BNSSG Elective Care Access Policy

- North Bristol Hospitals NHS Trust
- University Hospitals Bristol NHS Foundation Trust
- Weston Area Health NHS Trust
- NHS Bristol CCG
- NHS North Somerset CCG
- NHS South Gloucestershire CCG
- Other providers of elective care (e.g. AQP and ISTC)

Version 9.0: 1st July 2016 **Review Date: 1st July 2017**

APPROVALS

ORGANISATION	DATE	NAME	DESIGNATION	SIGNATURE
Bristol CCG				
South Glos CCG				
North Somerset CCG				
UH Bristol NHS Trust				
North Bristol Trust				
Weston Area Health NHS Trust				

VERSION HISTORY

VERSION	DATE	AMENDMENTS
Draft 1.0	10.07.14	
Draft 1.1	31.07.14	
Draft 1.2	07.08.14	Agreed changes and comments from the meeting held on 7th August 2014 between commissioners and acute Trust providers.
Draft 3.0	12.09.14	Cancer added to main document
Draft 4.0		
Draft 5.0	30.09.14	Final Draft incorporating comments following 2nd working group meet held 25th September 2014.
6.0	22.10.14	
7.0	15.02.16	Refresh following publication of two national DoH document's: - - 'National Cancer Waiting Times Monitoring Dataset Guidance – Version 9.0' - 'Referral to Treatment consultant led waiting times'. The BNSSG 'Non GP referral policy' has been reviewed and incorporated.
8.0	01.04.16	Outputs of consultation with providers, CCGs and Local Medical Committee (LMC) are recognised in this refresh.
9.0	15.04.16	IMAS review. Updates assert requirement for ensuring actions are in the clinical best interests e.g. DNA discharge

CONTENTS

Section One
General Principles

1) STATEMENT OF INTENT

All organisations within this BNSSG Access Policy are united in their commitment as a Local Health Economy (LHE) to ensure patients receive treatment in accordance with national standards and objectives. The purpose of this policy is to outline the LHE's expectations and requirements in terms of managing patients referred into elective non urgent care pathways.

2) SCOPE OF POLICY

This policy applies to the principles and procedures for the management of the different groups of patients encompassing elective pathways. These are 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 on a cancer pathway**
- **Patients who have been referred for a diagnostic investigation either by their GP or by a clinician**

3) STRUCTURE OF POLICY

The policy is structured in such a way which makes it easy to navigate in both hard copy and electronically. Where a separate Standard Operating Procedure (SOP) or document is referenced, a hyperlink will be shown allowing the reader to be taken directly to it if desired. The principles within the policy are applicable across all organisations comprising the Pan Bristol area, as detailed on the covering page. SOPs are generally specific to each organisation so there may be a number of different versions. The policy is split into the following five sections:

1. **General Principles**

2. **Pathway Specific Principles – following a logical chronological patient journey. Where there is a Standard Operating Procedure (SOP) providing a detailed process to be followed at a given stage, this is referenced at the relevant point. Readers can either click on the link taking them to the SOP or turn to the back of the Access Policy where they are listed as appendices**

3. **Cancer Pathways and SOPs which follow the same format as Pathway Specific Principles.**

4. **Reference Information**

5. **Standard Operating Procedures**

4) KEY POLICY PRINICPLES

a) This policy covers the way in which BNSSG will collectively manage administration for patients who are waiting for or undergoing treatment on an RTT pathway.

b) As set out in both Everyone Counts and the NHS Constitution, patients have the right to start consultant led treatment within maximum waiting times. The policies and procedures comprising this policy adhere to national best practice and provide a framework to ensure that patients are treated transparently, fairly and reasonably.

c) Trusts will give priority to clinically urgent patients and treat everyone else in turn.

d) Trusts will work to meet and better the maximum waiting times set by NHS England for all groups of patients.

e) Trusts will at all times negotiate appointment and admission dates and times with patients.

f) Trusts will work to ensure fair and equal access to services for all patients.

g) Cancer patients are expected to be managed to the RTT guidance laid out in this document, supported and overridden by specific cancer guidance laid out in section 3.

5) ROLES & RESPONSIBILITIES

a) BNSSG

The Local Health Economy is collectively responsible for the production, review and revision of this policy on at least an annual basis. All organisations will have a designated lead in this respect.

b) Clinical Commissioning Groups

I. Promote the rights and pledges enshrined in The NHS Constitution (2013)
II. Develop and manage the local health market to provide plurality and patient choice;
III. Ensure that all patients needing planned elective care are offered clinically appropriate choices of provider;
IV. Ensure that patients are treated within clinically appropriate, commissioned pathways and maximum treatment times.

c) Referrers Responsibilities

I. Ensure that the patient is clinically suitable for their referral and intended pathway of care;

II. Ensure that the patient is prepared to be treated within the maximum *Referral to Treatment* times;

III. Initiate the referral through the use of the NHS eReferral Service, identify clinically appropriate services for the patients, and discussing all locations available at the provider(s) of the patient's choice;

IV. Provide the national minimum core data set when transferring care to another provider;

V. Ensure that where appropriate, funding for interventions not normally funded has been obtained prior to referral.

d) Trusts

i) Chief Executives / Chief Operating Officers

Chief Executive Officers (CEOs) and Chief Operating Officers (COOs) have overall responsibility for the implementation of this policy and board level accountability for the delivery of elective access standards. COOs are responsible for ensuring the delivery of targets and monitoring compliance of elective access standards.

ii) Clinicians

Clinicians have a responsibility for adhering to key internal procedures in the proactive management of patients along their RTT journey. Key examples are the timely and accurate completion of the clinic outcome form and swift review of referrals.

iii) General Managers / Operational Managers

General Managers and Operational Managers are responsible for ensuring that staff are fully trained / competent in and performance managed against the principles and associated SOPs relevant to their role.

iv) Administration Staff

All administration staff must abide by the principles in this policy and the supporting standard operating procedures;

v) Patients

- Attend agreed appointments and give sufficient notice in the event of the need to change agreed date and time;

- Make every effort to accept an available appointment;
- Respond to hospital communications in a timely manner;
- Communicate immediately to the hospital or general practitioner if treatment and/or appointments are no longer required;
- Consider the choice options that are available to them;
- Immediately communicate to the hospital and general practitioner any changes in personal contact details.

6) NATIONAL ELECTIVE CARE STANDARDS

The table below provides the current national care elective standards.

Referral to Treatment	
Incomplete Pathways	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 the following diagnostic investigations	99% of patients to undergo the relevant diagnostic investigation within 6 weeks (or 41 days) from the date of decision to refer to appointment date
Cancer	
Two Week Wait Urgent Suspected Cancer Referral	• 93% of patients to be seen within two weeks of an urgent GP referral for suspected cancer • 93% of patients to be seen within two weeks of a GP referral with breast symptoms (where cancer is not suspected)
Decision to Treat to Treatment (31 Day Wait)	• 96% of patients to receive their first definitive treatment for cancer within 31 days of the decision to treat • 94% of patients to receive subsequent treatment for cancer within 31 days of the decision to treat/earliest clinically appropriate date to start a second or subsequent treatment where that treatment is surgery • 98% of patients to receive subsequent treatment for cancer within 31 days of the decision to treat/earliest clinically appropriate date to start a second or subsequent treatment where that treatment is an anti-cancer drug regime • 94% of patients to receive subsequent treatment for cancer within 31 days of the decision to treat/earliest clinically appropriate date to start a second or subsequent treatment where that treatment is a course of radiotherapy

	• Maximum wait of 31 days from urgent GP referral to first treatment for children's cancer, testicular cancer and acute leukaemia - no performance measure set for this – monitoring as a part of the 62 day wait for first treatment
62 day cancer (referral to treatment)	• 85% of patients to receive their first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer • 90% of patients to receive their first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service (breast, bowel and cervical) • Maximum wait of 62 days for patients to receive their first definitive treatment for cancer where their consultant has upgraded their referral to urgent – no national performance measure set for this at present but a local performance measure of 85% has been set

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

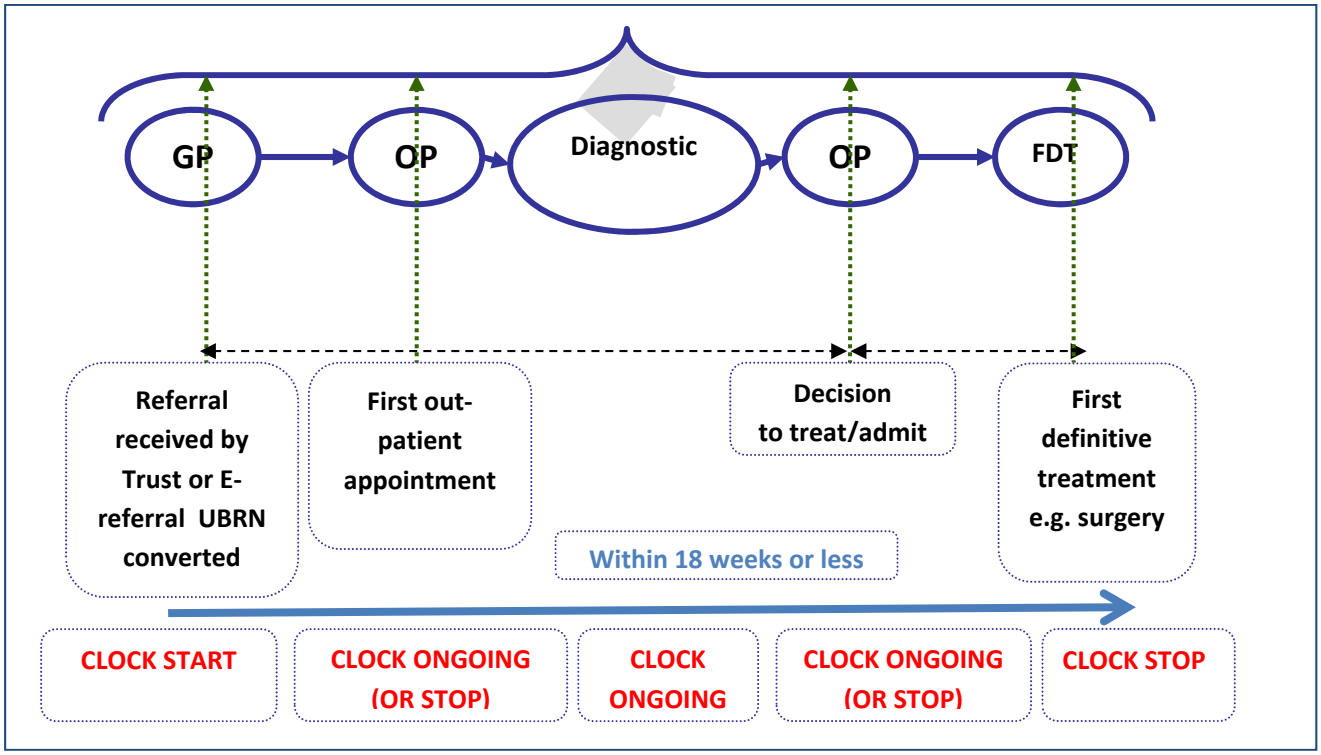
a) Exceptions – applicable to RTT pathways where it is in the patient's best clinical interest to receive treatment past 18 weeks.

b) Choice – applicable where patients choose to extend their pathways via rescheduling previously agreed appointment dates or admission offers

c) Co-operation – applicable where patients do not attend previously agreed appointment or admission date

7) OVERVIEW OF NATIONAL RTT RULES

The full national RTT rules suite can be accessed by clicking here. Detailed local application of the rules is provided in the standard operating procedures within section five at the end of this policy. An overview of the rules however is shown using the diagram and narrative below.



a) Clock Starts

The RTT clock starts when:

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

- A referral is received into an interface or referral management assessment centre which may result in an onward referral to a consultant led service before clinical responsibility is transferred back to the referrer.
- A patient self refers into a consultant led service for pre-agreed services agreed by providers and commissioners.

b) Clock Stops

The RTT clock stops upon first definitive treatment (FDT), if a decision is made that treatment is not required or if the patient declines treatment. FDT is defined as:-

An intervention intended to manage the patient's condition, disease or injury to avoid further intervention.

If a patient requires a procedure or surgery as a day case or inpatient, the clock stops upon admission. If the patient's treatment is medication prescribed in outpatients or if a decision not to treat is made in outpatients, this information is captured on the Clinic Outcome Form (COF) or directly in the PAS. There may also be occasions where a decision not to treat is made in an 'ad hoc' setting, for example following review of diagnostic results by a clinician in the office.

Clock stops such as these must also be captured in the Provider's PAS. A full list of clock starts and stops is documented in appendix 3

c) Patients Who Do Not Attend (DNA)

These rules are applicable only if the patient has had a reasonable offer of an appointment or admission date.

i) First Appointment Following Initial Referral

If a patient DNAs their first appointment following the initial referral which started their RTT clock, their RTT clock should be nullified (i.e. not stopped and reported).

Should the patient be offered another date, a new RTT clock will start on the date that the patient agrees their appointment. For example, if the patient DNA's an appointment on 4th July and a conversation with the patient happens on 7th July to agree another appointment for 18th July, the new clock starts on 7th July.

ii) Any Other Outpatient Appointment, Diagnostic Appointment or Admission Along the Patient's Pathway

- If the patient is offered another appointment / admission date – the RTT clock continues.
- If the patient is discharged back to GP – the RTT clock stops (following confirmation that it is not contrary to the patient's clinical interests).

d) Patient Reschedules of Outpatient & Diagnostic Appointments

If a patient chooses to reschedule their outpatient or diagnostic appointment, their RTT clock should continue to tick, even if they wish to reschedule their first appointment following initial referral.

e) Patient Reschedules of Admission Dates

If a patient has previously agreed to a reasonable admission (i.e. three weeks' notice and a choice of two dates) offer which they subsequently wish to change, the cancellation does not stop the RTT clock. However, as part of the rebooking process, the patient should be offered alternative dates for admission.

f) Active Monitoring

Active monitoring is where a decision is made that the patient does not require any form of treatment currently but is to be monitored in secondary care. When a decision to commence a period of active monitoring is made and communicated with the patient, the RTT clock stops. Stopping a 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.

8) PATHWAY MILESTONES

The agreement and measurement of performance against pathway specific milestones is an important aspect of successful RTT sustainability. 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 should occur:

- First outpatient appointment
- Treatment decision
- Treatment

Trusts will aim to identify and work to set timescales for each 'stage of treatment' by speciality as best practice identifies. If urgent, timescales will be clinically appropriate.

9) INTERVENTIONS NOT NORMALLY FUNDED (INNF)

INNF Guidance must be adhered to – any procedures undertaken without prior funding authorisation, will not be authorised by the Commissioners.. In these circumstances the 18 week clock will begin when the GP proceeds to make a formal referral, either with or without funding approval having been secured at the outset.

The majority of treatments or conditions require funding approval to be secured prior to referral to secondary care for assessment and treatment. There is however a small number of specialist treatments as set out on the INNF list where funding approval can only be sought by a secondary care Consultant. In these cases, the 18 week clock will not stop whilst funding approval is sought from the Commissioner."

The current list of INNF Procedures can be found here.

10) ACCESS TO HEALTH SERVICES FOR MILITARY VETERANS

In line with December 2007 guidance from the Department of Health all veterans and war pensioners should receive priority access to NHS care for any conditions which are related to their service subject to the clinical needs of all patients. Military veterans should not need first to have applied and become eligible for a war pension before receiving priority treatment. GPs should notify the Trust of the patient's condition and its relation to military service when they refer the patient so that the Trust can ensure that it meets the current guidance for priority service over other patients with the same level of clinical need. In line with clinical policy patients with more urgent clinical needs will continue to receive clinical priority.

11) PRIVATE PATIENTS

If a patient has been seen privately, and wishes to be treated at one of the Pan Bristol Trusts, by the same consultant as an NHS Patient, the patient must first obtain an NHS referral letter from their GP or referring consultant. On receipt of this letter the patient may then be treated as a new referral in outpatients or placed on a waiting list for investigations or treatment but will be treated according to their NHS medical priority. The RTT clock starts at receipt of referral to the NHS.

12) OVERSEAS PATIENTS

Trust will ensure they assess patient's eligibility for NHS care in line with the Guidance on implanting the overseas visitor's hospital charging regulations available here

13) VULNERABLE PATIENTS

It is essential that patients who are vulnerable for whatever reason have their needs identified at the point of referral. This group of patients might include but is not restricted to:

a) Patients with learning difficulties or psychiatric problems;
b) Patients with physical disabilities or mobility problems;
c) Elderly patients who require community care;

d) Children (as defined in The Children Act (2004)[1] – see Footnote1 below.

14) COMMUNICATION WITH PATIENTS

The rules and principles within which the LHE will operate to deliver elective care to all patients; whether they be urgent suspected cancer referrals, 18 week pathway patients or patients on planned waiting lists; must be made clear and transparent to patients at each stage of their pathway. All communications with patients whether verbal or written must be informative, clear and concise.

A key principle for RTT is that patients are explicitly made aware of the implications on their RTT wait should they choose to delay their treatment, either through cancellation of appointments, declining TCI offers or non-attendance.

Commissioners and providers will need to be able to demonstrate (to an auditor or the CQC or in the event of a patient complaint) that cases that take longer than 18 weeks to reach the start of first definitive treatment are legitimate exceptions.

Providers will ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate (Accessible Information Standard 2015)

15) ELECTIVE CARE GOVERNANCE STRUCTURE

Providers and commissioning organisations will ensure they have robust Board level reporting of RTT and suitable organisational structures beneath to support management, delivery and escalation reporting and action as required.

16) INFORMATION, MONITORING & REPORTING

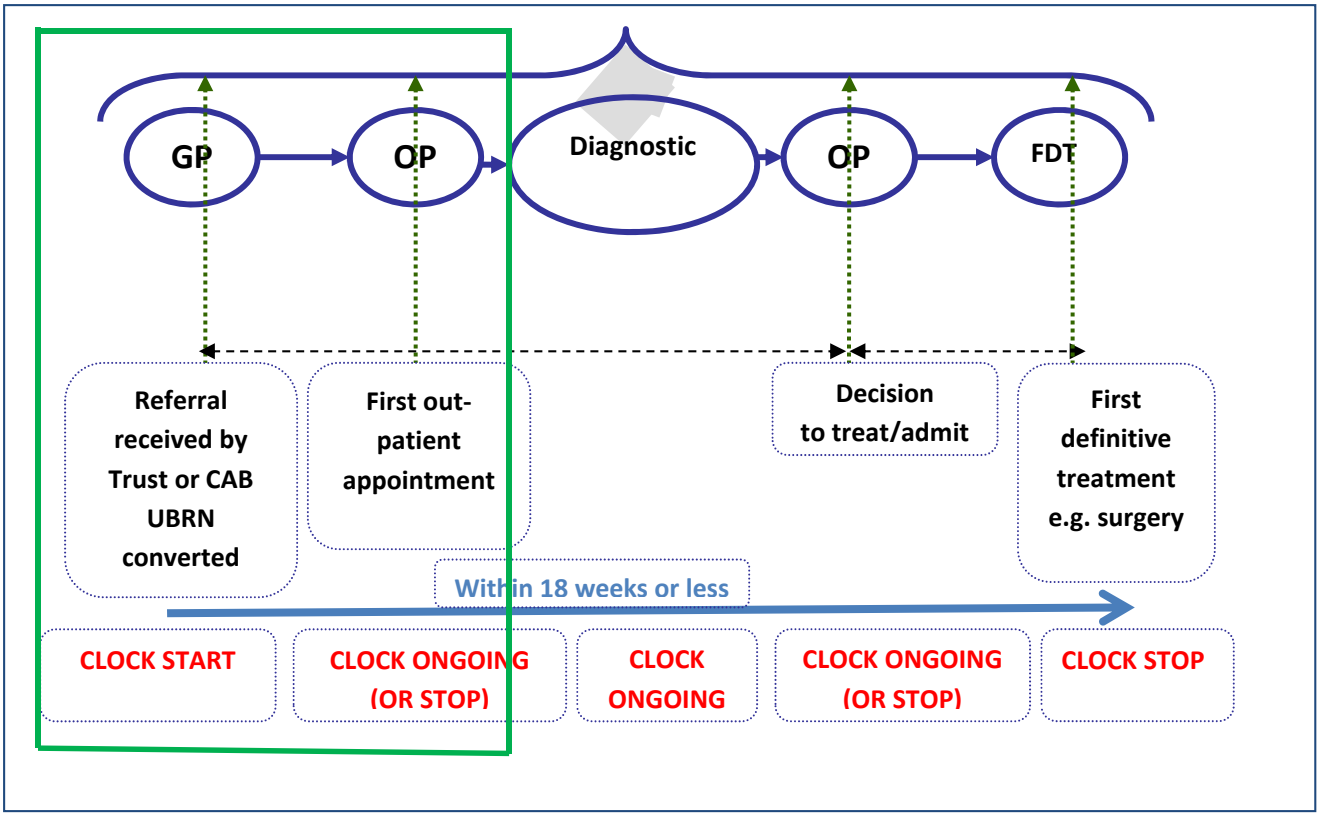
a) RTT monitoring and reporting will be managed through the information schedule of provider's acute contract. In addition other statutory returns to NHS England and monitor will be provided as required.

b) Providers will ensure robust systemic governance of data quality is in place with clear work plans, reporting and escalation.

[1] 1 The Children's Act defines children as any person under the age of 18 and in addition a person 18, 19, or 20 who; (a) has been looked after by a local authority at any time after attaining an age of 16; or (b) has a learning disability. A person is "looked after by a local authority" if: (a) for the purpose of the Children Act 1989 (c.41), they are looked after by a local authority in England and Wales; "learning disability" means a state of arrested or incomplete development of mind, which induces significant impairment of intelligence and social functioning.

Section Two
Pathway Specific Principles

Section 2 a) Referral, Outpatient Booking and Appointments



17) REFERRAL MANAGEMENT

a) Pre Requisites Prior to Referral

i) **Primary Care**

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

ii) **Secondary Care**

It is the responsibility of the management teams in conjunction with clinicians to ensure that the Directory of Services (DoS) is up to date in terms of the service specific criteria and that clinics are mapped to the relevant services. This gives the best chance of the patient being booked into the correct clinic at the first visit and reduces the rejection rate.

b) Referral Sources

i) General Practitioners

The vast majority of referrals should be made from primary to secondary Care (GP to consultant) for the following reasons:

- To maximise the choice opportunities for patients in terms of provider, date and time of appointment.

- To contribute to the management of secondary care capacity by ensuring only those genuinely needing secondary care receive it, and in a more timely way as part of an RTT pathway.

ii) Non GP Referrals

- When a consultant or member of their team decides that the opinion of another consultant/service should be sought, for all routine patients he/she can refer when: -

    - The referral is for the same presentation/symptom as the originating GP referral
    - The patient is on a suspected cancer pathway
    - The referral prevents an urgent admission

If the referral is asking for an opinion about a different condition, he/she shall write back to the referring GP detailing this opinion so that the patient and their GP can agree a further management.

iii) External Consultant to Consultant Referrals / Inter Provider Transfers

Referrals to other providers must be accompanied by the national Inter-Provider Transfer Administrative Minimum Dataset (IPTAMDS). All fields must be completed as fully as possible. Although primarily designed to help monitor patients on Referral to Treatment Time pathways, the IPTAMDS should accompany all inter-provider referrals, such as requests for diagnostic tests and referrals back to originating Trusts following treatment.

Patients Referred from Other Providers (including Primary Care Interface Services) should be accompanied by a completed IPTAMDS (Appendix 1). Where the IPTAMDS does not accompany the referral it may follow within 48 hours.
Whether an IPTAMDS is received or not, the identity of the referring Trust and Referral to Treatment Time information must be recorded as per the Standard Operating Procedures.

iv) **Referral Management Centres (RMC)**

A variety of RMCs exist across BNSSG to support triage of referrals, signposting of new services or attractive waiting times to patients. To ensure RMCs can successfully support referral processes, referrers must ensure a full data set is provided when referring. In addition all referrals on an RTT pathway will start the RTT clock at the point the referral is received by the RMC, who will then share this date with any onward referral.

c) Referral Methods

The LHE jointly supports and is working towards all referrals being made directly via NHS eReferral Service. Faxed referrals on the appropriate pro-forma will be accepted where this is an agreed process for a provider to receive faxes (e.g. Rapid Access Chest Pain (RACP)). Faxed referrals for any other patients will be returned back to the referring GP as inappropriate.

There are currently three recognised methods of referral for non cancer referrals as described below (see Section Three for Cancer Referral Methods).

i) **E-referrals**

Trusts will endeavour to give patients their choice of site within the Trust but as a single provider, patient appointments may be offered a different site if appropriate treatment is available. If patients choose to wait for a particular site or consultant, the implications on their overall RTT wait for treatment should be clearly explained to them. If this subsequently causes the patient to wait more than 18 weeks for treatment, this will be accounted for within the operational tolerances.

- **Directly Bookable Services**

Directly Bookable Services (DBS) via eRS enables the GP to book a first outpatient appointment slot while their patient is in the surgery, or will give the patient a Unique Booking Reference Number (UBRN) and a password so the patient can use The Appointment Line (TAL) or go online to book a slot at the hospital of their choice. Trusts will ensure that sufficient capacity is available for patients to directly book their first appointment. Patients who have been directly booked will have a referral automatically created on PAS by the E-Referrals software and the RTT clock start will be automatically triggered from the referral received date on PAS i.e. when the patient first attemts to book their appointment.

Exceptions to this are where the patient has experienced an Appointment Slot Issue (see section 18b) where the clock starts at the point that the patient attempts to book directly and a slot issue is experienced, or when the referral has been sent on from a Primary Care Interface Service, when the referral should be treated as an Inter-Provider Transfer.

- **Indirectly Bookable Services**

  GP referrals that have been booked under the Indirect Booking rules will need to have a referral added to PAS at the point of which the patient contacts the hospital to arrange their appointment. The referral received date (i.e. the RTT clock start date) must be the date at which the patient has contacted the hospital, unless referred through a Primary Care Interface Service.

ii) **Paper Based Referrals**

- All paper based referrals should be sent to a designated centralised location within each provider.
- Upon receipt of paper based referrals, the date of receipt should be clearly and permanently marked. This date is the RTT clock start date.

iii) Fax and Email Referrals

Referrals can be faxed or emailed when either of the above referral processes should be operationally interrupted. Providers and CCGs will communicate to all when and how these alternative referral mechanisms will be made available and will only occur in very limited circumstances.

d) **Referral Criteria / Minimum Data Sets**

i) The referrer is responsible for ensuring that the referral letter contains the essential minimum data set (Appendix 2). This includes but is not limited to the patient's NHS number, full patient demographics and including a day, evening and mobile telephone number that the patient would like to be contacted on as well as sufficient clinical data to enable the appropriate appointment to be made. The letter should also state the patient's current drug regime, clinical question to be answered and significant past medical history.

ii) Referrals should be addressed to a speciality rather than a named consultant and the patient will be offered an appointment with the consultant with the shortest waiting time. Named referrals will be allocated to the relevant consultant but if they do not have sufficient capacity to accept the referral then a decision will be made in conjunction with the consultant and the speciality operational / service manager 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 consultant they had requested.

e) **Clinical Triage / Review of Referrals**

i) Clinical triage will be undertaken in services where triage adds value to ensuring patients are received by the most clinically appropriate service. All referrals should be triaged to ensure clinical suitability, unless there are clear guidelines and evidence that demonstrates patients are all typically referred correctly first time.

18) FIRST APPOINTMENT

A reasonable offer for outpatients and diagnostics is an offer of a date and time three or more weeks from the time that the offer was made at any of the Trust's sites. Should a patient accept an appointment less than three weeks into the future, this becomes a reasonable offer.

Patients should be appointed firstly by their clinical priority (i.e. urgent patients first) and then within chronological order of their RTT clock start date.

a) Booking appointments via the NHS eReferral Service

Patients who do not book their appointment while with their GP can telephone the Appointments Line or go online to make their appointment using their Unique Booking Reference Number and password.

It is essential the sufficient appointment capacity is available to book patients within their clinical priorities and specialty specific milestones for first appointments.

b) Appointment Slot Issues (ASIs)

If booking via eRS is not possible due to lack of capacity, the UBRN will be directed to the Trust via the 'Defer to Provider' function on the eReferral Service for local management to resolve. This is referred to as an ASI. The RTT clock is ticking from the point at which the patient attempted to book their appointment even though they will not be visible on the Trust's patient administration system at this point. Appointment staff will then call the patient to offer an appointment within two working days for those clinically categorised as urgent and 5 working days for routine.

ASIs result in a poor patient experience and time consuming administrative workarounds. Sufficient capacity must therefore be made available via eRS to ensure patients can book directly into services. This is the responsibility of the operational / service management team responsible for the speciality.

c) Paper Based Referrals

i. **Urgent Referrals**

Urgent patients that are referred via the paper referral process will be placed on the outpatient waiting list and should be contacted via the telephone within one working day of receipt of referral to agree an appointment date. A letter should be sent to confirm the appointment which must also include details of how to cancel and reschedule appointments.

II. Routine Referrals

Routine patients that are referred via the paper referral process will be placed on the outpatient waiting list and will either be sent an invitation to call letter in order to book their appointment within pathway specific milestones, or appointments staff will contact the patient.

Patients should be offered a choice of dates and an appointment made which is mutually convenient. The patient's details including daytime contact number must be checked and corrected at this time and all appointment offers must be recorded on PAS. A letter should be sent to confirm the appointment, which must also include details of how to cancel and reschedule appointments.

If the patient fails to call within 14 days of the letter being sent out and all reasonable attempts have been made to contact the patient to agree an appointment, the outpatient waiting list entry is removed. A letter is sent to the patient's GP and the referral is closed. The code for the patient RTT pathway will be 'patient declined treatment'.

Where a patient is referred to a pooled service, they are to be offered an appointment with the consultant with the shortest waiting time.

19) HOSPITAL INITIATED APPOINTMENT CHANGES

a) In the event of a hospital initiated cancellation, the patient's RTT clock continues to tick from the original referred received date.

b) The patient will be contacted to arrange an alternative appointment date and time. Both an apology and a reason for cancellation will be given. The Trust will make every effort to ensure that they do not cancel patient's appointments.

c) If the cancellation is within two weeks of the appointment date, the patient will be informed of the cancellation by telephone.

20) PATIENT INITIATED APPOINTMENT CANCELLATIONS

Patients who wish to cancel their appointment and do not require a further appointment or treatment at any stage of a pathway should be removed from the waiting list, their RTT clock stopped and a letter should be sent to the patient and their GP confirming their decision.

21) PATIENT INITIATED APPOINTMENT CHANGES

Patients will have the opportunity to cancel or rearrange appointments during their pathway. The RTT clock continues to tick during the appointment reschedule but will be stopped if the patient is being discharged back to their GP. This should only happen if in the clinical best interests of the patient as determined by the hospital clinical lead.

22) CLINIC ATTENDANCE

a) Arrival of Patients

i) Patient demographic details should be checked at every clinic attendance and amended as necessary on the Trust's PAS system. The status of overseas visitors will be checked at this time. The relevant manager must be notified where it is suspected that there is an overseas visitor.

ii) All patients must have an attendance / arrival status recorded, i.e. Attended or Did Not Attend.

b) Clinic Outcomes

i) All patients must have an outcome (e.g. follow up, discharge or add to elective waiting list) and an updated RTT status record on the clinic on PAS. This includes patients who have already started treatment and have had a previous clock stop as they may need to start a new clock due to a new treatment plan or continue being monitored.

ii) The vast majority of non-admitted RTT performance is derived from the data transferred to PAS from the COF so it is critical that the data is recorded in an accurate and timely manner.

c) Follow Up Appointments

i) Patients who require an appointment within six weeks should be fully booked as they leave the outpatient appointment.

ii) Patients, who require an outpatient follow up appointment in more than six weeks' time, will be appointed e.g. pending list/partial booking waiting list.

Where clinically agreed, patients can be allocated a Patient Initiated Follow Up (PIFU) for up to 1 year, after which time the patient will be discharged back to their GP. This is intended as an alternative to a 12 month follow up appointment, empowering the patient to access a service at the point of need. (NB: this does not replace clinically determined 12 month follow up appointments).

23) DID NOT ATTENDS (DNAS)

a) Any patient who does not attend their agreed appointment (new or follow up) will be discharged back to the care of their GP. Both patient and GP will be notified of this in writing to ensure the referring GP is aware and can action further management of the patient if necessary. The patient's RTT clock will be stopped. Exceptions to this are:

i) when a clinical decision is taken that discharging the patient is contrary to the patient's clinical interests;

ii) clinically very urgent referrals including cancer, or active surveillance for cancer, rapid access chest pain, and other critical illnesses;

iii) Children of 18 years and under or vulnerable adults (See Footnote2 below[2]).

iv) When one of the following can be confirmed:-
   a. The appointment was sent to the incorrect patient address
   b. The appointment was not offered with reasonable notice

b) Where circumstances were beyond the patient's control, the Trust will endeavour to be as flexible as possible. The patient must first be contacted to ascertain the reasons for DNA and ensure compliance to attend a rescheduled appointment.

c) For paediatric patients after the reason for a DNA has been established, this should be documented in the health records. A further appointment needs to be offered to the patient and the importance of attendance needs to be reiterated to the parent / carer. If there are any safeguarding concerns about a child or young person under the age of 18 years further guidance should be sought from the relevant Trust policy or safeguarding lead.

[2] The Children's Act defines children as any person under the age of 18 and in addition a person 18, 19, or 20 who; (a) has been looked after by a local authority at any time after attaining an age of 16; or (b) has a learning disability. A person is "looked after by a local authority" if: (a) for the purpose of the Children Act 1989 (c.41), they are looked after by a local authority in England and Wales; "learning disability" means a state of arrested or incomplete development of mind, which induces significant impairment of intelligence and social functioning.

d) If a patient DNAs their first appointment following the initial referral which started their RTT clock, their RTT clock should be nullified (i.e. not stopped and reported).

Should the patient be offered another date, a new RTT clock will start on the date that the patient agrees their appointment. For example, if the patient DNA's an appointment on 4th July and a conversation with the patient happens on 7th July to agree another appointment for 18th July, the new clock starts on 7th July.

e) If a patient DNAs a subsequent appointment their RTT clock should be nullified (i.e. not stopped and reported). Should the patient be offered another date the RTT clock continues and cannot be paused.

24) CLINIC MANAGEMENT

a) **Ad Hoc Clinic Cancellation & Reductions**

i) Consultants, medical staff and other health professional staff must give at least six weeks' notice of annual leave. Where this is not given, the Consultants team or alternative health professional should make every effort to cover the clinic. Leave should be given as early as possible to minimise the effect on clinics.

ii) The Trust is committed to offering certainty to patients as well as choice in arranging care. As such, every effort will be made to avoid cancelling patient's appointments. Every effort will be made to backfill absent clinicians by the speciality. Cancellation will be a last resort.

iii) Clinics should not be cancelled or reduced for any purpose unless there are exceptional circumstances.

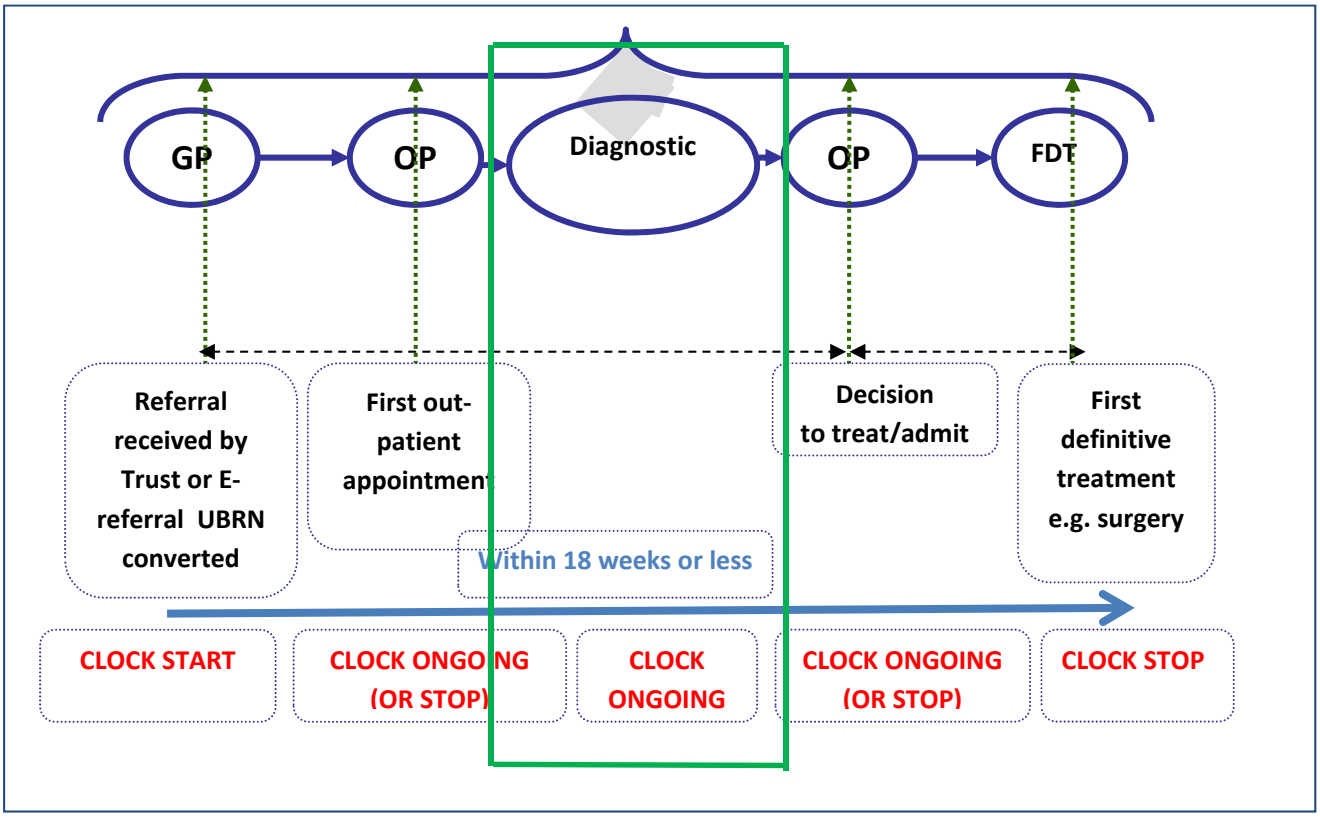
b) **Outpatient Clinic Capacity**

Providers should systematically undertake a review of clinic templates and room capacity to ensure they are aligned to demand (contracted activity).

Section 2 b) Diagnostic Pathways

The section within the border on the diagram below represents the diagnostic stage of the RTT pathway. It starts at the point of a decision to refer and ends upon the diagnostic procedure being reported on.

The diagnostic stage of the pathway can see patients start an RTT clock, continue on an RTT pathway, or not be on a RTT pathway should the GP retain responsibility for the patients care.



The following pages detail the agreed diagnostic policies and principles.

25) DIAGNOSTIC PATIENTS ON RTT PATWHAYS

a) Where a patient is referred for a diagnostic test to take place, the principles and policies within section 23 did not attends (DNA's) should be adhered to in terms of booking, cancellation and DNAs.

b) Some diagnostic tests will be undertaken on an admitted basis.

c) Patients who are referred for diagnostics as part of an RTT pathways need also to be seen within the current diagnostic waiting time.

d) Providers will work to establish one-stop appointments with outpatient and diagnostic elements occurring concurrently wherever clinically appropriate.

26) SUBSEQUENT DIAGNOSTICS

Where the patient has received first definitive treatment for a condition they were referred for and subsequent new treatment plan is agreed following the result of a 'check' diagnostic, a new RTT should commence.

27) STRAIGHT TO TEST

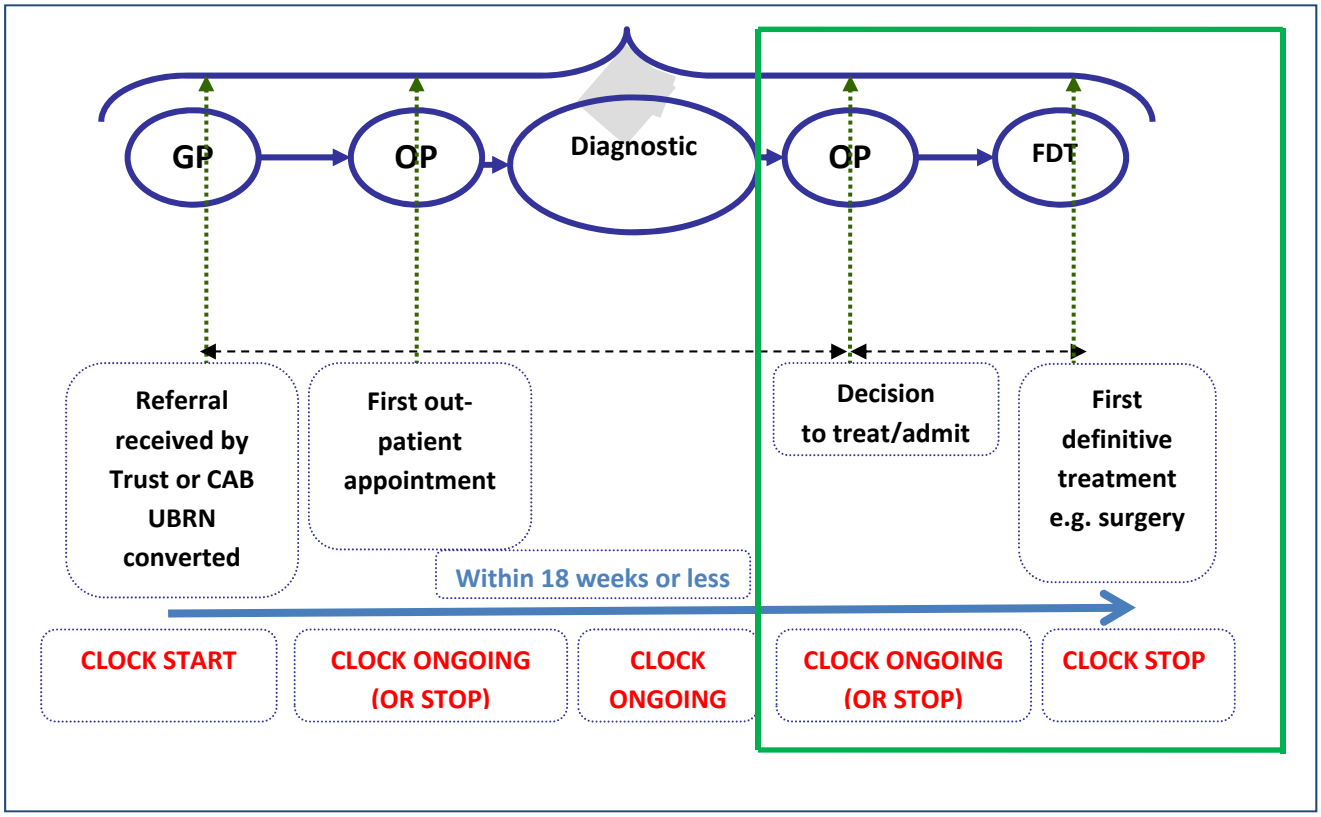
An RTT pathway starts when a GP refers a patient straight to test as the first step in a commissioned pathway. For example, where a consultant-led outpatient or pre-op appointment is the next commissioned step. This ensures by the time the patient attends their first OP appointment, they will have already had the test and the results can then be discussed at the OP appointment. In such instances, the RTT clock starts on the date that the provider receives the referral.

28) DIRECT ACCESS

Where a GP refers a patient for a diagnostic test but retains clinical responsibility for the patient and makes a decision regarding referral on the basis of the results; this does NOT constitute an RTT pathway. An RTT clock only commences if the GP subsequently makes a referral to a consultant led service.

SECTION 2 C) DECISION TO ADMIT

The section within the border on the diagram below represents the admitted stage of the pathway. It starts at the point of a decision to admit and ends upon admission for first definitive treatment.



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

a) **There is a sound clinical indication for surgery**

b) **The patient is clinically fit, ready and available to undergo surgery.** Patients who are added 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.

c) **The intended procedure is not on the INNF which should only be carried out with prior agreement from the CCG.** A number of procedures have been deemed low priority by the CCGs and therefore Interventions Not Normally Funded (INNF). For these procedures there must be evidence that the correct pathway has been followed and an approved prior approval form must have been received. It is the responsibility of the management team in the specialty where the surgeon works to gain prior approval for the procedure. Turnaround times for prior apporaval

decisions are guaranteed and detailed in the IFR Policy . All patients must be added to the waiting list at the time a Decision to Treat is made and prior approval must be sought thereafter (please note that the RTT clock continues during the time approval is sought). If approval is rejected, the patient must be removed from the waiting list and referred back to the GP with a letter documenting that prior approval was rejected. A copy of the letter must also be sent to the patient.

29) COMPLETION OF WAITING LIST TO COME IN (TCI) FORMS

a) A waiting list TCI form will be completed at the time of the decision to admit, in full by the clinician making the decision to admit for all patients added to the waiting list.

30) PRE-ANAESTHETIC & PRE-OPERATIVE ASSESSMENT

a) Patients should be pre-anaesthetically and pre-operatively assessed as soon as possible following the decision to admit, preferably immediately following the decision to admit.

   i) Pre- anaesthetic: - assessment required to ensure the patient is fit to undergo the anaesthetic
   ii) Pre-operative assessment: - is typically a conversation with the operating surgeon regarding the nature of the surgery. In some instances this will happen at the point of being listed and in other scenarios at a time closer to the surgery.

b) The purpose of these assessments is to ensure all patients are fit for treatment and that that they are listed for the appropriate type of admission (day case, short stay or inpatient care).

c) Patients who are medically not fit for treatment should be manged dependent on the nature of their condition as below : -

   i) **Acute conditions** – where the patients optimisation is resolvable via an individual management plan agreed with the acute clinician, the RTT pathway clock continues and the patient will be listed for their procedure.
   ii) **Chronic conditions** – where the patient requires referral back to the GP for optimisation that will likely take longer than available dates for admission (i.e. hypertension, BMI), the RTT pathway clock will be stopped and the will not be listed for their procedure. Once optimised the patient should be re-referred and start a new RTT pathway at the clinically appropriate point, i.e. pre-op assessment.

d) The decision to proceed with these types of patients lies entirely with the consultant anaesthetist / consultant surgeon who following a review will make a decision whether to proceed.

31) ADDING PATIENTS TO THE ADMITTED WAITING LIST

a) Patients must be added to the admitted waiting list within two working day of the decision to admit.

b) From the point of adding the patient to the admitted waiting list, the patient transfers from a non-admitted pathway to an admitted pathway.

c) When logging a patient onto the waiting list module of the PAS, staff must ensure all information is gathered and recorded in line with the Trust Standard Operating Policy (SOP).

32) LISTING PATIENTS/OFFERING TCI DATES

a) Where patients are not fully booked The Trust's RTT Patient Tracking List (PTL) must be used as the data source for scheduling admitted patients.

b) Listing must be undertaken by selecting patients firstly by their clinical priority and then within chronological order of RTT wait time.

c) Patients must be contacted to have the opportunity to agree their TCI date. This may be by telephone or letter.

d) Patients should be offered two separate dates with at least three weeks' notice for day case or inpatient admissions.

e) Where available, patients can be offered dates with less than three weeks' notice and if they accept, this then becomes a 'reasonable' offer.

f) If the patient fails to call within 2 weeks of a letter being sent, the waiting list entry is removed as the patient has declined treatment. A letter is sent to the patients GP and the patient's RTT pathway will be closed. This should only happen if in the clinical best interests of the patient as determined by the hospital clinical lead.

33) PATIENT CANCELLATION/DECLINING OF TCI OFFERS

a) When offering TCI dates, patients may need to decline for social reasons due to other commitments which cause them to be unavailable, e.g. holidays or exams. Patients could decline offers immediately during the telephone conversation or cancel / decline at any point between initially accepting and the admission date itself.

Operational tolerances in the national standard allow for patients to exercise the right to decline offers of admission for social reasons and in ALL cases the RTT clock continues without adjustment.

Patient choice to delay their treatment should be accommodated as long as in the view of the responsible clinician, it is in their best clinical interest to do so. An end date to their unavailability should be agreed with the patient and details of the dates that could have been offered should be recorded on PAS for audit purposes.

34) THE TCI LETTER

A letter must be generated immediately following the agreement of a TCI date. The TCI letter must contain all the relevant information associated to the attendance, as listed in the Trusts Standard Operating Policy (SOP).

35) VALIDATION OF PATIENTS ON THE ELECTIVE WAITING LIST

Some patients on the elective waiting list may no longer need their treatment (e.g. if they have been treated elsewhere) or need their operation to be performed by a different Trust (e.g. where a patient moves to another part of the country). To ensure that only those patients still needing their treatment are on the waiting list and to comply with the Data Protection Act, the Trust will validate the waiting list on a rolling basis. This will ensure the waiting list is consistently accurate and managed.

36) REINSTATING PATIENTS ONTO THE ADMITTED WAITING LIST

Patients who have been removed from the waiting list may need to be re-instated. In these cases the RTT clock will have a new start date.

37) HOSPITAL CANCELLATION OF TCI

a) Cancellation by the Trust for Clinical Reasons

If the operation is cancelled because the patient is unfit for surgery will either remain under the hospitals care for optimisation or be discharged back to their GP (revisit section 30 c). If the operation is no longer required the clock stops and the patient should be referred back to their GP.

b) Cancellation by the Trust for Non Clinical Reasons

The Trust will only cancel a patient's admission when it is not possible to carry out the procedure (e.g. bed capacity, unplanned leave, emergency cases). Before any cancellation is made, this must be discussed with the senior manager for that speciality. Everything must be done to try and avoid a hospital cancellation as it causes distress to the patient and an operational problem to the hospital.

If it is absolutely necessary for the hospital to cancel a patient's surgery, the patient will normally be given a new admission date at the time of cancellation. If this is not possible it is the responsibility of the senior manager who authorised the cancellation to ensure that the patient has a new date of admission within 28 days if the patient is cancelled on or after the day of admission or as soon as possible if cancelled prior to this.

Should it be necessary to cancel elective admissions, priority will be given to clinically urgent cases and long waiters.

38) PLANNED WAITING LIST

a) Patients who are waiting to be recalled to hospital for a further stage in their course of treatment are classed as Planned Admissions. This is an admission where the date of admission is determined by the clinical needs to the treatment. Examples of these would be follow up chemotherapy sessions, or a removal of internal fixation, three months post operation, check cystoscopy or repeat colonoscopies. These patients will be held on a 'planned waiting list', separate from the other waiting list, however will be subject to the same monitoring and validation process.

b) Operational managers are responsible for reviewing the planned list on a weekly basis to ensure compliance. This review will include checking that patients are being brought in, in accordance with their planned review dates and have been listed appropriately to the planned list definition.

c) Patients on planned waiting list are outside the scope of RTT rules. Planned procedures are part of an agreed programme of care, which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Planned activity is also sometimes known as 'surveillance'. Examples of procedures which should be on a surveillance list are:

   i) Check procedures such as cystoscopies, colonoscopies etc
   ii) Patients proceeding to the next stage of treatment e.g. patients undergoing chemotherapy or removal of metal work.

d) Patients who wait beyond their clinically defined interval between appointments or 'planned by date' should be transferred to the active RTT waiting list with a new clock start date. i.e. a planned second procedure or diagnostic

39) PATIENTS WHO DO NOT ATTEND (DNA) ADMISSION

a) It is important that the patient has been given instructions of who to notify and how if they subsequently cannot come in for their operation / procedure and that the letter clearly states the consequences of not attending for their appointment date.

b) Any patient who does not attend their agreed operation date will be discharged back to the care of their GP. Both patient and GP will be notified of this in writing to ensure the referring GP is aware and can action further management of the patient if necessary. The patient's RTT clock will be stopped. Exceptions to this are:

i) when a clinical decision is taken that discharging the patient is contrary to the patient's clinical interests;

ii) clinically very urgent patients including cancer, or active surveillance for cancer

iii) children of 18 years (See Footnote3 below[3]) and under or vulnerable adults.

iv) When one of the following can be confirmed:-
   c. The operation date was sent to the incorrect patient address
   d. The operation was not offered with reasonable notice

c) Where circumstances were beyond the patient's control, the Trust will endeavour to be as flexible as possible. The patient must first be contacted to ascertain the reasons for DNA and ensure compliance to attend a rescheduled operation. The rescheduled appointment must be made from the original referral and the RTT clock will continue.

d) For paediatric patients after the reason for a DNA has been established, this should be documented in the health records. A further operation needs to be offered to the patient and the importance of attendance needs to be reiterated to the parent / carer. If the patient DNA's a further operation dates, providers will refer to their SOP available here.

If there are any safeguarding concerns about a child or young person under the age of 18 years further guidance should be sought from then relevant Trust policy or safeguarding lead.

40) BILATERAL PROCEDURES

a) Patients will only be put onto the admitted waiting list for one procedure at a time.

b) The RTT clock will stop when first definitive treatment for the first side begins. A second new clock starts once the patient is fit and ready to proceed with the second procedure.

[3] The Children's Act defines children as any person under the age of 18 and in addition a person 18, 19, or 20 who; (a) has been looked after by a local authority at any time after attaining an age of 16; or (b) has a learning disability. A person is "looked after by a local authority" if: (a) for the purpose of the Children Act 1989 (c.41), they are looked after by a local authority in England and Wales; "learning disability" means a state of arrested or incomplete development of mind, which induces significant impairment of intelligence and social functioning.

41) ADMITTING PATIENTS

Where a patient's admission is a procedure or operation constituting first definitive treatment as part of an RTT pathway, the admission on PAS will stop the patient's clock.

42) EMERGENCY ADMISSIONS FOR AN ELECTIVE PROCEDURE

Where patients are admitted as an emergency procedure for a procedure the patient is currently waiting for as part of a RTT pathway, the patient will be removed from the waiting list and their RTT week clock stopped.

43) REMOVALS OTHER THAN TREATMENT

Patients who state that they do not wish to receive treatment will have their waiting list entry removed and their clock stopped.

Section Three
Cancer Pathways

44) AGREED OVERARCHING PRINCIPLES

The process for agreeing the Cancer Section of this document has been to make an underlying assumption that the general principles set out in the wider document are in line with Cancer pathways. Where this is not the case and the main principles need to differ in the case of cancer pathways then this has been specifically captured in this section.

The second key overarching principle that was agreed for this section was that all organisations recognise the national Cancer Waiting Times guidance available here (version 9).

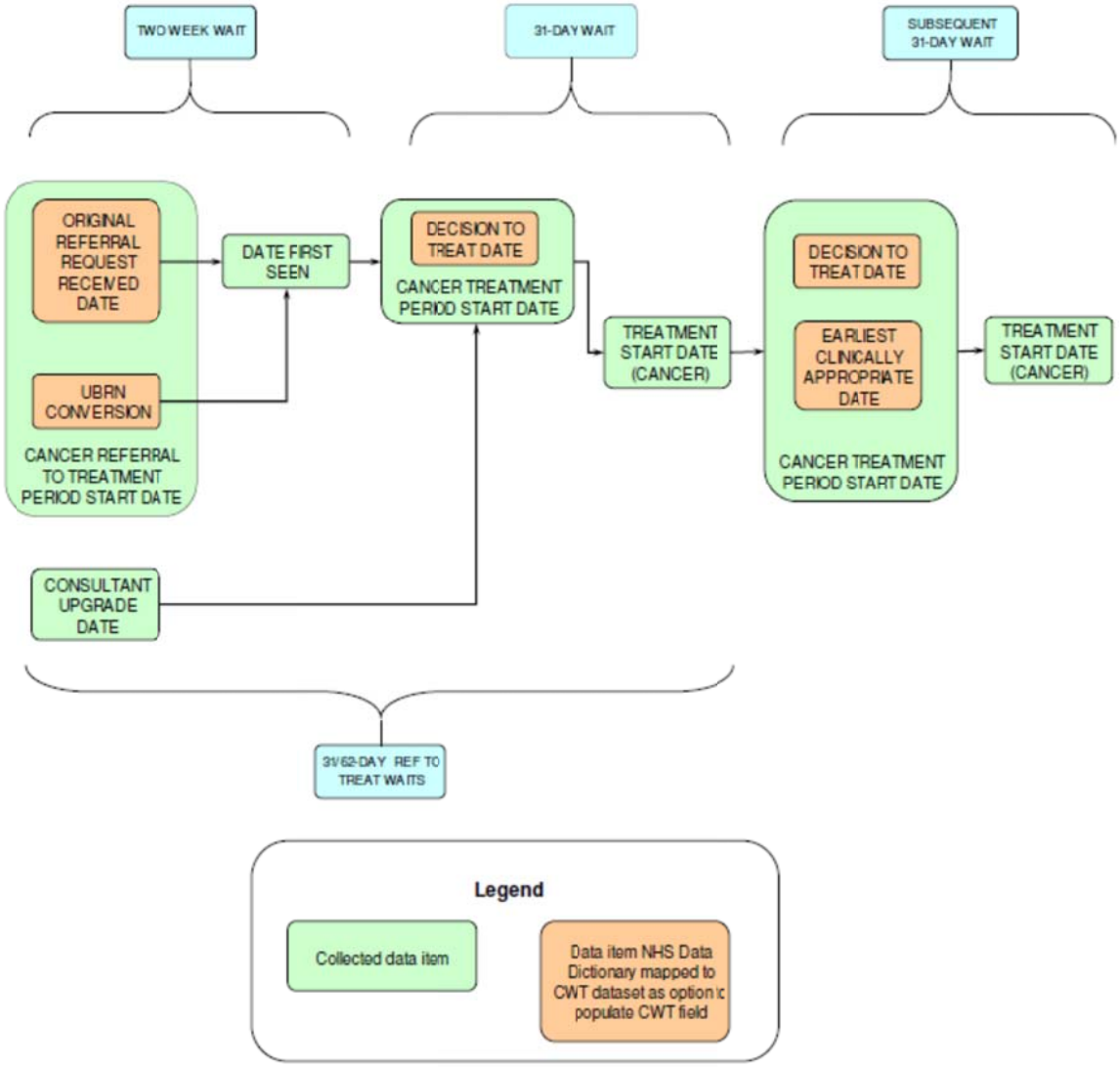
This forms the basis by which cancer pathways will be managed. This local policy aims to provide further clarity on the existing guidance where this is necessary. This guidance will be reviewed when the national guidance is updated in addition to the regular reviews that will take place. Should the local policy due to review time scales at any point directly contradict a new version of the national guidance the national guidance will take precedence.

Where a group from the South West Strategic Clinical Network identifies additional recommendations regarding access policies for cancer these will be reviewed and inserted into this policy if agreed*. Where the network policy differs from the BNSSG policy, the BNSSG policy will take precedence, as it is agreed with the commissioners and compliant with all aspects of version 9 of the guidance*

45) PATHWAY TIMINGS AND MILESTONES

Pathway milestones for cancer are nationally set through the CWT and therefore the section in this policy around local agreements will not be applicable to cancer pathways.

There is recognition that for cancer pathways there are shorter time scales for pathways to be delivered than for non-cancer patients as per the diagram below:



46) CLOCK START TIMES

Cancer pathways clock starts are as defined in the national cancer waiting times guidance (CWT).

There is recognition that some patients will also have a 31 day pathway clock start date, this is covered in a further heading entitled “Decision to Treat”

4. DECISION TO TREAT

Where a patient is consented for a surgical investigation and a separate surgical treatment simultaneously, this will be recorded as the DTT for tracking purposes.

If at the time of decision there was still uncertainty as to the likelihood of surgery, for example if alternative treatment modalities are still being considered or it is not clear if the patient is ‘resectable’ or if the disease has spread, the decision to treat should be considered to be the date on which surgery was confirmed as the most suitable treatment option and the patient agreed to this. This may be via a

telephone conversation if the patient was not brought back to clinic. Where this is the case, CNS contacts and PAS should be checked to ascertain the date of the agreement. Where no date is recorded, it will be presumed to be the day after the procedure (for patients where no histology is expected) or the day after the histology report (where histology is undertaken).

47) CLOCK STOPS

For Clock Stops for Cancer are defined as per CWT guidance, in addition below there is some local clarity around this guidance:

a) Patients who are Hard to Engage

The cancer waiting times guidance states that; *Patients should only be referred back to their GP after multiple (two or more) DNAs* (version 9, section 4.11). The guidance is also explicit about the circumstances in which a patient cannot be discharged.

In line with this guidance, BNSSG providers may remove from cancer pathways patients who DNA two consecutive appointments (including those for tests) during their pathway, following their first appointment.

Patients who DNA or cancel multiple appointments after the initial first outpatient appointment should be encouraged to come in via interventions from the CNS and GP. Discharge to the GP should be as a last resort and should wherever possible be explained to the patient first and should be accompanied by a letter to the GP stating that the patient has been discharged and may be re-referred when they wish to be seen.

Patients should be kept on a 62 day pathway for tracking purposes until they are treated or discharged, to ensure patient safety. The pathway will then be corrected as per the guidelines.

b) Active Monitoring for comorbidities as a result of the cancer

The cancer waiting times guidance states that; *If a patient has active anti-cancer treatment planned, but has other comorbidities, as a result of the cancer, which need to be addressed before the active cancer treatment can commence, then active monitoring can be used* (version 9, section 6.6.5).

To provide clarity for providers, examples of conditions and comorbidities as a result of the cancer that may require such treatment first, include:

- Malnutrition (except in non-metastatic skin cancer, where malnutrition is unlikely to be caused by the cancer)
- Anaemia, deranged blood test results (e.g. electrolytes, bilirubin, liver function), hormone imbalances
- Respiratory problems in patients with lung cancer, lung metastases, or extra-pulmonary tumours affecting the lung e.g. laryngeal or oesophageal
- Jaundice

- Poor performance status as a result of the cancer (i.e. where performance status deteriorated in line with the tumour becoming apparent/progressing), where there is anticipation that this can be improved to allow active treatment
- Psychological or neurological problems caused by the cancer (or its metastases) i.e. not pre-existing before the cancer diagnosis and that are delaying treatment

Treatment of a metastasis prior to treatment of the primary does not count and is covered by the cancer waiting times guidance in section 6.11 (version 9).

A programme of prehabilitation, which may include exercise, dietary changes, and smoking/alcohol cessation, in a patient with a cancer diagnosis does count as an active monitoring treatment, as agreed by the Department of Health Cancer Waiting Times team.

48) PRE-REQUISITES PRIOR TO REFERRAL (PRIMARY CARE)

The referring GP will inform the patient that they are being referred on a two week wait pathway for suspected cancer. If the referring GP has not informed the patient of this prior to referral this will be clearly indicated on the referral form providing the reason why this is the case. If a GP feels it is not appropriate to mention 'cancer' they should if possible emphasise to the patient that they feel it is important for them to be seen quickly and that the patient should make themselves available to attend appointments within a short timeframe.

Section Four
Reference Information

Definitions

A

Active monitoring

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

A new waiting time clock would start when a decision to treat is made following a period of active monitoring (also known as watchful waiting).

Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to refer the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such and also stops a waiting time clock.

If a patient is subsequently referred back to a consultant-led service, then this referral starts a new waiting time clock.

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 or inpatient)

B

Bilateral (procedure)

A procedure that is performed on both sides of the body, at matching anatomical sites. For example, removal of cataracts from both eyes.

C

Care Professional

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.

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 arrangements.

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 patient's appointment, but he/she takes overall clinical responsibility for patient care.

Convert(s) their UBRN

When an appointment has been booked via the NHS e-Referral Service (Choose and Book), the UBRN is converted. (Please see definition of UBRN).

D

DNA – Did Not Attend

DNA (sometimes known as an FTA – Failed to attend). In the context of consultant-led waiting times, this is defined as 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 day case or inpatient treatment.

Decision to treat

Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatments performed in other settings, for example, as an outpatient.

F

First definitive treatment

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

Fit and ready (in the context of bilateral procedures)

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.

H

Healthcare science intervention

See Therapy or Healthcare science intervention.

I

Interface service (non consultant-led interface service)

All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care.

Consultant-led referral to treatment relates to hospital/consultant-led care. Therefore, the definition of the term 'interface service' for the purpose of consultant-led waiting times does not apply to similar 'interface' arrangements established to deliver traditionally primary care or community provided services, outside of their traditional (practice or community based) setting.

The definition of the term does not also apply to:

- non consultant-led mental health services run by mental health trusts.
- referrals to 'practitioners with a special interest' for triage, assessment and possible treatment, except where they are working as part of a wider interface service type arrangements as described above.

N

NHS e-Referral Service (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 results in a clock stop for treatment that does not require an admission or for 'non-treatment'.

Non consultant-led

Where a consultant does not take overall clinical responsibility for the patient.

Non consultant-led interface service

See interface service.

P

Patient pathway

A patient pathway is usually considered to be their journey from first contact with the NHS for an individual condition, through referral, diagnosis and treatment for that condition. For chronic or recurrent conditions, a patient pathway will continue beyond the point at which first definitive treatment starts, as it will include further treatment for the same condition. A person may therefore have multiple RTT periods (see Referral to treatment period) along one patient pathway. NHS England often uses the term 'RTT pathway' in published reports and in this document and this is the same as an 'RTT period'.

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.

R

Reasonable offer

An offer is reasonable where the offer for an outpatient appointment or an offer of admission is for a time and date three or more weeks from the time that the offer was made.

Referral Management or assessment service

Referral management or assessment services are those that do not provide treatment, but accept GP (or other) referrals and provide advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient.

Referral Management and Assessment Services should only be in place where they carry clinical support and abide by clear protocols that provide benefits to patients. They must not be devices either to delay treatment or to avoid local clinical discussions about good referral practice.

A waiting time clock only starts on referral to a referral management and assessment service where that service may onward-refer the patient to a surgical or medical consultant-led service before responsibility is transferred back to the referring health professional.

Referral to treatment period

An RTT period is the time between a person's referral to a consultant-led service, which initiates a clock start, and the point at which the clock stops for any of the reasons set out in the RTT national clock rules, for example the start of first definitive treatment or a decision that treatment is not appropriate.

S

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 did not form part of the patient's original treatment plan, 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 (for example, 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.

T

TCI

To come in date or the date offered for admission to hospital.

Therapy or Healthcare science intervention

Where a consultant-led or interface service decides that therapy (for example physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science (for example, hearing aid fitting) is the best way to manage the patient's disease, condition or injury and avoid further interventions.

U

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 (Choose and Book). The UBRN is used in conjunction with the patient password to make or change an appointment.

Section Five
Standard Operating Procedures

Appendix 1: - INTER-PROVIDER ADMINISTRATIVE DATA TRANSFER DATA COLLECTION TEMPLATE

Referring organisation name:	Referring organisation code:
Referring clinician:	Referring clinician registration code:
Referring treatment function code:	Contact name:
Contact phone:	Contact e-mail:
Patient Details:	
Patient's family name:	Patient's forename:
Title:	Date of birth:
NHS number:	Local patient identifier:
Correspondence address: Post code:	Contact details: Patient is lead contact ☐ Lead contact if not the patient: ☐ Lead contact name: Contact home tel no: Contact work tel no: Contact mobile: Contact e-mail:
GP Details:	
GP Name:	GP practice code:
Referral To Treatment Information:	
Patient Pathway Identifier:	Allocated by (organisational code):
Is the patient on an 18 Weeks RTT pathway: Yes ☐ No ☐ (98)	
Is this referral the: Start of a new pathway – (New condition or change of treatment) ☐ (12) Continuation of an active pathway – (1st definitive treatment not given) ☐ (20) Continuing treatment for a stopped pathway (1st definitive treatment given) ☐ (90)	
Is this referral for: Diagnostic test only ☐ Opinion only ☐	
Date of decision to refer to receiving organisation:	Clock start:
List all organisations involved in the 18 Weeks pathway	
Receiving Organisation Details:	
Receiving organisation name:	Receiving organisation code:
Receiving clinician:	Receiving treatment function code:
Date IPTAMDS sent:	
For Receiving Organisation:	
Date received:	

Appendix 2: - GP Referral Letter Information Requirements

Minimum Data Set (MDS) – in bold

- **Referring GP**
- **Practice Address including postcode**
- **Telephone number**
- **Fax Number**
- **Practice code**

- **NHS Number**
- **Patient Surname**
- **Forename(s)**
- **Date of Birth and Age**
- **Sex**
- **Address**
- **Postcode**
- **House telephone**
- **Mobile telephone**

- **Specialty/Department**
- **Date**
- **Presenting complaint**
- **Reason for referral**
- **Expected outcome**
- **Treatments tried and outcomes**
- **Significant PMH**
- **Relevant investigations**
- **Current medication**
- **Allergy history**

- **Interpreter required? If so which language?**
- **Ambulance or other transport needed**

Optional Data items

- Does this patient have a learning disability? Yes/No
    - If yes, note to providers: *please ensure that reasonable adjustments are made to effectively meet the needs of this individual*
- BMI (to assess suitability for offering providers with BMI referral criteria)
- Smoking status

Appendix 3 - Referral to treatment consultant-led waiting times rules suite

Clock Starts

1) A 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 that 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.

2) A waiting time clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional permitted to do so.

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

a) when a patient becomes fit and ready for the second of a consultant-led bilateral procedure;

b) upon the decision to start a substantively new or different treatment that does not already form part of that 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 Did Not Attend (DNA) that stopped and nullified their earlier clock.

Clock Stops

Clock stops for treatment

4) A clock stops when:

a) First definitive treatment starts. This could be:

i) Treatment provided by an interface service;

ii) Treatment provided by a consultant-led service;

iii) 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.
Clock stops for 'non-treatment'

5) 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 DNAs their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient[9];

DNAs for a first appointment following the initial referral that started a waiting time clock nullify the patient's clock (in other words, it is removed from the numerator and denominator for Referral to Treatment time measurement purposes).

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

i) The provider can demonstrate that the appointment was clearly communicated to the patient;

ii) discharging the patient is not contrary to their best clinical interests;

iii) discharging the patient is carried out according to local, publicly available/published, policies on DNAs;

iv) These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g. children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders.