits within functional teams, specialities and cohorts of staffing groups will take place to evidence compliance with the trusts Access Policy.

2.10.6 In the event of non-compliance, a resolution should initially be sought by the team, specialty or individual's line manager. The matter should then be dealt with via the trust's disciplinary or capability procedure.

2.11 Monitoring and Reviewing Arrangements

2.11.1 This policy will be reviewed every three years unless there is a change to national policy.

2.12 Policy Approval

2.12.1 The policy will be approved in accordance with the Policy for the Management of Policies and Guidance (Ref 1126) and Procedure for the Development of Policies (Ref 1909).

2.13 Individual patient rights

2.13.1 The NHS Constitution clearly sets out a series of pledges and rights stating what patients, the public and staff can expect from the NHS. A patient has the right to the following:

- Choice of hospital and consultant

- To begin their treatment for routine conditions following a referral into a consultant-led service, within a maximum waiting time of 18 weeks to treatment

  If this is not possible, the NHS has to take all reasonable steps to offer a range of alternatives.

  The right to be seen within the maximum waiting times does not apply:

- If the patient chooses to wait longer

- If delaying the start of the treatment is in the best clinical interests of the patient

- If it is clinically appropriate for the patient's condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage.

2.13.2 All patients are to be treated fairly and equitably regardless of race, sex, religion or sexual orientation.

2.14 Patient Eligibility

2.14.1 All trusts have an obligation to identify patients who are not eligible for free NHS treatment and specifically to assess liability for charges in accordance with Department of Health guidance /rules.

2.14.2 The trust will check every patient's eligibility for treatment. Therefore, at the first point of entry, patients will be asked questions that will help the trust assess 'ordinarily resident status'. Some visitors from abroad, who are not ordinarily resident, may receive free healthcare, including those who:

- have paid the immigration health surcharge

- have come to work or study in the UK

- have been granted or made an application for asylum.

2.14.3 Citizens of the European Union (EU) who hold a European Health Insurance Card (EHIC) are also entitled to free healthcare, although the trust may recover the cost of treatment from the country of origin.

2.14.4 All staff have a responsibility to identify patients who are overseas visitors and to refer them to the overseas visitor's office for clarification of status regarding entitlement to NHS treatment before their first appointment is booked or date to come in (TCI) agreed.

2.15 Patients moving between NHS and private care

2.15.1 Patients can choose to move between NHS and private status at any point during their treatment without prejudice. This is provided NHS care is delivered in clear episodes which are demonstrably separate from any privately funded care. This is to ensure the patient does not combine elements of NHS and private treatment/care within the same episode.

2.15.2 Following a private outpatient appointment, a consultant can refer in to the NHS without the need for it to go via a GP. Where it has been agreed, for example, that a surgical procedure is necessary the patient can be added directly to the elective waiting list if clinically appropriate. The RTT clock starts at the point the GP or original referrer's letter arrives in the hospital.

2.15.3 Patients who have had a private consultation for investigations and diagnosis may transfer to the NHS for any subsequent treatment. They should be placed directly onto the NHS waiting list at the same position as if their original consultation had been within the NHS.

2.15.4 ALL MSK referrals in Dorset (NHS and private secondary care transferring to NHS) must be referred via the MSK triage service, with the exception of red flag referrals (time critical conditions for emergency attention). Private MSK referrals for surgery must be sent to the Dorset MSK triage service with a fully completed pro forma.

2.15.5 Dorset MSK triage service meets the definition of an interface service or a referral management assessment centre. The RTT clock therefore starts when Dorset MSK receive the referral and is inherited when the patient is referred to secondary care for treatment.

2.15.6 Consultants should not spend time during NHS consultations discussing private treatment with patients nor should they use their NHS patient lists to promote their private practice. An exception is where clinically appropriate treatment is not funded by the NHS. Where this is the case, patients should be informed, in order to be able to consider the options open to them, including the option of seeking the treatment privately.

2.15.7 All doctors have a duty to share information with others providing care and treatment for their patients. This includes NHS doctors providing information to private practitioners.

2.15.8 Private to NHS referrals should be made using 'consultant to consultant' functionality until functionality exists within e-RS to carry out 'any to any' referrals.

2.15.9 The RTT pathways of patients who notify the trust of their decision to seek private care will be closed with a clock stop applied on the date of this being disclosed by the patient.

2.16 Evidence based access criterial protocols

2.16.1 NHS Dorset CCG has a finite level of financial resources with which to commission healthcare interventions for its population. Consequently, it has to

prioritise which interventions that it commissions. In doing so it takes into consideration a number of factors including clinical effectiveness and value for money as well as the availability of alternative interventions and the implications of not commissioning the intervention.

2.16.2 Inevitably there will be some interventions which the CCG has not prioritised for routine commissioning. A series of evidenced based interventions (EBI) have been developed for these interventions which outline under what clinical circumstances an intervention would be made available. Some of these will only be made routinely available where specific clinical criteria are met, whilst in others they will not be made routinely available at all. In both cases consideration may still be given to provision for a specific patient if a case is made and accepted that there are clinical factors that make the patient clinically exceptional.

2.16.3 The process for considering requests on the basis of clinical exceptionality is outlined in the CCG's Policy for Individual Patient Treatment, which can be found here and was last updated in November 2019:

hhttps://www.dorsetccg.nhs.uk/wp-content/uploads/2020/03/Individual-Patient-Treatments.pdf

2.17 Military veterans

2.17.1 In line with the Armed Forces Covenant, published in 2015, all veterans and war pensioners will receive priority access to NHS care for any conditions related to their service, subject to the clinical needs of all patients.

2.17.2 Military veterans do not need first to have applied and become eligible for a war pension before receiving priority treatment.

2.17.3 The referrer are required to notify the trust of the patient's condition and its relation to military service when they refer the patient, so the trust can ensure it meets the current guidance for priority service over other patients with the same level of clinical need. In line with clinical policy, patients with more urgent clinical needs will continue to receive priority.

2.18 Prisoners

2.18.1 All elective standards and rules are applicable to prisoners. Delays to treatment incurred as a result of difficulties in prison staff being able to escort patients to appointments or for treatment do not affect the recorded waiting time for the patient.

2.18.2 The trust will work with staff in the prison services to minimise delays through clear and regular communication channels and by offering a choice of appointment or admission date in line with reasonableness criteria.

2.19 Internal Service standards

2.19.1 Key business processes that support access to care have clearly defined service standards, which are monitored by the trust. Compliance with each service standard will support effective and efficient service provision, and the achievement of referral to treatment standards.

2.19.2 Key standards for implementation include the following:

- Referral must be registered onto Trust systems within two working days.
- Clinical triage must take place within five working days of receipt of referral.
- Patients will be sent acknowledgement of requested appointments within 10 working days of receipt of referral, this will be an appointment letter/email or an outpatient waiting list letter/email.
- Additions to the waiting list on PAS or Booked Admissions must be made within three days of the decision to admit.
- When a patient is added to Booked Admissions for surgery the clinical priority of the patient must be included. The clinical prioritisation categories are as followed:

- Priority level 1a Emergency operation needed within 24 hours
- Priority level 1b Urgent operation needed with 72 hours
- Priority level 2 Surgery that can be deferred for up to 4 weeks
- Priority level 3 Surgery that can be delayed for up to 3 months
- Priority level 4 Surgery that can be delayed for more than 3 months

- It is assumed all admitted patients will have a 72 hour period of isolation. If, for clinical reasons, the patient is required to isolate for longer, this must be stated on Booked Admissions at the point of listing.
- All appointments will be confirmed in writing, where the trust has the patients consent, this will be sent electronically.
- Where possible, patients will not be cancelled more than once. In times of operational pressure and clinical urgency this may not be possible.
- A minimum or six weeks' notice of annual or study leave is required for clinic cancellation or reduction.
- Clinic Cancellation with less than 6 weeks' notice can only be authorised by the Chief Operating Officer or their appointed Deputy.
- Reporting of diagnostic results must be made available in time to allow progress through all likely stages of the RTT pathway. The timeframes in which reporting must be made available is dependent on the pathway and patients clinical urgency.
- For clinic letters, where there is information which the GP needs quickly in order to manage a patient's care, this must communicate by issue of a clinic letter within 7 days. Clinic letters must be sent by direct electronic transmission as structured messages using standardised clinical headings.
- 80% of Advice and Guidance requests through ERS must be responded to within 48 hours. 100% must be responded to within 5 days.
- Where a clinical review is required to determine if a patient should be returned to their GP if they are not ready, willing and able, the outcome of the review must be communicated to the patient within 5 working days.

- If a paper-based referral (non GP) is received directly into a specialty, the specialty must date stamp the referral and forward to the centralised booking office within one working day of receipt.

The standards above are described in greater detail in the Patient Access procedure manual.

2.20 Monitoring and Governance

2.20.1 Operational teams will regularly and continuously monitor levels of capacity for each pathway milestone to ensure any shortfalls are addressed in advance. This will avoid poor patient experience, resource intensive administrative workarounds and, ultimately, breaches of the RTT standard.

2.20.2 Operational teams are required to review their performance and patient tracking lists (PTLs) at least weekly. Performance will be reviewed and long waiters discussed at the weekly RTT, Diagnostic and Cancer performance meetings, chaired by the Chief Operating Officer (Executive Board member) or an appointed deputy.

2.20.3 RTT and Diagnostic performance must be included in each Care Groups Business and Governance meeting, this reports to the Divisional Business and Governance meetings, which then report to the Trusts Board two sub-committee's the Finance and Performance committee and the Quality committee.

2.21 Reasonableness criteria

2.21.1 'Reasonableness' is a term applicable to all stages of the elective pathway. Reasonableness refers to specific criteria which should be adhered to when offering appointments and admission dates to patients to demonstrate that they have been given sufficient notice and a choice of dates. A reasonable offer is defined as a choice of two dates with at least three weeks' notice.

2.21.2 Patients should be offered two dates for appointments (this covers all types of appointments including admission dates) with reasonable notice, which is defined as at least three weeks. Dates can be offered with less than three weeks' notice and if the patient accepts, this can then be defined as 'reasonable'.

2.21.3 If a patient wants to defer treatment/ appointments because of their concerns about COVID-19 priority 5 (P5) code can be applied to the patient's pathway. Patients who fit the P5 category will remain on the appropriate active waiting list(s) and therefore remain visible. In line with current waiting list rules, waiting times will not be 'paused' and clocks will continue to tick through the period that the patient chooses not to attend.

2.21.4 As patients in the P5 category have deferred rather than declined treatment, they must not be discharged back to their GP, unless this is in their clinical

interest and has been agreed by them following a conversation with their clinician. Patients must be given a review date to make sure their condition or preference has not changed. The maximum time before a review date is six months, with an aim that all PTLs are clinically prioritised and reviewed once a quarter. Paediatric, urgent and cancer patients must be brought to the attention of the clinician as soon as the patient has notified us of their decision (where this is not to a clinician).

2.21.5 Patients who have been offered two dates for treatment/ appointments, that meet reasonableness criteria, but have declined the dates for non- COVID-19 reasons, but still wish to remain on the waiting list will be coded as P6. As with P5 patients, the clock continues to tick. Patients must be given a review date to make sure their condition or preference has not changed. The maximum time before a review date is six months, with an aim that all PTLs are clinically prioritised and reviewed once a quarter. Paediatric, urgent and cancer patients must be brought to the attention of the clinician as soon as the patient has notified us of their decision (where this is not to a clinician).

2.21.6 The P5 and P6 rules apply to the 18 week referral to treatment pathway and not a 6 week diagnostic.

2.22 Chronological booking

2.22.1 Patients will be selected for booking appointments or admission dates according to clinical priority. Patients of the same clinical priority will be appointed/ treated in RTT chronological order, i.e. the patients who have been waiting longest will be seen first. Patients will be selected using the trust's patient tracking lists (PTLs) only. They will not be selected from any paper-based systems.

2.23 Communication

2.23.1 All communications with patients and anyone else involved in the patient's care pathway (e.g. general practitioner (GP) or a person acting on the patient's behalf), whether verbal or written, must be informative, clear and concise.

2.23.2 Copies of all correspondence with the patient must be kept in the patient's clinical notes or stored electronically for auditing purposes.

2.23.3 GPs or the relevant referrer must be kept informed of the patient's progress in writing. When clinical responsibility is being transferred back to the GP/ referrer, e.g. when treatment is complete, this must be made clear in any communication.

2.23.4 Patients who are sent a partial booking letter, but fail to respond within the requested timescale, will be contacted once more, following which their care maybe returned to the GP following a clinical triage review.

2.23.5 For clinic letters, where there is information which the GP needs quickly in order to manage a patient's care, this must communicate by issue of a clinic letter within 7 days. Clinic letters must be sent by direct electronic transmission as structured messages using standardised clinical headings.

2.23.6 80% of Advice and Guidance requests through ERS must be responded to within 48 hours. 100% must be responded to within 5 days.

2.23.7 The Trust will attempt to arrange all appointment and admission dates with the patient over the phone, and then confirm it in writing via a letter or email.

2.23.8 For outpatient appointments and diagnostic tests, a minimum of three call attempts at least 12 hours apart and one after 5pm must be made. If contact still hasn't been made, the appointment can be sent to the patient via letter or email.

2.23.9 For admission dates, including day surgery and endoscopic procedures, the date must be agreed with the patient over the phone then confirmed in writing via letter or email. Where contact with the patient cannot be made a no contact letter must be sent to the patient asking them to contact the relevant department within five working days. If the patient does not make contact a second letter will be sent to the patient to inform them that they have a further five days to make contact or they may be returned to the referrer. A clinical review is not required where contact with the patient cannot be made, before returning the patient to the referrer. A copy of both letters/ emails must also be sent to the patients GP when the GP is not the referrer.

3.0 An overview of the National referral to treatment and diagnostic standards

3.1 The standards

Referral to treatment	
Incomplete	92% of patients on an incomplete pathway (ie still waiting for treatment) to be waiting no more than 18 weeks (or 126 days)
Diagnostics	
Applicable to diagnostics tests	99% of patients to undergo the relevant diagnostic investigation within 5 weeks and 6 days (or 41 days) from the date of decision to refer to appointment date

3.1.1 While the aim is to treat all elective patients within 18 weeks, the national elective access standards are set at less than 100% to allow for the following scenarios:

- Clinical exceptions: when it is in the patient's best clinical interest to wait more than 18 weeks for their treatment.
- Choice: when patients choose to extend their pathway beyond 18 weeks by declining reasonable offers of appointments, rescheduling previously agreed appointment dates/admission offers, or specifying a future date for appointment/admission.
- Co-operation: when patients do not attend previously agreed appointment dates or admission offers (DNA) and this prevents the trust from treating them within 18 weeks.

3.2 RTT Clock starts

3.2.1 The RTT clock starts when any healthcare professional (or service permitted by an English NHS commissioner to make such referrals) refers to a consultant-led service. The RTT clock start date is the date the trust receives the referral. For referrals received through NHS e-Referral, the RTT clock starts the day the patient converts their unique booking reference.

3.2.2 A referral is received into a consultant-led service, regardless of setting, with the intention that the patient will be assessed and if appropriate, treated before clinical responsibility is transferred back to the referrer.

3.2.3 A referral is received into an interface or referral management assessment centre which may result in an onward referral to a consultant-led service before clinical responsibility is transferred back to the referrer.

3.2.4 A patient self-refers into a consultant-led service for pre-agreed services agreed by providers and commissioners.

3.2.5 A referral to most consultant-led services starts an RTT clock but the following services and types of patients are excluded from RTT:

- Obstetrics and midwifery
- Planned patients
- Referrals to a non-consultant led service
- Referrals for patients from non-English commissioners
- Genitourinary medicine (GUM) services
- Emergency pathway non-elective follow-up clinic activity.

3.2.6 Patients opting to participate into research projects will be outside of the 18 weeks to enable them to be treated according to the research protocol.

3.2.7 If a patient moves in to the county and is already on a care pathway the waiting time clock continues. A new clock does not start and the care is transferred via an inter-provider transfer (IPT)

3.3 New clock starts for the same condition

3.3.1 Following active monitoring: Some clinical pathways require patients to undergo regular monitoring or review diagnostics as part of an agreed programme of care. These events would not in themselves indicate a decision to treat or a new clock start. If a decision is made to treat after a period of active monitoring/watchful waiting, a new RTT clock would start on the date of decision to treat (DTT).

3.3.2 Following a decision to start a substantively new treatment plan: If a decision is made to start a substantively new or different treatment that does not already form part of that patient's agreed care plan this will start a new RTT pathway clock and the patient shall receive their first definitive treatment within a maximum of 18 weeks from that date.

3.2.3 For the second side of a bilateral procedure: A new RTT clock should be started when a patient becomes fit and ready for the second side of a consultant-led bilateral procedure.

3.2.4 Where a patient DNA's a first outpatient appointment and the clinical decision is to offer a further appointment: The RTT clock is restarted from the date contact is made with the patient not the date of the new appointment.

3.4 Planned patients

3.4.1 All patients added to the planned list will be given a due date by when their planned procedure/ test should take place. Where a patient requiring a planned procedure goes beyond their due date, they will be transferred to an active pathway and a new RTT and or DM01 clock started.

3.5 Clock stops for first definitive treatment

3.5.1 An RTT clock stops when first definitive treatment starts. This could be:

- Treatment provided by an interface service.
- Treatment provided by a consultant-led service
- Therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions.
- A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

3.5 Clock stops for non-treatment

3.5.1 A waiting-time clock stops when it is communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay that:

- It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care.
- A clinical decision is made not to treat.
- A patient did not attend (DNA) which results in the patient being discharged.
- A decision is made to start the patient on a period of active monitoring.
- A patient declines treatment having been offered it.

3.6 Active monitoring

3.6.1 Active monitoring is where a decision is made that the patient does not require any form of treatment currently but should be monitored in secondary care. When a decision to begin a period of active monitoring is made and communicated with the patient, the RTT clock stops. Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made.

3.6.2 It is not appropriate to stop a clock for a period of active monitoring if some form of diagnostic or clinical intervention is required in a couple of days' time, but it is appropriate if a longer period of active monitoring is required before further action is needed. Stopping a patient's clock for a period of active monitoring requires careful consideration case by case and needs to be consistent with the patient's perception of their wait.

3.7 Patient initiated delays- Did Not Attend and Did Not Bring (DNA & DNB)

3.7.1 Other than at first attendance, DNA's have no impact on reported waiting times. Every effort should be made to minimise DNAs.

3.7.2 Patients who cancel their appointments in advance should not be classed as a DNA and therefore should not have their clocks nullified.

3.7.3 The referral for all patients who DNA a first outpatient appointment will be clinically reviewed and acted upon accordingly. If at this point there is a decision to not reappoint the patient, both the patient and the GP will be made aware.

3.7.4 Patients who DNA a hospital appointment will be able to re-book directly with the hospital within two weeks without going back to their GP if deemed appropriate following clinical review. A new 18-week clock would restart from the date the patient contacts the hospital to rearrange the appointment (not the date of their new appointment). The hospital must contact the patient directly within 2 weeks to re-book. The GP should be notified if a new appointment is not able to be made for those deemed to require a further appointment.

3.7.5 When a patient DNA's a first outpatient appointment, The RTT clock is stopped and nullified in all cases (as long as the trust can demonstrate the appointment was booked in line with reasonableness criteria). If the clinician indicates another first appointment should be offered following clinical review, a new RTT clock will be started on the day the new appointment is agreed with the patient, or added back on the OWL.

3.7.6 When a patient DNA's a subsequent appointment (follow up) the RTT clock continues if the clinician indicates that a further appointment should be offered. If patients wait more than 18 weeks as a result of such delays, the 8% tolerance is in place to account for this. The RTT clock stops if the clinician indicates that it is in the patient's best clinical interests to be discharged back to their GP/referrer.

3.7.7 Patients who were not brought (DNB) should not be disadvantaged and every effort should be made to contact the patients primary care giver and re-appoint the patient.

3.8 Patient initiated delays- Cancellations

3.8.1 Patients can choose to postpone or amend their appointment or treatment if they wish, regardless of the resulting waiting time. Such cancellations or delays have no impact on reported RTT waiting times. Either a P5 or P6 code will be applied to the pathway depending on the reason for postponement, see 2.21.3 to 2.21.6.

3.8.2 Acting in the patient's best clinical interest at all times is paramount. It is generally not in a patient's best interest to be left on a waiting list for an extended period, and so where long delays (i.e. of many months) are requested by patients, a clinical review should be carried out, and the treating clinician should speak with the patient to discuss and agree the best course of action.

3.8.3 All PTL's must be clinically reviewed as a minimum of every 6 months but with an aim of every quarter. Patients that are either P5, P6 or on active monitoring, must be highlighted and prioritised for clinical review.

3.8.4 If a patient requests time to think about the offer of a clinical intervention, a week of thinking time can be given and the patient's clock will continue. If the patient either does not communicate in the agreed time or cannot make a decision, they could be returned to their GP following clinical review or have active monitoring applied to the pathway and an agreed review date set.

3.9 Provider initiated delays

3.9.1 If the Trust cancels an appointment at any point in the RTT pathway, this has no effect on the RTT waiting time. RTT clock should continue to tick.

3.9.2 If the treatment is cancelled by the provider after admission because of resource constraints (for example, lack of theatre time due to emergency procedures being carried out), then the RTT clock should continue to tick until the patient ultimately starts their treatment.

3.10 Patients who are unfit for surgery

3.10.1 If the patient is identified as unfit for the procedure, the nature and duration of the clinical issue should be ascertained.

3.10.2 Patients who become unwell with an illness that is expected to last less than two weeks will remain on their current pathway and their clock will continue. Patients who become unwell with a condition expected to last more than two weeks will be highlighted to treating clinician. The clinician can decide to keep the patient on the waiting list, noting the waiting times for the service and the length of time it is likely to take for the patient to become fit. If the clinician is concerned the length of time to become fit will exceed the time it is clinically appropriate to keep them on the waiting list they can discharge the patient back to the GP. If the patient requires secondary care intervention active monitoring can be applied, see 3.6.

3.10.3 Patients who become unwell with an illness that is expected to last more than two weeks, but will be optimised/ treated within secondary care will have their clock stopped through active monitoring. The decision to apply active monitoring must be made by the treating clinician. A new waiting time clock will start when the treating clinician deems the patients is fit to proceed with

surgery. The clinician must notify the Admission Officer in writing (via email is acceptable).

3.10.4 If the patient requires urgent secondary care intervention in another specialty, an onward referral will be made and the GP will be informed why this has happened.

4.0 Pathway specific principles referral to treatment and diagnostic pathways: Non Admitted pathways

4.1 The non-admitted stages of the patient pathway comprise both outpatients and the diagnostic stages.

4.2 Method of referral: National E-Referral system, other electronic systems and paper referrals

4.2.1 From 1 October 2018, all referrals from GPs to consultant-led services should be made electronically through the national e-Referral Service (e-RS). The trust will no longer be paid for activity which results from GP referrals made other than through e-RS therefore, where the GP referral is not made via e-RS it will be returned to the GP.

4.2.2 Referrals from non GP referrers are accepted via other electronic methods other than e-RS. Paper referrals are currently accepted but the Trust encourages electronic referral routes, such as secure encrypted email.

4.2.3 Where clinically appropriate, referrals should be made to a service rather than a named clinician. Services have agreed clinical criteria to support triage and vetting, and patients will then be allocated to the most appropriate clinician, taking into account waiting times. Referring to services is in the best interests of patients as pooling referrals promotes equity of waiting times and allows greater flexibility in booking appointments.

4.2.4 For all referrals, they will be reviewed and accepted or rejected by clinical teams within five working days. Where there is a delay in reviewing new referrals this will be escalated to the relevant Care Group Business Manager.

4.2.5 If a referral is received for a service not provided by the trust, it will be rejected back to the referring GP advising that the patient needs to be referred elsewhere. This will stop the patient's RTT clock.

4.2.6 Referrals should only be rejected if considered clinically inappropriate for that specialty.

4.2.7 Rejections should only happen occasionally and the Trust must not reject patients for capacity reasons or geographical reasons as choice has been made by the patient.

4.2.8 Clear feedback information in NHS e-Referral should be provided to the GP when rejecting a referral to help manage the patient's condition and/or help inform future similar.

4.2.9 Responsibility for acting on the rejection advice does rest with the referrer in line with how the referrer would act on a response for advice and guidance.

4.2.7 Where a paper referral is received from a non GP it should be sent to Central Appointments in Vespasian House.

4.2.8 Referrals must be date stamped on receipt at the trust. If a paper-based referral is received directly into a specialty, the specialty must date stamp the referral and forward to the centralised booking office within one working day of receipt. For patients referred by paper, the referral received date is the point that the RTT clock starts.

4.2.9 As a result of COVID, all services on e-RS have been polled in to prevent patients booking their own appointments as described in paragraph 4.6.1. This enables the trust to triage the referrals for either face to face or virtual appointments (telephone assessment or Attend Anyway). This is a temporary measure as it means all referrals are converted to an ASI.

4.3 Method of referral: Consultant to Consultant referrals

4.3.1 Unless otherwise requested by the GP, onward referral within the same provider for a non-urgent condition which is directly related to the original complaint or condition should be made without re-referral to the GP.

4.3.2 Onward referrals should not be made for non-urgent conditions which are not directly related to the original complaint or condition. In such cases the patient should be referred to their GP for a review.

4.3.3 Onward referral for urgent conditions should proceed automatically and without delay where:

- The referral is for investigation, management or treatment of cancer or a suspected cancer.
- The symptoms or signs suggest a life threatening or clinically urgent condition. It would be expected that such a situation would however be rare in the case of an outpatient referral.
- The onward referral for a non-urgent condition is directly related to the complaint or condition which caused the original referral.
- Failure to refer onwards may result in either hospital admission or re attendance for example through Accident and Emergency.
- Where a GP has specifically given approval for such an onward referral in their original referral letter.

- Diagnostics and investigation, for example where endoscopy is required as part of the patient pathway for the original presenting condition.

- An anaesthetic risk assessment is required.

4.3.4 The GP is the overseer of the patient's care and where a consultant or associate specialist is unsure about referring a patient on within the Trust they should consult with the GP to agree the appropriate course of action.

4.3.5 GPs, including locums, should provide adequate referral information to ensure that patients are directed to the appropriate consultant.

4.3.6 If an unrelated condition can be managed in primary care then the patient should be referred back to their GP practice (without a recommendation being made to the patient that they need to be referred to see another hospital specialist).

4.3.7 Patients with minor symptoms should be sent back to their GP with supporting information (for example patients with dizziness should not be referred routinely on to neurology unless the referral is deemed to be clinically urgent).

4.3.8 In the event that a patient mentions a condition during the hospital consultation that is coincidental or not relevant to the initial referral by the GP, the patient should be referred back to their GP with instructions to seek the GPs opinion regarding the management of the secondary condition.

4.3.9 If a patient is referred for a clinical opinion to exclude a specific cause, such as cardiac involvement in a breathless patient, they should not then be referred onto the respiratory team for further investigation. They should instead be referred back to the GP to determine if the patient can be managed in Primary Care without the need for further specialist support.

4.3.10 A single episode of care should not generate two first outpatient attendances in different hospitals for the same consultant within the same pathway;

4.3.11 If patients self-refer they should be advised to see their GP to initiate a referral, with the following exceptions:

- Genitourinary medicine.

- SOS returners.

4.3.12 In cases where an inter-specialty referral is appropriate the patients GP must be informed of all such referrals by receipt of a copy of the consultant's referral letters.

4.3.13 If inadequate information is provided on referral, providers must use the 'reject' option on e-Referral.

4.3.14 Internal non-emergency inter-specialty referrals (including accident and emergency to consultant referrals) can only be authorised by the consultant or associate specialist not members of their team such as: Specialist

nurses/Accident and Emergency nurses; Junior Doctors; and Allied Health Professionals.

4.3.15 Where the referrer has sent the patient to the correct specialty but to the wrong consultant the case should be forwarded to the correct clinician without delay. The patient should not be referred back to the original referrer.

4.3.16 If the patient has been referred to an incorrect speciality this should be sent onto the correct specialty without delay but the GP informed with details for the correct referral route.

4.4 Clinical assessment and triage services (CATS) and referral management centres (RMCs)

4.4.1 A referral to a CATS or an RMC starts an 18-week RTT clock from the day the referral is received in the CAT/RMC. If the patient is referred on to the trust having not received any treatment in the service, the trust inherits the 18-week RTT wait for the patient.

4.4.2 A minimum dataset (MDS) form must be used to transfer 18-week information about the patient to the trust.

4.5 Inter-provider transfers (IPTs)

4.5.1 All incoming IPT referrals will be received electronically via the trust's secure email account at DCH-FT.IPTMDS@nhs.net

4.5.2 The trust expects an accompanying MDS pro-forma with the IPT, detailing the patient's current RTT status (the trust will inherit any RTT wait already incurred at the referring trust if they have not yet been treated) and if the patient has been referred for a new treatment plan for the same condition (where a new RTT clock will start upon receipt at this trust). The patient's pathway identifier (PPID) should also be provided. If the IPT is for a diagnostic test only, the referring trust retains responsibility for the RTT pathway.

4.5.3 If any of the above information is missing, the referral should be recorded on PAS and the information actively chased by the Pathway Team.

4.5.4 For outgoing IPT's the trust will ensure that outgoing IPTs are processed as quickly as possible to avoid any unnecessary delays in the patient's pathway.

4.5.5 Referrals for outgoing IPTs and the accompanying MDS will be emailed securely from the specialty to the Pathway Team. The Pathway Team will verify (and correct if necessary) the correct RTT status for the patient. If the patient has not yet been treated, the RTT clock will be nullified at DCH. The Pathway Team will then forward to the receiving trust within one working day of receipt of the request to process the outgoing IPT.

4.6 Booking new outpatient appointments

4.6.1 Patients who have been referred from their GP via e-RS should be able to choose, book and confirm their appointment before the trust receives and accepts the referral.

4.6.2 If there are insufficient slots available for the selected service at the time of attempting to book (or convert their Unique Booking Reference Number UBRN), the patient will appear on the appointment slot issue (ASI) work list. The RTT clock starts from the point at which the patient attempted to book. Patients will be sent acknowledgement of requested appointments within 10 working days of receipt of referral, this will be an appointment letter/email or an outpatient waiting list letter/email.

4.6.3 If a patient's appointment has been incorrectly booked on the NHS e-Referral system into the wrong service at the trust by the referrer, the referral should be electronically re-directed in the e-Referral system to the correct service. A confirmation letter of the appointment change will be sent to the patient. The patient's RTT clock will continue to tick from the original date when they converted their UBRN.

4.6.4 Paper-based referrals (non-GP referrals) Appointments will be booked in order of clinical priority (urgent before routine) and then in chronological order of referral received date, in line with those received via e-RS.

4.6.5 Patients will be selected for booking from the trust's patient tracking list (PTL) only, where an appointment hasn't already been booked via e-RS.

4.6.6 Appointments booked via e-RS may be changed by the trust following clinical grading.

4.6.7 Patients will be offered a choice of at least two dates with three weeks' notice. Dates can be offered with less than three weeks' notice and if the patient accepts, this can then be defined as 'reasonable'.

4.6.8 Any appointment offers declined by patients should be recorded on PAS. This is important for two reasons: full and accurate record keeping is good practice and the information can be used at a later date to understand the reasons for any delays in the patient's treatment, e.g. hospital or patient initiated (P5 and P6, see section 2.21)

4.7 Clinic attendance and outcomes (new and follow-up clinics)

4.7.1 Every patient, new and follow-up, whether attended or not, will have an attendance status and outcome recorded on PAS at the end of the clinic.

4.7.2 Clinics will be fully outcomed or 'cashed up' within one working day of the clinic taking place.

4.7.3 Clinic outcomes (eg discharge, further appointment) and the patient's updated RTT status will be recorded by clinicians on the agreed clinic outcome form (COF) and forwarded to reception staff immediately.

4.7.4 When patients attend the clinic, they may be on an open pathway (i.e. waiting for treatment with an RTT clock running) or they may already have had a clock stop due to receiving treatment or a decision not to treat being agreed. It is possible for patients to be assigned any one of the following RTT statuses at the end of their outpatient attendance, depending on the clinical decisions made or treatment given/started during the consultation:

Patients on an open pathway

- Clock stop for treatment
- Clock stop for non-treatment
- Clock continues if requiring diagnostics, therapies or being added to the admitted waiting list.

Patients already treated or with a decision not to treat

- New clock start if a decision is made regarding a new treatment plan
- New clock start if the patient is fit and ready for the second side of a bilateral procedure
- No RTT clock if the patient is to be reviewed following first definitive treatment
- No RTT clock if the patient is to continue under active monitoring

4.7.5 Accurate and timely recording of these RTT statuses at the end of the clinic is therefore critical to supporting the accurate reporting of RTT performance.

4.8 Booking follow-up appointments

4.8.1 Where possible, follow up appointments for patients on an open RTT pathway should be avoided by discussing likely treatment plans at first outpatient appointment, and/or use of telephone/written communication where a face-to-face consultation is not clinically required. Where unavoidable, such appointments must be booked to a timeframe that permits treatment by week 18 (unless the patient choses a later date).

4.8.2 Patients on an open RTT pathway that require a follow up appointment should have this appointment agreed before leaving the clinic. This provides the best opportunity for patient choice to be accommodated within the required timescale for achievement of the RTT standard. Where insufficient capacity is available, the clinic receptionist (or similar role) will escalate in line with local

arrangements to obtain authorisation to overbook or where clinically appropriate, displace another patient.

4.8.3 Where there is a capacity shortage and patients cannot be seen within the required time frame as stipulated by the clinician, this must be escalated to the service manager. In partnership with the clinical lead, the Care Group must clinically risk stratify the backlog to ensure the most clinically urgent patients receive an appointment.

4.8.4 Patients who are not on an open pathway and have already been treated or who are under active monitoring and require a follow-up appointment should be managed via the partial booking of follow-ups (PBFU) process. Before they leave the clinic, the process will be clearly explained to the patient:

- They will be added to the follow up outpatient waiting list (FOWL)
- 6 weeks before their follow up appointment is due, they will receive a phone call to agree an appointment
- A minimum of three attempts will be made to call the patient, at least 12 hours apart, one of which will be after 5pm
- If there is still no contact, the no contact process can be started as described in paragraph 2.23.9 and following clinical review, may be discharged back to their GP

4.8.5 All DNA's and DNB's (new and follow-up) will be reviewed by the clinician at the end of clinic in order for a clinical decision to be made regarding next steps (see section 3.7). Paediatric and vulnerable patient DNAs and DNBs should be managed with reference to the trust's safeguarding policy.

4.9 Appointment changes and cancellations initiated by the patient

4.9.1 If the patient gives any prior notice that they cannot attend their appointment (even if this is on the day of clinic), this should be recorded as a cancellation and not DNA.

4.9.2 If the patient requires a further appointment, this will be booked with the patient at the time of the cancellation.

4.9.3 If the patient is on an open RTT pathway, the clock continues to tick.

4.9.4 If the patient has never been seen and advises they do not wish to progress their pathway, they will be removed from the relevant waiting list and a clock stop and nullification applied. The patient will be informed that their consultant and GP will be informed of this.

4.9.5 If as a result of the patient cancelling, a delay is incurred which is equal to or greater than a clinically unsafe period of delay (as indicated in advance by consultants for each specialty), the patient's pathway should be reviewed by their consultant.

4.9.6 Upon clinical review, the patient's consultant should indicate one of the following:

- Clinically safe for the patient to delay: continue progression of pathway. The RTT clock continues.
- Clinically unsafe length of delay: clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues.
- Clinically unsafe length of delay: in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP.

4.10 Appointment changes initiated by the hospital

4.10.1 Hospital-initiated changes to appointments will be avoided as far as possible as they are poor practice and cause inconvenience to patients.

4.10.2 Clinicians are actively encouraged to book annual leave and study leave as early as possible. Clinicians must provide 6 weeks' notice of a clinic has to be cancelled or reduced.

4.10.3 Patients will be contacted immediately if the need for the cancellation is identified and offered an alternative date(s).

4.10.4 The RTT clock will continue to tick if the patient is on an open pathway.

5.0 Diagnostics overview

5.1 This stage of a patient's pathway starts at the point of a decision to refer for a diagnostic test and ends on the results/report from the diagnostic procedure being available to the requester but the 6 week diagnostic waiting time clock starts once the referral is received by the trust. It is important to note that patients can also be referred for some diagnostic investigations directly by their GP where they might not be on an 18-week RTT pathway. This will happen where the GP has requested the test to inform future patient management decisions, i.e. they have not made a referral to a consultant-led service at this time.

5.1.1 By "diagnostic", this means a test or procedure used to identify and monitor a person's disease or condition and which allows a medical diagnosis to be made. In contrast, a "therapeutic procedure" is defined as a procedure which involves actual treatment of a person's disease, condition or injury.

5.1.2 The diagnostics section of an RTT pathway is a major pathway milestone. A large proportion of patients referred for a diagnostic test will also be on an open RTT pathway. In these circumstances, the patient will have both types of clock running concurrently:

- their RTT clock which started at the point of receipt of the original referral
- their diagnostic clock which starts at the point of the decision to refer for diagnostic test (often at the first outpatient consultation).

5.1.3 If a patient is referred on a straight to test pathway but the intention is for the patient to be reviewed and if appropriate treated within a consultant led service (without first being reviewed by their GP) an RTT clock should also start on receipt of the referral. These are called straight to test referrals.

5.1.4 Patients who are referred directly for a diagnostic test (but not consultant-led treatment) by their GP, i.e. clinical responsibility remains with the GP, will have a diagnostic clock running only. These are called direct access referrals.

5.2 National diagnostic clock rules

5.2.1 The 6 week clock starts when the request for a diagnostic test or procedure is received by the trust. For e-RS referrals, this is the time that the UBRN is converted, i.e. when the patient has accepted an appointment.

5.2.2 The 6 week clock stops when the patient receives the diagnostic test or procedure.

5.2.3 Patient waiting times for the following groups of tests and procedures should be reported:

- Imaging - Magnetic Resonance Imaging
- Imaging - Non-obstetric ultrasound Computed Tomography

- Imaging - Barium Enema
- Imaging - DEXA Scan
- Physiological Measurement - Audiology – Audiology Assessments
- Physiological Measurement - Cardiology - echocardiography
- Physiological Measurement - Cardiology - electrophysiology
- Physiological Measurement - Neurophysiology - peripheral neurophysiology
- Physiological Measurement - Respiratory physiology - sleep studies
- Physiological Measurement - Urodynamics - pressures & flows
- Endoscopy - Colonoscopy
- Endoscopy - Flexi sigmoidoscopy
- Endoscopy - Cystoscopy
- Endoscopy – Gastroscopy

5.2.4 All referral routes (i.e. whether the patient was referred by a GP or by a hospital-based clinician or other route) and also all settings (i.e. outpatient clinic, inpatient ward, x-ray department, primary care one-stop centres etc.) are to start a 6 week clock.

5.2.5 Surveillance patients who are on a planned waiting list do not have an active 6 week clock unless the procedure has not been completed within the specified time. The patient should be moved to an active waiting list, with the appropriate waiting time clock started if the patient goes past their clinical to be seen date.

5.2.6 Patients waiting for a procedure as part of a screening programme, expectant mother booked for confinement, therapeutic procedures and patients who are currently admitted to a hospital bed and is waiting for an emergency or unscheduled diagnostic/test procedure as part of their inpatient treatment should not have a 6 week clock start.

5.2.6 If a patient cancels or misses an appointment for a diagnostic test/procedure, then the diagnostic waiting time for that test/procedure is set to zero and the waiting time starts again from the date of the appointment that the patient cancelled/missed. This can only be applied if it can be evidenced that the offer met the definition of reasonableness. Resetting the diagnostic clock start has no effect on the patient's RTT 18 week or cancer clock.

5.2.7 If a patient turns down reasonable appointments, i.e. 2 separate dates and 3 week's notice, then the diagnostic waiting time for that test/procedure can be set to zero from the first date offered.

5.2.8 Patients waiting for 2 separate diagnostic tests/procedures concurrently should have 2 independent waiting times clocks, one for each test/procedure. For example, patient presenting with breathlessness could have a heart or a lung condition and therefore there might be the need to have cardiology and respiratory tests concurrently. Alternatively if a patient needs test X initially and once this test has been carried out, a further test (test Y) is required, in this scenario the patient would have one waiting times clock running for test X. Once test X is complete, a new clock is started to measure the waiting time for test Y.

5.2.9 Patients that DNA a diagnostic procedure follow the same rules as set out in section 3.7 regarding returning the patient to the referrer. What happens to the 6 week clock is described in paragraph 5.2.6 above.

6.0 Pre-operative assessment (POA)

6.1 If at POA the patient is identified as unfit for the procedure, the nature and duration of the clinical issue should be ascertained. If the clinical issue is short term and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold, UTI), the RTT clock continues.

6.2 However, if the clinical issue is more serious and the patient requires optimisation and/treatment, clinicians should indicate to administration staff if it is clinically appropriate for the patient to be removed from the waiting list, and if so whether the patient should be:

- optimised/treated within secondary care (active monitoring clock stop for existing pathway and potentially new clock start for optimisation treatment)
- Discharged back to the care of their GP (clock stop – discharge).
- When the patient becomes fit and ready to be treated for the original condition, a new RTT clock would start on the day this decision is made and communicated to the patient (end of active monitoring).

6.3 Following a decision from pre-assessment that the patient is not fit, this must be communicated to Admissions and the listing clinician. Administration staff must not discharge the patient back to the GP or move to active monitoring unless there is written instruction from a clinician. The pre-assessment nurse is required to make contact with the patient to advise them they are not fit for surgery, this must not be done by an administrator.

7.0 Acute therapy services

7.1 Acute therapy services consist of physiotherapy, dietetics, orthotics and surgical appliances. Referrals to these services can be:

- Directly from GPs where an RTT clock would not be applicable

- During an open RTT pathway where the intervention is intended as first definitive treatment or interim treatment.

7.2 For patients on an orthopaedic pathway referred for physiotherapy as first definitive treatment the RTT clock stops when the patient begins physiotherapy.

7.3 For patients on an orthopaedic pathway referred for physiotherapy as interim treatment (as surgery will definitely be required), the RTT clock continues when the patient undergoes physiotherapy.

7.4 Patients on an orthopaedic pathway referred for a surgical appliance with no other form of treatment agreed. In this scenario, the fitting of the appliance constitutes first definitive treatment and therefore the RTT clock stops when this occurs.

7.5 If patients are referred to the dietician and receive dietary advice with no other form of treatment, this would constitute an RTT clock stop. Equally, patients could receive dietary advice as an important step of a particular pathway (e.g. bariatric). In this pathway, the clock could continue to tick.

8.0 Non-activity related RTT decisions

8.1 Where clinicians review test results in the office setting and make a clinical decision not to treat, the RTT clock will be stopped on the day this is communicated in writing to the patient.

8.2 Administration staff should update PAS with the clock stop. The date recorded will be the day the decision not to treat is communicated in writing to the patient.

9.0 Admitted pathways overview

9.1 Ideally patients will be fit, ready and available before being added to the admitted waiting list. However, they will be added to the admitted waiting list without delay following a decision to admit, regardless of whether they have undergone preoperative assessment or whether they have declared a period of unavailability at the point of the decision to admit.

9.1.1 The active inpatient or day case waiting lists/PTLs includes all patients who are awaiting elective admission. The only exceptions are planned patients, who are awaiting admission at a specific clinically defined time.

9.1.2 In terms of the patient's RTT clock, adding a patient to the inpatient or day case waiting list will either:

- Continue the RTT clock from the original referral received date
- Start a new RTT clock if the surgical procedure is a substantively new treatment plan which did not form part of the original treatment package, providing that either another definitive treatment or a period of active monitoring has already occurred. The RTT clock will stop upon admission.

9.2 Patients requiring more than one procedure

9.2.1 If more than one procedure will be performed at one time by the same surgeon, the patient should be added to the waiting list with extra procedures noted.

9.2.2 If different surgeons will work together to perform more than one procedure, the patient will be added to the waiting list of the consultant surgeon for the priority procedure with additional procedures noted.

9.2.3 If a patient requires more than one procedure performed on separate occasions by different (or the same) surgeon(s):

- The patient will be added to the active waiting list for the primary (1st) procedure.
- When the first procedure is complete and the patient is fit, ready and able to undergo the second procedure, the patient will be added (as a new waiting list entry) to the waiting list, and a new RTT clock will start.

9.3 Patients requiring thinking time

9.3.1 Patients may wish to spend time thinking about the recommended treatment options before confirming they would like to proceed. It would not be appropriate to stop their RTT clock where this thinking time amounts to only a few days or weeks. Patients should be asked to make contact within one week as per paragraph 3.8.4.

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

9.3.3 In the scenario of active monitoring, a follow-up appointment must be arranged around the time the patient would be in a position to make a decision. A new RTT clock should start from the date of the decision to admit if the patient decides to proceed with surgery.

9.4 Scheduling patients to come in for admission

9.4.1 Clinically urgent patients will be scheduled first. All patients will be identified from the trust's PTL, and in clinical priority order as set out in paragraph 2.19.2 then by chronological order.

9.4.2 Patients will be offered a choice of at least two admission dates with three weeks' notice within the agreed milestone for the specialty concerned. Admission dates can be offered with less than three weeks' notice and if the patient accepts, this can then be defined as 'reasonable'.

9.4.3 Any admission offers declined by patients will be recorded on PAS. This is important for two reasons:

- Full and accurate record-keeping is good clinical practice.
- The information can also be used at a later date to understand the reasons for any delays in the patient's treatment, e.g. hospital or patient initiated.

9.4.4 Patients must be telephone to arrange an admission date, with it confirmed in writing. If contact cannot be made with the patient than the no contact process set out in paragraph 2.23.9 is to be followed.

9.5 Patients declaring periods of unavailability while on the inpatient/day case waiting list, cancelling or declining a TCI offer and patients who do not attend admission

9.5.1 Full details can be found in the section 2.21 and apply to the non-admitted and admitted elements of the patient pathway for patients that declare periods of unavailability, cancel or decline a TCI offer.

9.5.2 The reason for patient's unavailability and the length of time must be recorded on PAS.

9.5.3 Patients who do not attend for admission will have their pathway reviewed by their consultant. If the patient's consultant decides that they should be offered a further admission date, the RTT clock continues to tick. Should the patient's

consultant decide that it is in their best clinical interests to be discharged back to the GP, the RTT clock is stopped.

9.6 On the day cancellations

9.6.1 Where a patient is cancelled on the day of admission or day surgery for non-clinical reasons, they will be rebooked within 28 days of the original admission date and the patient must be given reasonable notice of the rearranged date.

9.6.2 The patient may choose not to accept a date within 28 days and in this case it will not be a reportable 28 day breach if the offer meets reasonableness criteria.

9.7 Planned admitted patients

9.7.1 Patients will only be added to a planned waiting list where clinically they need to undergo a procedure at a specific time.

9.7.2 The due date for their planned procedure will be included in the planned waiting list entry.

9.7.3 Patients on planned waiting lists will be scheduled for admission at the clinically appropriate time and they should not have to wait a further period after this time has elapsed.

9.7.4 When patients on planned lists are clinically ready for their care to begin and reach their due date for the planned procedure, they will either be admitted for the procedure or be transferred to an active waiting list and a new RTT clock will start. For some patients (e.g. surveillance endoscopies) a diagnostic would also start.