Hertfordshire and West Essex Integrated Care System

HWE ICS Access Policy

NHS Hertfordshire and West Essex Integrated Care Board

Hertfordshire and West Essex Integrated Care System

Access Policy

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Date document written / revised:	12/12/2023
Assessed and approved by (committee):	HWE ICS Planned Care Group
Ratified by or reported as approved to (if applicable)**:**	HWE ICS Planned Care Committee
To be reviewed before: This document remains current after this date but will be under review	Date: 20/12/2026
For use in:	HWE ICS
For use by:	Providers, Clinicians, Operational Managers
Key words:	Access, RTT, Cancer,
Reference and / or Trust Docs ID No:	
Version No:	V11.0 Final
Description of changes (for revised versions):	

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1. Introduction

The Hertfordshire and West Essex Integrated Care System are committed to ensuring patients receive treatment in accordance with national objectives, planning guidance and appropriate standards, with patients of the same clinical priority treated in chronological order of their waiting time.

The purpose of this policy is to outline the ICB requirements, standards for managing patient access to planned secondary care services, and the responsibility of patients, providers and referrers.

The HWE ICS and the local providers are working together to ensure the achievement of all the patient's constitutional rights and to ensure we deliver against all key standards set out in our contracting agreements. The policy is designed to ensure access to hospital services is fair, equitable and based upon clinical need for all patients.

This policy sets out the rules and definitions of the:

- **RTT 18 weeks standard**
- **Cancer standards**
- **Diagnostic Standards**

Link to national guidance and rules
Statistics » Consultant-led Referral to Treatment Waiting Times Rules and Guidance (england.nhs.uk)

It does not provide detailed guidance on how the rules should apply to every situation but provides an over-arching framework to work within to make clinically sound decisions locally, in consultation with patients, clinicians, providers and commissioners.

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

This policy has been produced collaboratively with stakeholders from the input of the HWE ICS, local acute providers, with support from the Elective Intensive Support Team.

2. Scope of Policy

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

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

The policy sets out the roles, responsibilities, processes and best practice guidelines to assist staff with the effective management of patients who need to attend the Trusts within Hertfordshire and West Essex ICB for treatment as an outpatient, inpatient, day case or to receive diagnostic care.

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

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

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

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

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

3. Structure of Policy

The policy is structured in a way which makes it easy to navigate to both electronically and in hard copy and links to other policies electronically. Where it is expected there will be a local separate Standard Operating Procedure (SOP) or document, it will be referenced in this policy to refer to local guidelines. The policy is set out in line with the following structure:

- General Principles
- Pathway Specific Principles – following a logical chronological patient referral to treatment pathway.
- Reference Information
- Appendices

4. Key Policy Principles

As set out in the NHS Operating Framework and NHS Constitution, by law patients have the right to access certain services commissioned by NHS bodies within maximum waiting times. Currently, there is a national backlog due to pressures on the NHS and this waiting time target is being worked towards in a staged approach in line with current NHS guidance. This includes starting consultant-led treatment within a maximum of 18 weeks (126 days), unless they choose to wait longer or it is clinically appropriate they wait longer. All the aspects of the patient pathway which lead up to first definitive treatment, including outpatient consultations, diagnostic tests and

procedures will be monitored and proactive action taken to reduce waiting times. All other aspects of elective care will also be monitored e.g. follow up of patients following definitive treatment, and those patients waiting for an elective planned procedure etc. The following key principles are pertinent throughout the policy:

a) This policy covers the way in which the Trusts will manage administration for patients who are waiting for or undergoing treatment on a Referral to Treatment Pathway, for an admitted, non-admitted or diagnostic referral.
b) This policy also covers Cancer pathways and standards
c) The policy will be adhered to by all staff members who are responsible for referring patients, managing referrals, adding to and maintaining waiting lists (outpatient or elective) for the purpose of advancing a patient through their treatment pathway.
d) The Trusts will give priority to clinically urgent patients and treat all other patients in turn.
e) The Trusts will work to meet and where possible better the maximum waiting times set by NHS England for all groups of patients.
f) Where possible, the Trusts will mutually agree appointments and admission dates with patients.

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

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

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

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

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

5. Roles and Responsibilities

Hertfordshire and West Essex ICB Providers

a) Chief Operating Officer/Divisional Directors

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

b) Clinicians

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

- Where possible, aim to review all patient referrals, allocating clinical priority and accepting / rejecting referrals within 2 working days of receipt.
- To complete accurate and timely clinic outcome forms with clear instructions of next steps e.g. 6 month follow up to be booked and RTT status.
- To produce a clinic letter following outpatient attendance or other activity logged in an outpatient setting (MDT, notes review etc.), confirming care plan to GP/Referrer/Patient.
- To communicate with patients to ensure patients' perceptions of their care mirrors clinical decisions made regarding care plans and treatment. (e.g. for clock starts and stops and mutually agreed periods of active monitoring etc.)
- Undertaking clinical review as necessary
- Clinicians should not place a patient on the waiting list to 'reserve a place' against the future possibility that treatment may be necessary or where the patient is not currently ready, willing, fit and able to proceed. Such patients should either be referred back to their GP after clinical review if it is in their best clinical interests, or followed up in clinic, until such time their condition improves / warrants treatment. Alternatively, patients will be managed on the waiting via the updated patient choice guidance, which allows for patients to remain on the waiting list even if they are unavailable for a period of time, and the RTT clock is amended to reflect this period of unavailability.

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

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

d) Administration Staff

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

- Where referrals are not received via ERS, to date stamp where appropriate and accurately register referrals within 1 working day of receipt where possible.
- To maintain up to date waiting lists, i.e. at Outpatient, Diagnostic and Admitted stages.
- To book activity to agreed specialty milestones and in line with clinical priority.
- To highlight capacity short falls in a timely manner to avoid patient wait times being compromised.
- To keep the patient informed of their 18 week RTT status, be open and provide clarity on clock stops and starts within the patient's pathway.
- To validate patient pathways to ensure accurate waiting times are recording on the PTL.
- To actively progress patients through their pathways ensuring appropriate measures are taken.
- To keep updated and informed of policies and procedures by ensuring training is completed, policies are read and digested and to make full use of Trust communication tools.
- To be competent and compliant in all related elective care and cancer policies.

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

Integrated Care Board (ICB)

If maximum waiting time rights under the NHS Constitution cannot be met, the ICB or NHS England, which commission and fund treatment, must ensure that all appropriate methodology has been explored, including requests for mutual aid via DMAS (Digital Mutual Aid System), as outlined in the ICB Mutual Aid Policy.

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

- Act with a view to securing health services are provided in a way which promotes the NHS Constitution, and promotes awareness of the NHS Constitution among patients, staff and the public.
- Act with a view to securing continuous improvements in the quality of services for patients, and in outcomes for patients, with particular regard to clinical effectiveness, safety and patient experience.
- Have regard to the need to reduce inequalities between patients with respect to their ability to access health services and the outcomes achieved for them.
- Promote the involvement of individual patients, their carer's and representatives where relevant, in decisions relating to the prevention or diagnosis of illness in them or their care and treatment.
- Act with a view to enabling patients to make choices about aspects of health services provided to them.
- Promote innovation in the provision of health services.
- Promote research on matters relevant to the health service, and the use of evidence obtained from research.
- Act with a view to securing health services are provided in an integrated way, and the provision of health services is integrated with provision of health-related or social care services, where the ICS considers this would improve quality of services or reduce inequalities.

- Have regard to the need to promote education and training of current or future health service staff.

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

General Practitioners and Referring Clinicians

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

Referrers are required to ensure all suspected cancer referrals are made through the agreed pathway **see management of cancer pathways** section

- Referrers must provide accurate, timely and complete information within their referral.
- Referrers must comply with national timeframes for referral attachments when referring via NHS e-Referral Service (formerly Choose and Book).
- Referrals to secondary care should only be made if all other alternatives have been explored (i.e. agreed patient/clinical pathways have been followed).
- GP referrals to consultant-led outpatient services should be made using the e-Referral System. Paper and Fax referrals will be rejected by the provider unless the service is exempt from eRS
- To minimise waiting times and to enhance patient access to services, referrers are encouraged to make unnamed referrals (referred to as Dear Doctor referrals) unless there is a specialist requirement for a named consultant or there is a patient history which requires continuity of care. Patient Choice must be taken into consideration when referring.
- When referring children or adults who cannot understand or give consent for their own treatment, the referrer must provide details of who is legally able to act on behalf of the patient.
- Referrers should identify any special communication requirements their patients may have and detail these on the referral letter e.g. literacy problems, need for British Sign Language (BSL) or other language interpreter. Information should be made available in accordance with the Accessible Information Standard.
- Referrers should identify any special access requirements their patients may have, e.g. wheelchair user to allow for access to clinics.
- Patients should be referred having already undergone all relevant tests, as outlined in the pathway and Directory of Service of the relevant specialty. The Trust retains the right to reject any referrals that do not meet the specification as outlined in the directory of services
- .After a referral has been made, the referrer must inform the hospital if the patient no longer wishes or requires to be seen.

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

5.3 Patient Responsibilities – Help us to Help You

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

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

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

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

6. National Elective Care Standards

The table below provides a summary of the national elective care standards, including the elective recovery staged waiting time targets for RTT and diagnostics:

Referral to Treatment – 18 weeks	
Incomplete Pathways	92% of patients on an incomplete non-emergency pathway (i.e. still waiting for treatment) to be waiting no more than 18 weeks (126 days)
Staged Waiting Time reduction targets	No patients waiting more than 78 weeks by end of March 2023 No patients waiting more than 65 weeks by end of March 2024 No patients waiting more than 52 weeks by end of March 2025
Diagnostics	
Diagnostic Investigations	99% of patients to undergo the relevant diagnostic investigation within 6 weeks from the date of decision to refer to appointment date
Staged diagnostic target	95% of patients needing a diagnostic test to receive it within six weeks by March 2025
Cancer – see cancer section for CWT12 standards	

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

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

7. Overview of National RTT Rules

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

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

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

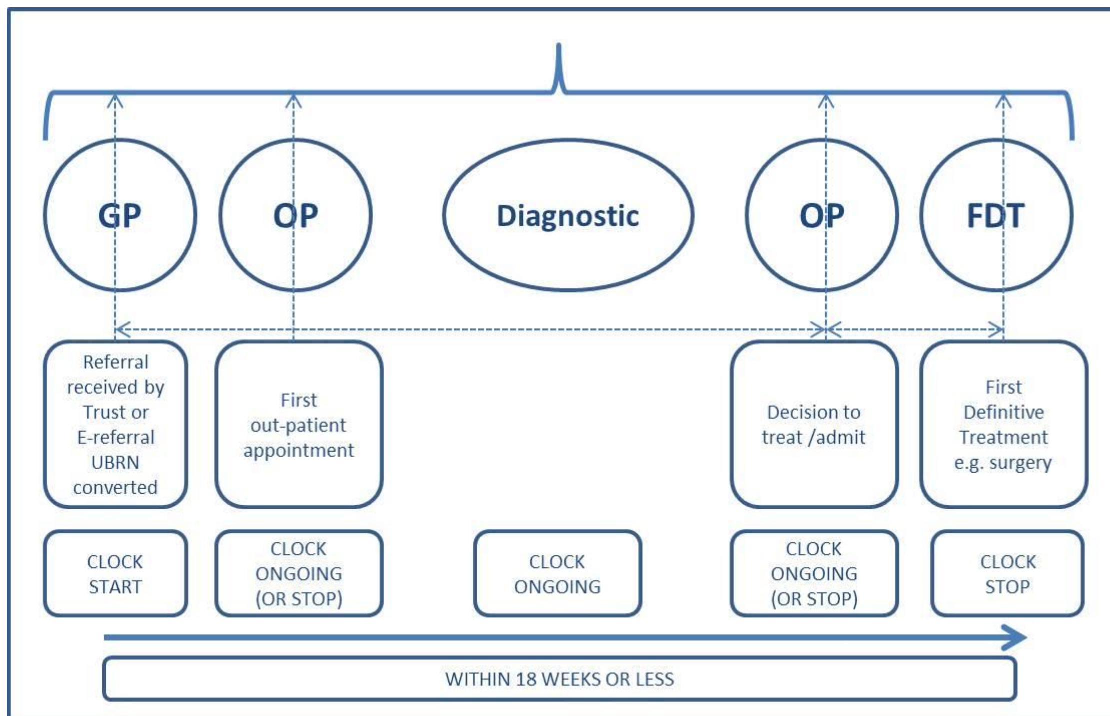
'clock' stops ticking on the day the patient is treated or for the non-treatment reasons as shown below.

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

Due to the significant pressures on NHS waiting times caused by the COVID 19 pandemic, the NHS is not currently meeting the 18 week target and has a staged elective recovery plan in place to reduce the numbers of long waiting patients and return to 18 week compliance. The milestones for this recovery plan are as follows:

- No patients waiting longer than 78 weeks by the end of March 2023
- No patients waiting longer than 65 weeks by the end of March 2024
- No patients waiting longer than 52 weeks by the end of March 2025

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



7.1 Clock Starts

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

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

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

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

7.2 Subsequent Clock Starts

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

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

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

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

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

e) When a patient's appointment is rebooked as requested following clinical review of a first appointment DNA which stopped and nullified their earlier clock.

f) When a patient, who is on the waiting list for a planned procedure, passes their clinical due date, a new RTT clock will start from the point the due date is passed

g) When a patient is ready to proceed with treatment following a period of patient choice unavailability

7.3 Clock Stops for Treatment

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

a) First definitive treatment starts. This could be:

- Treatment provided by an interface service;
- Treatment provided by a consultant-led service;
- Therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions;

b) A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

7.4 Clock Stops for Non-Treatment

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

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

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

b) A clinical decision is made to start a period of active monitoring (whether initiated by the clinician or the patient);

c) A patient declines treatment having been offered it;

d) A clinical decision is made not to treat;

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

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

- The Trust can demonstrate the appointment was clearly communicated to the patient.
- Discharging the patient is not contrary to their best clinical interests. Consideration must be given where the patient is a child or vulnerable adult (see section 10)

g) A request for funding for a particular treatment via Individual Funding Request (IFR) or Prior Approval is declined

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

For more information and scenarios on Clock Starts, Ongoing Clocks and Clock Stops and RTT Codes, please see the RTT Rules Suite on the Department of Health and Social Care (DHSC) website, or refer to any relevant local guidance.

7.5 Clock Stops for Active Monitoring

Active monitoring is also sometimes known as Watchful Waiting.

A waiting time clock may be stopped for active monitoring where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage. It should be noted that there may be occasions when a diagnostic test is required for a patient as part of a surveillance plan during a period of active monitoring and it would be appropriate for the clock to stop or remain closed whilst this takes place.

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

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

instances would be when a patient has been listed for an admission but is then unavailable to accept offers of admission dates as per the patient choice guidance (see section 53)

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

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

Patients who are placed on the Patient Initiated Follow Up (PIFU) pathway with a currently active RTT clock will have their clock stopped with active monitoring and be managed according to the specified pathway.

7.6 Patient Thinking Time

Stopping the patient's clock for a period of active monitoring requires careful consideration on a case by case basis and its use needs to be consistent with the patient's perception of their wait. Where patient thinking time is given by the consultant, the effect on the RTT clock will be dependent on the individual scenario, e.g. where invasive surgery is offered as the proposed first definitive treatment but the patient would like a few days to consider this before confirming they wish to go ahead with surgery, the clock would continue to 'tick'. If a longer period of thinking time is agreed, then active monitoring is more appropriate. E.g. the clinician offers a surgical intervention but the patient is not keen on invasive surgery as they view their symptoms as manageable, and a review appointment is agreed for three months' time. The patient would be placed on active monitoring and the RTT clock would stop at the point the decision is made to commence active monitoring.

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

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

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

8. Pathway Milestones

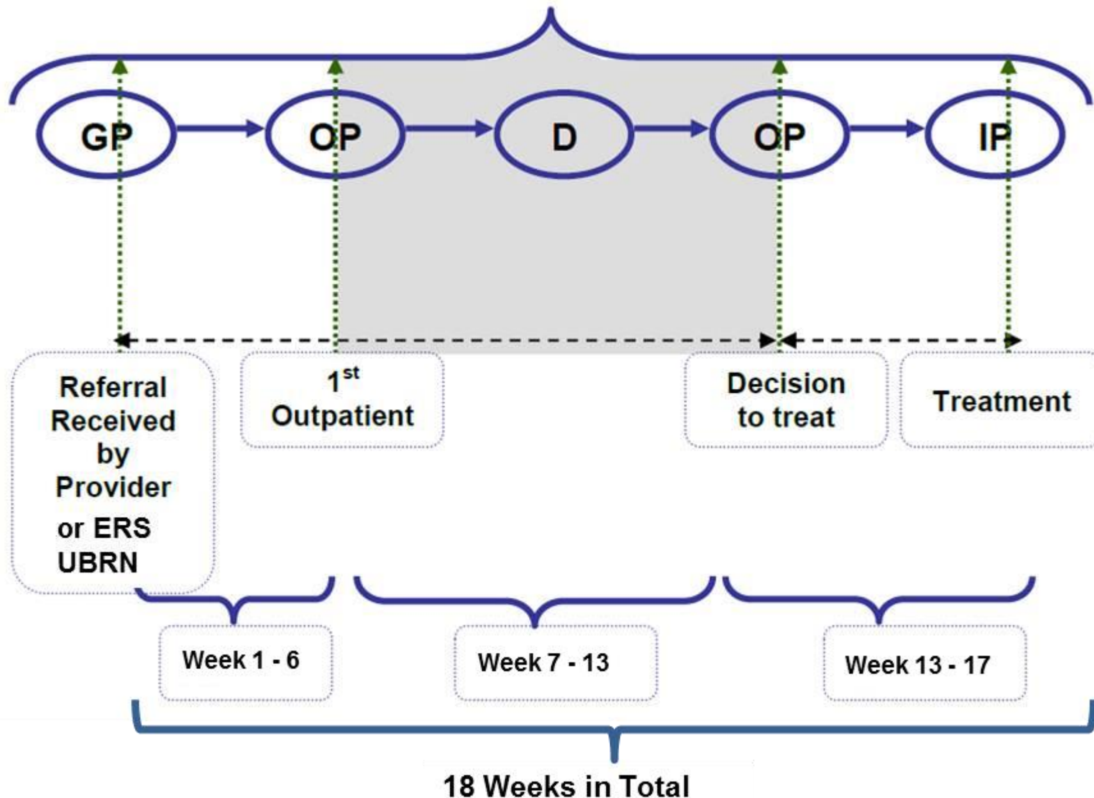
The agreement and measurement of performance against specific milestones is an important aspect of delivering waiting time standards sustainably. Pathway specific milestones should be agreed for each specialty (in line with robust demand and capacity analysis) in terms of the point of the pathway by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

- First Appointment
- Decision to Treat Date
- Treatment

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

8.1 Trust Internal Milestones

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



Any reason for delay against the internal milestones should be escalated via the weekly PTL meetings by Operational Managers or their deputy.

9. Overseas Visitors

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

An ordinarily resident person is anyone:

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

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

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

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

10. Vulnerable Patients

Vulnerable Adults

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

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

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

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

Children

All Trust staff have a duty to safeguard children from harm and it is expected staff familiarise themselves with their duty in this regard. For further guidance please see the relevant local Safeguarding Policy found on the Trusts' Intranet sites.

Paediatric was not bought in/ DNA

When children are not bought in for a planned appointment the case notes must be reviewed by a consultant or specialist registrar. The risk to the child will be assessed. Any safeguarding concerns will be addressed in line with local policies and procedures and primary care will be informed.

People involved in the Criminal Justice System

For the purposes of this policy, People involved in the Criminal Justice System
prisoners will be booked, and their referrals processed in the same way as vulnerable patients as they are not able to make choices about the time or date of their appointment and have no control over whether they cancel or do not attend.
Local guidance must be followed when booking patients who are in detention. This can be found on the individual Trusts' Intranet sites.

11. War Veterans and Military Personnel

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

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

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

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

12. Referral Management

12.1 Primary Care Responsibilities

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

12.2 Patient Choice

In line with the NHS constitution the patient has the right to choose the provider to which they are referred. At the point of referral and post any referral management assessment, a patient must be offered the choice of 5 appropriate providers via the Electronic Referral System (eRS), this will include distance from home to provider and the current average pathway completion time. Other information should be provided or direction to other sources of information such as 'My Planned Care' to allow an informed choice to be made.

Patients who cannot be treated within 18 weeks, have the right to request transfer to a suitable alternative provider. This request should be made their current provider, who will source a transfer. All transfer should be done using the Inter Provider Transfer (IPT) form and the minimum data set (MDS).

The HWE ICB has a responsibility to seek an alternative provider if patients within a provider will wait greater than 26 weeks.

12.3 Secondary Care Responsibilities

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

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

12.4 Referral Sources

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

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

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

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

Consultant to Consultant Referrals - Patients should continue to be referred internally as part of a continuing care pathway relating to the symptoms / condition for which the patient was referred by the GP. This will relate to patients for whom a diagnostic opinion and / or course of treatment needs to be determined. If, however, the consultant suspects cancer or other rapid access clinic condition that hasn't been previously identified (for example, cancer, cardiac conditions and transient ischaemic attacks) then the consultant should also make the referral even if it not related to the original referral, and inform the GP they have done so. The RTT clock should stop if the patient is no longer being treated for the original condition / referral.

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

The Trusts expect an accompanying Minimum Data Set (MDS) pro-forma with the Inter Provider Transfer (IPT), detailing the patient's current RTT status (the Trusts will inherit any RTT wait already incurred at the referring trust if the patient has not yet been treated) and if the patient has been referred for a new treatment plan for the same condition (where a new RTT clock will start upon receipt at this trust). The patient's pathway identifier (PPID) should also be provided. If the IPT is for a diagnostic test or expert opinion/advice only, the referring trust retains responsibility for the RTT pathway. For referrals without any MDS data, referrals will be logged on the system with new clock start and the correct MDS will be requested from the referrer and will need to be provided within 3 working days and escalated if not received.

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

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

12.5 Referral Methods

All referrals in Hertfordshire and West Essex ICB will be made directly via the NHS e-Referral Service. However, where written routine referrals are sent, each Trust will provide and maintain local guidance as to how these are managed.

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

12.6 Referral Minimum Dataset

The referrer is responsible for ensuring the referral letter contains the essential minimum data set. This should include, but is not limited to the patients full NHS number, full patients' demographics, the day, evening and mobile telephone number along with email address which the patient would like to be contacted on as well as sufficient data for the appropriate appointment to be made. The referral letter should contain the patients' current drug regime, clinical questions to be answered and significant past medical history as appropriate. (See Appendix A)

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

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

For further information on cancer referrals please see MANGEMENT OF CANCER PATHWAYS section

13. Clinical Triage/Review of Referrals

Referrals received at the Trust should be processed within 48 hours of receipt to ensure the referral detail can be assessed and accessed electronically by consultants and clerical staff as appropriate. It is best practice for consultants to review all patient referrals, allocating clinical priority and accepting / rejecting referrals within 2 working days of the referral being received at the Trust where possible and subject to local pathway management. Where referrals are taking longer than agreed timeframes to be triaged this will be escalated as per agreed local processes.

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

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

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

14. Reasonable Offer (RO) of Appointment/TCI

Reasonable Offers – Where possible, to reduce patient cancellations and DNAs, activity dates will be mutually agreed with the patient. Consideration should be given, where clinically appropriate, to offer a virtual consultation (Telephone or Video).

'Reasonableness' is a term applicable to all stages of the elective pathway. Reasonableness refers to specific criteria which should be adhered to when offering routine appointments and admission dates to patients to demonstrate that they have been given sufficient notice and a choice of dates. A reasonable offer is defined as an offer of a date with at least 3 weeks' notice and best practice is to offer a choice of two dates. All offers made to the patient should be recorded on PAS.

Discretion should be applied when booking appointments; however, there is an expectation patients will make themselves available to attend appointments in a timely manner. If a patient makes themselves unavailable for a period of time such that they are unable to accept 2 dates with reasonable notice, **after clinical review as necessary**, the patient referral may be discharged back to GP in order for them to clinically manage the patient as appropriate. This should be communicated to the patient in all appointment letters, as the patient may not be aware of the clinical implications of choosing to wait longer.

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

Alternatively, the patient can be managed via applying patient choice guidance, which allows the patient to remain waiting but they will be placed on active monitoring for their period of unavailability. This will be for an initial maximum of 12 weeks and a new RTT clock will be started when the patient is available. This process is described in more detail in section 53.

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

15. Booking notice

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

If a patient is sent a letter for an unconfirmed appointment or TCI date this needs to be with at least 3 weeks' notice. Any appointments made within that timeframe of notice should be confirmed via telephone.

For the offering of TCI dates, sending out a letter with an unconfirmed date is not recommended and should only be used as a last resort. If patients cannot be contacted by telephone, generally a letter will be sent to patients asking them to contact the Trust to book their TCI and providing a time window for response. Patients may be removed from the waiting list if contact is not received in the requested timeframe.

For further information and guidance please see local SOPs and on the individual Trust Intranets.

16. Patient Cancellations

(Rules are different for Cancer Waiting Times – please refer to Management of Cancer Pathways section)

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

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

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

Alternatively, patients who are unavailable to accept offer dates for outpatient appointments can be managed via updated patient choice guidance. If a patient cannot accept 2 reasonable notice offer dates for an outpatient appointment for social reasons, consideration can be given to stopping the RTT clock with active monitoring for a given duration until the patient is available again, following the patient choice guidance in section 53. For the purposes of this process, cancelled appointments that had been agreed or booked with reasonable notice can be treated as rejected appointment offer dates.

17. Hospital Cancellations – Appointments (including diagnostics and other activity)/TCI

(Rules are different for Cancer Waiting Times – please refer to the page 39 Management of Cancer Pathways)

If the hospital cancels an appointment or TCI anywhere on an RTT pathway, the clock continues to tick, unless this was due to a clinical reason, in which case it should be managed via the appropriate pathway as outlined in section 19. The patient should be re-dated within the existing RTT standards and departmental pathway milestones.

18. Cancelled Operations on the Day of Admission for non-clinical reasons

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

19. Patients who are unfit to proceed with their pathway

If the patient is unfit for a procedure or to continue their pathway for treatment, the nature and duration of the clinical issues should be ascertained. Patients who are referred for investigations when they are listed for a procedure will not be deemed unfit until this has been confirmed via the investigation results.

Short term illness – temporarily unfit

If the clinical issue is short-term and has no impact on the original clinical decision to undertake the procedure e.g. a cough or cold, the RTT clock will continue unless it is deemed not clinically

appropriate to keep the patient on an active RTT pathway. The patient will be offered a re-scheduled date within the RTT standards while adhering to the reasonable offer guidelines.

Longer term illness

If a patient is unable to accept a reasonable notice (3 weeks) offer due to not being fit to proceed and the patient requires optimisation and/or treatment for a clinical issue, a clinical review should be carried out and clinicians should indicate to administrative staff:

- If it is clinically appropriate for the patient to be removed from the waiting list (this will stop the RTT clock event via the application of active monitoring).
- If the patient should be optimised / treated within secondary care (active monitoring clock stop) or if they should be referred to their GP for the management of the condition rendering the patient unfit for the required surgical procedure. (active monitoring clock stop). Patients being managed within secondary care will be monitored via the Pre-Operative Assessment (POA) pathway – once the patient is fit to proceed, the POA team (or the patient if appropriate) will notify the waiting list team for the patient to be listed again for the procedure and a new RTT clock to start

If the patient's condition is being managed by the GP, the letter to the GP will state the optimisation required and the need to notify the Trust when the patient is fit to proceed. A copy of the letter will be sent to the patient and a copy filed in the patient's case notes. Once the patient has been informed the RTT pathway can then be stopped. A new pathway will start when the GP notifies the Trust that the patient is now fit to proceed.

MRSA positive patients

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

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

A new RTT clock should start when/if a patient is referred back into consultant-led care or when the Trust is notified by a GP that the patient can now proceed with treatment.

COVID positive patients

Patients who have an admission date cancelled due to testing positive for COVID will be rebooked within clinically appropriate timeframes as per current national guidance.

Patients who are unavailable due to self-isolation during a pandemic should be classed as 'temporarily unfit', the RTT clock should continue to tick.

20. Patients Who Did Not Attend (DNA)

(Rules are different for Cancer Waiting Times – please refer to Management of Cancer Pathways section)

These rules are applicable if the patient has had the opportunity to agree their appointment or admission date in advance or if the patient has been sent a reasonable notice appointment / admission through the post.

20.1 DNA of First Appointment / Activity Following Initial Referral

(Rules are different for Cancer Waiting Times – please refer to Management of Cancer Pathways section)

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

- The Trust can demonstrate the appointment was clearly communicated to the patient. PAS must be used to record all offers of appointment., where available
- Discharging the patient is not contrary to their best clinical interests
- The clinical interests of vulnerable patients and prisoners are protected

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

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

(Rules are different for Cancer Waiting Times – please refer to Management of Cancer Pathways section)

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

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

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

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

21. Patients Transferring from the Private Sector to the NHS

Patients can choose to convert between an NHS and private status at any point during their treatment without prejudice. Patients referring from the Private Sector can be referred directly to the Trust.

The patient's RTT 18 week clock will start **upon receipt of the referral** and the patient will be added on to the relevant waiting list, if clinically appropriate, on the same date. This is called straight to list.

It will be clarified with the referrer that the patient is a true private patient and not undergoing NHS treatment in a private setting. For any referrals for patients who are undergoing NHS treatment in a private setting, MDS information will be required to be sent with these referrals.

Patients who are referred via their GPs from a private service can be added directly to a NHS therapeutic or diagnostic waiting list. This will be a clinical decision made by the Health Care

Professional accepting the referral. An NHS outpatient appointment may not be required if the clinician accepting the referral deems it unnecessary.

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

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

23. Individual Funding Requests (IFR)

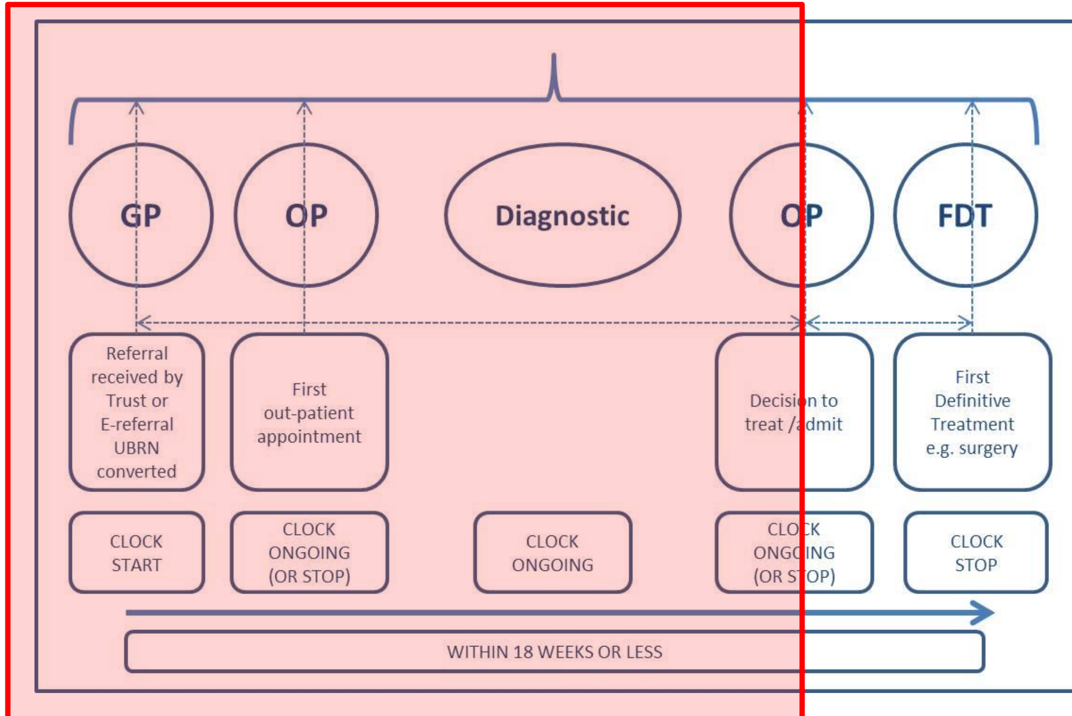
On an individual basis, there may be situations where a clinician believes that their patient's clinical situation is so different to other patients with the same condition that they should have their treatment paid for when other patients would not. In such cases, NHS clinicians can ask NHS England, on behalf of a patient, to fund a treatment which would not usually be provided by NHS England for that patient. This request is called an Individual Funding Request (IFR). Where IFR is required patients **will not** be added to a waiting list without a prior authorisation number from Commissioners.

The patients RTT pathway continues to tick while Individual Funding Requests (IFR) are being processed if the IFR is submitted by the Trusts. If the IFR is declined, the RTT clock will stop. IFRs should be processed and a decision reached within 2 weeks of the request.

PATHWAY SPECIFIC PRINCIPLES

Management of Non-Admitted RTT Pathways

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



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

24. Outpatients General Principles

For booking and Management of Outpatients, all staff should adhere to the local guidance and SOPs regarding the general principles of outpatient booking. Please also refer to local validation guidance and SOPs in regards to appropriate validation of waiting lists.

25. Referral Criteria Proformas

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

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

26. Patient Initiated Follow-up (PIFU)

PIFU gives patients control over their follow-up care, allowing them to be seen quickly when they need to, while avoiding the inconvenience of appointments that are of low clinical value. PIFU allows a patient, or carer, to initiate follow-up appointments when they need one if this is considered clinically appropriate. PIFU is specifically designed for patients with stable or long term conditions to allow them to directly access clinical teams if symptoms return or their condition deteriorates. Patients under follow-up care should be considered for suitability of patient initiated follow-up. When the PIFU pathway is implemented, there will be a timeline in place depending on which service this patient is under. Typically, at the end of that time frame (often 6 or 12 months) patients will either be discharged or there will be clinical review for discharge depending on the agreed pathway at each Trust. Patients will be provided with the relevant contact information to get in touch with the Trust during their PIFU period to request an appointment as necessary.

When a patient is placed on a PIFU pathway, if they are on an active RTT clock, this will be stopped with active monitoring.

Local guidance will be in place for the implementation and monitoring of PIFU.

27. Appointment Letters

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

28. Arrival of patients at Clinic

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

29. Clinic Outcomes

- All patients must have a clinic outcome (e.g. add to elective waiting list, discharge, follow-up etc.) and an updated RTT status recorded for the clinic entered on to PAS. This includes patients who have already started treatment and who have had a previous clock stop as they may need to have a new RTT clock start due to a new treatment plan, or continue to be monitored.
- The vast majority of non-admitted RTT data regarding a patients RTT pathway is derived from information transferred to PAS from the Clinic Outcome Form, so it is **critical** that data is completed correctly in clinic and recorded in an accurate and timely manner; clinic outcomes should be recorded on PAS on the day of the appointment – any issues that need to be addressed will be done so at the time with the staff completing the forms.
- Departments are required to have a process in place to ensure that any incorrect outcome forms are addressed with the clinician in real time in order to ensure the correct outcome and PAS is updated with an accurate RTT code. If it is a validation issue it will be reviewed and corrected as per provider guidance.

- Access and Choice – Operational Managers are to ensure that post session reporting is carried out to reduce any potential delays to patient pathways if an outcome is missed. It is good practice to enter waiting list entries onto PAS within 24 hours of the decision to admit in clinic; **all waiting list entries must be entered onto PAS within 2 working days of a decision to treat**, unless the patient requires an IFR approval code. Any reason for delay in creating the waiting list entries on PAS should be escalated via the weekly PTL meetings.

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

a. Trust policies confirm at least 6 weeks' notice must be given for clinic cancellations. Local policies and guidance must be followed for cancellations under 6 weeks.
b. It is the responsibility of the Operational Management Team to monitor clinic cancellations and undertake remedial action where identified as necessary.

31. Pathway specific principles - referral to acute therapy services

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

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

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

Physiotherapy

For patients referred to physiotherapy as first definitive treatment from a consultant led service, the RTT clock stops when the patient begins physiotherapy. For patients that are referred to a community physiotherapy service, the clock will stop on the date of the referral to this service.

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

Surgical Appliances

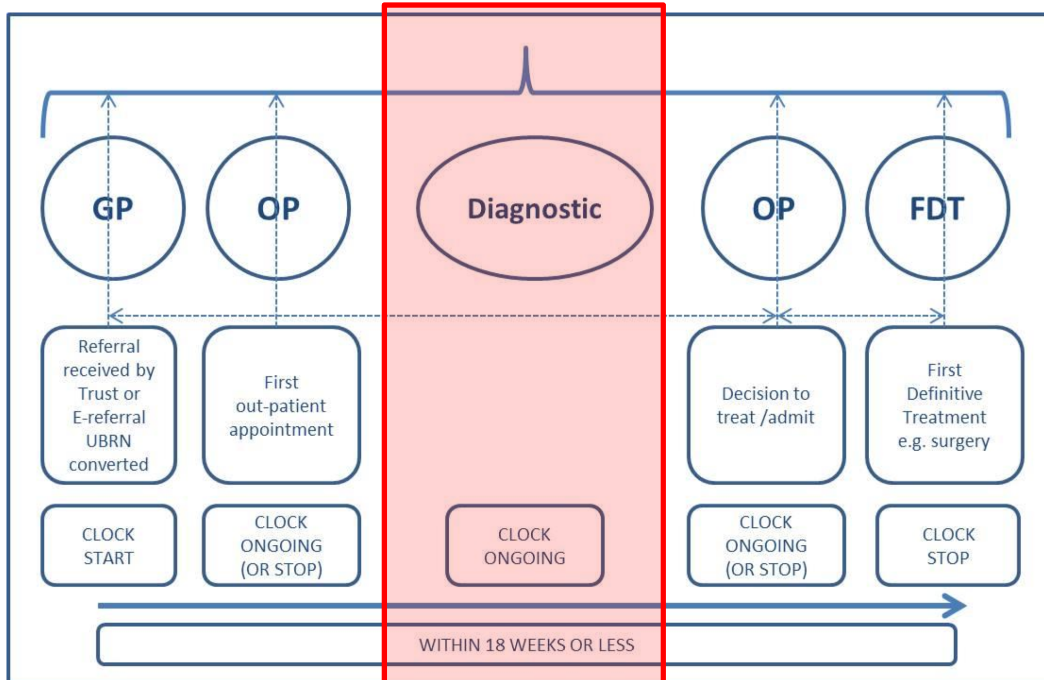
Patients referred from a consultant led service for a surgical appliance with no other form of treatment agreed would be on an open RTT pathway with an RTT clock ongoing until the fitting of the appliance. It is the act of fitting the appliance that constitutes first definitive treatment, when the appliance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

Dietetics

If patients are referred to the dietitian from a consultant led service for dietary advice, and received the advice with no other form of treatment, this would constitute an RTT clock stop. Equally, patients could receive dietary advice as an important step of a particular pathway, and in this instance, the RTT clock would continue to tick, as the intention was not as treatment, but to optimise the patient pathway leading to first definitive treatment or surgery.

Management of Diagnostic Pathways

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



The following pages detail the agreed diagnostic principles and policies.

32. Diagnostics

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

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

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

33. Diagnostic General Principles

Many patients require diagnostic tests to determine a diagnosis and therefore subsequent treatment of a patient. Diagnostic tests cover a wide range of procedures, including radiology, blood tests, biopsy and endoscopy procedures, among others. Diagnostic tests must be performed within 6 weeks of the request for the test to ensure delivery of the national waiting time target. In many instances the diagnostic tests will form part of the patient's RTT 18 week journey.

Different DNA and cancellation principles apply to diagnostic patients (including non-compliance of patients who are requested to book blood tests) in regards to the diagnostic clock and pathway. These principles allow the diagnostic clock to be reset in the event of patient cancellations or DNAs and are outlined in detail in sections 37 and 38.

34. Diagnostic Standards

The national standard is that less than 1% of patients should be waiting longer than 6 weeks from referral to test. However, in line with the phased waiting time reduction described in the elective recovery plan, there is an acceptance that this target cannot be met currently and the revised ambition is for 95% of patients needing a diagnostic test to receive it within six weeks by March 2025. The 6 week diagnostic clock starts when the request for a diagnostic test or procedure is made. For straight to test patients using the NHS e-referral system referrals, this is the time that the UBRN is converted, i.e. when the patient chooses an appointment.

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

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

The Trust can offer appointments that do not fulfil the reasonableness criteria **where it is in the best interest of the patient**, for example, to receive an appointment with less than 3 weeks’ notice (e.g. no choice appointment). To note, diagnostic clock resets for patient cancellation and DNA as outlined in sections 37 and 38 only apply to appointments that fulfil the “reasonableness” criteria.

35. Diagnostic waiting list types

Active diagnostic waiting list

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

Planned diagnostic waiting list

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

Patients who require a diagnostic test to be carried out at a specific point in time for clinical reasons (planned patients) are exempt from the diagnostic clock rules and will be held on a planned waiting list with a clinically determined due date identified. If a patient on a planned diagnostic waiting list passes their clinical due date, then the patient should be moved to an active diagnostic waiting time clock if they have not attended for their test,

Therapeutic procedures at a diagnostic stage

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

36. GP requested diagnostics

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

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

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

37. Other requested diagnostics

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

38. Patient Cancels a Diagnostics Appointment / Procedure

If a patient cancels a diagnostic procedure, and requests a further appointment, the patient should be rebooked.

If the patient does not request a rebook or the patient cancels on multiple occasions consecutively, the patient's pathway should be reviewed by their consultant. Upon clinical review, the patient's consultant should indicate one of the following:

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

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

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

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

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

For patients who DNA any modality imaging or diagnostic appointment the appropriate clinical team should review the patients record to decide on the next steps, regarding whether this should be rebooked/re-requested or it is more appropriate for the patient to be discharged back to the care of their GP. If discharge is agreed by the clinical team, the patient will be discharged back to the care of their GP and a letter will be sent to confirm.

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

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

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

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

If a patient does not attend their diagnostic appointment, then the diagnostic waiting time for that test/procedure is set to zero and the waiting time starts again from the date of the appointment that the patient missed.

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

In regard to the RTT clock, this will remain ticking if the patient is rebooked and will only stop if there is an agreement, following clinical review, that the patient will be discharged, as per section 43.

40. Escalation

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

41. RTT Clock Stops at Diagnostic Stage

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

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

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

- The Trust can demonstrate that the appointment was clearly communicated to the patient.

- Discharging the patient is not contrary to their best clinical interests.

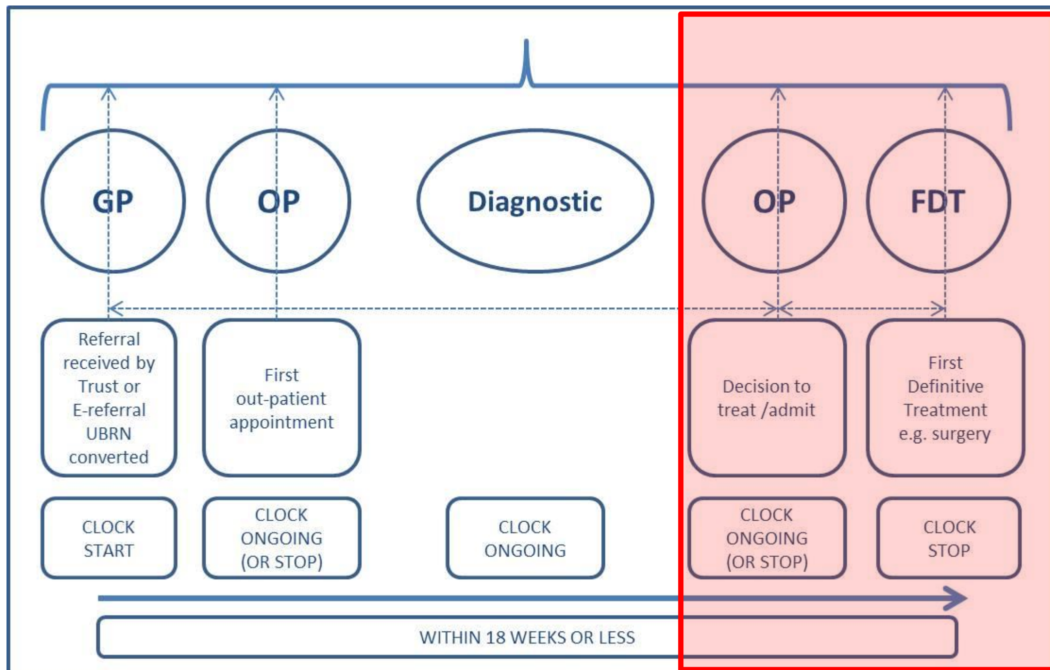
42. Post Diagnostic – non-activity related RTT decisions

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

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

Management of Admitted Pathways

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



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

43. Decision to Admit

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

- The patient is, to the best of knowledge, clinically fit, ready and available to undergo surgery. Patients who are added to the waiting list must be clinically and socially ready

for admission on the day the decision to admit is made. Patients should be offered any admission dates with reasonable notice

- Following pre-operative assessment, patients who are deemed to be clinically **not** fit for treatment (e.g. for a heart condition or after having a stroke etc.) should be referred back to the responsible clinician who can decide whether to refer the patient back to their GP for the management of the condition rendering the patient unfit for the required surgical procedure. Alternatively, the management and optimisation of this condition may take place in secondary care and the patient would also be considered unfit to proceed in these instances. The RTT clock will stop until the patients are determined to be fit to proceed with treatment.

44. Pre-Operative Assessment (POA)

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

Where Pre-Operative Assessment is required, a patient should be pre-operatively assessed as soon as possible after the Decision to Admit is made to ensure the patient is fit for procedure. A pre-operative assessment can be completed up to 12 weeks in advance of the TCI. If a patient is listed under a consultant or service with waiting times known to be in excess of this, then POA should be arranged at an appropriate time in relation to current waits. If a patient cancels or DNAs a pre-operative assessment the following applies:

- Patients who DNA POA will be contacted by the POA booking team to confirm the reason for the DNA and, if necessary, will be returned to the responsible consultant for clinical review. **The RTT clock continues to tick throughout this process.**

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

45. COVID-19 testing prior to admission

Patients should adhere to local and national guidance regarding requirements to undertake a COVID-19 test prior to admission for their procedure.

46. Clinical Prioritisation for Inpatient and Day Case Active Waiting Lists

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

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

The Priority codes have been expanded from the previous priorities of Urgent and Routine to the below:-

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

  - P1a Emergency procedures to be performed in <24 hours clinical priority patients, e.g. urgent and potential/confirmed cancers
  - P1b Procedures to be performed in <72 hours
  - P2 clinically stratified patients, - procedures to be performed in < 1 month with patients booked in chronological order, starting with the patient who has waited the longest at this category, unless otherwise directed by the clinical team.
  - P3 clinically stratified patients; - Procedures to be performed in < 3 months - long waiters should be booked in chronological order, starting with the patient who has waited the longest, unless otherwise directed by the clinical team.
  - P4 clinically stratified patients; - Procedures to be performed in >3 months - long waiters should be booked in chronological order starting with the patient who has waited the longest, unless otherwise directed by the clinical team.
- This prioritisation should be undertaken by the responsible clinician at the point of listing the patient for surgery.

47. Inpatient and Day case General Principles

For booking and Management of Inpatient and Daycase Admissions, all Trust staff should adhere to the local Inpatient and Day Case General booking principles and guidance.

48. Elective Waiting List

A patient is added to an Inpatient or Day Case waiting list having been given no date of admission at the time a decision was made to admit. The patient will be on an active elective waiting list with a ticking RTT clock and patients will be booked for their TCI dates in order of clinical urgency and then chronologically in order of their waiting time.

49. Planned Waiting List

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

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

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

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

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

50. Bilateral Procedures

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

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

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

In line with new national guidance, patients who make themselves unavailable for a period of time whilst awaiting treatment can be managed using the below process.

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

In circumstances where a patient wishes to delay their treatment the following approach may be considered:

- Following declining a 1st TCI, the patient should be recorded as a 'C-code'.
- A 2nd TCI should be offered which is within 6 weeks of the 1st TCI, even if the patient has stated a period of unavailability following the first offer.
- TCIs offered should be reasonable (ie with 3 weeks-notice)
- If a 2nd TCI is declined it may be appropriate, following a clinical conversation and agreement with the patient, to consider placing a patient on hospital initiated active monitoring.
- Where it is appropriate to place a patient on active monitoring, this should be for a maximum period of 12 weeks.
- If a patient is placed on active monitoring the RTT clock should be stopped.
- Patients placed on active monitoring should be managed through local reporting and local clinical governance arrangements.
- Throughout the agreed active monitoring period the patient should be advised of the process to follow should they wish to go ahead with treatment and be reinstated on the waiting list.
- If a patient wishes to go ahead with treatment, the provider should offer a new TCI date acting as if the patient is on the waiting list at the point which they previously left ie. They should not be returned to the beginning of the waiting list.

Best practice in regards to implementation of this guidance is to have 2 dates to offer and ensure both of these dates are offered.

If the length of the period of unavailability is equal to or greater than a clinically unsafe period of delay (as indicated in advance by consultants for each specialty), the patient's pathway will be reviewed by their consultant. Upon clinical review, the patient's consultant will indicate one of the following:

Clinically safe for the patient to delay: continue management of pathway via the patient choice guidance.

Clinically unsafe length of delay: in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP. The patient could also be actively monitored within the Trust.

In all cases the Trust must demonstrate the patient has been offered treatment options in line with this policy.

A review process should be put in place for long waiting patients choosing to wait at the agreed time as specified at the point of the guidance being enacted. Patients should be logged with relevant C code (C2, C3 or C4) depending on clinical priority and that should be taken into account when agreeing the appropriateness of implementing this guidance.

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

52. Emergency Admissions for an Elective Procedure

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

53. Escalation

If a TCI date is not available within the prescribed pathway milestone for a particular speciality or the TCI date offered is declined and another TCI date is not available, local escalation processes should be followed.

HOW THE TRUSTS MANAGE REFERRAL TO TREATMENT (RTT)

54. Patient Tracking List (PTL)

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

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

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

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

55. Speciality PTL meetings

The PTL is produced daily, to enable discussion of the detail of the PTL and it is best practice to meet weekly to review the PTL. Each Speciality area operational management team must be sufficiently prepared for the PTL meeting to:

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

The PTL meetings are action-orientated and focused upon:

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

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

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

- Patient Tracking List information on a consultant level basis against 18 weeks delivery
- Performance data on referral acceptance times
- Outpatient wait times (new and follow-up)
- Conversion rates (new to follow-up, new to DTA etc)
- Waiting list size (Inpatient and day-case)
- Best Practice Tariff and Intended Management
- Breach data
- Referral data (Internal, Tertiary and Primary Care).

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

57. Patient Review Process

The Trusts waiting lists must be regularly reviewed by the waiting list holder i.e. at least monthly, or as determined by the length of patient wait. A regular review of the waiting list will result in accurate numbers of patients on a waiting list and improve data quality by ensuring patient demographic details; including contact telephone numbers are up to date.

Validation of waiting lists will take place regularly in line with NHSE guidelines and national targets. The requirements and associated supporting information has been outlined in the Elective Recovery Validation Toolkit and Guidance, issued in December 2022. This clarifies the different types of validation required to be completed for patients, including patient contact as part of

administrative validation, and clinical validation, which can fall under Clinical Harm processes, as referenced in section 83.

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

Staff need to be mindful, to meet the reasonable offer criteria, reviews need to be carried out in a timely manner to allow the relevant 3 weeks' notice to be given for appointments and TCIs.

58. Breach Reasons and RTT Pathway Validation

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

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

Where it is not possible to treat patients within 18 weeks, all patients who breach the 18 week standard will have their RTT pathway validated to ascertain if the breach is genuine. If validation confirms a definite breach the reason for the breach must be recorded on PAS, if the breach is not valid, then PAS must be amended to reflect the true RTT history.

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

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

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

59. Adherence to RTT Principles

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

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

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

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

60. Reporting

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

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

61. National Month End Reporting Requirements

Information is provided monthly to the DHSC on capturing and recording data on clock starts and, clock stops and on calculating RTT times.

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

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

62. Clinical Harm

The potential for Clinical Harm being caused due to long waits for patients must be managed effectively to reduce risk. Please see Trust’s local guidance on clinical harm for further information.

63. Training

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

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

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

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

Management of Cancer Pathways

64. Principles

As defined in the NHS Constitution, patients have the right to expect to be seen and treated within national operational standards ensuring timely diagnosis and treatment, equity of care and patient choice.

Patients will, wherever possible, be offered dates for appointment or treatment in chronological order, based on the number of days they have been waiting on their cancer pathway, unless there are clinical exceptions.

Wherever possible, patients will be given reasonable notice and choice of appointments and 'to come in' (TCI) dates as defined within the policy.

Accurate data on the trust's performance against the national cancer waiting times is recorded in the cancer management system and reported to the National Cancer Waiting Times Database within nationally predetermined timescales.

Where patients are at risk of breaching any of the cancer standards it is expected that all staff will follow the trusts cancer escalation policy which should also be in line with the national best practice timed pathways.

The National Cancer Waiting Times Monitoring Dataset Guidance was published in August 2023 and the new standards implemented from 1st October 2023. The new guidance contains 3 standards which can be found below.

Maximum 28 days from: Receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel or cervical and receipt of urgent referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out cancer.	75%
Maximum one month (31 days) from; From decision to treat/ earliest clinically appropriate date to **treatment** of cancer	96%
Maximum two months (62 days) from: From receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade to **first definitive treatment** of cancer.	85%

The CWT12 guidance provides a set of rules to ensure that Cancer Waiting Times data are recorded consistently, and in a way which allows transparent and accurate reporting. These take into account as far as possible the appropriate clinical management of patients, recognising that specific rules cannot be created for every situation, and that there will be some instances in which appropriate clinical care results in a breach. The thresholds set make allowance for such instances, and this guidance does not prohibit or discourage appropriate clinical practice.

It aims to ensure that staff who manage cancer pathways understand which patients should be reported on, and how to record data to monitor the CWT standards.
This guidance has been written based on the following principles:

- The thresholds have been set taking into account that there will be patients who choose to delay their pathway, pathway delays for clinical reasons or pathways which are clinically complex.
- Patients must have confidence that any advice or decisions affecting their treatment are based solely on clinical grounds, rather than the need to meet these standards.

This document should be read in conjunction with the Cancer Waiting Times User Manual provided by NHS Digital.

NHSE have updated the CWT guidance to version 12.0 to apply to activity that ends on or beyond the 1st October 2023. Any future or further amendments to the national CWT guidance will prompt an amendment to this policy document.

This updated guidance:

- Completes the process of replacing the Two Week Wait standards with the Faster Diagnosis Standard following the approval of changes to Cancer Waiting Times by Government in August 2023.
- Merges existing 31-day decision to treat/earliest clinically appropriate date to treatment into one standard for all treatments of cancers. This also brings some subsequent treatments not currently in scope of existing standards, into scope of this new standard.
- Merges the 62-day referral/consultant upgrade standards into one 62-day standard for patients from either an urgent suspected cancer referral, breast symptomatic referral, urgent screening referral or a consultant upgrade
- Introduces additional guidance on consultant upgrades, where by a patient is automatically upgraded on referral to a Cancer Multi-Disciplinary Team meeting, unless a patient is already on a 62-day pathway.

The full CWT12 guidance can be found here National Cancer Waiting Times Monitoring Dataset Guidance V12.0 (england.nhs.uk)

All staff have a duty to comply fully with the CW12 and any subsequent versions and are responsible for ensuring they attend NHSE cancer pathway training.

All staff are responsible for bringing this policy to the attention of any person not complying with it.

All staff will ensure any data created, edited, used, or recorded on the trust’s IT systems in their area of responsibility is accurate and recorded in accordance with this policy and other trust policies relating to collection, storage and use of data to maintain the highest standards of data quality and maintain patient confidentiality.

All patient referrals, diagnostics, treatment episodes and waiting lists must be managed on the trust’s systems. All information relating to patient activity must be recorded accurately and in a timely manner.

65. Summary of the cancer rules

Clock start

Urgent suspected cancer referral

A clock starts at the receipt of referral

62 day

A 62-day cancer clock can start following the below actions:

a) urgent referral for suspected cancer.

b) urgent referral for breast symptoms (where cancer is not suspected).

c) a consultant upgrade.

d) referral from NHS cancer screening programme.

e) non NHS referral (and subsequent consultant upgrade).

28 day Faster Diagnosis Standard (FDS)

A 28-day (FDS) cancer clock can start following the below actions:

a) urgent referral for suspected cancer.

b) urgent referral for breast symptoms (where cancer is not suspected).

c) referral from NHS cancer screening programme.

d) Consultant upgrade

31 day

A 31-day cancer clock will start following:

a) a DTT for first definitive treatment.

b) a DTT for subsequent treatment.

c) an ECAD following a first definitive treatment for cancer.

If a patient's treatment plan changes, the DTT can be changed, ie if a patient had originally agreed to have surgery but then changed their mind and opted for radiotherapy instead.

Clock stops

62 day

A 62-day cancer clock will stop following:

a) delivery of first definitive treatment.

b) placing a patient with a confirmed cancer diagnosis onto active monitoring.

Removals from the 62-day pathway (not reported):

a) making a decision not to treat.

b) a patient declining all diagnostic tests and treatment

c) confirmation of a non-malignant diagnosis.

28 day Faster Diagnosis Standard (FDS)

A 28-day (FDS) cancer clock will stop following communication to the patient of either:

a) a diagnosis of cancer.

b) or confirmation of a non-malignant diagnosis.

c) or a patient declining all diagnostic tests

d)

31 day

A 31-day cancer clock will stop following:

a) delivery of first definitive treatment.

b) placing a patient with a confirmed cancer diagnosis onto active monitoring.

c) confirmation of a non-malignant diagnosis.

In some cases where a cancer clock stops the 18-week RTT clock will continue, ie confirmation of a non-malignant diagnosis if this needs further management within a consultant led service.

66. Consultant upgrades/ downgrades

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 (by completing the upgrade pro forma) that an upgrade has occurred, in order for the patient to be tracked on the correct pathway.

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

Consultant downgrades
If a consultant thinks the referral is inappropriate this should be discussed with the referrer. Only the referrer can downgrade or withdraw a referral. This includes where it is considered that insufficient information has been provided.

See CWTv12 (or most recent version if subsequent updates) for specific guidance around FIT Implementation in relation to downgrades where it may not be appropriate for patients to continue on the Lower GI urgent suspected cancer pathway.

67. Reasonableness

For patients on a cancer pathway, an offer will be deemed to be reasonable if 48 hours' notice of an appointment/diagnostic test/admission is given.

68. Waiting-time adjustments

- **62-/31-day pathways:**

  a) If a patient declines admission for a treatment, providing the offer of admission was 'reasonable' the clock can be adjusted from the date offered to the date the patient is available.

  b) If it is deemed clinically essential to treat another medical condition before treatment for cancer can be given, after a decision to treat the cancer has been made the clock can be adjusted from the point at which it is confirmed that a patient needs treatment for the other medical condition, to the point at which after receiving treatment for this condition the patient is deemed clinically fit to commence their cancer treatment.

  c) Where a patient opts for egg harvesting prior to their cancer treatment, an adjustment can be applied from the point at which the decision is made until eggs are harvested.

If the patient during a consultation, or at any other point, while being offered an appointment date states that they are unavailable for a set period of time (eg due to holiday or work commitments), an adjustment can be applied from the date that would have been offered to the patient to the date that they are available.

Any adjustment must be supported by clear documentation in the cancer management system and PAS or other relevant clinical system. The trust will ensure that TCIs offered to the patient will be recorded.

69. Patient cancellations

If the patient gives any prior notice that they cannot attend their appointment (even if this is on the day of clinic), this should be recorded as a cancellation and not DNA. The trust will make every effort to reschedule patient appointments at the convenience of the patient. If a patient cancels an appointment the following guidance must be followed.

First appointment cancellations

Urgent suspected cancer referral patients who cancel their first appointment should be offered another appointment within the two weeks of the referral being received.

Subsequent cancellations

Patients who cancel an appointment/investigation date will be offered an alternative date within seven days of the cancelled appointment (no waiting time adjustment will apply).

Multiple cancellations

All patients who are referred on a urgent suspected cancer 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.

70. 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.) A waiting time adjustment can be applied in accordance with CWT guidance.

First appointment .

First appointment adjustments can be made in accordance with CWT guidance.

Subsequent appointments

If a patient DNAs any subsequent appointment they should be re-booked as quickly as possible, if they DNA a second time they should be escalated to the consultant in clinic for a decision on the next step which may include discharge back to the GP.

71. Patients who are uncontactable

If the patient is uncontactable at any time on their urgent suspected cancer 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.

Providers should make reasonable efforts to contact the patient. Each of these calls must be recorded in real time on PAS. 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 standard, stating the trust has attempted to offer a choice of appointment, and that the patient should contact the office to rearrange the appointment if it is inconvenient
- **Appointments (other than first) patients on urgent suspected cancer pathway**: Attempts to contact the patient will be made as outlined above. If contact cannot be made, a letter should be sent asking the patient to make contact to arrange the appointment giving them 3 weeks to do so. If they do not make contact within the 3 weeks the responsible clinician should be contacted to decide on the next step which may include discharge to the GP.

72. Patients who are unavailable

If a patient indicates they will be unavailable, 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 will not be discharged if they make themselves unavailable.

73. Diagnostics

Providers will ensure diagnostics are undertaken in a timely manner to ensure the 28 day standard is met including best practice timed pathways.

Refusal of a diagnostic test

If a patient refuses a diagnostic test, the refusal will be escalated to the managing clinician to discuss with the patient. If the patient continues to refuse all diagnostic tests, they will be removed from the cancer pathway and may be discharged back to their GP.

74. Managing the transfer of private patients

If a patient decides to have any appointment in a private setting, they will remove themselves from the cancer pathway.

If a patient transfers from a private provider onto an NHS waiting list, they will need to be upgraded on to an urgent suspected cancer pathway if they have not made a DTT and the consultant wants them to be managed against the 62-day target. If a DTT has been made in a private setting the 31-day clock will start on the day the referral was received by the trust.

75. Tertiary referrals

Process

Inter provider transfer (IPT) forms will be used for all outbound referrals for patients on a cancer pathway.

All referral information will be transferred between trusts electronically. Transfers will be completed via a named NHS contact.

An agreed minimum dataset, all relevant diagnostic test results, images, MDT information and outcomes will be provided when the patient is referred.

Entering patients on the tracking pathway

- **Suspected cancers:**

On receipt of an urgent suspected cancer referral, the office will record the referral (including known adjustments, referring symptoms and first appointment) onto the cancer management system within 24 working hours of receiving the referral.

The co-ordinators are responsible for confirming a patient's attendance at the first appointment and recording the outcome, checking all dates are correct and that DNAs/breach reasons are entered correctly.

- **Suspected cancers: screening patients**

The MDT co-ordinating team will be responsible for entering patients referred via the screening programme onto the cancer management system database within 24 hours of receiving notification of the referral.

- **Suspected cancers: consultant upgrades**

For upgrade before initial appointments the relevant booking office/ teams will be responsible for entering patient details onto the cancer management system database and allocating the patient an appointment within the CWT12 guidelines.

For upgrades at any other point of the pathway the MDT co-ordinator will be responsible for updating the cancer management system and will begin the tracking of the pathway.

- **Suspected/confirmed cancers (31-day patients)**

Patients not referred via an urgent suspected cancer referral should not be entered onto the cancer management system until they have a confirmed cancer diagnosis. The only exception is patients with suspected cancer who are being discussed at an MDT meeting.

Once a patient has been diagnosed with either a new cancer or recurrence, a record should be entered in the cancer management system, selecting the appropriate cancer status (by the MDT co-ordinator) within 24 hours of being notified.

- **Cancer's diagnosis**

The MDT co-ordinator is responsible for ensuring a patient with a newly diagnosed cancer has a record entered on the cancer management system, and keeping that record updated.

- **Non cancer diagnosis**

Where the diagnosis is not cancer patients should be informed within 7 days of this outcome and an appropriate follow up should be arranged or patient discharge back to referrer.

76. Adherence to Policy

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

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

77. Local Provider Standard Operating Procedures (SOPs) and Policies

Please follow local provider SOPs and Policies that are relevant for the interpretation and utilisation of this policy.

78. Definitions or Explanation of Terms Used

Term	Definition
Active Monitoring HCP Initiated	A clock stop may apply where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage.
Active Monitoring Patient Initiated	Where a patient and a clinician agree the patients symptoms are not severe at the moment. The patient does not want treatment at this stage, a review appointment is agreed for x months and the patient is placed on Patient Initiated Active Monitoring. Patients may initiate the start of a period of active monitoring themselves (for example by choosing to decline treatment to see how they cope with their symptoms).
Admission	The act of admitting a patient for a day case or inpatient procedure.
Admitted Pathway	A pathway that ends in a clock stop for admission (day case/inpatient).
Bilateral Procedure	A procedure that is performed on both sides of the body, at matching anatomical sites i.e. Cataracts removed from both eyes.
Clinical Decision	A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning
Clock Stop	The date an RTT pathway stops
Consultant	A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. Consultant-led waiting times exclude non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.
Consultant Led	A Consultant retains overall clinical responsibility for the service, team or treatment. The Consultant will not necessarily be physically present for each appointment, but takes overall clinical responsibility for the patient care.
Converts Unique Booking Reference Number (UBRN)	On the date the patient converts their UBRN and book an outpatient appointment via NHS e-Referral Service, is the start of an 18 week pathway.
Day Case	Patients who need to be admitted for a procedure but do not need to stay in hospital overnight.
Did Not Attend (DNA)	Where a patient fails to attend an appointment/admission without prior notice.
Decision to Admit	Where a clinical decision is taken to admit the patient for either a day case or inpatient procedure.
Decision to Treat	A clinical decision is taken to treat the patient on admitted or non-admitted pathway.
Earliest Reasonable Offer (ERO) – Admissions	For an elective admission this is the earliest reasonable offer for admission date and should be a date three of more weeks from the time that the offer was made (unless clinically inappropriate).

	If a patient mutually agrees a short notice appointment, then that appointment date becomes a reasonable offer..
Elective Booked (EB)	Patient awaiting elective admission and was given an admission date at the time of the decision to treat.
Elective Planned (EP) - Excluded from Active RTT Waiting List	Patients who are to be admitted as part of a planned sequence of treatment or investigation. The patient has been given a date, or approximate date at the time a decision to admit was made (target date). The date is set for clinical reasons (e.g. check cystoscopy) and there is no clinical advantage in admitting the patient earlier or when a child needs to be a certain age at the point the procedure takes place. Patients who go beyond their clinically determined treat by date should be clinically reviewed and where appropriate move to the active waiting list and an RTT clock should start.
Elective Waiting (EW)	A patient is added to a waiting list having been given no date of admission at the time the decision to admit was made.
Electronic Referral Service (ERS)	NHS e-Referral Service - A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic.
Fit and Ready for a Bilateral Procedure	A new RTT clock should start once the patient is fit and ready for a subsequent bilateral procedure. In this context, fit and ready means that the clock should start from the date that it is clinically appropriate for the patient to undergo that procedure, and from when the patient says they are available
Fully Booked (FB)	The patient is given the opportunity to agree a mutually convenient appointment within one working day of the referral received date.
First Definitive Treatment	An intervention intended to manage a patient's disease, condition or injury to avoid further intervention. What constitutes first definitive treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.
Health Care Professional (HCP)	A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
Incomplete Pathway	Patients who are waiting for treatment and their RTT clock is still ticking.
Inpatient	Patients who need to come into hospital for treatment or investigations and who are expected to stay in hospital for at least one night.
Inter-Provider Transfer	Transferring a patient between one provider and another for diagnostic, treatment or advice. Any referral of a patient from one organisation to another should be accompanied by the IPTAMDS (Inter-Provider Transfer Administrative Minimum Data Set), whether this referral is through the NHS e-Referral Service or not. The IPTAMDS will provide the Patient Pathway Identifier (PPI) and the date of the consultant-led RTT clock start.
NHS e-Referral Service – formerly Choose and Book	A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic.
Non Admitted Pathway	A pathway that does not require an admission for diagnosis or treatment.

Outpatients	Patients referred to the hospital by a healthcare professional /GP for clinical advice or treatment in an outpatient setting.
Patient Thinking Time	Where a patient is giving 'Thinking Time' an agreed time scale is agreed between the patient and clinician, the RTT clock will continue to tick up to the point of the agreed timescale.
Patient Tracking List (PTL)	Patient Tracking List is a report used to ensure patients are managed and booked in turn according to their clinical priority. The report also ensures that the maximum waiting times standards are achieved by identifying all patients that will breach the current wait time's standards.
Planned Care	An appointment /procedure or series of appointments/ procedures as part of an agreed programme of care which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.
Reasonable Offer (RO)	An offer of a time and date three or more weeks from the time that the offer was made. If a patient agrees a short notice appointment of a date in less than three weeks, then that appointment date becomes a reasonable offer.
Referral to Treatment (RTT) Period	The part of a patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other clock stop.
Straight to Test	A specific type of direct access diagnostic service whereby a patient will be assessed and might, if appropriate, be treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional.
Substantively New or Different Treatment	Upon completion of a consultant-led referral to treatment period, a new waiting time clock starts upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan. It is recognised that a patient's care often extends beyond the consultant-led referral to treatment period, and that there may be a number of planned treatments beyond first definitive treatment. However, where further treatment is required that was not already planned; a new waiting time clock should start at the point the decision to treat is made. Scenarios where this might apply include: • where less 'invasive/intensive' forms of treatment have been unsuccessful and more 'aggressive/intensive' treatment is required (e.g. where Intra Uterine Insemination (IUI) has been unsuccessful and a decision is made to refer for IVF treatment); • Patients attending regular follow up outpatient appointments, where a decision is made to try a substantively new or different treatment. In this context, a change to the dosage of existing medication may not count as substantively new or different treatment, whereas a change to medication combined with a decision to refer the patient for therapy might. Ultimately, the decision about whether the treatment is substantively new or different from the patient's agreed care plan is one that must be made locally by a care professional in consultation with the patient.
To Come In Date (TCI)	The date of agreed admission for a procedure/treatment.

UBRN (Unique Booking Reference Number)	The reference number that a patient receives on their appointment request letter when generated by the referrer through the NHS e-Referral Service. The UBRN is used in conjunction with the patient password to make or change an appointment.
War Veterans	Are ex-service personnel who have served at least one day in the UK armed forces and have sustained injuries during that service.

79. Monitoring and audit

Monitoring Compliance / Effectiveness Table

Element to be monitored	***Lead Responsible for monitoring***	***Monitoring Tool / Method of monitoring***	***Frequency of monitoring***	***Lead Responsible for developing action plan & acting on recommendations***	***Reporting arrangements***	***Sharing and disseminating lessons learned & recommended changes in practice as a result of monitoring compliance with this document***
Adherence to policy and the effective management of the referral to treatment pathway	ICB Elective Director/Provider Performance Leads		Mthly through Trust Access and performance meetings	Provider Performance leads	Trust Access Boards/Meetings to ICB Planned Care Committee to ICB Performance Committee.	Planned Care Group through to Trust Access Meetings.

80. Appendices

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4	Consultant to Consultant Referral	62

Appendix 1

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

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

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

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

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

Inter Provider Minimum Data Set (IPTAMDS)

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

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

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

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

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

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

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

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

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

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

Appendix 2 - Inter-Provider Administrative Data Transfer (also for Internal Referrals)

This excludes where an existing Tertiary Pro-forma exists. ***Please complete all relevant fields***

Referring Organisation Code: **RM100**	Referring Specialty Code:
Referring Clinician:	Referring Clinician GMC Code:
Contact Name:	Contact Tel. No: Contact e-mail:
Patient Information	
Hospital No:	NHS No:
Surname:	Forename(s)
DOB:	Title:
Sex: Male ☐ Female ☐	Lead Contact: Patient ☐ Other ☐ If Other, Name: & Relationship:
BMI:	
Address & Postcode:	Contact Home Tel:
	Contact Work Tel:
	Contact Mobile:
	Contact e-mail:
Registered GP Information	
Registered GP Name:	GP Practice Code:
Registered GP Tel. No:	
Referral Information	
Is this patient on an 18 week pathway (on-going 18 week pathway at the point of requesting a transfer of care)?	
YES	**Answer**
Latest RTT Code 21 or 20:	
Latest Clock start date:	
Date of decision to refer:	
Unique Pathway Identifier if appropriate:	
Pathway Identifier allocated by organisation:	
Is this referral for: A diagnostic test only? or Opinion only (with no view for treatment)?	☐ ☐
Reason for referral:	
NO	**Answer**
Latest RTT Code 3 or 9:	
Date patient was treated:	
Date of decision to refer:	
Is this referral for: A diagnostic test only? or Opinion only (with no view for treatment)?	☐ ☐
Reason for referral:	
Receiving Organisation details:	
Receiving Organisation Name:	
Receiving Organisation Code:	
Receiving Clinician (optional):	
Receiving Specialty Code:	Date data transfer sent:
For Receiving Organisation	Date Received:

Appendix 3 – Admitted Priority Code Table

Code	Definition
P1a	Emergency procedures to be performed within 24 hours
P1b	Procedures to be performed within 72 hours (very urgent)
P2	Procedures to be performed within 1 month
P3	Procedures to be performed within 3 month
P4	Procedures to be performed >3 months (delay of 3 months possible)

Appendix 4 – Diagnostic Priority Code Table

Code	Definition
D1	Potentially life-threatening or time-critical conditions e.g., cancer, cardiac failure, significant bleeding, chest pain, renal failure, vision loss
D2	Potential to cause severe disability to or severe reduction of quality of life e.g. intractable pain
D3	Chronic complaints that impact on quality of life and may result in mild or moderate disability. Routine patients that would normally be seen within the next 4-6 weeks
D4	Chronic complaints that impact on quality of life and may result in mild or moderate disability. Routine patients that would normally be seen within the next 6-12 weeks
D5	Patients should be reassured about the trusts approach to managing their care during the Covid-19 pandemic, and given the opportunity to indicate if they are willing to proceed. Patients who are not currently willing to proceed due to Covid-19 should remain on the waiting list and be categorised as D5
D6	Patients should also be asked to provide details of any periods of unavailability, and general reason for this. It may be appropriate for the patient to have a clinical review with their referring clinician. Where patients are offered reasonable dates for diagnostic tests or procedures which are declined for non-Covid reasons, these patients will be categorised D6

Appendix 5 – Consultant to Consultant referrals

<table>
<tr><th>No</th><th>Type of Referral</th><th>Source of Referral</th><th>Definition</th><th>Agreed referral protocol</th><th>Action based on RTT Policy</th></tr>
<tr><td rowspan="3">1</td><td rowspan="3">Urgent referral</td><td>Within Trust (including</td><td rowspan="3">Urgent defined as suspected cancer or life threatening condition (includes referrals for TIA, RACP and Heart failure using the appropriate pro-forma)</td><td rowspan="3">Accept referral</td><td rowspan="2">Continuation of previous wait</td></tr>
<tr><td>Other provided of NHS care (NHS hospital, NHS treatment centre, private provider)</td></tr>
<tr><td>Provider of private care, (NHS hospital, private provider)</td><td>For previously private patient, clock start on date of C2C</td></tr>
<tr><td rowspan="3">2</td><td rowspan="3">Same condition</td><td rowspan="2">Within Trust</td><td>Internal referrals for any specialty directly relating to the original reason for referral, i.e. patient has associated symptons.</td><td>Accept referral</td><td>Continuation of previous wait</td></tr>
<tr><td>Does not include referrals for secondary condition or where referral is only loosely associated with original problem or referrals to the wrong clinical team.</td><td>Back to GP</td><td>Clock stop</td></tr>
<tr><td>Other provided of NHS care (NHS hospital, NHS treatment centre, private provider)</td><td>Referrals from other NHS providers only to be accepted when referred on as a tertiary referral for complexity on an agreed pathway.</td><td>Accept if part of an agreed pathway</td><td>Clock stop</td></tr>
<tr><td></td><td></td><td>Provider of private care, (NHS hospital, private provider)</td><td>Referrals from private providers should go back to GP for further discussion regarding onward treatment</td><td>Back to GP</td><td>Clock stop</td></tr>
<tr><td rowspan="3">3</td><td rowspan="3">Different condition</td><td>Within Trust</td><td rowspan="3">Referral for secondary condition, loosely associated problem or where original referral was to the wrong clinical team</td><td rowspan="3">Back to GP</td><td rowspan="3">Clock stop</td></tr>
<tr><td>Other provider of NHS care (NHS hospital, NHS treatment centre, private provider)</td></tr>
<tr><td>Provider of private care, (NHS hospital, private provider)</td></tr>
<tr><td>4</td><td>Second opinion</td><td>All providers</td><td></td><td>Back to GP</td><td>Clock stop</td></tr>
</table>

No	Type of Referral	Source of Referral	Definition	Agreed referral protocol	Action based on RTT Policy
5	Referral from ED - referrals only for a symptomatic condition directly related to presentation at ED	All providers of ED care (Trauma only)	Patient reviewed via emergency department and referred on to a specialty as a direct result of their presentation at ED when further intervention or significant specialist dressings are expected	Accept referral	Clock start on date of Consultant to Consultant referral
			If non symptomatic, patient to be referred back to GP. Consultant to Consultant referral will not be accepted within ED	Back to GP	Clock start if new referral from GP
6	Referral from ED - not trauma related	All providers of ED care	Patient reviewed via emergency department and referred on to a specialty as a result of non- trauma related injury	Back to GP	Clock start if new referral from GP
	Referral from ED - not trauma related but urgent	All providers of ED care	Urgent defined as suspected cancer or life threatening condition (includes referrals for TIA, RACP and Heart failure)	Accept referral	Clock start
	Allied Health Professionals	All non GP Health Professionals		Back to GP	Clock start if new referral from GP
7	Self-referral	Patients	Referral should be initiated by a GP	Back to GP	Clock start if new referral from GP
		Patients with an SOS appointment within 6 months	Referral can only be activated if specialty specific triggers for follow up are met	Accept referral	New clock start if activated within 6 month
8	Bilateral procedure		Decision taken following completion of first side that patient is fit and ready for a subsequent bliateral procedure - GP to be informed if second procedure necessary		Clock starts from the date of patient has confirmed they are fit ready and able to undertake a second procedure
9	Military patients	GO referrals from Military Medical Centres	Patient referred via Senior Medical Officer	Accept referral	Clock start
10	Midwife referrals	Antenatal referrals only. (if the referral doesn't relate to pregnancy, send back to GP)		Accept referral	Clock start
11	Dental referrals			Accept referral	Clock start
12	Ophthalmology referrals	Referrals from GP		Accept referral	Clock start
		Referrals from opticians		Not accepted, return	Clock start if new referral from GP

Equality Analysis

Title of policy, service, proposal etc being assessed:
HWE System Access Policy

What are the intended outcomes of this work? The aim of the policy is to ensure patients receive treatment in accordance with national objectives, planning guidance and appropriate standards, with patients of the same clinical priority treated in chronological order of their waiting time. Through the use of a system policy rather than individual trusts it will remove variation between different providers ensuring all patients are treated the regardless of who is treating them. The system access policy is also the first step to enable other areas of work such as aligning patient lists and levelling up waiting times across the system, ensuring greater equity of access. The policy clearly sets out what should happen if a patient declines treatment or does not attend the first or future appointments.
How will these outcomes be achieved? The policy will mean that all providers are working to the same policy which is based on standard national guidance.
Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc. If you believe that there is no likely impact on people explain how you've reached that decision and send the form to the equality and diversity manager for agreement and sign off Staff, provider organisations and patients

Evidence
Impact Assessment Not Required There may be occasions the papers presented do not require a decision and/or will have no impact (positive or negative) on people from the equality and health inequality groups, for example papers presented for information or for assurance. Where you can show that this is the case use this box to explain why. You will not need to complete the rest of the template. The template will still need to be sent to Paul Curry who will, if it is the case, confirm that no equality impact assessment is required.
Impact Assessment Required **What evidence have you considered?** Against each of the protected characteristics below list the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group. If you are submitting no evidence against a protected characteristic, please explain why. If there are gaps in evidence, please state how (and when) you will gather evidence and review the equality impact assessment in the Next Steps section of this document. Evidence for all groups could include population data and service usage data, Applies to all characteristics

The policy sets out the process for informing patients about appointments and when the use of letter and telephone is advisable depending on notice. Patients are offered opportunity to rebook their appointment at a more convenient time. It also sets out the process for DNAs and ensuring that as a failsafe GPs are informed if a patient has DNA'd two appointments. This includes not discharging the patient if is against their clinical best interests and consideration should be given where the patient is a child or a vulnerable adult.
Age Consider and detail age related evidence. This can include safeguarding, consent and welfare issues. This policy will not impact on age as patients of the same clinical priority will be treated in chronological order. All Trusts will have a safeguarding policy which details their responsibilities for safeguarding. The policy sets out the responsibility of the referrer to provide details of who can legally act on a patients behalf for children and adults who are unable to give consent. Paediatric DNA - When children do not attend for a planned appointment the case notes must be reviewed by a consultant or specialist registrar. The risk to the child will be assessed. Any safeguarding concerns will be addressed in line with local policies and procedures and primary care will be informed. In relation to children and clinical prioritization they may be deemed lower priority compared to adults, however the social and development impact is much bigger for children. To ensure children are not disadvantaged by the priority coding a piece of work is taking place separate to this policy that will review the prioritization of children and ensure it takes into account social and development factors. This is a completely separate workstream to the policy but will support ensuring that the clinical priority of patients is more equitable between adults and children.
Disability Detail and consider disability related evidence. This can include attitudinal, physical and social barriers as well as mental health/ learning disabilities. People with disabilities, learning disabilities and mental health conditions will have equal access to treatment and care packages within each trust. Their views and opinions will be respected, care plans will be personalized and reasonable adjustments to care packages and the environment will be made. The specific needs of people such as communication, information, use of advocacy services and involving carers according to the patient's wishes must be taken into consideration when these patients are accessing elective and acute services. The policy sets out the responsibility of the referrer to provide details of who can legally act on a patients behalf who are unable to give consent. Referrers should identify any special access requirements and and any special communication requirements so that reasonable adjustments can be made and information sent in line with the Accessible Information Standard. All procedures including consent will be in line with the Mental Capacity Act 2005. All Trusts have a safeguarding policy.
Gender reassignment (including transgender) Detail and consider evidence on transgender people. This can include issues such as privacy of data and harassment. There is no impact for this group as patients are treated in chronological order based on the clinical priority.

Marriage and civil partnership Detail and consider evidence on marriage and civil partnership. This can include working arrangements, part-time working, caring responsibilities. There is no impact on this group as patients are treated in chronological order based on the clinical priority.
Pregnancy and maternity Detail and consider evidence on pregnancy and maternity. This can include working arrangements, part-time working, caring responsibilities. There is no impact for this group as patients are treated in chronological order based on the clinical priority.
Race Detail and consider race related evidence. This can include information on difference ethnic groups, Roma gypsies, Irish Travellers, nationalities, cultures, and language barriers. Referrers are expected to identify any special communication requirements such as a language interpreter so that information can be provided in line with the Accessible Information Standard.
Religion or belief Detail and consider evidence on people with different religions, beliefs or no belief. This can include consent and end of life issues. There is no impact on this group as patients are treated in chronological order based on the clinical priority.
Sex Detail and consider evidence on men and women. This could include access to services and employment. There is no impact for this group as patients are treated in chronological order based on the clinical priority.
Sexual orientation Detail and consider evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers. There is no impact for this group as patients are treated in chronological order based on the clinical priority.
Carers Detail and consider evidence on part-time working, shift-patterns, general caring responsibilities. If a carer is known to a GP or secondary care provider this will be recorded on their notes and an individual provider policy will support carers in accessing healthcare.
Other identified groups Detail and consider evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include different socio-economic groups, geographical area inequality, income, resident status (migrants, asylum seekers). **People involved in the Criminal Justice System** For the purposes of this policy, People involved in the Criminal Justice System prisoners will be booked, and their referrals processed in the same way as vulnerable patients as they are not able to make choices about the time or date of their appointment and have no control over whether they cancel or do not attend. **War Veterans and Military Personnel**

Military personnel and veterans should receive priority access to NHS secondary care for any conditions which are likely to be related to their service, subject to the clinical needs of all patients. Priority should not be given for unrelated conditions.
However, it remains the case that military personnel and veterans should not be given priority over other patients with more urgent clinical needs.

Engagement and involvement

How have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?

The policy was developed by the three local acute providers and has had engagement with primary care through Planned Care Group, Performance Committee and Planned Care Committee.
The policy is based on national rules.
During the development of the policy new data become available which looks at waiting lists by characteristics which can then be overlaid with Primary Care data. Once the new ICB data platform is in place the aim is to create this data for all waiting lists and use it to support this work and understand further how we can reduce health inequalities.

How have you engaged stakeholders in testing the policy or programme proposals?

As above

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

As above

Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impacts, if so state whether adverse or positive and for which groups and/or individuals. How you will mitigate any negative impacts? How you will include certain protected groups in services or expand their participation in public life?
This policy is the first step in terms of being able to reduce health inequalities due to a variation in waiting times across providers. This policy is based on national rules and removes local variation.

Now consider and detail below how the proposals could support the elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups. This is the part of the Public Sector Equality Duty (see page 2).

Eliminate discrimination, harassment and victimisation

This policy ensures that all patients should be treated based on their clinical priority and in chronological order so no patient should be waiting any longer than someone else with the same clinical priority.

Advance equality of opportunity

As above

Promote good relations between groups
This policy has been jointly developed by the 3 acute providers.

Next Steps

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This is your action plan and should be SMART.
This is the first step in improving equity of access to elective care across the system. Once this policy is approved and embedded in practice across the system work will begin on the other planned care priorities which focus on reducing health inequalities based on different waiting times.
The impact of the policy will be monitored through the Planned Care Committee using waiting list data to determine if those with protected characteristics are waiting longer. This will then allow us to determine what action is neccessary.
This policy does not cover patient communication and digital exclusion and providers will have individual policies which align with the Accessible Information Standard, however if the waiting list data identified that a group were experiencing a health inequality which related to communication this would be raised with the relevant provider through Planned Care Committee and appropriate action agreed and followed up.

How will you share the findings of the Equality analysis? This can include sharing through corporate governance or sharing with, for example, other directorates, partner organisations or the public. The completed EqIA will be published on the CCG website either as part of the report on the proposals or separately on the equality and diversity pages.
This will be shared at the Planned Care Committee and other trust governance routes.

Health Inequalities Analysis

Evidence

1. What evidence have you considered to determine what health inequalities exist in relation to your work? List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each health inequality group. If there are gaps in evidence, state what you will do to mitigate them.
During the development of the policy new data become available which looks at waiting lists by characteristics which can then be overlaid with Primary Care data. Once the new ICB data platform is in place the aim is to create this data for all waiting lists and use it to support this work and understand further how we can reduce health inequalities.

Impact

2. What is the potential impact of your work on health inequalities? Can you demonstrate through evidenced based consideration how the health outcomes, experience and access to health care services differ across the population group and in different geographical locations that your work applies to?
This will remove local variation in the current access policies.

3. How can you make sure that your work has the best chance of reducing health inequalities?
This is the first step to allow the planned care programme to undertake other projects which will reduce health inequalities.

Monitor and Evaluation

4. How will you monitor and evaluate the effect of your work on health inequalities?
During the development of the policy new data become available which looks at waiting lists by characteristics which can then be overlaid with Primary Care data. Once the new ICB data platform is in place the aim is to create this data for all waiting lists and use it to support this work and understand further how we can reduce health inequalities.
We will be able to use this data to monitor the impact of the policy and other projects.

For your records

Name of person(s) who carried out these analyses:
Rebecca Cornish

Date analyses were completed: 19.1.23

Equality and Diversity Lead Sign off

An equality impact assessment has been completed and when considering equity and equality it is likely that decision makers will have sufficient information to be able to show Due Regard, as required by the Equality Act 2010. Paul Curry, Equality and Diversity Lead, 26 January 2024