Patient Access Policy

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Contribution List
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Change of History

Version	Date	Author	Reason for change
V1	October 2013	Piers Young	Updated in line with national guidance
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V15	October 2015	Jane Shentall	Updated in line with national guidance. More user-friendly format.
V16	May 2017	Jane Shentall	Updated in line with national guidance
V17	September 2019	Jane Shentall	Updated in line with eRS; separation into access policy document only
V18	September 2022	Jane Shentall	Alignment with NHS England's Model Access Policy Inclusion of prioritisation codes for diagnostic and admitted pathways Inclusion of Active Monitoring for patients deferring treatment Updated to include Cerner, EPR references, changes in the commissioning landscape and inclusion of COVID-19 related information and guidance, Cancer Waiting times v11
V18.1	November 2022	Jane Shentall	Radiology prioritisation codes corrected Updated IRM(E)R reference

Abbreviations and Acronyms

Abbreviations and Acronyms	Description
MDT	Multidisciplinary Team
PGRG	Policy & Guideline Review Group
QSG	Quality & Safety Group

Contents

1. Introduction

This policy is to be used by all staff in the local health economy dealing with waiting list management. It will ensure that patients will be treated in order of clinical priority, and that patients of the same clinical priority will be seen in turn. It will also ensure equity of access within specialties across sites throughout the Trust.

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

Staff must not carry out actions they feel may be inconsistent with this policy. If in doubt about rules and their application, a staff member must check with their supervisor or with the Head of RTT Pathway Support Services or the Director of Performance.

The aim of this document is

- to establish a consistent approach to patient access across the Trust
- to ensure that national and local standards of care are met through clarity of definition

Treating patients and delivering a high quality, efficient and responsive service, ensuring prompt communications with patients, is a core responsibility of the Trust, each hospital site, all staff and the wider local health community.

Staff must ensure that national standards are met and that all notification rules are adhered to. These are detailed throughout the policy and summarised below for ease of reference.

Failure to adhere to this policy will be managed through the Trust's disciplinary process.

2. Objectives

The purpose of this document is to outline and define the overarching rules and principles for managing access to outpatient appointments, diagnostics and elective inpatient or day-case services, ensuring fair, transparent and equitable treatment for all patients.

The policy is based on the key principles of national referral to treatment (RTT) and cancer waiting times guidance.

The Trust is committed to providing high quality and timely elective care services which meet the needs of all patients and does not discriminate against any employee, patient or visitor.

Ultimately arrangements for each individual patient should be applied locally on a common sense basis, with compassion and consideration of patients' individual circumstances.

3. Definitions

See appendix 1

4. Scope

The purpose of this policy is to ensure all patients requiring access to outpatient appointments, diagnostics and elective inpatient or day case treatment are managed equitably and consistently, in line with national waiting time standards and the NHS Constitution.

Scope of the policy:

- All elective appointments and admissions (arranged in advance) provided by the trust

- All clinical and administrative staff involved in managing patients referred to elective care services

5. Responsibilities

Although responsibility for achieving standards lies with 1) Assistant Divisional Managers (ADMs)/Service Managers, 2) Divisional Managers and 3) Divisional Directors and, ultimately, the Trust Board, all staff with access to and a duty to maintain elective care information systems, are accountable for their accurate upkeep.

- The Director of Performance is accountable for ensuring services have the frameworks, policies and processes to support delivery of operational standards relating to the provision of elective care, diagnostic and cancer services.
- Divisional Directors, with Divisional Managers, are accountable for waiting list management, and ensuring compliance with the policy within their divisions
- Waiting list co-ordinators, including clinic staff, secretaries and outpatient booking staff are responsible to Assistant Divisional Managers for compliance with all aspects of the Trust's elective access policy.
- The Information team are responsible for producing and maintaining regular reports to enable divisions to accurately manage elective pathways.
- Outpatient booking staff, diagnostics and elective inpatient or day-case staff are responsible for the day-to-day management of their lists and are supported in this function by the Assistant Divisional Managers and clinicians.
- Clinicians are responsible for checking patients in and out of appointments within Cerner and for ensuring the accurate entry of clinic outcome data in the Electronic Patient Record (EPR).
- Any other staff member with clinic cashing up responsibilities is responsible for the entering outcomes accurately in Cerner.
- Assistant Divisional Managers and Divisional Managers are responsible for ensuring data is accurate and services are compliant with the policy.
- Assistant Divisional Managers are responsible for ensuring the NHS e-referral service directory of services (DOS) is accurate and up to date.
- Referrers play a pivotal role in ensuring patients are fully informed during their consultation of the likely waiting times for a new outpatient consultation and of the need to be contactable and available when referred.
- Commissioners are responsible for ensuring all patients are aware of their right to treatment at an alternative provider in the event that their Referral to Treatment (RTT) wait goes beyond 18 weeks or it is likely to do so.
- In the event that patients' RTT waits go beyond 18 weeks, reasonable steps must be taken to offer a suitable alternative provider, or if there is more than one, a range of suitable alternative providers, able to see or treat patients more quickly than the provider to which they were referred. This should be done via the Mutual Aid process, established by NHS England and co-ordinated regionally via the Herts & West Essex (HWE) Integrated Care Board (ICB) and East of England NHSE. A suitable alternative provider is one that can provide clinically appropriate treatment and is commissioned by an ICB or NHS England.
- Commissioners are responsible for ensuring there are robust communication links for feeding back information to GPs and other referrers commissioned by the ICB. GPs should ensure quality referrals are submitted to the appropriate provider first time and are compliant with clinical criteria, NICE guidance and any relevant national or local prior approval process.
- Patients should provide accurate information regarding their contact details and availability.

- Patients should be ready, willing and available to come to appointments and start treatment when referred and GPs or other referrers are responsible for confirming this at the point of referral.

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.

Patients who are vulnerable and/or require additional support may require additional communication between trust clinician and GP/referrer. Such patients should be identified at the outset at the point of referral.

Staff should always refer to related policies and resources relating to vulnerable or at risk patients, available on the trust intranet.

Patients with specific information or communication needs due to a disability, impairment or sensory loss, must be identified at the outset at the point of referral and relevant details provided as part of the minimum data set, in accordance with accessible information standards.

6. National Standards/Performance Measures

The NHS Constitution for England

The NHS has set maximum waiting time standards for elective access to healthcare. In England, waiting time standards for elective care (including cancer) come under two headings:

- The individual patient's rights (as in the NHS Constitution - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf)

- The standards by which individual providers and commissioners are held accountable by NHS Improvement and NHS England (https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf)

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

- Choice of hospital and consultant
- To begin their treatment for routine conditions following a referral into a consultant-led service, within a maximum waiting time of 18 weeks to treatment
- To be seen by a cancer specialist within a maximum of two weeks from a GP referral for urgent referrals where cancer is suspected.

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

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

- The patient chooses to wait longer

- Delaying the start of the treatment is in the best clinical interests of the patient (note that in both of these scenarios the patient's RTT clock continues to tick)
- It is clinically appropriate for the patient's condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage.

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

National elective care waiting time standards

RTT waiting times for non-urgent, consultant led treatment	92% of patients on incomplete pathways (yet to start treatment) wait no more than 18 weeks from referral
Diagnostic test waiting times	99% of patients will wait no longer than 6 weeks for a diagnostic test, investigation or image
Cancer waiting times – 2 week waits	93% of patients will be seen within two weeks of an urgent GP referral for suspected cancer or where identified as breast symptomatic
Cancer waiting times – 31 days	96% of patients will wait a maximum of one month (31 days) from diagnosis to first definitive treatment for all cancers
	94% of patients will wait a maximum of one month (31 days) for subsequent treatment where treatment is surgery
	94% of patients will wait a maximum of one month (31 days) for subsequent treatment where treatment is radiotherapy
	98% of patients will wait a maximum of one month (31 days) for subsequent treatment where treatment is an anti-cancer drug regimen
Cancer waiting times – 62 days	85% of patients will wait a maximum of two months (62 days) from urgent referral for suspected cancer to first treatment for all cancers
	90% of patients will wait a maximum of two months (62 days) from NHS cancer screening service referral to first definitive treatment

The current (October 2015) national clock rules for consultant-led elective care can be found at
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting-RTT-guidance-v24-2-PDF-703K.pdf

The latest (April 2021) Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care can be found at
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/05/Recording-and-Reporting-guidance-April_2021.pdf

Further information can be found in the Frequently Asked Questions (FAQs)
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Accompanying-FAQs-v7.2.pdf

For further information on the management of RTT pathways in relation to COVID
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/03/C0009-RTT-measurement-and-COVID-19.pdf

Elective Care IST RTT Rules Application COVID-19 FAQs V2.0 August 2022 - Elective Care IST Network - FutureNHS Collaboration Platform

National diagnostic waiting times guidance can be found at:
https://nhsenglandfilestore.s3.amazonaws.com/stats/DM01-guidance-v-5.32.doc

Details of frequently asked questions can be found at:
https://nhsenglandfilestore.s3.amazonaws.com/stats/DM01-FAQs-v-3.0.doc

Cancer waiting times guidance can be found at:
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/09/national-cancer-waiting-times-monitoring-dataset-guidance-v11-sep2020.pdf

7. Elective Access Principles

This policy will be applied consistently and without exception across the Trust. This will ensure that all patients are treated equitably and according to their clinical need.

All staff employed by West Hertfordshire Teaching Hospitals NHS Trust will adhere to the Patient Access Policy.

All stakeholders including, commissioners, patient representatives, patients and others will have access to this policy

Patients will be treated in strict order of clinical priority and chronological waiting time.

Exclusions

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

- obstetrics and midwifery
- planned / surveillance patients (patients who have to wait for a specified period of time before treatment can occur)
- referrals to a non-consultant led service
- referrals for patients from non-English commissioners
- genitourinary medicine (GUM) services
- emergency pathway non elective follow up clinic activity

Referral to treatment principles

As a general principle, the Trust expects that before a referral is made for treatment, the patient is clinically fit for assessment and available for treatment. The patient must be available for treatment within 18 weeks of referral.

The Trust will work with GPs, ICBs, local healthcare partnerships and other primary care services to ensure patients have a full understanding of this before starting an elective care pathway.

RTT clock starts

An RTT clock starts when any health professional (or service permitted by an English NHS Commissioner to make such referrals) refers to a consultant-led service.

The RTT clock start date is the date that the Trust receives the referral. For referrals received through NHS e-Referral, the RTT clock starts when the patient converts their unique booking reference number (UBRN) into an appointment.

A new RTT clock should be started when a patient becomes fit and available for the second of a consultant-led bilateral procedure.

RTT clock stops for treatment
An 18-week clock stops when:

- A patient receives definitive treatment in an outpatient setting; this could be medication, advice, fitting of a brace or appliance, or the initiation of a therapy treatment plan
- The patient is admitted for definitive treatment.

Where the treatment requires day case or inpatient admission, the clock stops on the day of admission. It does not stop where admission is for diagnostic tests only.

A diagnostic procedure that turns in to a therapeutic procedure or the fitting of a medical device also stops the RTT clock.

RTT clock stops for non-treatment
An RTT clock stops when the patient and subsequently their GP are informed that:

- It is clinically appropriate to return the patient to community based or primary care for non-consultant-led treatment
- A clinical decision is made not to treat
- A patient DNA (did not attend) results in the patient being discharged after clinical review
- A patient declines treatment having been offered it
- A decision is made to start the patient on a period of watchful wait / active monitoring
- A patient initiates a period of active monitoring
- A clinical decision is made to begin a period of Patient Initiated Follow Up (PIFU)

Active monitoring/watchful waiting
There will be times when it is clinically appropriate to start a period of active monitoring without further clinical intervention or diagnostic procedure.

The clock stops when this decision is made and communicated to the patient.

Some clinical pathways require patients to undergo regular monitoring/review diagnostics as part of an agreed programme of care - these events do not indicate a decision to treat or start a new clock.

It is not appropriate to stop a clock for a period of active monitoring if some form of diagnostic or clinical intervention is required in a couple of days' time, but it is appropriate if a longer period of active monitoring is required before further action is needed.

Where a period of thinking time is agreed with the patient, the effect on the RTT clock will depend on the individual scenario.

- A short period of thinking time, for example where the patient would like a few days to consider proposed treatment before confirming they wish to go ahead would not initiate active monitoring and the clock would continue
- If a longer period of thinking time (two weeks or more) is agreed, then active monitoring is more appropriate, including periods when the patient wishes to see how their condition can be managed or progresses before making a decision on whether to proceed; the clock would stop in these circumstances.

When a decision to treat is made after a period of active monitoring / watchful waiting, a new RTT clock would start on the date of decision to treat (DTT).

The following guidance should assist in determining active monitoring.

- The patient must have a confirmed diagnosis or understand the clinical risk relating to the condition being monitored. This must be recorded as part of the clinical correspondence to both the patient and GP.
- A clinical decision is documented that the most appropriate course of action at that point is to monitor the condition rather than offer treatment.
- The patient knows that they are not being treated and why.
- The period of active monitoring is defined on a case by case basis.
- A clinical decision is made to move the patient on to a patient initiated follow up pathway (PIFU)

Interim operational guidance released by NHSE in September 2022 confirms the use of active monitoring is acceptable if a patient wishes to delay treatment in the following circumstances:

- Two dates with reasonable notice have been offered and declined by the patient, the second date being within 6 weeks of the first
- A clinical review has been undertaken confirming that it is clinically and socially acceptable to initiate a period of active monitoring
- The patient fully understands the implications of a delay

The period of active monitoring in these circumstances should be no longer than 12 weeks. Patients should be given details of who to contact if they change their mind or wish to end the monitoring period earlier than originally agreed.

Clinically initiated delays (patient not fit for treatment)

When a patient is listed for surgery but is identified, or self-reports, as unfit for that procedure, the scheduler should ascertain the nature and duration of the clinical issue.

When the clinical issue is short term (1-2 weeks) ie for a cold and has no impact on the original clinical decision to undertake the procedure, the patient must be offered a new TCI date within their 18 week breach date. The clock will continue running during this time.

The clock will continue running for patients who are unable to proceed with treatment as a result of a positive test for COVID-19 near or at the time of admission. The patient must be offered a new TCI date in line with current guidelines for rebooking patients following COVID infection.

However, if the clinical issue is not short term, or is due to more serious issues, the consultant should advise if:

- it is clinically appropriate for the patient to be removed from the waiting list (this will be a clock stop event)
- the patient should be optimised/treated within secondary care (this will be active monitoring – clock stop)
  or
- the patient should be discharged back to the care of the GP (clock stop) for further management/optimisation.

The patient should be re-listed and a new clock started when confirmation is received from either the GP or the relevant clinician, that the patient is fit to undertake the procedure. The treating consultant must review the case and indicate whether the patient needs to be reviewed in outpatients or whether they can be added directly to the inpatient waiting list.

Ultimately patients should be clinically considered on a case by case basis and decisions based on the best interests of the patient.

Clinicians must make decisions on removal from the waiting list. Decisions must be communicated with the GP, other referrer and patient by letter and correspondence must be kept in the EPR for auditing purposes.

Validation letters to contact patients
Validation letters are used to contact patients who cannot be contacted first by telephone using all available contacts. Where telephone contact still cannot be made (two attempts on different days/times) the patient is to be sent a standard validation letter inviting them to make contact with the department within 10 working days.

If the patient does not respond within the timeframe, this will be brought to the attention of the clinical team to confirm whether, in the absence of any contact with the hospital, it would be appropriate to discharge the patient back to the care of their GP or other referrer. This discharge must be communicated by letter to the patient and GP in a timely manner. This decision would stop the RTT clock.

A separate validation process exists for contacting patients on a cancer pathway.

New clock starts
When a decision is made to start a substantively new or different treatment that does not already form part of that patient's agreed care plan, a new RTT pathway clock will start and the patient should receive their first definitive treatment within a maximum of 18 weeks from that date.

This will include all patients whose pathway has been stopped previously but who are then added to an elective waiting list for surgery or other therapeutic intervention.

Clinic (new and follow up) attendance and outcomes (cashing up)
Every patient, new and follow up, whether attended or not, will have an attendance status and outcome recorded on Cerner at the end of the clinic. Clinics must be fully outcomed or cashed up within 1 working day of the clinic taking place.

Clinic outcomes (eg discharge, further appointment) and the patient's updated RTT status will be recorded by clinicians within the EPR.

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

<u>Patients on an open pathway</u>
- Clock stop for treatment
- Clock stop for non-treatment
- Clock continues if requiring diagnostics, therapies or being added to the admitted waiting list

<u>Patients already treated or with a decision not to treat</u>
- New clock start if a decision is made regarding a new treatment plan

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

Accurate and timely recording of these outcomes at the end of the clinic are therefore critical to supporting the accurate reporting of RTT performance.

8. General Principles

Patient eligibility

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

The Trust has a legal obligation to:

- ensure that patients who are not ordinarily resident in the United Kingdom are identified
- assess liability for charges in accordance with the charging Regulations
- charge those liable to pay in accordance with the Regulations
- In the context of charging overseas visitors, when to charge can be considered in terms of the urgency of the treatment needed:

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

Patients moving between NHS and private care

Patients can choose to move between NHS and private status at any point during their treatment without prejudice. Where it has been agreed, for example, that a surgical procedure is necessary, the patient can be added directly to the elective waiting list if clinically appropriate (ensuring, where required, that any prior approval process in place at the time has been followed before treatment is given). The start date for the patient will be the transfer date, not the original referral date. A copy of the original referral letter should be provided for inclusion in the patient's clinical record.

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

Referrals for low priority treatments (LPT)

Some conditions have been designated as low priority by commissioners which means that a patient may need to meet specific criteria before approval is given.

These patients will be added to the inpatient waiting list, but must not be treated, while explicit approval is being sought. Once approval has been obtained, the booking of treatment can be processed in the normal way. The RTT clock will continue while approval for treatment is sought.

Patients referred for treatment outside of existing contracting agreements will follow the agreed protocol as laid out in commissioners' Low Priority Treatment Policy before booking. GPs should send the completed LPT form with the patient's eRS referral (as per commissioner policies).

When a request for approval is declined the patient, the Trust and the clinician will be notified of the decision by the commissioner. This notification will stop the RTT clock.

Patients requiring individual funding approval (IFR)
Where a patient requires individual funding approval, this must be obtained from the commissioner before the patient is offered an admission date. The RTT clock will continue to tick whilst approval is sort. The process for obtaining approval to treat must be followed as per the local Individual Funding Request Policy.

When a request for approval is declined the patient, the Trust and the clinician will be notified of the decision by the commissioner. This notification will stop the RTT clock.

Military veterans
All veterans and war pensioners should receive priority access to NHS care for any conditions related to their service subject to the clinical needs of all patients. Military veterans should not need 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 it meets the current guidance for priority service over other patients with the same level of clinical need. In line with clinical policy, patients with more urgent clinical needs will continue to receive priority.

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

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

Should two appointments (made with reasonable offer - Section 8.1) be cancelled by the prison on two or more consecutive occasions, the referral will be reviewed by the consultant and a letter explaining duty of care be sent to the prison.

9. Referral Methods

Referral letters
Referrals from GPs to consultant-led services should be made electronically via the NHS e-referral service.

Where clinically appropriate, referrals should be made to a service (an open/generic referral) rather than a named clinician. This is in the best interests of patients as it promotes equity of waiting times and allows greater flexibility in terms of booking appointments.

As a general principle, generic referrals will be sent to the consultant with the shortest waiting time in that specialty. However, it is the patient's right to request a named consultant.

NHS e-referrals
Patients who have been referred from their GP via the NHS e-referral service should be able to choose, book and confirm their appointment before the Trust receives and accepts the referral.

The e-referral service has been set up with both directly bookable appointments ie the patient can see and choose the appointment, or indirectly bookable. The indirectly bookable services have been set up as referral assessment services so that the service may triage the referral before offering an appointment.

All NHS e-referrals must be reviewed and accepted / rejected within 1 working day for an urgent referral and 2 working days for a routine referral by clinical teams. The referral should include the completed low priority treatment form where the diagnosis is pre-determined.

Should an NHS e-referral be received for a service not provided by the Trust, it will be rejected back to the referring GP advising that the patient needs to be referred elsewhere – this will nullify the patient's RTT pathway.

However, if the patient has been booked into the wrong sub specialty, the service will re-direct the patient into the correct service and a confirmation letter of the appointment change will be sent.

The patient will appear on the Appointment Slot Issue (ASI) work list if there are no appointments available for the selected service. Patients on this list must be contacted within 14 days and offered an appointment as soon as one becomes available. They will stay on the ASI list if they cannot accept the appointment offered until another is available.

However, if the patient cannot accept the second appointment offered the patient should be advised that the relevant clinician will review the referral and confirm whether a further appointment should be offered or if the patient should be discharged back to their GP.

The patient will be removed from the waiting list and discharged back to the GP if the patient advises that the appointment is no longer required. The 18 week clock will be nullified.

Where a patient cancels the appointment twice, the relevant clinician will review the referral and confirm whether the appointment should be upheld or if the patient should be discharged back to their GP.

Diagnostic referrals
Order Comms / ICE referrals are the only acceptable methods for receiving referrals from primary and secondary care. Paper based referrals are still accepted by some non-consultant led services but the Trust discourages this. All referrals must be completed correctly and signed electronically or on paper.

Referral forms should be addressed to either the Radiology department and/or appropriate modality. They will be date stamped on receipt, the request form scanned and added to the CRIS request received list. This process is automated for requests received via Order Comms/ICE.

Any form that is incomplete or unsigned will be returned to the requester. Requests must be entered on CRIS as request received and the status updated to 'awaiting clinical information' – this provides a clear audit trail if required.

A dedicated form should be used for MRI – including the patient safety questionnaire.

Referral requests will be allocated to the appropriate person for prioritisation according to the protocol for each modality, utilising D codes to indicate the priority timelines.

D Code	Description
D1	(CRIS Urgency 6) Inpatient
D2a	(CRIS Urgency 7) Cancer pathway
D2b	(CRIS Urgency 5) Urgent
D3	(CRIS Urgency 2) Soon
D4	(CRIS Urgency 1) Routine

Referrals justified as D1, D2a&b by a Radiologist, Radiographer or Sonographer must be given priority. Routine referrals should be given appointments in turn, providing equity of access. Once requests have been allocated to a specific person, patients will be treated equally.

Regular review of session templates must take place to ensure best use of available slots.

Following acceptance of the request the CRIS status requires updating to record 'Request Accepted'. This applies to both GP and consultant to consultant referrals, where they exist.

The diagnostic waiting time clock starts when the request for a diagnostic test or procedure is made. This is when the request for a diagnostic procedure is entered onto Order Comms/ICE or by using the date written on the diagnostic request form by the referring clinician.

Straight to test referrals
For patients who are referred for a diagnostic test where one of the possible outcomes is review and, if appropriate, treatment within a consultant-led service (without first being reviewed by their GP) an RTT clock will start on receipt of the referral.

Ionising Radiation (Medical Exposure Regulations IR(ME)R
The request will be returned to the referring clinician if the referral does not comply with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R).

For MRI and ultrasound the same principles will apply and the request will be rejected if not clinically warranted.

A non-justification proforma letter will be attached to the request form detailing the reason for rejection.

Non GP referrals
All paper referrals (consultant to consultant/tertiary) must be date stamped upon receipt at point of entry to the Trust.

Details of the paper referral will be entered onto PAS at this point reflecting the date received by the Trust and this is the point that the Referral to Treatment (RTT) clock starts.

Appointments will be booked in order of clinical priority (urgent before routine) and then in chronological order of referral received date.

Referrals from Clinical Assessment and Triage Services (CATS)
These services provide intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care. A referral to CATS starts an RTT clock.

The Trust inherits the 18 week RTT wait for the patient if the patient is referred on to the Trust having not received any treatment or having had a non-treatment clock stop prior to onward referral.

Minimum Data Set forms must be used to transfer 18 week information about the patient to the Trust

Rapid Access Chest Pain Clinic (RACPC) referrals
To meet NHS standards, RACPC referrals must be seen by a specialist within 14 days of the Trust receiving the referral. To ensure that this is achieved:

- Referrals from GPs should be made via the NHS e-referral service only using the proforma.
- GPs should ensure that appropriate information regarding the RACPC referral is provided to the patient as well as the importance of being seen quickly.
- Referrals must be sent by the GP (within 24 hours of the patient being seen) to the RACPC NHS e-referral service to ensure that the patient is booked within 14 days (by the GP or by the patient).
- In the unlikely event that no slots are available on NHS e-Referral, the referral will appear on the appointment slot issue list (ASI) and the RACPC team will liaise with the consultant to ensure that all patients will be offered a date within 14 days.
- When a patient cannot attend an appointment within 2 weeks, the GP should delay making the referral until the patient is available to be seen within 2 weeks.
- Should the patient not be able to accept the second appointment offered they will be advised that the relevant clinician will review the referral and indicate whether a further appointment should be offered or if the patient should be discharged back to their GP.
- The management of patient DNAs will be in line with Section .8.9

Any difficulty encountered in meeting the booking guidelines must be escalated to the relevant Assistant Divisional Manager or Divisional Manager for action and resolution.

The quality of RACPC referrals will be the subject of regular audit, (with appropriate feedback to individual GPs and commissioners). Appropriate action will be agreed with the commissioners if there is evidence of training needs in general practice in relation to RACPC referrals, or that this route is being misused to secure fast-track appointments for inappropriate patients.

Transient Ischaemic Attack (TIA) clinic referrals
To meet NHS standards all high risk TIA patients should be seen and treated as a medical emergency within 24 hours of the first contact with a healthcare professional.

All low risk TIA patients should be seen and treated within 7 days of the first contact with a healthcare professional.

Referrals from GPs will be by referral protocol only and must be accompanied by a completed ABCD2 score proforma.

Patient scoring 4 or above on the ABCD2 should be referred to the high risk clinic within 24 hours of the first contact.

GPs must contact the TIA referral hotline and an urgent appropriate appointment will be agreed for the patient whilst still in consultation with the GP.

Patients who score below 4 on the ABCD2 should be referred as low risk and will be given an appointment in the TIA clinic within 7 calendar days of contact.

GPs must email the referrals to the Stroke Office (wherts-tr.tiareferral@nhs.net) and the patient will be contacted to agree an appropriate appointment date and time.

The quality of TIA referrals will be the subject of regular audit, (with appropriate feedback to individual GPs and the CCG). Action will be agreed with the CCG if there is evidence of training needs in general practice in relation to TIA referrals, or evidence that this route is being misused to secure fast-track appointments for inappropriate patients.

Consultant to consultant referrals (C2C)
Consultant to consultant (C2C) referrals should be kept to a minimum wherever possible and should relate to the original referred condition.

C2C referrals must follow the strict referral protocol in the Consultant to Consultant Commissioners policy. At present referrals may be accepted under the following circumstances:

- Consultant to consultant outpatient referral or Accident & Emergency to consultant outpatient referral is considered of benefit to the patient when a different specialist consultant opinion is needed to advance the management of the presenting or associated condition
- When the referral is for investigation, management or treatment of cancer, or a suspected cancer
- Symptoms or signs suggest a life threatening or urgent condition
- Surgical assessment of an established medical condition with a view to surgical treatment
- Medical assessment of an established surgical condition with a view to medical management
- Anaesthetic risk assessment
- A&E referrals to fracture clinic
- Referrals that are part of the continuation of investigation/treatment of the condition for which the patient was referred. These will continue their existing pathway.
- Suspected cancer referral. This will be vetted and dated by the receiving consultant and upgraded if deemed necessary. Once upgraded the patient will be treated within 62 days of the date the referral was received by consultant.
- Management of pain where surgical intervention is not yet appropriate.

All other referrals must be returned to the referring consultant for referral back to the patient's GP.

Investigation for or treatment of any condition other than the condition for which the patient was originally referred, requires the patient to be referred back to the GP for onward referral to a different specialist.

Referrals from AAU and wards
Patients who require an outpatient appointment with the consultant team that was responsible for their care during their non elective inpatient stay will be booked as 'follow-up appointments'.

These patients do not need to be placed on an 18 week RTT pathway. Appointments should be agreed with the patient and booked by the ward before the patient is discharged.

Patients who require an outpatient appointment with a different specialty or new consultant team following an inpatient admission will be booked as 'new appointments'. These patients fall under the 18 week RTT requirements, and an RTT clock will start at this point.

Waiting time standards as detailed in Section 3.2 will apply to these patients. Appointments should be agreed with the patient and booked by the ward before the patient is discharged.

Patients who require an outpatient appointment with a different specialty or new consultant team following an inpatient admission who are already under the care of that consultant team for outpatient treatment will be booked as 'follow-up appointments'. The appointment should be booked under the existing outpatient registration for that consultant team.

The guidance on consultant to consultant referrals (Section 6.10) must be applied when booking appointments for this group of patients.

Acute therapy services (including outpatient physiotherapy, dietetics, orthotics & surgical appliances)
Requests must include all relevant clinical information and indicate clinical urgency.

All requests will be vetted by the relevant department within 24 hours of the request being made. Requests with missing clinical information or considered to be inappropriate will be returned to the responsible clinician within this timescale and the patient will not be added to the waiting list.

The patient is informed by letter that the request has been rejected with the reason why and is asked to make contact with their consultant.

Inappropriate referrals
Inappropriate referrals received via eRS (eg service not provided by the Trust) will be rejected back to the referring GP advising that the patient needs to be referred elsewhere – this will nullify the patient's RTT pathway.

However, if a referral has been made to the diagnostic team, the radiologist must add comments on CRIS detailing the reasons why the referral is considered inappropriate.

The request status on CRIS requires updating by entering 'Request Unjustified' or 'Request Rejected' ensuring that the reason for rejection is recorded in the comments box, providing a clear audit trail should the reason for rejection be required in the future.

Inter-provider transfers (IPT)
The majority of inter-provider transfers are referrals out of the Trust.

All outgoing IPT referrals will be sent electronically via nhs.net from each service.

The Trust expects to receive an accompanying MDS proforma with the IPT, detailing the patient's current RTT status, along with the patient's pathway identifier:

- the Trust will inherit any RTT wait already incurred at the referring Trust if they have not yet been treated
  or
- if the patient has been referred for a new treatment plan for the same condition, a new RTT clock will start upon receipt

Where the IPT is for a diagnostic test only, the referring Trust retains responsibility for the RTT pathway.

10. Waiting Lists

Principles of waiting list management
The decision to add a patient to a waiting list must be made by a member of the clinical team. Patients must be allocated a P code indicating the clinical prioritisation and timeline for treatment.

P Code	Description
P1a	Emergency procedures to be performed in < 24 hours
P1b	Emergency procedures to be performed in < 72 hours
P2	Procedures to be performed in < 1 month
P3	Procedures to be performed in < 3months
P4	Procedures to be performed > 3 months
C1	Postponed by patient due to non-COVID-19 concerns

Clinically urgent patients (P1 and P2 categories) will be prioritised and booked according to clinical need, then routine patients (P3 followed by P4).

All routine elective patients must be booked chronologically, meaning patients on the waiting list the longest are booked first.

War pensioners and service personnel must receive priority access for any conditions which are related to their service (over other patients with the same level of clinical need).

Patients should not be added to the waiting list unless they are deemed fit, ie if a bed was available the following day the patient must be medically fit to proceed.

Patients who are considered to be insufficiently fit/well enough to proceed must be discharged back to their GP with a full explanation and clear details of the criteria that need to be met in order for the patient to be reconsidered for treatment at a later date.

The consultant may choose to continue to review them in the outpatient department. A decision not to treat or active monitoring clock stop should be applied to the patient's 18 week RTT pathway following the clinician's decision.

The use of effective early pre-operative clinics (POA) forms the basis of efficient waiting list management. The attendance at a POA clinic following the decision to treat determines the suitability and fitness to treat at an early stage. In cases where fitness is an issue POA will be responsible for notification to the treating clinician and GP.

When a patient declines the first offer of a TCI date, requesting to delay treatment they should be assigned a C1 category. A second TCI date should be offered to the patient. This date should be within 6 weeks of the first offered date. All dates should be with reasonable notice.

If a patient declines both dates, it may be appropriate, following a clinical review and agreement with the patient, to consider placing the patient on active monitoring. Where it is appropriate this should be for a maximum period of 12 weeks.

If a patient is placed on active monitoring the RTT clock will be stopped (using code 32). Patients should be advised of the process to follow if they wish to go ahead with treatment at any point during this period.

If a patient wishes to go ahead with treatment they should be offered a new TCI date as if they were on the waiting list at the point they left it. They should not be returned to the bottom of the waiting list.

Before the end of the period of active monitoring a patient should be offered a new TCI date (with reasonable notice). If the patient declines the date and requests a further delay a further clinical review should take place to consider whether it is clinically appropriate to extend the period of active monitoring further. The clinician may also wish to consider whether discharge back to the care of the GP is appropriate at this point.

Active waiting list (PTL)
The active waiting list should consist of patients who are fit and available to proceed with their treatment/diagnostic procedure within the waiting time standard.

Therapeutic procedures carried out within Radiology are governed by the RTT 18 week rules (radiologically guided steroid injections/angioplasty).

All patients, irrespective of procedure, form part of the elective waiting list and must be treated in line with DHSC guidance:

Day case/inpatient/therapeutic	18 weeks (from referral to treatment)
Diagnostic procedure	6 weeks (from receipt of referral to test)

Clinical priority should be defined through the P or D codes (see sections 6.3 and 7.1).

Planned waiting list
Patients should only be added to a planned list where clinically they need to wait for a clinician specified period of time. This includes planned diagnostic tests (eg check cystoscopy) 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 or repeated at a specific frequency. The planned list is also used for those patients requiring follow up imaging.

When patients on planned lists are clinically ready for their test to commence and reach the date for their planned appointment, they should either receive that appointment or be transferred to an active RTT waiting list and an 18 week clock should start (and be reported in the relevant waiting time return). The key principle is that where patients' treatment can be started immediately, then they should start treatment or be added to an active waiting list.

Adding patients to active inpatient / day case waiting lists
The definition of an inpatient is any patient admitted electively or by other means with the expectation that they will remain in hospital for at least one night, including any patient admitted with this intention who leaves hospital for any reason without staying overnight.

The definition of a day case is 'A patient admitted electively during the course of a day with the intention of receiving care who does not require the use of a hospital bed overnight and who returns home as scheduled.' Where this original intention is not fulfilled and the patient stays overnight, such a patient should be counted as an ordinary admission.'

- A day case must be an elective admission
- A consultant is responsible for the patient's medical care
- The patient uses a hospital bed for recovery purposes. When a bed or trolley is used for a specific short procedure rather than because of the patient's condition, this does not count as a hospital bed.
- The patient is not intended to occupy a hospital bed overnight, and does not actually occupy a bed overnight.

Patients listed for more than one procedure to be carried out at the same time
When more than one procedure is to be performed at one time by the same surgeon the patient should be added to the waiting list with the additional procedures noted.

When different surgeons will be working together to perform more than one procedure the patient should be added to the waiting list of the surgeon for the priority procedure with the additional procedures noted.

If the patient requires more than one procedure performed on separate occasions by different or same surgeon

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

Maintaining the waiting list
Waiting lists should be kept up to date by waiting list co-ordinators or identified staff managing individual lists using the 18 week RTT Patient Tracking List (PTL). They need to ensure that patients are listed promptly and that the list does not contain patients who no longer need their procedures. Telephone validation of the PTL should be undertaken by the waiting list co-ordinators on a regular basis, eg monthly, to ensure the list is up to date and accurate, ensuring good data quality standards are maintained.

All waiting lists are to be maintained in Cerner. Manual card based systems should remain only as a backup to the main database for business continuity purposes.

Details of patients to be admitted must be entered within 2 working days of the decision to admit being made. Patients will be added to the waiting list with the date the decision to admit was made. The waiting list episode must be attached to the correct 18 week RTT pathway.

11. Booking Principles

The options in booking from first outpatient or diagnostic through to TCI are covered below.

Reasonable offers

A reasonable offer is an offer of an appointment\admission with at least 3 weeks' notice of the appointment date and time.

Where a patient accepts an offer with less than 3 weeks' notice, it will be considered a reasonable offer should the patient subsequently cancel. However, if a patient declines such an offer the patient's waiting time must continue.

Patients who decline one reasonable offer must be offered at least one further reasonable offer. Patients should be warned that after declining the first reasonable offer only one other offer will be made.

If a patient declines two reasonable offers or if the patient is unable to confirm their availability for admission the patient should be brought to the attention of the clinical team for review. The patient may be discharged back to their GP and the RTT clock stopped unless it is agreed by the consultant that this is contrary to their best clinical interests.

Any patient who requests a period of delay before progressing to treatment should be brought to the attention of the clinical team for review. These patients should be assigned a P6 code on the waiting list. Patients should be asked to confirm the postponement reason and duration and this detail must be recorded on Cerner. The clinical team must consider the implications of delay and advise the patient accordingly if there is a clinical risk. The clinical team will also consider whether it is appropriate for the patient to remain on the admitted waiting list or if it is more appropriate to discharge the patient back to the care of the GP until they are available to proceed with treatment.

If a delay is agreed, prior to the end of the specified period, the patient should be contacted to confirm their availability. If the patient remains unwilling to proceed to treatment, the clinical team should be asked to consider discharge back to the care of the GP for re-referral when the patient is available.

If the clinician feels the delay request is inappropriate and not in the best clinical interests of the patient, a follow up clinical review must be arranged. The patient will be discharged back to the care of their GP if the patient does not accept the advice of the clinician provided that the clinical interests of vulnerable patients are protected.

Ultimately patients should be considered on a case by case basis, however it is generally not in patients' best interests to be left on a waiting list for extended periods of time (several months or more).

There must be specific protection for the clinical interests of suspected cancer patients, children and young people and vulnerable adults.

If a decision to discharge is made, the reason should be made clear in a letter to the GP/referrer and the patient.

Diagnostic waiting time
The clock for the 6 week diagnostic standard can be re-set from the first appointment date offered. The clock cannot be re-set if there is no evidence that the appointments offered to and declined by the patient were reasonable.

Adjustments to the 6 week diagnostic standard do not affect the patient's 18 week RTT waiting time.

RTT waiting time
Advice must be sought from the clinical team if a patient elects to defer surgery to ascertain that the:

- delay is not contrary to their best clinical interest.
- clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected.

Providing the above has been confirmed, the patient may be offered a further date.

However, if the clinician feels the delay is inappropriate and not in the best clinical interests of the patient, a follow up clinical review must be arranged. The patient will be discharged back to the care of their GP if the patient does not accept the advice of the clinician provided that the clinical interests of vulnerable patients are protected.

Any patient who requests a period of delay before progressing to treatment should be brought to the attention of the clinical team for review. These patients should be assigned a P6 code on the waiting list. Patients should be asked to confirm the postponement reason and duration and this detail must be recorded on Cerner. The clinical team must consider the implications of delay and advise the patient accordingly if there is a clinical risk. The clinical team will also consider whether it is appropriate for the patient to remain on the admitted waiting list or if it is more appropriate to discharge the patient back to the care of the GP until they are available to proceed with treatment.

If a delay is agreed, prior to the end of the specified period, the patient should be contacted to confirm their availability. If the patient remains unwilling to proceed to treatment, the clinical team should be asked to consider discharge back to the care of the GP for re-referral when the patient is available.

Booking appointments
E-referral appointments
All patients will be offered appointments (including acute therapy services)/admissions dates within the current guidelines for patient choice and in line with the national guidance for waiting times.

The majority of outpatient appointments will be chosen by the patient via the NHS e-referral service (directly bookable). NHS e-referral patients will automatically receive a confirmation letter.

Indirectly bookable services have been set up as referral assessment services so that the service may triage the referral before offering an appointment.

Diagnostic appointments
Following prioritisation, patients will be contacted by telephone to arrange a convenient imaging appointment or an appointment letter will be sent directly to the patient confirming the appointment.

It should be noted that outpatient imaging may be offered to a patient at any site within the Trust, although consideration will be given to the patient's place of residence where possible.

All offered and declined imaging appointments will be recorded on CRIS.

Telephone contact
Patients must be contacted by telephone to agree their admission date wherever possible. Two attempts are to be made to contact the patient at different times of the day. However, if this is unsuccessful the patient will be sent a letter requesting that they make contact within 10 working days.

If the patient does not respond within the timeframe, this will be brought to the attention of the clinical team to confirm whether in the absence of any contact with the hospital, it would be appropriate to discharge the patient back to the care of their GP or other referrer. This discharge must be communicated by letter to the patient and GP in a timely manner. This decision would stop the RTT clock.

A separate validation process exists for contacting patients on a cancer pathway.

Booking follow up appointments
Where possible, follow up appointments should be agreed with the patient prior to leaving the clinic. This provides the best opportunity for patient choice to be accommodated within the required timescale for achievement of the RTT standard. Where insufficient capacity is available, the clinic receptionist will escalate in line with local arrangements to obtain authorisation to overbook or, if no authorisation, to escalate to the service.

Discussing likely treatment plans at first outpatient and/or use of telephone/written communication where a face-to-face consultation is not clinically required, may avoid the need for follow up appointments - these are referred to as virtual clinics. However, follow up appointments must be booked to a timeframe that permits treatment by week 18 (unless the patient chooses a later date or is on active monitoring).

The decision to move a patient on to a PIFU pathway will stop the RTT clock. If the patient requests a follow up appointment during the agreed period, a new RTT clock should not be started unless there is a decision to treat.

Non-clinical on the day cancellations (last minute)
On the day cancellations are defined as occurring 'on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation'. For example, the patient is to be admitted to hospital on a Monday for an operation scheduled for the following day (Tuesday). When the hospital cancels the operation for non-clinical reasons on the Monday, this would be considered a last-minute cancellation. This includes patients who have not actually arrived in hospital and have been telephoned at home prior to their arrival on the day they were due to arrive.

Where theatre lists or patients are cancelled on the day of admission or day of surgery, patients must be booked as close to their original appointment as possible, and within a

maximum of 28 days of the cancellation date or before their 18 week RTT breach date – whichever is sooner.

Two reasonable offers must be made to the patient and the patient may choose not to accept a date within 28 days. Where a patient accepts an offer with less than 3 weeks' notice, it will be considered a reasonable offer should the patient subsequently cancel.

When the Trust cannot offer the patient a date within 28 days of the cancellation, the Trust may offer to fund the patient's treatment at the time and hospital of the patient's choice where clinically appropriate.

Patient discharged – treatment not taken place
In the event of a patient being unable to tolerate an examination or procedure the relevant system and this is abandoned (eg as a result of claustrophobia), details must be entered onto CRIS (including the reason) and the referrer notified. Where possible, consideration will be given to an alternative imaging procedure.

Where a patient refuses to take sedation/undergo the procedure, the consultant will make the decision whether to discharge the patient or offer an alternative solution (if available).

Clinical on the day cancellations
When a patient is cancelled on the day of admission or day of surgery for clinical reasons, the nature and duration of the clinical issue should be ascertained.

The patient must be offered a new admission date within their 18 week breach date if the clinical issue is short term (eg cough, cold) and has no impact on the original clinical decision to undertake the procedure. The clock will continue running during this time.

However, if the clinical issue is more serious and the patient requires optimisation and/or treatment for it, clinicians should indicate whether:

- It is clinically appropriate for the patient to be removed from the waiting list (this will be a clock stop event – active monitoring)
  or
- Whether the patient should be optimised/treated within secondary care (clock stop – active monitoring, until fit to proceed or if they should be discharged back to the care of the GP

The patient will be re-listed and a new clock started when confirmation is received that the patient is fit to undertake the procedure. The patient can be added directly to the waiting list again within a 12-week period. Any delay over 12 weeks will require a new referral from the GP.

The RTT clock should not be stopped if a patient is cancelled as a result of testing positive for COVID. The patient should be offered a new date for admission in keeping with current guidelines.

Further appointment requests after discharge
Patients can request a follow up within a 6 month period of being discharged with the same clinical team for the same side and condition. A new referral is required for a new side/condition.

Patients requesting time to consider treatment options (thinking time)
Patients may wish to spend time thinking about the recommended treatment options before confirming they are willing and able to proceed. Where a period of thinking time is agreed with the patient, the effect on the RTT clock will depend on the individual scenario.

The patient and clinician should agree a set time by when the patient will decide and notify the clinician. If there is no communication from the patient within this period, the clinician should take a view on whether it is appropriate to commence a period of active monitoring while the patient comes to a decision.

If, when discussing the decision making period, a patient suggests that they need a number of months to come to a decision, the clinician should take a view at that point, on whether it is appropriate to commence a period of active monitoring.

Should the patient subsequently decide to go ahead with the recommended treatment they can be added to the waiting list and a new clock started when the patient confirms they are willing to proceed. They can be added directly to the waiting list within a 12-week period. Any delay over 12 weeks may require an outpatient review as directed by the clinician. In some instances the clinician may place the patient back on to the waiting list without a further review.

Patients who decline reasonable offers for admission because they are undecided on whether to proceed or not, should be advised to make a further outpatient consultation with the clinical team in order to come to a decision. The clinical team should be made aware of the patient's request and should indicate whether a period of active monitoring should be initiated. Removal from the waiting list may also be indicated if clinically appropriate.

Did not attend (DNA)
All patients who do not attend must be reviewed by the clinician.

Where a patient does not attend a reasonably offered date they should be clinically reviewed before being discharged back to the care of their GP provided that:
- discharge is not contrary to their best clinical interest
- the clinical interests of vulnerable patients (see the Safeguarding Adults at Risk Policy and Procedure, or the Child Protection Policy) are protected

Should the clinical decision be made not to rebook, the patient will be:
- removed from the waiting list
- referred back to the responsible clinician (with a view to discharging the patient back to their GP)
- discharged back to their GP

Cerner will be updated to reflect the outcome and a letter will be sent to the patient and GP.

Should the clinical decision be made to rebook:
- the RTT clock start will be amended if it is a patient's first appointment
- the diagnostic waiting time for that test\procedure is reset to zero and the diagnostic waiting time starts again from the date of the appointment that the patient missed (this adjustment has no effect on the patient's 18 week RTT pathway)
- there is no effect on the patient's RTT pathway unless it is a first appointment

In the case of not attending an imaging appointment, following a radiologist's decision not to rebook:

- A copy of the request form plus the CRIS generated DNA letter will be sent to the referring consultant/GP
- The request will be cancelled on CRIS

Should the decision be made to rebook, the request should be treated as a new referral and re-entered on to CRIS as a new event, ensuring a new request received date is entered accordingly.

The diagnostic waiting time for that test/procedure is reset to zero and the waiting time starts again from the date of the appointment that the patient missed. This adjustment has no effect on the patient's 18 week RTT pathway.

Failure to attend an agreed appointment date will result in the patient being discharged. The referrer will be informed of the failure to attend and of the removal. The patient may be re-referred at the General Practitioner's/referrer's discretion.

If a patient does not attend an admission, a further admission date will not be routinely offered, and the patient will be discharged back to the GP/referrer where the following criteria is met:

- The admission date was reasonable and clearly communicated
- Discharging the patient is not contrary to their best clinical interests
- There is specific protection for the clinical interests of suspected cancer patients, children and young people and vulnerable adults.

Patient cancellations

Patients who cancel an agreed appointment once should be given an alternative date at the time of the cancellation (including patients who cancel their admission for non-medical reasons). However, it is reasonable for patients to cancel appointments if the dates were not negotiated with them.

Should a patient cancel an appointment on two or more consecutive occasions or they are unable to re-book their appointment within their breach date:

- Clinical appointment - their case should be reviewed by medical staff to ensure there is no clinical risk in not treating the patient and it is agreed that the patient is not considered to be vulnerable (see Safeguarding Adults at Risk policy, Child Protection Policy) - where no risk is identified, patients should be discharged back to their GP
  or
- Diagnostic appointment - the imaging request should be returned to the referring clinician and the patient discharged providing the referral is not for a suspected/confirmed cancer - the patient should be removed from the waiting list and cancelled on CRIS, noting the appropriate reason.

Patients can cancel an admission date once. If a patient cancels an admission date and asks to rearrange this a second time they should be discussed with the clinical team and considered for discharge back to the care of the GP. Unless it is clinically inappropriate (and the admission date was reasonable and clearly communicated), the patient will be discharged.

There must be specific protection for the clinical interests of suspected cancer patients, children and young people and vulnerable adults.

When discharging a patient, a letter must be sent to the GP/referrer and the patient. All cancellation reasons/details must be recorded on PAS.

Patients arriving late for clinic
It will be the consultant's decision whether they will see the patient if the clinic is still running. Where the clinic has actually finished, the patient will be recorded as did not attend.

Hospital cancellations in advance
Sessions should not be cancelled with less than six weeks' notice unless there are exceptional circumstances.

No session should be cancelled at short notice without the authorisation of the Director of Performance or Chief Operating Officer or a nominated deputy.

A minimum of six weeks' notice of planned leave should be given. Clinics should not be cancelled for any other reason unless there are exceptional circumstances and the cancellation has been authorised by the Divisional Manager, Director of Performance or the Chief Operating Officer or a nominated Deputy Director.

When theatre lists have to be unavoidably cancelled at short notice, liaison with the Divisional Manager, Assistant Divisional Manager for Theatre and Theatre Manager is essential.

- Only leave approved by the relevant clinical lead will be actioned.
- Session cancellation notifications will only be accepted if submitted on the appropriate form, unless there are exceptional circumstances.
- Session cancellation notification must be passed to the relevant administrative manager for action.
- Session cancellation requests will be actioned at the earliest opportunity and within a maximum of five working days.
- Where patients have to be cancelled, the relevant clinician should review clinical priorities and waiting times and identify the rebooking requirement.
- Patients who have previously been cancelled should not be cancelled a second time.

Patients who are cancelled by the hospital must be offered an alternative which is:

- Within their 18 week RTT breach date for outpatients/admissions/therapeutic procedures
- Within their 6 week diagnostic breach date for diagnostic patients

Pre-operative assessment (POA)
Where possible, patients will be offered pre-operative assessment on the day that they are added to the waiting list in outpatients. In the event that this is not possible the patient will be offered a subsequent appointment to attend for pre-operative assessment.

<u>Patient assessed as fit to proceed</u>
When the patient is considered fit for treatment, and prior approval is not required, the admissions department will negotiate a date for treatment with the patient in due course. The patient will be treated within their 18 week pathway unless this is not clinically appropriate or the patient chooses to wait longer for treatment.

Patients assessed as not fit to proceed

When a patient is listed for surgery but is identified, or self-reports, as unfit for that procedure, the nature and duration of the clinical issue should be ascertained.

When the clinical issue is short term (eg 1-2 weeks) and has no impact on the original clinical decision to undertake the procedure, the patient must be offered a new TCI date within their 18 week breach date. The clock will continue running during this time.

However, if the clinical issue is more serious the consultant should advise if:

- it is clinically appropriate for the patient to be removed from the waiting list (this will be a clock stop event)
- the patient should be optimised/treated within secondary care (this will be active monitoring – clock stop) or
- the patient should be discharged back to the care of the GP (clock stop).

The patient should be re-listed and a new clock started when confirmation is received from either the GP or the relevant clinician, that the patient is fit to undertake the procedure. The treating consultant must review the case and indicate whether the patient needs to be reviewed in outpatients or whether they can be added directly to the inpatient waiting list.

12. Cancer Pathways

Management of Cancer waiting times is governed by a separate set of rules and principles. This section describes how staff should manage waiting times for patients with suspected and confirmed cancer to ensure that patients are diagnosed and treated as rapidly as possible and within the national waiting times standards.

This policy is consistent with the latest version of the Department of Health's Cancer Waiting times guidance (v11)
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/09/national-cancer-waiting-times-monitoring-dataset-guidance-v11-sep2020.pdf

Cancer waiting times standards

The table below outlines the key cancer waiting times standards that must be complied with.

Cancer waiting times – 2 week waits	93% of patients will be seen within two weeks of an urgent GP referral for suspected cancer or where identified as breast symptomatic
Cancer waiting times – 31 days	96% of patients will wait a maximum of one month (31 days) from diagnosis to first definitive treatment for all cancers
	94% of patients will wait a maximum of one month (31 days) for subsequent treatment where treatment is surgery
	94% of patients will wait a maximum of one month (31 days) for subsequent treatment where treatment is radiotherapy
	98% of patients will wait a maximum of one month (31 days) for subsequent treatment where treatment is an anti-cancer drug regimen
Cancer waiting times – 62 days	85% of patients will wait a maximum of two months (62 days) from urgent referral for suspected cancer to first treatment for all cancers
	90% of patients will wait a maximum of two months (62 days) from NHS cancer screening service referral to first definitive treatment

Clock starts

- A two week wait clock starts on receipt of referral
- A 62 day clock can start following any of the below:
  - urgent 2 week wait referral for suspected cancer
  - urgent 2 week wait referral for breast symptoms (where cancer is not suspected)
  - a consultant upgrade
  - referral from an NHS cancer screening programme
  - non-NHS referral (and subsequent consultant upgrade)
- A 31 day clock will start following:
  - a decision to treat (DTT) for a first definitive treatment
  - a DTT for subsequent treatment
  - an ECAD (earliest clinically appropriate date) following a first definitive treatment for cancer

If the patient's treatment plan changes, the DTT can be changed, for example if a patient initially agrees to surgery but then changes their mind and the subsequently instead chooses radiotherapy.

Clock stops

- A 62 day clock will stop following any of the below:
  - Delivery of first definitive treatment
  - Placing a patient with a confirmed cancer diagnosis on to active monitoring

- Removal from a 62 day pathway should occur when:
  - a clinician makes a decision not to treat
  - a patient declines all diagnostic tests
  - confirmation of a non-malignant diagnosis

In some cases where there is a cancer clock stop the RTT clock continues, eg on confirmation of a non-malignant diagnosis.

Two week wait (2ww) referrals

All referrals (including patients referred with breast symptoms) should be referred by the GP/GDP/Optometrist on the relevant cancer pro forma and submitted electronically. Day 0 is the date the referral was received.

The first appointment can be either an outpatient appointment with a consultant or a member of the consultant's team, or an investigation relevant to the referral (a straight to test – STT – pathway).

Downgrading 2ww referrals

The Trust cannot downgrade 2ww referrals. If a consultant believes the referral does not meet the criteria for a 2ww referral they must contact the GP to discuss this. If it is agreed that the referral does not meet the criteria, the GP must retract it and refer in line with the relevant non-2ww pathway. It is however only the GP who can make this decision.

If two referrals are received on the same day, both must be seen within 14 days and if two primary cancers are diagnosed, treatment for both must start within 62 days of receipt of referral if clinically appropriate.

Screening pathways
The clock start is the receipt of the referral (day 0) which for the individual screening programmes is as follows:

- breast: receipt of referral for further assessment (ie not back to routine recall)
- bowel: receipt of referral for an appointment to discuss suitability for colonoscopy with a specialist screening practitioner (SSP)
- cervical: receipt of referral for an appointment at colposcopy clinic.

Consultant upgrades
Hospital specialists have the right to ensure that patients who are not referred urgently as suspected cancer referrals or through the screening programmes, but who have symptoms or signs indicating a high suspicion of cancer, are managed on the 62-day pathway. This can be achieved by upgrading the patients onto a 62-day upgrade pathway.

The 62-day pathway starts (day 0) from the date the patient is upgraded.

Upgrade must occur before the DTT date. Patients not upgraded at this point will be measured against the 31-day DTT to first definitive treatment.

An upgrade is intended for suspected new primaries only, not those who may be suspected of a recurrence.

Who can upgrade patients onto a 62-day pathway?
The specialist team receiving the referral or reviewing the patient or diagnostic result can delegate the responsibility to upgrade the patient. This could be:

- specialist nurse/practitioner, either by triaging the referral form/letter or at nurse led initial clinic.
- specialist registrar either by triaging the referral form/letter or at initial clinic.
- radiologist/histologist/other trust clinicians on reviewing patients and/or diagnostics.

Responsibilities
The consultant or delegated member of the team upgrading the patient is responsible for informing the MDT co-ordinator that an upgrade has occurred, in order for the patient to be tracked on the correct pathway. Infoflex must be updated to show the date of the consultant upgrade and Cerner updated with the new referral and the reason referral marked appropriately (CU62). The patient will not appear on the PTL unless these steps are taken.

If a patient has been upgraded to a 62 day pathway, this must be communicated to the patient so they understand why they are being upgraded and the GP should be notified.

Subsequent treatments
If a patient requires any further treatment following their first definitive treatment for cancer (including after a period of active monitoring) they will be monitored against a 31-day subsequent treatment clock. The clock will start following the patient agreeing a treatment plan with their clinician. This will be the decision to treat (DTT) date.

In some circumstances it may be appropriate for the clinician to set an ECAD (earliest clinically available date) which is when a patient needs to recover following their first definitive treatment. An ECAD can be adjusted but only if the date has not passed. The 31 day clock start date should be the same as the ECAD date for these patients.

Waiting time adjustments
Unlike RTT pathways, it is possible to make adjustments (pauses) to cancer clocks in two instances as follows:

- 2ww: if a patient DNAs their initial (first) appointment or attendance at a straight to test diagnostic appointment (eg colonoscopy), the start date can be reset to the date the patient rebooks their appointment (the date the patient agrees the appointment, not the appointment date).
- 31/62 day: if a patient declines admission for a day case/inpatient treatment procedure, providing the offer was reasonable, the clock can be paused from the date offered to the date the patient is available, provided the offered date is recorded clearly.

If a patient, during a consultation (or at any other point), while being offered an appointment date for cancer treatment (not a diagnostic date), states that they are unavailable for a set period of time (eg holiday or work commitments), a pause can be applied from the date that would have been offered to the date the patient is available. This applies only if the date the Trust would have offered is clearly recorded.

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

Patients who cancel an appointment/investigation date should be offered an alternative date within 7 days or the cancelled appointment.

Multiple cancellations
All patients who are referred on a 2 week wait or 62-day GP pathway, screening pathway or breast symptomatic referral who cancel two consecutive appointments (ie outpatient, diagnostic investigation) will be contacted by an appropriate member of staff to identify any factors that may be stopping the patient attending. Another appointment will be offered if the patient agrees.

Patients can be discharged after multiple (two or more) appointment cancellations if this has been agreed with the patient. However, where a patient has cancelled multiple appointments on a 62-day GP pathway, screening pathway or breast symptomatic referral (ie outpatient, diagnostic investigation), an appropriate member of staff will contact the patient to identify any factors that may be stopping the patient attending and another appointment will be offered if the patient agrees. Patients should never be referred back to their GP after an appointment cancellation unless this has been agreed with the patient – by cancelling an appointment the patient has shown a willingness to engage with the NHS.

Patient DNAs
Patients will be recorded as a DNA if they do not turn up to a clinic or diagnostic appointment, turn up late or turn up in a condition where the trust cannot carry out whatever was planned for them: for example, if they have not taken a preparation they needed to take before the appointment. (This also includes patients who have not complied with appropriate instructions prior to an investigation.)

First appointment DNA - all patients referred as suspected cancer including 2WW, screening, upgrade and breast symptomatic who DNA their first outpatient appointment should be offered an alternative date within 14 days of the DNA. A waiting-time adjustment applies from receipt of referral to the date the patient makes contact to rearrange the appointment and all details must be recorded on the cancer management system. If a patient DNAs their first appointment for a second time they will be escalated to the

consultant in clinic for a decision on the next step which may include discharge back to the GP.

Subsequent appointment DNA - if a patient DNAs any subsequent appointment they should be escalated to the consultant in clinic for a decision on the next step which may include discharge back to the GP.

Patients who are uncontactable

If the patient is uncontactable at any time on their 2 week wait (including breast symptomatic),62-/31- day pathway, a record of the time and date of the call to them in the 'additional information' section on PAS should be made at the time of the call.

Two further attempts will be made to contact the patient by phone, one of which must be after 5.00pm. Each of these calls must be recorded in real time on Cerner. These attempted contacts must be made over a maximum two-day period.

If contact cannot be made by such routes, the GP surgery must be contacted to ask for alternative contact routes.

If the patient remains uncontactable:

- For first appointments: An appointment will be sent to the patient offering an appointment within the 2WW standard, stating the trust has attempted to offer a choice of appointment, and that the patient should contact the 2WW office to rearrange the appointment if it is inconvenient
- Appointments (other than first) on 62-/31- day clinical pathway: Attempts to contact patient will be made as outlined above. If contact cannot be made, the consultant should decide: – to send a 'no choice' appointment by letter, or to send a no contact letter requesting response within 7 days or to discharge the patient back to the GP.

  If, after all attempts to contact the patient, there is still no response, the consultant should be made aware and asked to advise on next steps, which may include discharge back to the GP.

Patients who are unavailable

If a patient indicates they will be unavailable for 28 days or more on their pathway after their first appointment, the patient's healthcare records will be reviewed by the managing clinician to ascertain if the delay is safe for the patient. If the clinician has any concern over the delay, they will contact the patient to discuss if they can make themselves available. Patients should not be discharged if they make themselves unavailable. The clinician should indicate whether the patient is to stay on the cancer pathway (and will be a potential breach) or that following discussion with the patient, there is agreement to discharge back to the GP.

Tertiary referrals

Inter provider transfer (IPT) forms will be used for all outgoing referrals for patients on a cancer pathway. Information will be transferred electronically and a minimum dataset and all relevant diagnostic results and images will be provided when the patient is referred.

13. Training/Staff Competency and Compliance

Staff induction will include referral to treatment rules, the Access Policy and the modular training (Acorn). Refresher training and workshops are booked for teams as and when necessary. Individual training may be given where required

14. Monitoring & Compliance

1	Following local and national policies and guidelines, what key elements require monitoring?	List elements to be monitored	a. Understanding of events that constitute clock start / stop by all staff with administrative responsibility for pathway management b. Reasonable notice offers of appointments and admission dates. c. Correct application of policy when recording pathway events, eg process for patients who DNA. d. Accurate and valid recording of offers and patient choice on relevant system with appropriate pathway management
2	Who will lead/be accountable for monitoring?	Lead title and/or MDT	Head of RTT Access team
3	Describe how the key elements will be monitored?	List tools to evidence compliance	a. 18 week pathway multiple choice test on e-learning b. This is picked up through validation of open pathways and pathway audits (random selection of 20 non-admitted and 20 admitted pathways with a clock stop event) c. This is picked up through validation and pathway audits (random selection of 20 non-admitted and 20 admitted pathways with a clock stop event) d. Pathway audits (random selection of 20 non-admitted and 20 admitted pathways with a clock stop event)
4	How frequently will each element be monitored?	List frequency of monitoring for each element	a. Bi annually b. Bi monthly c. Bi monthly d. Bi monthly
5	Explain the protocols for escalation in the event of problems?	List the processes of escalation	a. Via Access meetings, Divisional RTT meetings and Elective Care Programme Board
6	Which Committee/ Panel/ Group will reports go to?	List the Committee/Panel/ Group/Peer Review that the reports will go to	a. Acorn, Head of RTT Access, staff line manager b. Trust Elective Care Access Meeting, Outpatient and Admissions managers c. Trust Elective Care Access Meeting, Service Managers, Outpatients and Admission Managers d. Trust Elective Care Access Meeting, Service Managers, Outpatients and Admission Managers
7	Explain how the policy/guideline will be disseminated within the Trust?	List ways identifying how this document will be shared and how it will be recorded that appropriate staff have been made	a. Available on Trust intranet b. Emailed to operational management teams

		aware of the document and where to find it	

15. Safeguarding

Does this document have any impact on safeguarding issues for adults and/or children?

16. Patient & Carer Involvement

Reference any group/individual patient/carer involvement in developing this document

17. Related Policies and Guidelines

Child Protection Policy
Consultant to Consultant Referral Policy
Commissioner Low Priority Policy
Commissioner Individual Funding Request Policy V7
RACPC Policy
Safeguarding Adults at Risk Policy & Procedure
Private Patients Policy

18. Equality Impact Statement (EIA)

What is an equality impact assessment?

There are many benefits in conducting an equality impact assessment (EIA) prior to making business decisions about policies, clinical guidelines or any other work that may potentially impact on a wide range of people with protected characteristics. Equality impact assessments should not be seen as an afterthought once decisions have already been made.

Benefits:

- Improved capacity to consider equality, diversity and inclusion as part of business management
- Reduced costs as a result of not having to revisit a policy/project
- Take into account a diverse range of views and needs
- Enhanced reputation as a Trust that is seen to understand and respond positively and proactively to diversity.

Whatever approach you take to an equality impact assessment, case law has established that you should keep an accurate, dated, written record of the steps you have taken to analyse the impact on equality. This will help you to check whether you are complying with the duty and it will be useful if your decisions are challenged.

When completing an equality impact assessment you should consider:

- Treating a person worse than someone else because of a protected characteristic (known as direct discrimination)
- Putting in place a rule or way of doing things that has a worse impact on someone with a protected characteristic than someone without one, when this cannot be objectively justified (known as indirect discrimination)
- Treating a disabled person unfavourably because of something connected with their disability when this cannot be justified (known as discrimination arising from disability)
- Failing to make reasonable adjustments for disabled people.

Equality impact assessment process
Stage 1 (Screening)

This stage provides an opportunity to explore whether the policy decision may have a negative, neutral or positive impact on different groups of people.

- If yes, use the ‘comments’ column to describe what this impact could be.

- If no, outline how have you arrived at this conclusion.

- If unsure use the ‘comments’ column to describe what you need to do to find out.

Stage 2 (Full Assessment)
This should be carried out in compliance with policy HR028 Equality & Human Rights Policy.

Does this policy/guideline affect one group less or more favourably than another on the basis of:				
				Comments
1	Age (younger people & children& older people)		no	
2	Gender (men & women)		no	
3	Race (include gypsies and travellers)		no	
4	Disability (LD, hearing/visual impairment, physical disability, mental illness)		no	
5	Religion/Belief		no	
6	Sexual Orientation (Gay, Lesbian, Bisexual)		no	
7	Gender Re-assignment		no	
8	Marriage & Civil Partnership		no	
9	Pregnancy & Maternity		no	
	Is there any evidence that some groups maybe affected differently?		no	
	Could this document have an impact on other groups not covered by a protected characteristic? (e.g.: low wage earners or carers)		no	
	If '**NO IMPACT'** is identified for any of the above protected characteristics then no further action is required.			
	If '**YES IMPACT**' is identified a full impact assessment should be carried out in compliance with HR028 Equality & Human Rights Policy and linked to this document			

Any other comments:
Please use this box to add any additional comments relevant to the assessment

Assessment completed by:	*Jane Shentall*	Date completed:	24 October 2022

If you have any queries or concerns about completing the EIA form, contact the Trust's Inclusion & Diversity Team at WestHerts.Inclusion@nhs.net

Appendix 1 – Definitions

AAU	Acute Admissions Unit
Active Waiting List	Patients awaiting elective admission and are currently available ie fit, able and ready, to be called for admission at entry to waiting list.
ASI (appointment Slot Issues)	List of patients who were not able to book an appointment through the NHS e-Referral system because there were no appointment slots available
Booked Admissions	Patients who have the opportunity to book their admission or treatment date immediately following their clinic appointment or very shortly after.
Booked Patients	Patients awaiting elective admission who have been given an admission date at the time of the decision to admit. These patients form part of the active waiting list. Elective Booked.
CATS	Clinical Assessment and Treatment Services – interface services providing an intermediate level of clinical assessment and triage/treatment of patients which sit in between primary and secondary care.
Cancer Waiting Times (CWT)	NHS cancer plan 2000 has set a specific goal of reducing cancer-waiting times (CWT) in UK.
Cerner	Patient Administration System
Choice	Patients Value Choice to be offered to all patients waiting for 6 months for elective care by summer 2004. Choice at point of referral for elective care by December 2005.
CRIS	Computerised Radiology Information System
Day cases	Patients who required admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.
DHSC	Department of Health & Social Care
DTA	Decision to Admit.
DTC'S	Diagnostic Treatment Centres
Did Not Attend (DNA)	Patients who have been informed of their admission date (inpatients/day cases) or appointment date (outpatients) and who without notifying the hospital did not attend admission /outpatient appointment.
DTT	Decision to treat date
ECAD	Earliest clinically appropriate date
e-RS	Electronic referral service – enables GPs to refer to a consultant-led service electronically
GP	General Practitioner
IFR	Individual funding request
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night
IPT	Inter provider transfer form – used in conjunction with the MDS
LPT	Low Priority Treatment – approval is required from commissioners before certain procedures may go ahead
MDS	Minimum dataset – the minimum amount of data required to transfer a patient in or out of the Trust (used in conjunction with the IPT form)
Order Comms/ICE	Systems used by Radiology to book diagnostic tests
Outpatients	Patients referred by a General Practitioner, General Dental Practitioner or another consultant for clinical advice or treatment.
Partial Booking List or waiting list	A holding list for patients waiting for an Outpatient Appointment. This process ensures patients are seen in chronological order and have the opportunity to choose a convenient date.

Planned Admissions	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment/investigation. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18 week RTT pathway
POA	Pre-operative assessment
PTL	Patient Tracking List a tactical tool used to deliver 18 week RTT national operational standards. The Trust's current tool is iReporter.
Referral to Treatment (RTT)	18-week pathway from referral from GP to commencement of treatment in secondary care.
Self-deferrals	Patients, who, on receipt offer of admission, notify the hospital that they are unable to come in.
SITREPS	Situation Reports made to Area Teams on current indicators.
SOP	Standard operating procedure
STT	Straight to test
TCI	To come in date or letter.
TIA	Transient Ischaemic Attack