Referral to Treatment Access Policy

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Compliance links:	18 Week Rules Suite, How to Measure and DH FAQ RTT Data Collection, NHS Constitution, The National Cancer waiting time standards.

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1. Introduction

The Norfolk & Waveney Acute Hospitals are committed to ensuring patients receive treatment in accordance with national objectives, planning guidance and appropriate standards, with patients of the same clinical priority treated in chronological order of their waiting time. The purpose of this policy is to outline the three Trusts' and Commissioners' requirements and standards for managing patient access to secondary care services from referral to treatment.

The Three Acute Trusts and local Integrated Care Systems are working together to ensure the achievement of all the patient's constitutional rights and to ensure we deliver against all key standards set out in our contracting agreements. The policy is designed to ensure access to hospital services is fair and equitable for all patients.

This policy sets out the rules and definitions of the Referral to Treatment standard to ensure each patient's 18 week clock starts and stops fairly and consistently and in line with national rules. It does not provide detailed guidance on how the rules should apply to every situation but provides an over-arching framework to work within to make clinically sound decisions locally, in consultation with patients, clinicians, providers and commissioners.

Although commissioners of services have a responsibility for ensuring agreed activity levels are sufficient to achieve waiting list times / targets, it is recognised this is a shared responsibility. The Trusts contribute to this process by ensuring patient activity is managed as effectively and efficiently as possible. Waiting lists should therefore be managed in accordance with the stated Trust policy and meet agreed waiting times and activity levels.

This policy has been produced collaboratively with stakeholders from the Local Health Community and public and patient groups, including the Norfolk and Waveney Integrated Care Board, Norfolk County Council and Public Health, with input from the Elective Intensive Support Team.

2. Scope of Policy

This policy applies to the principles and procedures for the management of patients accessing elective care services as categorised as follows:

- **Patients on a Referral to Treatment (RTT) pathway awaiting treatment**
- **Patients not on an RTT pathway but still under review by clinicians**
- **Patients who have been referred for a diagnostic investigation either by their GP or by a clinician**

The policy sets out the roles, responsibilities, processes and best practice guidelines to assist staff with the effective management of patients who need to attend the Norfolk & Waveney Acute Hospitals for treatment as an outpatient, inpatient, day case or to receive diagnostic care.

Patients on a Cancer Pathway are managed according to the Trusts Cancer Services Operational Policies which can be found on individual Trust Websites.

This policy covers the processes for booking, notice requirements, patient choice and waiting list management for all stages of a referral to treatment pathway. This policy should be read in conjunction with the policies below which are available on the individual Trusts Intranet/Website:

- The Cancer Services Operational Policy
- The Referral Management Policy

- The Overseas Visitors Policy
- PAS User Guides & Policies
- Clinical Thresholds & Individual Funding Request (IFR) Policy
- Privacy and Dignity

The Trusts will ensure the management of patient access to services is transparent, fair and equitable with patients of the same clinical priority treated in chronological order of their waiting time.

The Trusts are committed to promoting and providing services which meet the needs of individuals and do not discriminate against any employee, patient, or visitor.

People with Learning Disabilities (PWLD) and people with a mental health condition will have equal access to treatment and care packages within each Trust. Their views and opinions will be respected, care plans will be personalised and reasonable adjustments to care packages and the environment will be made.

The specific needs of PWLD and people with a mental health condition, such as communication, information, use of advocacy services and involving carers according to the patient's wishes must be taken into consideration when these patients are accessing elective and acute services. All procedures, including consent to treatment will be in accordance with the Mental Capacity Act 2005. All Trusts have a responsibility for safeguarding. Further details can be found in the individual Trusts safeguarding policies.

3. Structure of Policy

The policy is structured in a way which makes it easy to navigate to both electronically and in hard copy and links to other policies electronically. Where a separate Standard Operating Procedure (SOP) or document is referenced, a hyperlink will be shown enabling the reader to access it directly if required. The hyperlinks are shown in blue and underlined. The policy is split into 4 sections:

- General Principles
- Pathway Specific Principles – following a logical chronological patient referral to treatment pathway. *(Where there is a Standard Operating Procedure (SOP) providing a detailed process to be followed at a given stage, this will be referenced at the relevant point; all SOPs are available on the individual Trusts Intranet).*
- Reference Information
- Appendices

4. Key Policy Principles

As set out in the NHS Operating Framework and NHS Constitution, by law patients have the right to access certain services commissioned by NHS bodies within maximum waiting times. This includes starting consultant-led treatment within a maximum of 18 weeks (126 days), unless they choose to wait longer, or it is clinically appropriate they wait longer. All the aspects of the patient pathway which lead up to first definitive treatment, including outpatient consultations, diagnostic tests and procedures will be monitored and proactive action taken to reduce waiting times. All other aspects of elective care will also be monitored e.g., follow up of patients following definitive

treatment, and those patients waiting for an elective planned procedure etc. The following key principles are pertinent throughout the policy:

a) This policy covers the way in which the Trusts will manage administration for patients who are waiting for or undergoing treatment on a Referral to Treatment Pathway, for an admitted, non-admitted or diagnostic referral.
b) This policy does not cover Cancer pathways – a separate policy exists for this cohort of patients.
c) The policy will be adhered to by all staff members who are responsible for referring patients, managing referrals, adding to and maintaining waiting lists (outpatient or elective) for the purpose of advancing a patient through their treatment pathway.
d) The Trusts will give priority to clinically urgent patients and treat all other patients in turn.
e) The Trusts will work to meet and where possible better the maximum waiting times set by NHS England for all groups of patients.
f) The Trusts will mutually agree appointments and admission dates with patients.

Patients have a right to be seen within 18 weeks; however, there are the following exceptions

The right to start treatment within 18 weeks does not apply:

- If a patient chooses to wait longer.
- If delaying the start of treatment is in the patients best clinical interests, for example where stopping smoking or losing weight is likely to improve the outcome of the treatment.
- If it is clinically appropriate for a condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage.
- If a patient fails to attend appointments they had chosen from a set of reasonable options.
- If the treatment is no longer necessary.

The following services are **not** covered by the right:

- mental health services which are not consultant-led
- maternity services
- public health services commissioned by local authorities

5. Roles and Responsibilities

Norfolk & Waveney Acute Hospitals

a) Chief Operating Officer/Divisional Directors

The Chief Operating Officer (COO) and the appropriate Divisional Directors are accountable for delivery of the referral to treatment (RTT) standards. The COO has overall responsibility for the implementation of this policy and board level accountability for the delivery of elective access standards. The appropriate Divisional Directors are responsible for ensuring the delivery of elective access standards and monitoring compliance of elective access standards.

b) Clinicians

Clinicians have a responsibility for adhering to key internal procedures in the proactive management of patients along their RTT pathway including:

- To review all patient referrals, allocating clinical priority and accepting / rejecting referrals within 2 working days
- To complete accurate and timely clinic outcome forms with clear instructions of next steps e.g., 6 month follow up to be booked and RTT status.
- To produce a clinic letter following outpatient attendance, confirming care plan to GP/Referrer/Patient.
- To communicate with patients to ensure patients' perceptions of their care mirrors clinical decisions made regarding care plans and treatment. (e.g., for clock starts and stops and mutually agreed periods of active monitoring etc.)
- Undertaking clinical review as necessary within 5 working days (e.g., for patient initiated delay or clinical harm review).
- Clinicians should not place a patient on the waiting list to 'reserve a place' against the future possibility that treatment may be necessary or where the patient is not currently ready, willing and able to proceed. Such patients should either be referred back to their GP after clinical review if it is in their best clinical interests, or followed up in clinic, until such time their condition improves / warrants treatment.

c) Divisional Directors, Clinical Directors/Associate Medical Directors, Clinical Leads, Divisional General Managers (DGM), Deputy DGM's and Operational Managers

- The Divisional Director, Operational Managers and Clinical Director for each Directorate / Specialty have overall responsibility for implementing and ensuring adherence to the RTT Access policy within their area.
- The Divisional Director, Operational Managers and Clinical Director for each Directorate / Specialty have overall responsibility for ensuring staff members are fully trained and annual training records are up to date.
- Operational Managers will work closely with Clinicians to review capacity and demand in all specialty areas to ensure patients are seen within agreed milestones to enhance the patient experience and to ensure adherence to national standards and planning guidance and appropriate standards The Clinical Director will manage medical staff to ensure scheduled outpatient clinics and operating sessions are held / covered to avoid the need to cancel patient activity.
- It is the responsibility of the speciality management teams and clinicians to ensure the Directory of Service (DOS) is current in terms of the service specific criteria and clinics are mapped to the relevant service. This gives the patient the best chance of being booked into the correct clinic at their first visit and reduces rejection rates.
- It is the responsibility of speciality management teams and Clinicians to ensure correct utilisation of virtual attendances to new and follow-up appointments.
- It is the responsibility of the speciality management teams and Clinicians to ensure correct utilisation of the Patient Initiated Follow Up (PIFU) pathways within their individual specialities

d) Administration Staff

All administration staff must abide by the principles in this policy and supporting standard operating procedures. Administrative Managers are responsible for ensuring all administration staff involved with RTT pathways, as appropriate to job role, undertake:

- To date stamp and accurately register referrals within 24 hours of receipt including the accurate management of tertiary referrals.
- To maintain up to date waiting lists, i.e., at Outpatient, Diagnostic and Admitted phases.
- To book activity to agreed specialty milestones.
- To highlight capacity short falls in a timely manner to avoid patient wait times being compromised.
- To keep the patient informed of their 18 week RTT status, be open and provide clarity on clock stops and starts within the patient's pathway.
- To validate patient pathways in real time.
- To actively progress patients through their pathways ensuring appropriate measures are taken.
- To keep updated and informed of policies and procedures by ensuring training is completed, policies are read and digested and to make full use of the Trusts communication tools.
- To be competent and compliant in all related elective care and cancer policies.

All staff will ensure any data created, edited, used or recorded on the Trusts Patient Administration System (PAS, Patient Centre or iPM) is accurate, timely, relevant, valid, complete and fit for purpose. Staff must keep themselves updated and informed by reading and digesting other Trust policies relating to collection, storage and use of data in order to maintain the highest standards of data quality and to maintain patient confidentiality.

5.1 Integrated Care Board

If maximum waiting time rights under the NHS Constitution cannot be met, the ICB or NHS England, which commission and fund treatment, must take all reasonable steps to offer a commissioned suitable alternative provider, which would be able to see or treat the patient more quickly.

In the exercise of its functions, an ICB will have duties to:

- Act with a view to securing health services are provided in a way which promotes the NHS Constitution, and promotes awareness of the NHS Constitution among patients, staff and the public.
- Act with a view to securing continuous improvements in the quality of services for patients, and in outcomes for patients, with particular regard to clinical effectiveness, safety and patient experience.
- Have regard to the need to reduce inequalities between patients with respect to their ability to access health services and the outcomes achieved for them.
- Promote the involvement of individual patients, their carers and representatives where relevant, in decisions relating to the prevention or diagnosis of illness in them or their care and treatment.
- Act with a view to enabling patients to make choices about aspects of health services provided to them.
- Promote innovation in the provision of health services.

- Promote research on matters relevant to the health service, and the use of evidence obtained from research.
- Act with a view to securing health services are provided in an integrated way, and the provision of health services is integrated with provision of health-related or social care services, where the ICB considers this would improve quality of services or reduce inequalities.
- Have regard to the need to promote education and training of current or future health service staff.
- Ensure appropriate facilities are made available to any university which has a medical or dental school in connection with clinical teaching or research.

ICBs are responsible for ensuring there are robust communication links for feeding back information to GPs and other primary care staff, and to provide guidance and information to GPs and other primary care staff regarding observance of the principles set out in this policy.

5.2 General Practitioners and Referring Clinicians

The Trusts rely on all referring clinicians to ensure patients understand their responsibilities and potential pathway steps and timescales when being referred. This will help ensure patients are referred under the appropriate clinical guidelines and are aware of the speed at which their pathway may be progressed and are in the best position to accept timely and appropriate appointments. Before a referral is made for treatment on an 18 week Referral to Treatment pathway, the patient is ready, willing and able to attend for an appointment and undergo any treatment which may be required. This will include being both clinically fit for assessment and possible treatment of their condition and available for treatment across that pathway. This is the responsibility of the referring clinician, e.g., the GP.

*** Referrers are required to ensure all suspected cancer referrals are made through the agreed 2ww pathway as per the Trusts* Cancer Services Operational Policies*. Referrers must ensure 2ww patients are available to attend an appointment within 14 days from the date of referral.*

- Referrers must provide accurate, timely and complete information within their referral.
- Referrers must comply with national timeframes for referral attachments when referring via NHS e-Referral Service.
- Referrals to secondary care should only be made if all other alternatives have been explored (i.e., agreed patient/clinical pathways have been followed).
- GP referrals to consultant-led outpatient services should be made using the e-Referral System. Paper and Fax referrals will be rejected by the provider unless service exempt from eRS
- To minimise waiting times and to enhance patient access to services, referrers are encouraged to make unnamed referrals (referred to as Dear Doctor referrals) unless there is a specialist requirement for a named consultant or there is a patient history which requires continuity of care. Patient Choice must be taken into consideration when referring.
- When referring children or adults who cannot understand or give consent for their own treatment, the referrer must provide details of who is legally able to act on behalf of the patient.
    - Referrers should identify any special communication requirements their patients may have and detail these on the referral letter e.g., literacy problems, need for British Sign Language (BSL) or other language interpreter. Information should be made available in accordance with the Accessible Information Standard.

- Referrers should identify any special access requirements their patients may have, e.g., wheelchair user to allow for access to clinics.

Patients should be referred having already undergone all relevant tests, as outlined in the pathway and Directory of Service of the relevant specialty.

After a referral has been made, the referrer must inform the hospital if the patient no longer wishes or requires to be seen.

All referrals should include a Minimum Data Set (MDS), Further Referral information and minimum dataset information which should be supplied within a referral can be found within Appendix A

5.3 Patient Responsibilities – Help us to Help You

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 timeframe.

As a patient, you can help contribute to the success of the NHS by being aware of your responsibilities, these include:

- Upon referral to a consultant led service, ensure you are available to accept multiple appointments at a designated hospital site within the Norfolk and Waveney ICB area. This includes appointments for outpatients, diagnostics and for treatment if required.
- Attending blood tests, radiology and all appointments as required.
- To collect equipment and carry out home assessments/tests where required within agreed timespans.
- Keeping GP and hospital appointments, or if you have to cancel, doing so in good time to allow the slot to be reallocated to protect a precious resource. Following the courses of treatment which you have agreed to.
- Inform the hospital of any changes to demographic details.
- Inform the GP if medical condition improves or deteriorates.
- Inform the GP and Consultant if referral/treatment is no longer required.

6. National Elective Care Standards

The table below provides a summary of the national elective care standards with effect from 01st October 2015.

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

All of the standards above are set at less than 100% to allow for tolerances which apply in the following scenarios:

a) Clinical Exceptions – applicable to RTT pathways where it is in the patients best clinical interest to extend treatment beyond 18 weeks.
b) Choice – applicable where patients chose to extend their pathways by rescheduling previously agreed appointments or admission offers
c) Co-operation – applicable where patients do not attend previously agreed appointments or admission dates and clinicians deem it is appropriate to retain clinical responsibility for the patient; e.g., the patient will be complying with a prescribed sequence of treatments.

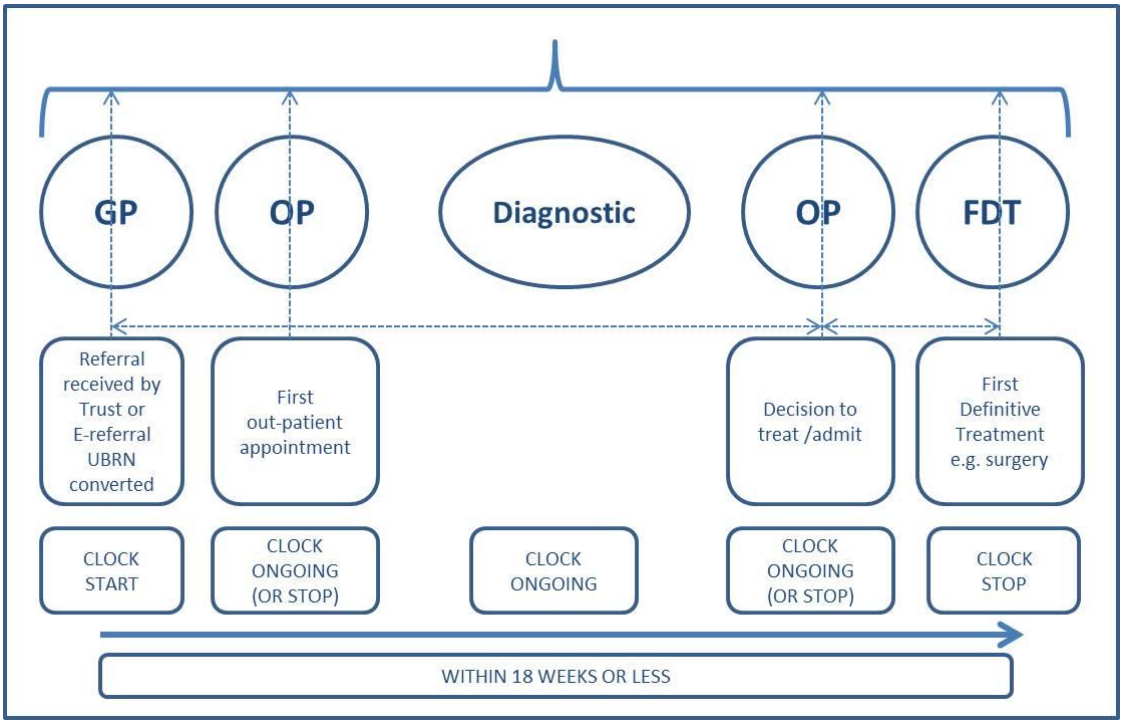
7. Overview of National RTT Rules

In England, under the NHS Constitution, patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times (126 days or 18 weeks), or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'.

This right is a legal entitlement protected by law and applies to the NHS in England. The maximum waiting times are described in the Handbook to the NHS Constitution.

In simple terms, a patients' 18 week 'clock' starts ticking on the day the hospital (or referral management/triage centre) receives the referral letter (the original hospital in the case of tertiary referrals) or on the day the patient converts their Unique Booking Reference Number (UBRN) via the NHS e-Referral Service (formerly Choose and Book) and then the 'clock' stops ticking on the day the patient is treated or for the non-treatment reasons as shown below.

The full national RTT rules suite can be accessed via the NHS England Website at http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/.
Detailed local application of the rules is provided in the standard operating procedures on each Trust's Intranet. An overview of the rules is presented in the diagram and narrative below.



7.1 Clock Starts

An RTT waiting time clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to:

a) a consultant led service, regardless of setting, with the intention the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner;

b) an interface or referral management or assessment service, which may result in an onward referral to a consultant led service before responsibility is transferred back to the referring health professional or general practitioner.

c) a self-referral by a patient into a consultant led service for pre-agreed services agreed locally by commissioners and providers.

7.2 Subsequent Clock Starts

Upon completion of a consultant-led referral to treatment period, a new RTT waiting time clock only starts:

a) When a patient becomes fit and ready for the second of a consultant-led bilateral procedure. A bilateral procedure is one which is performed on both sides of the body at matching anatomical sites.

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

c) Upon a patient being re-referred in to a consultant-led; interface; or referral management or assessment service as a new referral;

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

e) When a patient rebooks their appointment following a first appointment DNA which stopped and nullified their earlier clock.

7.3 Clock Stops for Treatment

An RTT Clock stops for **treatment** when:

a) 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;

b) 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.

7.4 Clock Stops for Non-Treatment

An RTT Clock stops for **'non-treatment'** when:

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:

a) It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care;

b) A clinical decision is made to start a period of active monitoring;

c) A patient declines treatment having been offered it;

d) A clinical decision is made not to treat;

e) A patient does not attend (DNA) their first appointment following the initial referral which started their waiting time clock, provided the Trust can demonstrate the appointment was clearly communicated to the patient. The patients RTT clock should then be nullified (i.e., removed from the numerator and denominator for RTT measurement purposes).

f) A patient DNAs any other appointment and is subsequently discharged back to the care of their GP, provided that:

- The Trust can demonstrate the appointment was clearly communicated to the patient.
- Discharging the patient is not contrary to their best clinical interests.

From 01st October 2015, there is no provision to 'pause' or 'suspend' an RTT waiting time clock under any circumstances. All clocks will continue to tick unless there is a reason to stop the clock for treatment or non-treatment as above.

For more information and scenarios on Clock Starts, Ongoing Clocks and Clock Stops and RTT Codes, please see the RTT Code Scenario's SOP which can be found on the Trusts individual Intranets.

The RTT Codes used nationally and locally can be found in the RTT Codes Guidance on the Trusts individual Intranets.

8. Pathway Milestones

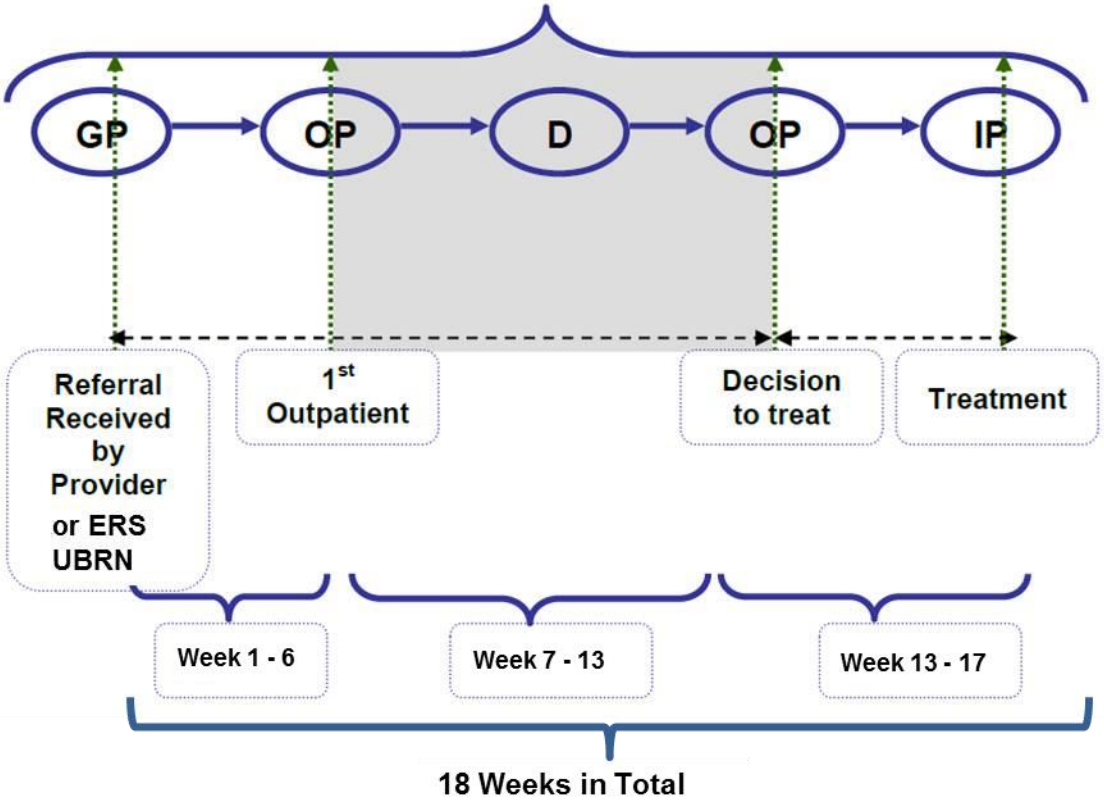
The agreement and measurement of performance against specific milestones is an important aspect of delivering waiting time standards sustainably. Pathway specific milestones should be agreed for each specialty (in line with robust demand and capacity analysis) in terms of the point of the pathway by which the following occur:

- First Appointment
- Decision to Treat Date
- Treatment

The Trusts will identify clinically appropriate timescales for urgent and routine patients and Specialities will be required to work to set timescales for each pathway milestone; if a patient requires urgent treatment timescales will be clinically appropriate.

8.1 Trust Internal Milestones

The Trusts will aim to deliver patient care for routine cases within the milestones shown below; timescales for urgent patients will be shorter as clinically appropriate. Specific milestones for each speciality will be set in accordance with annual review, business planning cycle, clinical review and demand and capacity modelling.



Any reason for delay against the internal milestones should be escalated via the weekly PTL meetings by Operational Managers or their deputy. (See the 18 Weeks RTT Capacity and Demand Escalation SOP for further information.)

9. Overseas Visitors

An overseas visitor is defined as any person (adult or child) of any nationality not ordinarily resident in the United Kingdom.

An ordinarily resident person is anyone:

"Living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, with an identifiable purpose for their residence here which has a sufficient degree of continuity to be properly described as "settled".

The Trusts will ensure patients' eligibility for NHS care is assessed in line with the Trusts Overseas Visitors Policy, or contact the Overseas Visitors team.

Where the patient's overseas visitor status is unknown in terms of eligibility upon referral, an RTT clock would start. This should continue to tick until their status is ascertained. If they are NOT eligible for treatment funded by an English commissioner, their RTT clock should be nullified.

Further information on the management of Overseas Visitors can be found in the Overseas Visitors Policy on the Trusts Intranet sites.

10. Vulnerable Patients

Vulnerable Adults

It is essential patients who are vulnerable for whatever reason have their needs identified by the referrer at the point of referral.

A vulnerable adult is any person over the age of 18 who is or may be:

- In need of community care services by reason of mental or other disability, age or illness; and
- Unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation

For further guidance regarding Vulnerable Adults follow the Safeguarding Adults Policy found on the Trusts' Intranet sites.

Children

All Trust staff have a duty to safeguard children from harm and it is expected staff familiarise themselves with their duty in this regard. A person is considered to be a child from pre-birth until their 18th birthday. For further guidance regarding Safeguarding Children Policy found on the Trusts' Intranet sites.

It is possible children who are not brought to clinical appointments may be at risk of child abuse. When children do not attend for planned care the case notes must be reviewed by a consultant or specialist registrar. The risk to the child will be assessed. Primary care will be informed. Decisions about next steps depend on the clinical situation and are described in the individual Trusts policies for the management of children who do not attend outpatient appointments or leave Accident and Emergency before being seen. These can be found on individual Trusts' Intranet sites.

Prisoners

For the purposes of this policy, prisoners will be booked, and their referrals processed in the same way as vulnerable patients as they are not able to make choices about the time or date of their appointment and have no control over whether they cancel or do not attend.

The Trusts Demographic Details – Protocols for Prisoners SOP must be followed when booking patients who are in detention. This can be found on the individual Trusts' Intranet sites.

11. War Veterans and Military Personnel

Military personnel and veterans should receive priority access to NHS secondary care for any conditions which are likely to be related to their service, subject to the clinical needs of all patients. Priority should not be given for unrelated conditions.

A veteran is anyone who has served for at least one day in the armed forces, whether regular or reserve. This also applies to Merchant Navy seafarers and fishermen who have served in a vessel when it was being used for military operations by the armed forces.

GPs are required to state clearly in referrals the patient is military personnel or a military veteran and requires priority treatment for a condition which in their clinical opinion may be related to their military service. On receipt of such requests, Trust administrative staff must highlight the status of the patient to the relevant clinician and to the service manager for appropriate recording, prioritisation and action.

However, it remains the case that military personnel and veterans should not be given priority over other patients with more urgent clinical needs.

More information around the Trusts management of War Veteran patients can be found in the War Veterans SOP on the Trusts individual intranet.

12. Clock Stops for Active Monitoring

Active monitoring is also sometimes known as Watchful Waiting.

A waiting time clock may be stopped for active monitoring where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage.

When a decision to commence a period of active monitoring is made, communicated and agreed with the patient this stops a patient's waiting time clock.

Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made and a patient has been added to a waiting list.

Patients may initiate the start of a period of active monitoring themselves (for example, by choosing to decline treatment offered to see if they cope with their symptoms).

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

13. Patient Thinking Time

Stopping the patient's clock for a period of active monitoring requires careful consideration on a case by case basis and its use needs to be consistent with the patient's perception of their wait. Where patient thinking time is given by the consultant, the effect on the RTT clock will be dependent on the individual scenario, e.g., where invasive surgery is offered as the proposed first definitive treatment, but the patient would like a few days to consider this before confirming they wish to go ahead with surgery, the clock would continue to 'tick'. If a longer period of thinking

time is agreed, then active monitoring is more appropriate. E.g., the clinician offers a surgical intervention, but the patient is not keen on invasive surgery as they view their symptoms as manageable, and a review appointment is agreed for three months' time. The patient would be placed on active monitoring and the RTT clock would stop at the point the decision is made to commence active monitoring.

A new RTT clock would start when a decision to treat is made following a period of active monitoring for patient thinking time.

It may be appropriate for the patient to be entered into active monitoring (and the RTT clock stopped) 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.

In this scenario, 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.

14. Referral Management

14.1 Primary Care Responsibilities

In line with National RTT rules, before any patient is referred to secondary care, GPs and other referrers should ensure patients are ready, willing and able to attend for any necessary outpatient appointments and/or treatment and they fully understand the implications of any surgery or other treatment which may be necessary.

14.2 Secondary Care Responsibilities

It is the responsibility of the speciality management teams and clinicians at each Trust to ensure that the Directory of Services (DoS) is current in terms of the service specific criteria and clinics are mapped to the relevant service. This gives the patient the best chance of being booked into the correct clinic at their first visit and reduces the rejection rates.

For further information see individual Trusts Referral Management and DoS management policies.

14.3 Referral Sources

Primary Care to Secondary Care - The vast majority of referrals should be made from primary to secondary care, GP to consultant. This maximises the choice opportunities for patients in terms of provider and date and time of appointment and contributes to the management of secondary care capacity by ensuring only those genuinely needing secondary care receive it, in a timely way as part of an RTT pathway.

Advice and Guidance - There may be a number of reasons why a GP may wish to seek advice and guidance including:

- asking for specialist advice on a treatment plan, and/or the ongoing management of a patient;
- clarification (or advice) regarding a patient's test results;
- seeking advice on the appropriateness of a referral for their patient (e.g., whether to refer, or what the most appropriate alternative care pathway might be).

- Identifying the most clinically appropriate service to refer a patient in to.

The referring GP can attach documents to the advice request on e-RS, which may include diagnostic results, clinical photos, scanned images, or previous correspondence relating to the patient.

Consultant to Consultant – Internal Tertiary Referrals - Patients should continue to be referred internally as part of a continuing care pathway relating to the symptoms / condition for which the patient was referred by the GP. This will relate to patients for whom a diagnostic opinion and / or course of treatment needs to be determined. However, if there is an incidental condition identified in the course of one treatment quite unconnected to the reason for the original primary care referral, the consultant should inform the GP, for the GP to determine with the patient future management / referral for the new condition, and the RTT clock should stop if the patient is no longer being treated for the original condition / referral.

The Trusts Consultant to Consultant policy provides further detail.

Inter Provider Transfers (Tertiary Referrals from Other Providers) – NHS Patients who are referred to the Norfolk & Waveney Acute Hospitals from other providers for the treatment of the same condition as the original referral from the GP should have an RTT clock start date of the date the referral was received at the original provider; the RTT clock should not stop and restart.

The Trusts expect an accompanying Minimum Data Set (MDS) pro-forma with the Inter Provider Transfer (IPT), detailing the patient's current RTT status (the Trusts will inherit any RTT wait already incurred at the referring trust if the patient has 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.

Clinical assessment and triage services (CATS) and referral management center's (RMCs) These services provide intermediary levels of clinical triage, assessment, and treatment between traditional primary and secondary care.

A referral to a CATS or an RMC starts an RTT clock from the day the referral is received in the CAT/RMC. If the patient is then referred on to the Trust having not received any treatment in the service, the Trust inherits the RTT wait for the patient. A minimum dataset (MDS) form must be provided to transfer the RTT status information about the patient to the Trust.

14.4 Referral Methods

The Norfolk & Waveney Acute Hospitals support and are working towards all referrals being made directly via the NHS e-Referral Service. However, where written routine referrals are sent each Trust maintains a Trust Referral Management policy, which should be referred to for guidance.

If a paper referral is received, the date of receipt **must** be clearly and permanently marked; this is the RTT clock start date (excludes inter-provider transfer referrals, see guidance).

The Standard Contract for 2018/19 requires the full use of the NHS e-Referral Service (eRS) for all consultant-led first outpatient appointments. From 1 October 2018, providers will only accept and be paid for activity resulting from referrals made through eRS.

14.5 Referral Minimum Dataset

The referrer is responsible for ensuring the referral letter contains the essential minimum data set. This should include but is not limited to the patients full NHS number, full patients' demographics, the day, evening and mobile telephone number which the patient would like to be contacted on as well as sufficient data for the appropriate appointment to be made. The referral letter should

contain the patients' current drug regime, clinical questions to be answered and significant past medical history as appropriate. (See Appendix A)

Referrals should be addressed to a specialty rather than a named consultant and the patient will be offered an appointment with the consultant with the shortest waiting time as clinically appropriate. Named referrals will be allocated to the relevant consultant, but if sufficient capacity is not available to accept the referral, then a decision will be made in conjunction with the consultant and the speciality management team to allocate the referral to an appropriate alternative consultant. Exceptions to this would be where denying access to a sub-speciality opinion would compromise clinical care or patients choose to wait to see the named consultant.

(See Appendix A for Inter Provider Transfers and Minimum Data Set)

For CANCER Referrals – See the Cancer Services Operational Policy and the Referral Management Policy

15. Clinical Triage/Review of Referrals

Referrals received at the Trust will be actioned within 48 hours of receipt to ensure the referral detail can be assessed & accessed electronically by consultants and clerical staff as appropriate. Consultants should review all patient referrals, allocating clinical priority and accepting / rejecting referrals within 2 working days of the referral being received at the Trust. Referrals not reviewed within 5 working days will be escalated to the weekly PTL meeting for review.

If a consultant deems a referral to be inappropriate, it must be sent back to the referring GP with an explanation provided for the reason for rejection of the referral. If a referral has been made and the special interest of the consultant does not match the needs of the patient, the consultant should cross-refer the patient to the appropriate colleague or sub speciality within the same speciality; the patients RTT clock continues to tick. If a referral has been made to an incorrect speciality, the individual Trusts Referral Management policy should be followed. For all other details pertaining to the management of referrals, please see the Trusts Referral Management Policy.

All communications with patients and anyone else involved with the patients care pathway (e.g., GP or a person acting on the patients behalf) whether written or verbal, must be informative, clear and concise. Copies of all correspondence with the patient must be recorded in the patient's clinical notes.

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.

16. Reasonable Offer (RO) of Appointment/TCI

Reasonable Offers - To enable the Trusts to offer patient's choice of dates; to reduce patient cancellations and DNA's, dates will be mutually agreed with the patient. Where clinically appropriate to do so the appointing Specialty should offer a virtual consultation (Telephone or Video) before offering a face to face.

An offer is reasonable where:

- the offer of an out-patient appointment or an offer of admission is for a time and date three or more weeks from the time the offer was made
- the patient accepts the offer
- the appointment is for a patient referred on a 2WW Cancer pathway

A reasonable offer should be made and the date offered should be recorded on the Trusts Patient Administration System (PAS). If two dates are available for the patient to choose from, the patient should be offered a choice of dates. It is best practice to offer two dates.

All offers made to the patient should be recorded on PAS.

Discretion should be applied when booking appointments; however, there is an expectation patients will make themselves available to attend appointments in a timely manner. If a patient makes themselves unavailable, **after clinical review as necessary**, the patient referral may be discharged back to GP in order for them to clinically manage the patient as appropriate. This should be communicated to the patient in all appointment letters, as the patient may not be aware of the clinical implications of choosing to wait longer.

If a reasonable offer is declined and the patient makes themselves unavailable, clinical advice must be sought to assess whether the delay is contrary to the patient's best clinical interests, and it is therefore in the patient's best interest to be discharged and return to the care of their GP. The clinical interests of vulnerable patients and prisoners must be protected.

Short Notice - If a patient is offered a short notice appointment, diagnostic procedure or admission date and they are happy to accept the date offered, this becomes a reasonable offer. If a patient accepts a short notice offer but then cancels or DNAs the activity, they have still agreed the appointment and therefore this will be treated as a reasonable offer. This must be made clear to the patient at the time of the short notice offer.

17. Booking System Type

It is good practice for a provider to mutually agree all appointments and admission dates with the patient. This will assist in reducing patient cancellations, DNA rates and enhance the patient experience.

Full Booking is when the date and time of an appointment/admission is agreed with the patient within 24 hours of the decision to refer/admit.

Partial Booking is when an appointment is agreed with the patient at any other time.

Patients who have had the opportunity to agree a date within 1 working day but choose to wait longer than the 1 day to agree the date, should still be counted as a fully booked patient.

The appointment booking system type must be recorded each time an outpatient appointment / To Come In date (TCI) is agreed with a patient or sent to a patient.

N.B If a No Choice appointment / TCI is sent in the post to a patient and the patient calls the Trust to cancel / rearrange the date, the cancellation must be recorded as a hospital cancellation, the RTT clock continues to tick. This is not good practice and no choice appointments should be only used as a last resort.

If the patient DNA's after a No Choice appointment / TCI is sent in the post to a patient, a DNA code cannot be added and another appointment / TCI needs to be arranged. The RTT clock will continue to tick.

No Choice Given - An appointment (new or follow-up) or TCI date is booked and sent to the patient, without any negotiation with the patient. This process is not recommended and should only be used as a last resort.

For further information and guidance please see the SOP for Booking System which can be found on the individual Trust Intranets.

18. Patient Cancellations

(Rules are different for Cancer Waiting Times – please refer to the Cancer Services Operational Policy)

If a patient cancels, rearranges or postpones their appointment (this could be a face to face, virtually or telephone appointment), the RTT clock is not affected and continues to tick. Patients should not be discharged back to their GP simply because they have cancelled or rearranged appointments. Any decision to discharge should always be a clinical decision, based on the individual patient's best clinical interest.

If the patient has previously agreed to a reasonable offer of appointment (i.e., three weeks' notice and a choice of dates, or the patient has accepted a short notice date) which they subsequently wish to change, the patient can make two cancellations anywhere in their RTT pathway and the RTT clock will continue to tick (on-going). Upon a third cancellation the patient may be discharged back to their GP's/referrers care if this is in their best clinical interests. Clinical advice **must** be sought to confirm:

- Discharging the patient is not contrary to their best clinical interests
- The clinical interests of vulnerable patients and prisoners are protected

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. 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.
- The requested delay is clinically acceptable but the clinician believes the delay will have a consequential impact (where the treatment may fundamentally change during the period of delay) on the patient's treatment plan-active monitoring

19. Hospital Cancellations – Appointments/TCI

(Rules are different for Cancer Waiting Times – please refer to the Cancer Services Operational Policy)

If the hospital cancels an appointment or TCI anywhere on an RTT pathway, the clock continues to tick. The patient should be re-dated within the existing RTT standards and departmental pathway milestones.

Patients who are unfit to proceed with their pathway

If the patient is unfit for a procedure or to continue their pathway for treatment, the nature and duration of the clinical issues should be ascertained.

Short term illness – temporarily unfit

If the clinical issue is short-term and has no impact on the original clinical decision to undertake the procedure e.g., a cough or cold, the RTT clock will continue unless it is deemed not clinically appropriate to keep the patient on an active RTT pathway. The patient will be offered a re-scheduled date within the RTT standards while adhering to the reasonable offer guidelines.

Longer term illness

If the clinical issue is more serious and the patient requires optimisation and/or treatment for it, a clinical review should be carried out and clinicians should indicate to administrative staff:

- If it is clinically appropriate for the patient to be removed from the waiting list (this will stop the RTT clock event via the application of active monitoring).
- If the patient should be optimised / treated within secondary care (active monitoring clock stop) or if they should be discharged back to the care of their GP for the management of the condition rendering the patient unfit for the required surgical procedure. (RTT clock stop and discharge of referral).

The letter to the GP will state the optimisation required and the need for re-referral when the patient is fit to proceed. A copy of the letter will be sent to the patient and a copy filed in the patient's case notes. Once the patient has been informed the RTT pathway can then be stopped upon referring back to the GP's care. A new pathway will start upon receipt of re-referral.

MRSA positive patients

If a patient is MRSA positive, this does not affect their RTT clock as in some cases it is entirely clinically appropriate for patients to undertake treatment despite their MRSA status.

If a patient is identified as being MRSA positive and the consultant makes a clinical decision it is in the interest of the patient to refer them back to primary care, then the patient's RTT clock may be stopped, on the date this decision is made and communicated to the patient. It is not expected that patients will be referred back to primary care just because they are MRSA positive, exceptional reasons will be needed to support such clinical decisions.

A new RTT clock should start when/if a patient is referred back into consultant-led care.

COVID-19 positive patients

Patients who are unavailable due to contracting COVID-19 should be managed in accordance with Trusts local policies.

Cancelled Operations on the Day of Admission for non-clinical reasons - In the event the Trust has to cancel a patient's elective procedure on the day of admission or day of surgery for a non-clinical reason, the patient must be offered another TCI date within 28 days of the cancelled procedure date, a reasonable offer still applies. See the Cancelled Ops SOP on each Trusts' Intranet for further information.

20. Patients Who Did Not Attend (DNA)

(Rules are different for Cancer Waiting Times – please refer to the Cancer Services Operational Policy)

These rules are applicable only if the patient has had the opportunity to agree their appointment or admission date in advance as opposed to sending a No Choice Appointment / Admission through the post.

20.1 DNA of First Appointment / Activity Following Initial Referral

(Rules are different for Cancer Waiting Times – please refer to the Cancer Services Operational Policy)

If a patient DNA's their first appointment / activity following the initial referral which started their referral to treatment pathway, the patient may be discharged back to the GP / Referrer and their RTT clock nullified, provided that:

- The Trust can demonstrate the appointment was clearly communicated to the patient. PAS must be used to record all offers of appointment.

- Discharging the patient is not contrary to their best clinical interests
- The clinical interests of vulnerable patients and prisoners are protected

Should the patient be offered another date, a new pathway will start on the date the patient mutually agrees their appointment (not the date of the future appointment) and the original clock start date will be nullified.

20.2 DNA of Subsequent Activity – Any Other Outpatient Appointment, Diagnostic, or Admission along a Patients Pathway

(Rules are different for Cancer Waiting Times – please refer to the Cancer Services Operational Policy)

If a patient DNA's at any other point on the RTT pathway it will not stop the RTT clock unless the patient is being discharged back to the care of their GP. This will stop the clock provided the Trust can demonstrate the appointment was clearly communicated to the patient, otherwise the RTT clock will still tick. All appointments offered must be recorded on PAS.

If a patient does DNA any subsequent activity, a clinical review will take place and the patient will be either:

- Discharged back to the GP's care, provided that discharging the patient is not contrary to their best clinical interest. The RTT clock will stop on the date the patient DNA's appointment / TCI. A DNA letter must be sent to the GP and the patient (copy filed in case notes). The clinical interests of vulnerable patients and prisoners must be protected

- The clinician will request the patient is offered another appointment / TCI, in this instance the RTT clock will continue to tick.

21. Patients Transferring from the Private Sector to the NHS

Patients can choose to convert between NHS and private care at any point during their journey without prejudice. A patient who has chosen to pay privately for an element of their care, such as a diagnostic test, is entitled to access other elements of care as an NHS patient, provided the patient meets NHS commissioning criteria for that treatment.

Routine referrals from consultants undertaking Private Practice within the N&W ICB will be accepted by the acute Trusts under this arrangement as a tertiary referral. Each Trust will publish how they accept these referrals on their own intranet.

Any patient referred from consultants undertaking Private Practice must have a letter sent to their GP by the referring consultant explaining the reason for the referral and any relevant associated clinical information.

The Acute Trusts will only accept routine referrals which meet the POLCV/Clinical Threshold set by the ICB, and will not accept any referrals that require an IFR.

The Referral to Treatment 18-week clock starts at the point at which clinical responsibility for the patient's care transfers to the NHS (i.e., upon receipt of the referral by the hospital.)

Patients transferring from a private practice pathway in this way will be treated in turn within the terms of this Patient Access policy i.e., by clinical priority and then chronologically in accordance

with all other NHS patients currently waiting. This is to ensure that there is no disadvantage to NHS patients.

Patients who are referred via a private service can be added directly to an NHS therapeutic waiting list. This will be a clinical decision made by the Health Care Professional accepting the referral. An NHS outpatient appointment may not be required if the clinician accepting the referral deems it unnecessary.

As per the Norfolk and Waveney ICB Consultant to Consultant Policy the private service will NOT refer for NHS diagnostic investigations; the Acute Trusts will not accept referrals for diagnostic investigations.

If a patient is on an NHS RTT 18-week pathway and is offered treatment in the private sector to reduce the time waiting for treatment, they will remain on an NHS RTT 18-week pathway.

22. Patients transferring from NHS to Private Care at Their Own Request

NHS patients already on an NHS waiting list who opt to have a private procedure **must be removed from the NHS waiting list and their RTT clock stopped**. The RTT pathway should be stopped on the date the patient informs the Trust they no longer require treatment and the referral should be discharged.

23. Clinical Threshold and Individual Funding Requests (IFR)

Some procedures are subject to patients meeting clinical thresholds to being able to be listed on a waiting list. Click on the following link for the Policy for Non-Routine Treatments and Thresholds' which gives a full list of procedures and the qualifying patient criteria. Norfolk CCG Policy for Non-Routine Treatments and Thresholds

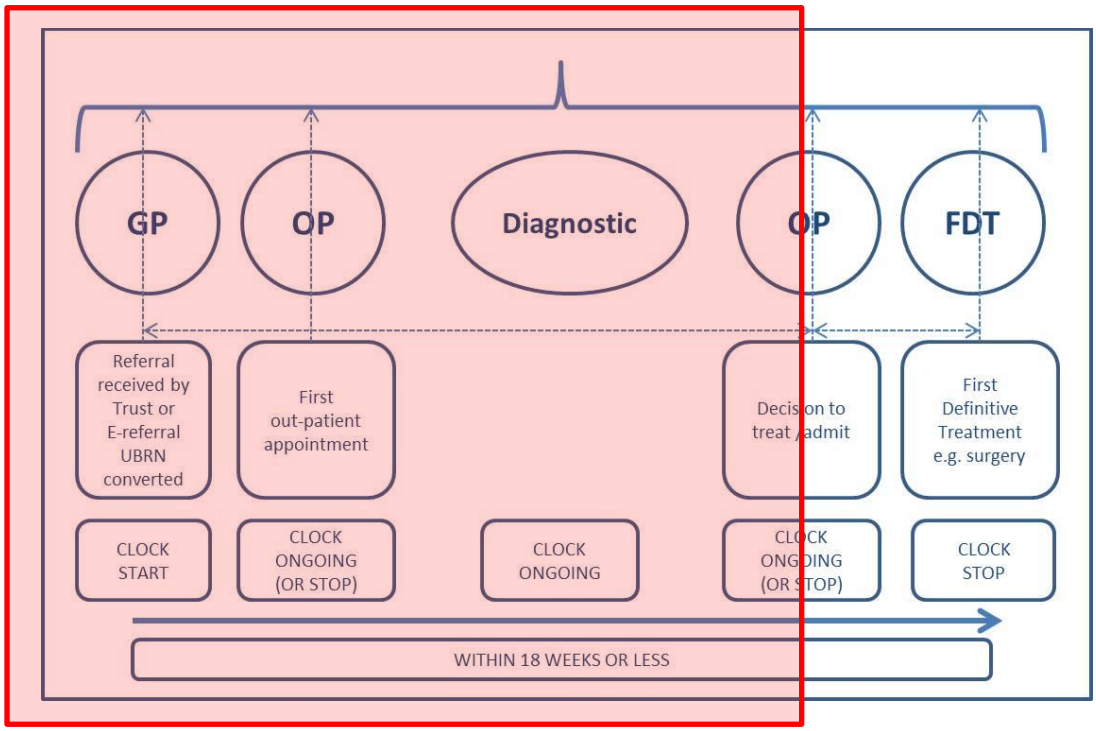
Where IFR is required patients **will not** be added to a waiting list without a prior authorisation number from Commissioners.

The patients RTT pathway continues to tick while Individual Funding Requests (IFR) are being processed if the IFR is submitted by the Trusts.

For further guidance follow the link: Clinical Thresholds Policy **PATHWAY SPECIFIC PRINCIPLES**

Management of Non-Admitted RTT Pathways

The non-admitted stages of the patients' pathway comprise of both outpatient and the diagnostic phase (shaded in red below). It starts from the clock start date (i.e., the date the referral is received or UBRN converted) and ends when either a clock stop happens in outpatients, or when a decision to admit is made and the patient transfers onto an admitted pathway.



The following pages detail the agreed principles and policies for the management of patients on a non-admitted pathway up to the point they transfer onto an admitted pathway or are treated.

24. Outpatients General Principles

For booking and Management of Outpatients, all staff should adhere to the Outpatient General Principles found in the Outpatient General Principles Guidance SOP, which can be found on the individual Trusts Intranet.

25. Referral Criteria Proformas

In a number of specialities there are specific referral criteria Proformas available for GPs to use when referring patients to the Trusts. These include 2ww Cancer pathway referrals. These Proforma documents contain details of the minimum data set required along with advice and requirements of any tests necessary prior to the patient being accepted by the hospital. They also allow for the provision of clinical history and medications that might complicate surgery or treatment.

The use of the Proforma ensures all primary care options have been considered prior to referral to secondary care.

Further details of the referral criteria Proformas can be found at www.knowledgeanglia.nhs.uk

26. Patient Initiated Follow-up (PIFU)

PIFU is specifically designed for patients with stable or long term conditions to allow them to directly access clinical teams if symptoms return or their condition deteriorates. Patients under follow-up care should be considered for suitability of patient initiated follow-up.

27. Appointment Letters

All appointment letters should contain enough detail for the patient to fully understand who the letter is from where and when the appointment is, where to report to on arrival and what will happen to them if they cancel or DNA an appointment. Associated literature about the appointment should also be included. Further details of the suggested content of the appointment letter and associated literature can be found in the SOP – Contents of the Appointment Letter.

Further information on outpatient appointments can be found in the Trusts Referral Management Policy, which can be found on the individual Trust Intranets.

28. Arrival of patients at Clinic

a. Patient demographics should be checked at every clinic attendance and amended where necessary on the Trust's PAS system. The status of overseas visitors will be checked at this time and the overseas department should be notified where it is suspected that the patient is an overseas visitor.
b. All patients must have an attendance/arrival status recorded i.e., attended or did not attend.

29. Clinic Outcomes

a. All patients must have a clinic outcome (e.g., add to elective waiting list, discharge, follow-up etc.) and an updated RTT status recorded for the clinic entered on to PAS. This includes patients who have already started treatment and who have had a previous clock stop as they may need to have a new RTT clock start due to a new treatment plan or continue to be monitored.
b. The vast majority of non-admitted RTT data regarding a patients RTT pathway is derived from information transferred to PAS from the Clinic Outcome Form, so it is **critical** that data is completed correctly in clinic and recorded in an accurate and timely manner; clinic outcomes should be recorded on PAS within 24 hours of the clinic taking place.
c. Departments are required to have a process in place to ensure that any RTT codes added to an outcome form which are out of sequence are validated and corrected, and PAS is updated with an accurate RTT code.
d. Access and Choice – Operational Managers are to ensure that post session reporting is carried out to reduce any potential delays to patient pathways if an outcome is missed. It is good practice to enter waiting list entries onto PAS within 24 hours of the decision to admit in clinic; **all waiting list entries must be entered onto PAS within 4 working days of a decision to treat**, unless the patient requires an IFR approval code. Any reason for delay in the addition waiting list entries on PAS should be escalated via the weekly PTL meetings. (See escalation process SOP for further information).

30. Clinic Management - Cancellation of clinic sessions/part sessions

a. Trust policies confirm 6 weeks' notice must be given for clinic cancellations. The Clinical Director and Divisional Operational/Service Managers must give authorisation for cancellations under 6 weeks.
b. It is the responsibility of the Operational Management Team to monitor clinic cancellations and undertake remedial action where identified as necessary.

31. Escalation

If an appointment is not available within the prescribed pathway milestone for a particular speciality or the first appointment offered is declined and another appointment is not available the escalation process should be applied. (See Outpatient Escalation SOP for further details)

32. Clock Stops at the First Outpatient Appointment

(Rules are different for Cancer Waiting Times – please refer to the Cancer Services Operational Policy)

A patients RTT clock can stop at the first Outpatient appointment for clinical or non-clinical reasons as per the national guidance described on page 9 and 10.

E.g., For first definitive treatment - if the patient is given advice or prescribed medication to treat the condition, or

For non-treatment if:

a) It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care;
b) A clinical decision is made to start a period of active monitoring;
c) A patient declines treatment having been offered it;
d) A clinical decision is made not to treat;
e) A patient DNAs (does not attend) their first appointment following the initial referral that started their waiting time clock, provided that the Trust can demonstrate that the appointment was clearly communicated to the patient.

33. Clock Stops at Subsequent Outpatient Appointments

(Rules are different for Cancer Waiting Times – please refer to the Cancer Services Operational Policy)

A patients RTT clock can stop at subsequent Outpatient appointments for the reasons given above; however, if a patient DNA's a subsequent appointment they should be discharged back to the care of their GP provided that:

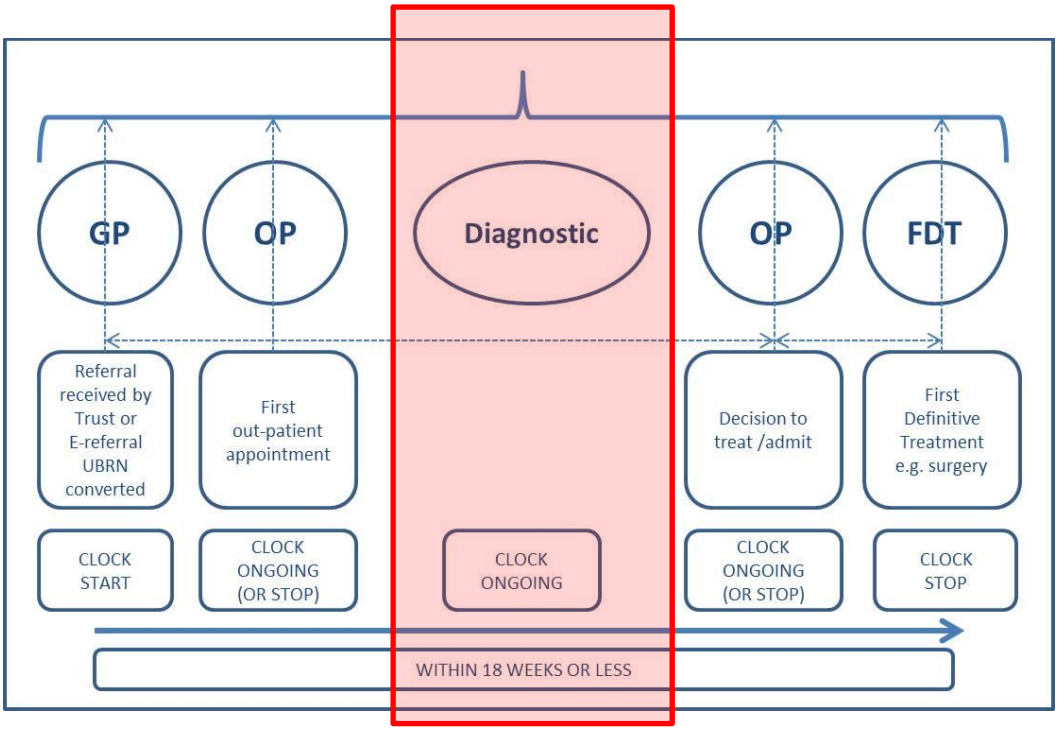
- The Trust can demonstrate that the appointment was clearly communicated to the patient.
- Discharging the patient is not contrary to their best clinical interests.

For more information and scenarios on Clock Starts, Ongoing Clocks and Clock Stops and RTT Codes, please see the RTT Code Scenario's SOP which can be found on the Trusts Intranet.

Further guidance on the RTT Codes used nationally and locally can be found on the individual Trust intranet by clicking here.

Management of Diagnostic Pathways

The Diagnostic stage of the patients' pathway is shown shaded in red below, which forms part of the non-admitted pathway.



The following pages detail the agreed diagnostic principles and policies.

34. Diagnostics

NHS England Clinical Prioritisation of Waiting Lists for Endoscopy and Diagnostic Procedures Policy states that Diagnostic procedures need to be prioritised according to clinical need rather than waiting time. (Refer to Appendix 1 for code table and definitions)

It should be noted that patients may or may not be on an 18 week RTT pathway whilst waiting for a diagnostic test or procedure and may be on more than one diagnostic pathway at the same time.

If a patient is on an RTT Pathway, the RTT Pathway continues to tick when diagnostic tests have been requested by a Consultant or an HCP within a consultant led service. The clock will not stop until the patient receives first definitive treatment or a decision is made not to treat, or to start a period of active monitoring has been communicated to the patient.

35. Diagnostic Standards

The national standard is that the 6 week diagnostic clock starts when the request for a diagnostic test or procedure is made. For straight to test patients using the NHS e-referral system referrals, this is the time that the UBRN is converted, i.e., when the patient chooses an appointment.

- Outpatient Diagnostics – 6 weeks from receipt of referral at the trust or 6 weeks from the request for diagnostic if in a Trust OP setting.
- Imaging Diagnostics - 6 weeks from request date
- Outpatient and Day case Diagnostics – 6 weeks from the request made at the decision to treat / list.

The Trust should seek to fulfil "reasonableness" criteria when offering patients appointments for diagnostic tests/procedures. In summary, this means they should be offered an appointment date with at least 3 weeks' notice of the appointment or the patient agrees to a short notice appointment.

The Trust can offer appointments that do not fulfil the reasonableness criteria **where it is in the best interest of the patient**, for example, to receive an appointment with less than 3 weeks' notice (e.g., no choice appointment). However, the Diagnostic 6 week clock resets for cancellation or failure to attend appointments that do not fulfil the reasonableness criteria should not be applied.

36. Diagnostic General Principles

Many patients require diagnostic tests to determine a diagnosis and therefore subsequent treatment of a patient. Diagnostic tests can be in the form of a blood test, biopsy or an endoscopy procedure or an x-ray. Diagnostic tests must be performed within 6 weeks of the request for the test to ensure delivery of the national waiting time target. In many instances the diagnostic tests will form part of the patients RTT 18 week journey.

DNA and cancellation principles apply to diagnostic patients.

37. Diagnostic waiting list types

Active diagnostic waiting list
The active diagnostic waiting list should consist of patients awaiting diagnostic tests/procedures, who are to be offered appointments within the waiting time standard (6 weeks).

Planned diagnostic waiting list
For some patients, the timing of their diagnostic test is dependent upon other clinical factors. In these circumstances patients are called for an appointment at a clinically indicated time and these requests are classed as planned.

Patients who require a diagnostic test to be carried out at a specific point in time for clinical reasons (planned patients) are exempt from the diagnostic clock rules and will be held on a planned waiting list with a clinically determined due date identified.

Therapeutic procedures at a diagnostic stage

A number of procedures carried out within the Diagnostic departments are therapeutic procedures and not diagnostic procedures and as such, the 6 week diagnostic waiting time standards do not apply. These procedures are governed by the RTT rules.

38 GP requested diagnostics

When a GP requests a diagnostic test via direct access to determine whether onwards referral to secondary care or management in primary care is appropriate, the patient is not on an RTT pathway and the 18 week clock does not start. The patient must have the diagnostic procedure within 6 weeks of receipt of referral. If the GP subsequently refers the patient to secondary care, then the patient commences on an RTT pathway and the RTT clock starts on the date the referral is received.

When a GP refers a patient for a diagnostic test prior to an Outpatient appointment with a consultant and as part of an agreed clinical pathway, then the patient begins an RTT pathway and the clock starts on receipt of the GP referral. The patient must have the diagnostic procedure within 6 weeks of received referral.

N.B. – It is the GPs responsibility to be clear within the content of the referral whether they are referring the patient for treatment or are requesting a diagnostic test to enable them to make a decision regarding the patient's treatment /care plan.

39. Other requested diagnostics

Where a diagnostic procedure is requested by a health care professional from the hospital, then the patient must receive their diagnostic procedure within 6 weeks of the decision to treat/list.

40. Patient Cancels a Diagnostics Appointment / Procedure

If a patient cancels a diagnostic procedure, this Access policy must be followed i.e., two patient cancellations in an 18 week pathway or adherence to the cancer policy if on a cancer pathway

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. 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

If a patient cancels an appointment for a diagnostic test/procedure that has been offered under "reasonable" criteria (see section 33 above), 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. A new 6 week diagnostic target will start from the date of the cancelled activity (actual date of appointment / TCI); however, staff must be mindful of the 18 week pathway and re-schedule the activity within 2 weeks of the cancelled diagnostic appointment / TCI or before if the patient is able to accept this or make another reasonable offer.

If a patient declines an offer of an appointment sent by post that does not fulfil "reasonableness" criteria, the clock is not reset and the patient should be offered an alternative appointment date.

N.B. If the Trust cancels a diagnostic appointment / procedure the activity should be re-scheduled in line with their clinical priority code (P-code or D-code) and the original diagnostic waiting time clock will continue to tick.

41. Imaging and diagnostic appointment did not attend (DNA)

For patients who DNA any modality imaging or diagnostic appointment the appropriate clinical team should review the patients record to decide on the next steps.

Direct access patients may be discharged back to GP if indicated after clinical review.

Straight to test patients should not be automatically discharged back to GP without clinical review from the requesting clinical team.

Patients can be discharged back to the referrer but it must not be contrary to their best clinical interest. Each diagnostic/modality area should have a local policy on DNA management.

Vulnerable and cancer patients should be given special consideration in regard to offering further appointments.

If a patient does not attend their diagnostic appointment, 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 missed.

If a patient does not attend their diagnostic appointment that does not fulfil "reasonableness" criteria, the clock is not reset and the patient should be offered an alternative appointment date.

42. Escalation

If a diagnostic appointment is not available within the prescribed pathway milestone for a particular speciality or the first diagnostic appointment or TCI offered is declined and another appointment is not available the 18 Weeks RTT Capacity and Demand Escalation SOP should be followed.

43. RTT Clock Stops at Diagnostic Stage

A patients RTT clock can stop at the Diagnostic Stage if the patient is treated therapeutically whilst the diagnostic procedure is being carried out.

An RTT clock could stop at the diagnostic stage for non-treatment if:

a) It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care; the referring consultant may need to make this decision not to treat based on the diagnostic results.
b) A clinical decision is made to start a period of active monitoring after reviewing a diagnostic and the decision has been communicated and agreed with the patient;
c) A clinical decision is made not to treat and the decision has been communicated and agreed with the patient;
e) A patient DNAs (does not attend) their diagnostic appointment following the initial referral that started their waiting time clock, provided that:

- The Trust can demonstrate that the appointment was clearly communicated to the patient.
- Discharging the patient is not contrary to their best clinical interests.

For more information and scenarios on Clock Starts, Ongoing Clocks and Clock Stops and RTT Codes, please see the RTT Code Scenario's SOP which can be found on the Trusts Intranet.

Further guidance on the RTT Codes used nationally and locally can be found on the individual Trust intranet by clicking here.

44. Post Diagnostic – non-activity related RTT decisions

Where clinicians review test results in an office or virtual setting, without the patient present, and make a clinical decision based on the results of a diagnostic test not to treat the patient. The RTT clock will stop on the day that the clinical decision is made and communicated to the patient.

Administration staff should ensure that PAS systems are updated with the RTT clock stop. The clock stop date recorded will be the date that the decision not to treat is made and communicated with the patient.

45. Pathway specific principles - referral to acute therapy services

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

- Directly from GPs when an RTT clock would NOT be applicable.
- During an open RTT pathway where the intervention is intended as first definitive treatment **or** interim treatment.

Depending on the particular pathway or patient, therapy interventions could constitute an RTT clock stop, equally the clock could continue to tick. It is critical that staff in these services know if patients are on an open RTT pathway and if the referral to them is intended as first definitive treatment.

Physiotherapy

For patients referred to physiotherapy as first definitive treatment from a consultant led service, the RTT clock stops when the patient begins physiotherapy.

For patients referred for physiotherapy from a consultant led service as an interim measure to optimise their condition (support only) or assist them until surgery is available (as surgery will definitely be required), the RTT clock will continue when the patient undergoes physiotherapy.

Surgical Appliances

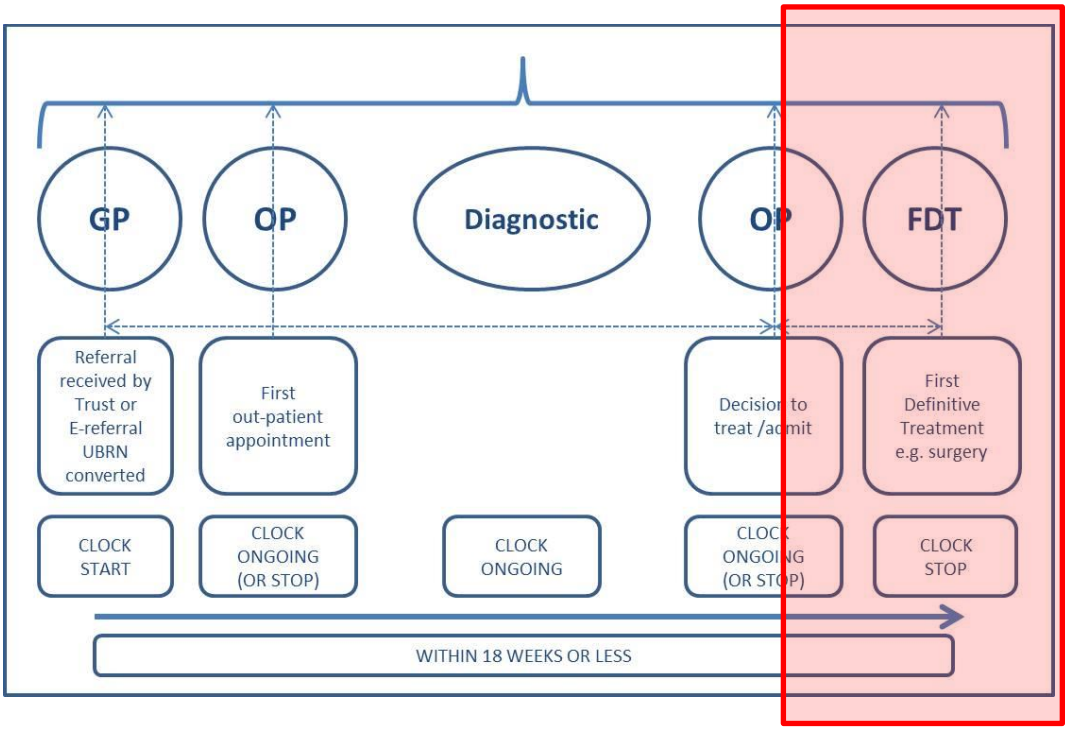
Patients referred from a consultant led service for a surgical appliance with no other form of treatment agreed would be on an open RTT pathway with an RTT clock ongoing until the fitting of the appliance. It is the act of fitting the appliance that constitutes first definitive treatment, when the appliance is ready for use by the patient, and therefore the RTT clock stops when this occurs.

Dietetics

If patients are referred to the dietician from a consultant led service for dietary advice and received the 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, and in this instance, the RTT clock would continue to tick, as the intention was not as treatment, but to optimise the patient pathway leading to first definitive treatment or surgery.

Management of Admitted Pathways

The Admitted stage of the patients' pathway is shown shaded in red below, which forms the-admitted pathway. It starts at the point of a decision to admit for treatment and ends upon the first definitive treatment being received by the patient or a clock stop for non-treatment.



The following pages detail the agreed principles and policies for the management of patients on an admitted pathway.

46. Decision to Admit

The decision to admit a patient for Surgery or a Medical therapy (as a day-case or inpatient) must be made by a consultant or by another clinician who has been given delegated authority. A patient should only be added to an active waiting list if:

- The patient is clinically fit, ready and available to undergo surgery. Patients who are added to the waiting list must be clinically and socially ready for admission on the day the decision to admit is made, i.e., if there was a bed available tomorrow in which to admit a patient, they are fit, ready and able to come in.
- Following pre-operative assessment, patients who are deemed to be clinically **not** fit for treatment (e.g., for a heart condition or after having a stroke etc.) they should be referred back to the responsible clinician who can decide to refer the patient back to their GP for the management of the condition rendering the patient unfit for the required surgical procedure.

47. Best Practice Application and Management of Clinical Prioritisation

The Clinical Guide to prioritisation was produced by the Federation of Surgical Specialty Associations at the request of NHS England at the start of the Covid pandemic. This was endorsed by the Royal College of Surgeons and is still used to show clinical priority of patients. The principle of this guidance was to enable clinicians to determine patient's clinical urgency profile. (See Appendix 2 for code table).

Patients should be assigned a clinical priority category when added to an admitted waiting list (including patients added to a planned list), and that all patients on an admitted waiting list have an up-to-date priority code so that patients are prioritised by clinical need rather than RTT waiting time. Prioritisation should be part of a SDM process between clinicians and the patient. For patients on a planned waiting list, the clinical priority category should be used to indicate the urgency for booking any patients who are not seen in line with their admit by date.

Each Trust has individual SOPs of how to record the clinical prioritisation code on PAS so that booking staff and operational managers can easily see this information alongside other waiting list information and can identify patients at each priority level.

Clinical Prioritisation of admitted waiting lists will produce a clinically validated waiting list that allows operating lists to run effectively, by:

- Checking on a patient's condition and establishing any additional risk factors.
- Establishing the patient's wishes regarding treatment.
- Providing good communication with patient, carer and GP.

Patients choosing to delay treatment should continue to be managed, overseen and recorded in line with the current RTT rules. These patients should be easily identified, and next steps discussed with their clinician to ensure that any decision is made in their best clinical interests.

Patients that have not been booked for admission within the period indicated by their prioritisation category should be re-reviewed. All patients should be reviewed to make sure their condition or preference has not changed. The maximum time between reviews is six months. Reviews should be undertaken in line with the timescale indicated by the patient's priority category, or sooner if appropriate (for example if a change in the patient's condition has been highlighted). See Appendix B for review timescales.

48. Pre-Operative Assessment (POA)

All patients with a decision to admit (DTA) requiring a general anaesthetic will attend a POA clinic to assess their fitness for surgery. The vast majority of patients can be assessed by the Trust's dedicated POA nurse specialists. Patients should be made aware in advance that they may need stay longer on the day of their appointment for attendance in POA where appropriate. Some patients with complex health issues may require a POA appointment with a nurse consultant or anaesthetist.

Where Pre-Operative Assessment is required, a patient should be pre-operatively assessed as soon as possible after the Decision to Admit is made to ensure the patient is fit for procedure. A pre-operative assessment can be completed up to 12 weeks in advance of the TCI. If a patient cancels or DNAs a pre-operative assessment the following applies:

- Patients who DNA POA will be returned to the responsible consultant for clinical review. **The RTT clock continues to tick throughout this process.**

A procedure information Leaflet should be given to the patient when they are undergoing pre-operative assessment if appropriate.

49. Inpatient and Day Case Waiting Lists

All admitted patients will be treated in clinical priority and then chronological order (longest waiting first). (Please see Appendix D)

Since the COVID-19 pandemic priority codes have been expanded from the previous priorities of Urgent and Routine to the below: -

Patients should be offered appointments using the following principles starting with patients from group 1, then group 2 and so on:

- Clinical priority patients, e.g., urgent and potential/confirmed cancers / P1 and P2 clinically stratified patients, with patients booked in chronological order, starting with the patient who has waited the longest at this category.
- P3 clinically stratified patients; long waiters should be booked in chronological order, starting with the patient who has waited the longest.
- P4 clinically stratified patients; long waiters should be booked in chronological order starting with the patient who has waited the longest.

50. Inpatient and Day case General Principles

For booking and Management of Inpatient and Daycase Admissions, all Trust staff should adhere to the Inpatient and Day Case General Principles found in the Inpatient and Day Case General Principles SOP on the Trusts individual Intranets.

51. Elective Waiting (EW)

A patient is added to an Inpatient or Day Case waiting list having been given no date of admission at the time a decision was made to admit.

52. Elective Booked (EB)

A patient is added to an Inpatient or Day Case waiting list, having been given a date to come in at the time the decision to admit was made. Care must be taken to ensure that patients with the same clinical priority are treated in chronological order of their waiting time. Consultants should have sight of where the patient is on their RTT pathway and which other patients are waiting, along with the length of wait, before agreeing TCI dates with patients to ensure that patients are being treated in order of clinical urgency and then chronologically.

53. Elective Planned (EP)

A patient is added to an Elective Planned waiting list where there is a clinical need to wait for a period of time before the procedure.

There are strong clinical governance and safety reasons why patients on a planned care pathway should not be deferred and these patients should be treated at the right time and in order of clinical priority.

Patients should only be added to a planned list where clinically they need to wait for a period of time. This includes planned diagnostics tests or treatments, or a series of procedures carried out as part of a treatment plan – which are required for clinical reasons to be carried out at a specific time, for example, where the procedure has to be performed at a set point linked to a clinical criteria (e.g., a certain age for a child before a procedure can be performed) or a procedure / test repeated at a specific frequency.

Elective planned waiting list entries **must** include a clinically determined treat by or 'target' date and patients should be booked for the procedure within the timelines as requested by the clinician.

When patients on planned waiting lists are clinically ready for their care to commence and reach the date for their planned appointment / admission, they should either receive that appointment or be transferred to an active waiting list and a waiting time clock should start. The key principle is that where patient's treatment can be started immediately then they should start treatment or be added to an active waiting list and treated within 6 weeks of addition.

Please see the Elective Planned SOP for further information and guidance which can be found on the individual Trusts Intranets.

54. Advice and support for shared decision-making (SDM) when arranging planned care

Before scheduling an elective admission, the clinician should have discussed with the patient (or carer/family) the possible outcomes of the procedure or investigation before reaching a shared decision. This should include:

- The benefits of having the procedure, and the effects on their health and wellbeing of postponing or not having the procedure.
- Ensuring that the patient understands the risks associated with COVID-19 during their hospital visit and procedure and has given informed consent.
- Alternative options if the procedure is declined or postponed by the patient.

55. Contents of the 'To Come In' (TCI) Letter

A TCI letter should be produced for every patient awaiting an Elective procedure.

All TCI letters should contain enough detail for the patient to fully understand who the letter is from where and when their TCI appointment is, where to report to on arrival and what will happen to them if they cancel or DNA an appointment. Associated literature about fasting, medication, transport and who to contact should they wish to discuss the procedure should also be included.

Further details of the suggested content of the TCI letter and associated literature can be found in the Inpatient and Daycase TCI Letters and Patient Information SOP on the Trusts individual intranets.

56. Bilateral Procedures

Patients will only be added to the admitted waiting list for one procedure at a time, for a bilateral procedure, that is a procedure that is performed on both sides of the body, at matching anatomical sites e.g., Cataracts removed from both eyes.

The initial RTT clock will stop at first definitive treatment for the first procedure. Once the patient is fit and ready for the second procedure then a new RTT clock should start from the date that it is clinically appropriate for the patient to undergo that procedure, and from when the patient says they are available (not from the date that the Trust has the capacity to admit/treat the patient).

57. Patient Choice - Patients declaring periods of unavailability while on the inpatient / Daycase waiting list

*Interim Operational Guidance has been provided by the Department of Health and Social Care regarding the management of patients on the waiting list choosing to decline offered treatment dates at a current or an alternative provider**

Patients can request to delay any aspect of their RTT pathway for social or personal reasons. Delays to delivery of treatment will need to be discussed with patients, supported by clinical conversations, and current RTT rules applied as appropriate.

Each Trust has an individual process for record patient-initiated delays for audit and RTT rules application purposes on their PAS systems.

Patients choosing to delay, or who are otherwise unavailable for admission must have an appropriate clinical prioritisation recorded. Individual patient circumstances must be considered when applying RTT rules to pathways where patients have chosen to delay treatment.

If patients contact the hospital to communicate periods of unavailability for social reasons (e.g., holidays, exams), this period should be recorded on the Trusts PAS system.

If the length of the period of unavailability 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 will be reviewed by their consultant. Upon clinical review, the patient's consultant will indicate one of the following:

Clinically safe for the patient to delay: The national RTT Rules state that where it is clinically safe for the patient to delay the RTT pathways should continue to progress. The RTT clock continues.

*To help hospitals to manage patient choice fairly and effectively, the Department of Health and Social Care has approved this interim operational guidance which sets out:

- the circumstances when it is appropriate to offer patients the choice to travel elsewhere and how it should be recorded and managed on Referral to Treatment (RTT) waiting list.
- that when patients make a decision to delay their treatment there should be clinical oversight, and the patient fully understands the clinical implications of the delay.
- for a number of patients who wish to continue to delay their treatment it may be appropriate for them to not remain on the waiting list until such time as they are available to have their treatment.

Each Trust follows their own local process due to digital constraints.

Clinically unsafe length of delay: clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues. In exceptional circumstances if a patient decides to delay their treatment it may be appropriate to place the patient under active monitoring (clock stop) if the clinician believes the delay will have a consequential impact on the patient's treatment plan.

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. The patient could also be actively monitored within the Trust.

If patients make themselves unavailable after two reasonable offers of TCI, the access policy should be applied and a clinical review carried out.

The Trust must demonstrate the patient has been offered treatment options in line with this policy, but the patient is not willing to accept the dates offered.

A review process should be put in place for long waiting patients choosing to wait at agreed intervals to ensure changes in status including patient's condition are captured and acted upon. The reviews should take place in line with the patient's priority stratification of P2 to P4, e.g., P2 patients should be reviewed on a monthly basis, P3 patients on a 3 monthly basis and P4 patients on a 6 monthly basis

Patients and GPs must be communicated with to confirm the clinical appropriateness of any patient initiated delay.

58. Emergency Admissions for an Elective Procedure

If a patient has a procedure they were waiting for electively (on an 18 week pathway) during an emergency admission, then the RTT clock would stop on the date of the emergency admission. The patient should be removed from the elective waiting list.

59. Escalation

If a TCI date is not available within the prescribed pathway milestone for a particular speciality or the TCI date offered is declined and another TCI date is not available the 18 Weeks RTT Capacity and Demand Escalation SOP should be followed.

60. Clock Stops at the Elective Inpatient or Daycase Admitted Phase

(Rules are different for Cancer Waiting Times – please refer to the Cancer Services Operational Policy)

A patients RTT clock can stop at the Elective Inpatient or Daycase Admitted phase for clinical or non-clinical reasons as per the national guidance described on page 13 and 14.

E.g., For first definitive treatment - if the patient is treated by surgical means or for non-treatment if:

a) It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care;
b) A clinical decision is made to start a period of active monitoring;
c) A patient declines treatment having been offered it;
d) A clinical decision is made not to treat;
e) If a patient DNA's a subsequent appointment they should be discharged back to the care of their GP provided that:

- The Trust can demonstrate that the appointment was clearly communicated to the patient.
- Discharging the patient is not contrary to their best clinical interests.

For more information and scenarios on Clock Starts, Ongoing Clocks and Clock Stops and RTT Codes, please see the RTT Code Scenario's SOP which can be found on the Trusts Intranet.

Further guidance on the RTT Codes used nationally and locally can be found on the individual Trust intranet by clicking here.

HOW THE TRUSTS MANAGE REFERRAL TO TREATMENT (RTT)

61. Patient Tracking List (PTL)

A PTL is a list of patients who need to be treated by given dates in order to start treatment within maximum waiting times set out in the NHS Constitution. The Trust also has PTL's for patients waiting for Diagnostic and Planned Elective treatment.

A Patient Tracking List (PTL) is an established, forward-looking, management tool that is used by the Trust to help achieve and sustain short Referral to Treatment and diagnostic waits. It provides a prospective viewpoint, and acts as a planning tool for managing patient waiting lists in a way that a retrospective data collection cannot.

Essentially, a PTL contains the data required to manage patients' pathways, by showing clearly which patients are approaching the maximum waiting time so operational staff (e.g. staff booking appointments or admissions for patients) can offer dates according to clinical priority and within maximum waiting times. The Trust PTLs also show when patients are approaching a pathway milestone without a date for that pathway event to ensure proactive management, these milestones are escalated at the weekly PTL meetings if they are not being met.

All patients will be monitored via the associated PTL. A PTL meeting is held weekly, chaired by the relevant Director, or relevant delegated authority, who holds responsibility for the delivery of the RTT standards. The meetings are attended by the operational management team who hold the operational responsibility for delivering the standards within each speciality.

62. Weekly Speciality PTL meetings

The PTL is produced at least twice weekly, to enable discussion of the detail of the PTL. Each Speciality area operational management team must be sufficiently prepared for the PTL meeting to:

- have a management plan at an individual patient level;
- have addressed the majority of the key issues;
- have an action plan for those issues to be resolved; and
- escalate any issues that cannot be resolved within the Directorate.

The PTL meetings are action-orientated and focused upon:

- performance management and accountability;
- breaches and prospective management of patients along the 18 week pathway and cancer pathway as appropriate;
- clearing the backlog of patients waiting more than 18 weeks;
- delivery of the RTT and cancer pathways; and
- monitoring and managing the number of incomplete pathways.

63. Guidance for Information to be provided to Consultants Regarding RTT Performance and Individual Waiting Times.

It is Trust best practice for Operational Managers to provide Consultants with the following patient level and performance data for review to facilitate management of the RTT waiting times and thereby ensure patients receive treatment in accordance with national standards

- Patient Tracking List information on a consultant level basis against 18 weeks delivery
- Performance data on referral acceptance times
- Outpatient wait times (new and follow-up)

- Conversion rates (new to follow-up, new to DTA etc)
- Waiting list size (Inpatient and day-case)
- Best Practice Tariff and Intended Management
- Breach data
- Referral data (Internal, Tertiary and Primary Care).

This data should be included in discussions at all Divisional Board and speciality meetings and issues raised should be minuted to ensure that actions and outcomes remain patient focussed and to provide a vehicle for escalation of governance issues for Board assurance.

64. Breaches of the Referral to Treatment 18 Week Standard

A breach of the Referral to Treatment 18 week's standard can be simply defined as a patient who has waited longer than 126 days i.e., 127 days or more, from the date of clock start to the date of clock stop for treatment or non-treatment as defined in the national rules.

65. Patient Review Process

The Trusts waiting lists must be regularly reviewed by the waiting list holder i.e., at least monthly, or as determined by the length of patient wait. A review letter can be sent to the patient requesting them to contact the waiting list holder within 21 days to either mutually agree an appointment or admission date, to check demographic details or to ascertain if the procedure the patient is listed for is still required. A regular review of the waiting list will result in accurate numbers of patients on a waiting list and improve data quality by ensuring patient demographic details; including contact telephone numbers are up to date.

To ensure that only those patients still needing their treatment are on the waiting list, and to comply with the Data Protection Act, validation of waiting lists should be carried out by administrative and Operational Managers on a regular basis i.e., at least monthly, or as determined by the length of patient wait.

Staff need to be mindful, to meet the reasonable offer criteria, reviews need to be carried out in a timely manner to allow the relevant 3 weeks' notice to be given for appointments and TCIs.
See the SOP on Patient Review Process on waiting list management for further information and guidance which can be found on the Trust Intranet.

66. Breach Reasons and RTT Pathway Validation

Under the NHS Constitution patients have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of alternative providers if this is not possible and the patient requests it. There will always be some patients who choose to wait longer or for whom this is clinically appropriate, i.e., where waiting longer than 18 weeks is in the patient's clinical interest (rather than clinically complex patients who nevertheless can and should start treatment within 18 weeks).

It is good practice to undertake pathway validation at all points along the patient pathway e.g., at Decision to Treat to check the pathway is accurate and identify any issues which may contribute towards the patient waiting longer than they should. All appropriate administrative staff are trained in validation and should ensure that real time validation is carried out when any patient activity is recorded.

Where it is not possible to treat patients within 18 weeks, all patients who breach the 18 week standard will have their RTT pathway validated to ascertain if the breach is genuine. If validation

confirms a definite breach the reason for the breach must be recorded on PAS, if the breach is not valid, then PAS must be amended to reflect the true RTT history.

It is considered good practice to review the number of days of avoidable delay at each stage of the pathway. If there is more than one delay, the one with the largest number of days would be recorded as the breach reason.

Breach reasons must be added (RTT pathway validated to ensure definite breach) in a timely manner to enable accurate 18 week submissions at the end of the month.

Further information and guidance on Validation can be found in the Validation SOP on the Trusts individual Intranets.

67. Adherence to RTT Principles

The underlying principle of RTT is that patients should be treated in chronological order is fundamental and should be adhered to at all times. Where there is insufficient capacity to date patients within agreed timeframes, staff should escalate capacity issues to the relevant manager, and ensure patients continue to be dated in accordance with the principles outlined above.

There are, however, some clinical and operational caveats to this principle:

- Patients whose condition is urgent (including those with suspected or an actual diagnosis of cancer) will be both seen and treated within a shorter timescale and in priority over those whose condition is more routine in nature.
- Patients who choose to wait for longer periods of time at any stage of their pathway may do so.

NHS resources must be used effectively and to this end, some patients may be treated 'out of order' to ensure maximum utilisation of resources. For example, a minor, routine operation may be performed at an early date to ensure theatre capacity is not wasted.

68. Reporting

The individual Trusts will accept appropriate tertiary inter-provider referrals for patients that have already breached their 18 week referral to treatment target, subject to a full inter provider transfer minimum data set being received with clock start times clearly identified.

The individual Trusts will report these breaches, but for the sake of clarity, will not accept penalties levied against the breach of the 18 week standard or any associated further fines for these patients.

69. National Month End Reporting Requirements

Information is provided monthly to the Department of Health (DH) on capturing and recording data on clock starts and, clock stops and on calculating RTT times.

All NHS Trusts submit RTT data to the DH via Unify, DH's online data collection system. This facilitates the collection of aggregate RTT data in a consistent way across the NHS.

Capture of RTT data in local IT systems, e.g., PAS, either through clinic outcome sheets or local business processes, should be timely enough to allow for a weekly submission of activity data to Unify to support RTT measurement.

70. Clinical Harm

The potential for Clinical Harm being caused due to long waits for patients must be managed effectively to reduce risk. The Trusts Clinical Harm Policy, which can be found on each individual Trust intranet, documents the process for managing this risk.

71. Training

RTT training is available to all staff who manage / facilitates any part of an a patient's 18 week pathway, to ensure accurate & timely data collection / recording to enable the Trust to meet the waiting time standards, and more importantly to ensure that patients are treated in a timely way. Each year all relevant staff will undergo compulsory refresher E-Learning training.

It is the responsibility of the Administration and Operational Managers to ensure all staff are fully compliant with RTT Training.

RTT Spot Check Audits will be undertaken, and it is the responsibility of the Administration managers to monitor audits and undertake remedial action where identified as necessary.

Please refer to the Trusts RTT Training Strategy for further information and guidance which can be found on the Trust Intranet.

72. Adherence to Policy

The Data Quality/Validation/Business Team and Operational Managers will routinely monitor the appropriate application of this policy. This will be achieved by:

- RTT Quality Audits
- Validation of RTT pathways for monthly performance reporting purposes and Ad hoc spot checks on themes or specialities
- Monitoring performance against the weekly / monthly Trust KPIs and performance reports and taking appropriate action where required

The Data Quality Strategy which can be found on the Trusts' intranet describes how the RTT Audit programme above is undertaken and how themes are identified across the Trust.

73. Associated Documentation

Useful information including examples of pathway scenarios are contained on the Trusts intranet and can be accessed by clicking here.

74. This Policy should be read in conjunction with the following policies:

- PAS Policies relating to job role
- Data Quality Policy
- Data Quality Strategy
- Referral *Policy*
- Cancer Policy
- Safe Haven Policy
- Confidentiality Policies
- Overseas Visitors Policy
- Clinical Threshold Policy
- RTT Training Strategy
- Clinical Harm Policy

75. Standard Operating Procedures (SOPs)

Please click on this link to find the associated SOP's. Use the index to find the guidance as required.

76. Definitions or Explanation of Terms Used

Active Monitoring HCP Initiated	A clock stop may apply where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage.
Active Monitoring Patient Initiated	Where a patient and a clinician agree the patients symptoms are not severe at the moment. The patient does not want treatment at this stage, a review appointment is agreed for x months and the patient is placed on Patient Initiated Active Monitoring. Patients may initiate the start of a period of active monitoring themselves (for example by choosing to decline treatment to see how they cope with their symptoms).
Admission	The act of admitting a patient for a day case or inpatient procedure.
Admitted Pathway	A pathway that ends in a clock stop for admission (day case/inpatient).
Bilateral Procedure	A procedure that is performed on both sides of the body, at matching anatomical sites i.e., Cataracts removed from both eyes.
Choose & Book (C&B) - See NHS e-Referral Service	Now known as NHS e-Referral Service - A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic.
Clinical Decision	A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning
Clock Stop	The date an RTT pathway stops
Consultant	A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. Consultant-led waiting times exclude non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.
Consultant Led	A Consultant retains overall clinical responsibility for the service, team or treatment. The Consultant will not necessarily be physically present for each appointment but takes overall clinical responsibility for the patient care.
Converts Unique Booking Reference Number (UBRN)	On the date the patient converts their UBRN and book an outpatient appointment via NHS e-Referral Service, is the start of an 18 week pathway.
Day Case	Patients who need to be admitted for a procedure but do not need to stay in hospital overnight.
Did Not Attend (DNA)	Where a patient fails to attend an appointment/admission without prior notice.
Decision to Admit	Where a clinical decision is taken to admit the patient for either a day case or inpatient procedure.
Decision to Treat	A clinical decision is taken to treat the patient on admitted or non-admitted pathway.
Earliest Reasonable Offer (ERO) – Admissions	For an elective admission this is the earliest reasonable offer for admission date and should be a date three of more weeks from the time that the offer was made (unless clinically inappropriate). If a patient mutually agrees a short notice appointment, then that appointment date becomes a reasonable offer.
Elective Booked (EB)	Patient awaiting elective admission and was given an admission date at the time of the decision to treat.
Elective Planned (EP) - Excluded from Active RTT Waiting List	Patients who are to be admitted as part of a planned sequence of treatment or investigation. The patient has been given a date, or approximate date at the time a decision to admit was made (target date). The date is set for clinical reasons (e.g., check cystoscopy) and there is no clinical advantage in admitting the patient earlier or when a child needs to be a certain age at the point the procedure takes place.

	Patients who go beyond their clinically determined treat by date should be clinically reviewed and where appropriate move to the active waiting list and an RTT clock should start.
Elective Waiting (EW)	A patient is added to a waiting list having been given no date of admission at the time the decision to admit was made.
Fit and Ready for a Bilateral Procedure	A new RTT clock should start once the patient is fit and ready for a subsequent bilateral procedure. In this context, fit and ready means that the clock should start from the date that it is clinically appropriate for the patient to undergo that procedure, and from when the patient says they are available
Fully Booked (FB)	The patient is given the opportunity to agree a mutually convenient appointment within one working day of the referral received date.
First Definitive Treatment	An intervention intended to manage a patient's disease, condition or injury to avoid further intervention. What constitutes first definitive treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.
Health Care Professional (HCP)	A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
Incomplete Pathway	Patients who are waiting for treatment and their RTT clock is still ticking.
Inpatient	Patients who need to come into hospital for treatment or investigations and who are expected to stay in hospital for at least one night.
Inter-Provider Transfer	Transferring a patient between one provider and another for diagnostic, treatment or advice. Any referral of a patient from one organisation to another should be accompanied by the IPTAMDS (Inter-Provider Transfer Administrative Minimum Data Set), whether this referral is through the NHS e-Referral Service or not. The IPTAMDS will provide the Patient Pathway Identifier (PPI) and the date of the consultant-led RTT clock start.
NHS e-Referral Service – formerly Choose and Book	A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic.
Non Admitted Pathway	A pathway that does not require an admission for diagnosis or treatment.
Outpatients	Patients referred to the hospital by a healthcare professional /GP for clinical advice or treatment in an outpatient setting.
Patient Thinking Time	Where a patient is giving 'Thinking Time' an agreed time scale is agreed between the patient and clinician, the RTT clock will continue to tick up to the point of the agreed timescale.
Patient Tracking List (PTL)	Patient Tracking List is a report used to ensure patients are managed and booked in turn according to their clinical priority. The report also ensures that the maximum waiting times standards are achieved by identifying all patients that will breach the current wait time's standards.
Planned Care	An appointment /procedure or series of appointments/ procedures as part of an agreed programme of care which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.
Reasonable Offer (RO)	An offer of a time and date three or more weeks from the time that the offer was made. If a patient agrees a short notice appointment of a date in less than three weeks, then that appointment date becomes a reasonable offer.
Referral to Treatment (RTT) Period	The part of a patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other clock stop.
Straight to Test	A specific type of direct access diagnostic service whereby a patient will be assessed and might, if appropriate, be treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional.
Substantively New or Different Treatment	Upon completion of a consultant-led referral to treatment period, a new waiting time clock starts upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.

	It is recognised that a patient's care often extends beyond the consultant-led referral to treatment period, and that there may be a number of planned treatments beyond first definitive treatment. However, where further treatment is required that was not already planned; a new waiting time clock should start at the point the decision to treat is made. Scenarios where this might apply include: • where less 'invasive/intensive' forms of treatment have been unsuccessful and more 'aggressive/intensive' treatment is required (e.g., where Intra Uterine Insemination (IUI) has been unsuccessful, and a decision is made to refer for IVF treatment); • Patients attending regular follow up outpatient appointments, where a decision is made to try a substantively new or different treatment. In this context, a change to the dosage of existing medication may not count as substantively new or different treatment, whereas a change to medication combined with a decision to refer the patient for therapy might. Ultimately, the decision about whether the treatment is substantively new or different from the patient's agreed care plan is one that must be made locally by a care professional in consultation with the patient.
To Come In Date (TCI)	The date of agreed admission for a procedure/treatment.
UBRN (Unique Booking Reference Number)	The reference number that a patient receives on their appointment request letter when generated by the referrer through the NHS e-Referral Service. The UBRN is used in conjunction with the patient password to make or change an appointment.
War Veterans	Are ex-service personnel who have served at least one day in the UK armed forces and have sustained injuries during that service.

77. Equality Impact Assessment

This policy has been screened to determine equality relevance for the following equality groups: race, gender, age, sexual orientation and religious groups. This policy is considered to have little or no equality relevance.

78. APPENDICES

APPENDIX A

Referral Information & Inter-Provider Minimum Data Set (IPTAMDS)

On making an RTT referral, the referrer must inform the patient that:

- They will be expected to attend agreed appointments or admission dates
- Patients should be advised to contact the Trust as soon as possible if there is any likelihood that they will not attend the appointment in order to use this appointment for another patient.
- Patients will be fast tracked to the most appropriate specialist who may be another Consultant or an appropriate specialist unless they specifically request to be seen by a particular consultant.
- An appointment may not be available at the patient's local site, dependent upon the services provided at that site, so an appointment at an alternative trust hospital site may be necessary.
- Patients should be ready and willing to receive treatment within the next 18 weeks from their referral.
- The referrer must notify the trust of the patient's eligibility for NHS care.
- The referrer has a responsibility to follow agreed referral pathways of those directed by commissioning and contractual arrangements. Referrals may be rejected if made inappropriately.

At the time of the referral the following information should be supplied:

- Patient demographics & contact address.
- NHS number (and hospital number identifier if known)
- Home, work and mobile telephone numbers wherever possible
- All relevant clinical information together with the referrer's assessment of the level of clinical urgency
- The patient's availability (as well as their willingness to be seen at short notice).
- For routine referrals, if it is known patients will be unavailable to be seen for a period of time, the referrer should delay the referral.
- Any relevant information regarding the patient's capacity or relevant information related to safeguarding.
- Wherever possible, referrals should be made electronically through NHS e-Referral Service (formerly Choose and Book (C&B).

Inter Provider Minimum Data Set (IPTAMDS)

Tertiary referrals, both internal and external must include the Inter Provider Minimum Data Set (IPTAMDS), thus allowing the receiving provider/specialty to report on the patient's pathway. This must include the clock start date, the Pathway ID Number (PID) and confirmation the patient has received no treatment for the condition they were referred for prior to the request of the transfer of care.

If a tertiary referral is submitted with conflicting 18 week IPTAMDS information, then the team member recording the referral must contact the department/hospital/Triage Centre and challenge the information. This process will ensure accurate recording of 18 week clock start information.

It is best practice for the RTT history to tell a story of the patient's journey, including activity attended, results requested, results received, and clock stops. There can be multiple clock starts and stop on one referral.

Patients on a 20 code showing on the incomplete report must be progressed through their pathway. This may involve checking diagnostic tests have been booked, attended, or reported. A follow up appointment may need to be booked to discuss a diagnosis or care plan or a letter may need to be typed confirming the test is clear and no follow up required, the patient is being discharged from our care.

Delays with progressing patients through their pathway can impact the ability to treat within 18 weeks.

Admin delays such as a typing back log can delay a clock stop being added in a timely manner, this could impact month end performance and 18 week submissions. All admin concerns which could impact 18 weeks must be escalated to Operational Managers as soon as possible so proactive measures can be taken.

3 codes must be validated to ensure the clock stop is valid; stopping a pathway too soon is not in the best interest of the patient. If the clock stop was added in error and corrected at a later date it could create a breach.

9 codes will be added following 3 codes, as per the sequence of RTT codes, again the RTT history should tell the story of the patient's pathway. Have we missed a new clock start in the pathway?

There can be multiple clock starts and stops on a patient's pathway, for further guidance please refer to clock stops/starts .

Please see the following page for the Trust Inter-Provider Administrative Data Transfer Proforma

Inter-Provider Administrative Data Transfer (also for Internal Referrals)
This excludes where an existing Tertiary Pro-forma exists. *Please complete all relevant fields*

Referring Organisation Code: **RM100**	Referring Specialty Code:
Referring Clinician:	Referring Clinician GMC Code:
Contact Name:	Contact Tel. No: Contact e-mail:
Patient Information	
Hospital No:	NHS No:
Surname:	Forename(s)
DOB:	Title:
Sex: Male ☐ Female ☐	Lead Contact: Patient ☐ Other ☐
BMI:	If Other, Name: & Relationship:
Address & Postcode:	Contact Home Tel:
	Contact Work Tel:
	Contact Mobile:
	Contact e-mail:
Registered GP Information	
Registered GP Name:	GP Practice Code:
Registered GP Tel. No:	

Referral Information

Is this patient on an 18 week pathway (on-going 18 week pathway at the point of requesting a transfer of care)?

YES	**Answer**
Latest RTT Code 21 or 20:	
Latest Clock start date:	
Date of decision to refer:	
Unique Pathway Identifier if appropriate:	
Pathway Identifier allocated by organisation:	
Is this referral for: A diagnostic test only? or Opinion only (with no view for treatment)?	☐ ☐
Reason for referral:	

NO	**Answer**
Latest RTT Code 3 or 9:	
Date patient was treated:	
Date of decision to refer:	
Is this referral for: A diagnostic test only? or Opinion only (with no view for treatment)?	☐ ☐
Reason for referral:	

Receiving Organisation details:	
Receiving Organisation Name:	
Receiving Organisation Code:	
Receiving Clinician (optional):	
Receiving Specialty Code:	Date data transfer sent:
For Receiving Organisation	Date Received:

Monitoring Compliance / Effectiveness Table				**Appendix B.**		
Element to be monitored *(For NHSLA documents this must include all Level 1 minimum requirements)*	***Lead Responsible for monitoring*** *(Title needed & name of individual where appropriate)*	***Monitoring Tool / Method of monitoring***	***Frequency of monitoring***	***Lead Responsible for developing action plan & acting on recommendations***	***Reporting arrangements*** *(Committee or group where monitoring results and action plan progress are reported to)*	***Sharing and disseminating lessons learned & recommended changes in practice as a result of monitoring compliance with this document***
Adherence to policy and the effective management of the referral to treatment pathway	Data Quality Manager	RTT Quality Audit Programme, KPI Reports, Weekly / monthly Performance Reports	Annual Audits Weekly / monthly via reports and PTL	DQ Manager Head of Business Support Services DGM's Service Managers Support Managers	Responsiveness & Performance Exec Sub Board	REG Information Governance Steering Group (ISSG) Trust Access Group (TAG)

Appendix C – Therapeutic Code Table

The clinical prioritisation programme was established in 2020 in response to COVID-19 and the increase in waiting lists and wait times, to support the prioritisation of waiting lists as part of elective activity recovery. All patients on, or added to, an admitted waiting list should be clinically prioritised:

- To support discussions with patients about their procedure.
- To support the booking of patients by priority.
- To give greater clarity about the number of patients awaiting procedures at each priority level.
- To inform service capacity planning.

Clinical prioritisation criteria for each elective speciality should be agreed by Clinical Leads following by guidance from respective Royal Colleges. These follow a standard format as detailed below:

P code	Booking timescale	Review timescale
P1a	Emergency procedures to be performed in <24 hours - **would not usually apply to patients awaiting elective admission**	
P1b	Procedures to be performed in <72 hours **- would not usually apply to patients awaiting elective admission**	
P2	Procedures to be performed in <1 month	1 month
P3	Procedures to be performed in <3 months	3 months
P4	Procedures to be performed in >3 months	6 months; patients waiting 104 weeks or more should be reviewed every 3 months as a minimum

Appendix D – Interim Operational Guidance
Management of patients on the waiting list choosing to decline offered treatment dates at current provider or alternative provider.

Key Points

- New patients should not be assigned the P6 category. C1 category should be used as appropriate.
- There are no changes to the existing Regulatory requirements.
- The movement of a patient to active monitoring must be agreed by the responsible clinician.
- Patients in both categories for which active monitoring is deemed to be appropriate should be recorded with an RTT status outcome code 32 (Start of active monitoring – Hospital).
- It is the responsibility of each provider to establish robust processes to locally record those patients who have been placed in activity monitoring, including the start date of that period and the end date of the period.
- It is the responsibility of each provider to provide patients who have been placed on active monitoring with the contact point should they wish to be reinstated on the waiting list during the active monitoring period.
- If the patient has not made contact with the hospital to be reinstated on the waiting list either during or at the end of the active monitoring period the hospital should contact the patient in a timely period to determine the next steps.

Interim Choice Guidance Document - DHSC