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This version supersedes all previous versions.

Version Control

Version	Release	Author/Reviewer	Ratified / Authorised by	Date	Changes (Please identify page no.)
3.0	May 2024	K. Webb	SMT	May 2024	Full review and update onto new template

Contents

1. Introduction

This policy is based around core principles established within the NHS Constitution and Everyone Counts, which states the rights patients, public and staff are entitled to. The NHS Constitution is a document enshrined in law, and as such all NHS providers are bound to take account of the document in all aspects of their operations. Somerset Surgical Services (SSS) follows all local and national rules regarding patient access to elective care.

For more information please refer to:

Referral To Treatment (RTT) rules suite:
https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

This policy should be read in conjunction with the BNSSG Elective Care Access Policy.

2. Purpose

The aim of this policy is to provide guidance on elective care principles, key administration processes, timeframes and referral to treatment rules for managing patients along their elective care pathways.

The policy also details the expectations and responsibilities of both patient and provider (SSS) in managing access to services.

SSS will ensure that the management of patient access to services is transparent, fair, equitable, and managed according to clinical priority.

3. Scope

This policy details the rights and responsibilities of patients and staff in relation to accessing elective secondary care services with SSS. The policy covers the way in which SSS will manage patients who are waiting for treatment on admitted, non-admitted, or diagnostic pathways.

The policy applies to all sites where SSS provides secondary care services, including outreach clinics.

SSS do not accept Fast Track referrals (Two Week Wait) on a cancer pathway or referrals for diagnostic investigation only and therefore these elective pathways are excluded from the scope of this policy.

4. Structure of Policy

The policy will be structured as follows:

1. General Principles
2. Pathway Specific Principles
3. Cancer Pathways
4. Reference Information

Section One

General Principles

5. Key Principles

SSS is committed to delivering high quality and timely elective care to patients and this policy is underpinned by the following principles:

- This policy details how SSS manage administration for patients who are waiting for or undergoing treatment on an RTT pathway.
- As set out in both Everyone Counts and the NHS Constitution, patients have the right to start consultant led treatment within maximum waiting times. The policies and procedures comprising this policy adhere to national best practice and provide a framework to ensure that patients are treated transparently, fairly and reasonably.
- SSS will give priority to clinically urgent patients and treat everyone else in chronological turn.
- SSS will work to meet and better the maximum waiting times set by NHS England for all groups of patients.
- SSS will at all times negotiate appointment and admission dates and times with patients.
- SSS will work to ensure fair and equal access to services for all patients.

6. Roles and Responsibilities

6.1 Local ICB's

- Promote the rights and pledges enshrined in The NHS Constitution 2021
- Develop and manage the local health market to provide plurality and patient choice
- Ensure that all patients needing planned elective care are offered clinically appropriate choices of provider
- Ensure that patients are treated within clinically appropriate, commissioned pathways and maximum treatment times

6.2 Referrers Responsibilities

- Ensuring that the patient is clinically suitable for their referral and intended pathway of care
- Ensuring that the patient is ready, willing and able to attend for any necessary outpatient appointments and/or treatment (at the point of referral)
- Initiating the referral and discussing the choice of providers with patients
- Providing the national minimum core data set when referring a patient, taking into account any referral criteria.
- Ensuring that where appropriate, funding is in place prior to referral for interventions not normally funded.
- Ensure that the patient meets the criteria set out in an relevant commissioning policy for that procedure and that this is clearly recorded on the referral

6.3 Provider (SSS) Responsibilities

The Managing Director is accountable for:

- delivery of the referral to treatment (RTT) targets
- performance against national standards

The Operations Director has overall responsibility for:

- updating this policy in line with national and local changes
- statutory performance reporting as required
- being the NHS E-Referral lead
- reporting on breaches of any national performance standard as required

The Administration Manager has responsibility for:

- ensuring adherence to the policy and ensuring that staff are fully trained
- updating SOP support documents to complement this policy as required
- providing advice and support for administration staff so that the patient pathway can be managed in line with targets and policy guidelines.
- investigating breaches of RTT pathways or national maximum treatment time pathways as required

The SSS Consultant has responsibility for:

- reviewing where appropriate patient referrals, allocating clinical priority and accepting / rejecting referrals within a reasonable time frame
- assisting administrators to manage the patient pathway by providing outpatient and theatre availability within reasonable timeframes.
- Reviewing where required patient referrals and confirming following outpatient review that a patient meets commissioning criteria

Patient Pathway Co-ordinators have responsibility for:

- Recording referrals on Careflow within 24 hours of receipt if a paper copy
- Accepting/Rejecting eRS referrals within 48 hours of receipt
- Maintaining up to date waiting lists/trackers for their specialties, covering the entire RTT pathway
- Highlighting capacity short falls to the Administration Manager in a timely manner to avoid patient wait times being compromised. This is both for consultant availability and lack of appropriate facility space.
- Planning patients in order of clinical priority and then in chronological order, case mix permitting
- Offering patients' earliest reasonable offer dates, ensuring a choice of dates and relevant notice
- Ensuring that any data created, edited, used or recorded on Careflow is accurate, timely, relevant, valid, complete and fit for purpose
- Ensuring they keep themselves updated and informed by reading the available supporting materials on RTT, policies relating to collection, storage and use of data in order to maintain the highest standards of data quality and to maintain patient confidentiality
- Ensuring all activity is validated and any breaches have an accurate reason attached to indicate the reason for the breach
- Adhering to the rules expressed in this policy

6.4 Patient Responsibilities

- ensuring that accurate and up to date contact details are provided to both SSS and their GP
- consider the choice options that are available to them
- making every effort to accept an available appointment

- attending agreed appointments, or giving sufficient notice in the event of the need to change an agreed date or time
- responding to SSS communications in a timely manner
- advising SSS if appointments or treatments are no longer required

7. National Elective Care Standards

The table below provides the current national elective care standards for treatment delivered by SSS

Referral to Treatment	
Incomplete Pathways	92% of patients on an incomplete pathway (i.e. still waiting for treatment) to be waiting no more than 18 weeks (or 126 days)
Diagnostics	
Applicable to specific diagnostics investigations	Less than 1% of patients should wait 6 weeks (or 41 days) or more for a diagnostic test, from the date of referral to appointment date for the following (specific to SSS): Endoscopy – Colonoscopy Endoscopy – Flexible sigmoidoscopy Endoscopy – Gastroscopy Endoscopy - Cystoscopy

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

- **Exceptions** – applicable where it is in the patient's best clinical interest to receive treatment past 18 weeks.
- **Choice** – applicable where a patient chooses to delay treatment due to personal or social reasons and can include requesting to delay an appointment booking or extend their pathways via rescheduling previously agreed appointment dates or admission offers.
- **Co-operation** – applicable where patients do not attend (DNA) previously agreed appointment or admission dates (TCI) and this prevents SSS from treating within 18 weeks.

8. Clinical Prioritisation

The Clinical Prioritisation Programme was introduced in the third phase of the NHS response to COVID-19 and was designed to support the prioritisation of waiting lists as part of the recovery of elective activity.

The programme aims to ensure that all patients have been reviewed and clinically prioritised to support discussions with patients about their planned care, to give greater clarity of the number of

patients awaiting procedures at each priority level, to inform service capacity planning, and support the booking of patients.

The clinical review of key cohorts of patients ensures that they are prioritised with regard to the length of time they can wait for treatment without significant detrimental effect.

Categories of P1 to P4 have been introduced in addition to the Routine, Urgent, 2 week wait and Cancer priorities for clinical prioritisation and waiting lists have been re-prioritised to ensure that all patients waiting for admitted treatment are visible to be booked in priority order and to enable timely clinical review.

P code	Booking Timescale	Review timescale
P1a	Emergency procedures to be performed in <24 hours – **would not usually apply to patients awaiting elective admission**	
P1b	Emergency procedures to be performed in <72 hours – **would not usually apply to patients awaiting elective admission**	
P2	Procedures to be performed in <1 month	1 month
P3	Procedures to be performed in <3 months	3 months
P4	Procedures to be performed in >3 months	6 months

All patients, including those who have chosen to delay treatment should be reviewed to make sure their condition or preference has not changed. The maximum time between reviews is six months. Reviews should be undertaken in line with the timescale indicated by the patient's priority category, or sooner if appropriate (for example if a change in the patient's condition has been highlighted).

In October 2022 Interim Operational Guidance on the Management of patients on the waiting list choosing to decline offered treatment dates at a current provider or an alternative provider was released. This Guidance introduced C coding to replace P6 (patients who had chosen to delay treatment).

9. Individual patient rights

The NHS Constitution clearly sets out a series of pledges and rights stating what patients, the public and staff can expect from the NHS.

A patient has the right to the following:

• Choice of hospital and consultant.
• To begin their treatment for routine conditions following a referral into a consultant led service, within a maximum waiting time of 18 weeks to treatment.
• To be seen by a cancer specialist within a maximum of two weeks from a referral for urgent referrals where cancer is suspected.
• If this is not possible, the NHS has to take all reasonable steps to offer a range of alternatives.

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

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

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

10. Patient eligibility

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

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

• Have paid the immigration health surcharge.
• Have come to work or study in the UK.
• Have been granted or made an application for asylum.
• Citizens of the European Union (EU) who hold a European Health Insurance Card (EHIC), PRC or S2 are also entitled to free healthcare, although the SSS may recover the cost of treatment from the country of origin.

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

11. Patients moving between NHS and private care

Patients can choose to move between NHS and private status at any point during their treatment without prejudice. Where it has been agreed, for example, that a surgical procedure is necessary the patient can be added directly to the elective waiting list if clinically appropriate.

The RTT clock starts at the point the GP or original referrer's letter arrives with SSS. CBA and PA policies still apply and should be reviewed before a referral is made. Patients are not given priority to earlier treatment and cannot avoid required steps on the care pathway if they have sought the clinical advice privately. If an intervention is recommended in a private facility, the patient may not be eligible to receive the treatment in the NHS based on the agreed commissioning policies in place and this must be clearly explained to patients before referral

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

If a patient is due for a bilateral procedure and opts to have their first procedure privately, the same RTT rules would apply in a private setting as in an NHS setting and the RTT clock will stop when first definitive treatment for the first side takes place. A second new clock starts once the patient is fit and ready to proceed with the second procedure.

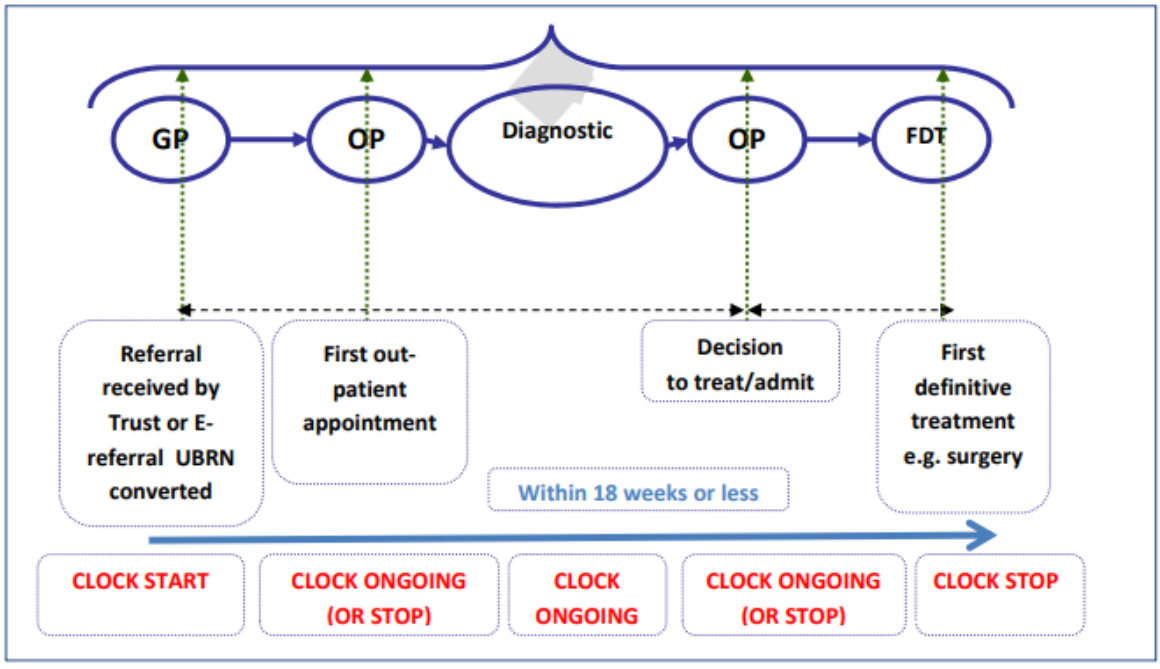
12. Commissioner-approved procedures

Patients referred for specific treatments where there is limited evidence of clinical effectiveness, or which might be considered cosmetic can only be accepted with the prior approval of the relevant ICB. Patients referred on the basis of criteria based access should have this demonstrated in the referral letter. Clinicians should be aware of the list of procedures to ensure it is appropriate to offer a procedure prior to listing the patient. Clinicians will be supported by Patient Pathway Coordinators to ensure any prior approval or criteria based access procedures are clearly documented and supported prior to arranging any appointment or admission dates.

13. Pathway milestones

To achieve treatment within RTT timeframes, pathways should be designed with key milestones and sufficient capacity agreed with clinicians and commissioners.

For example, you could break down a surgical pathway into the milestones shown below.



14. Overview of national referral to treatment rules

14.1 Clock starts

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

An RTT clock can also start when any healthcare professional (or service permitted by an English NHS commissioner to make such referrals) refers to an interface service which may result in an onward referral to a consultant-led service.

14.2 The need for a new clock

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

a) when a patient becomes fit and ready for the second of a consultant-led bilateral procedure.
b) upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.
c) upon a patient being re-referred into 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. Some clinical pathways require patients to undergo regular monitoring or review diagnostics as part of an agreed programme of care. These events would not in themselves indicate a decision to treat or a new clock start. If a decision is made to treat after a period of active monitoring/watchful waiting, a new RTT clock would start on the date of decision to treat (DTT).
e) when a patient rebooks their appointment following a first appointment did not attend (DNA) that stopped and nullified their earlier clock.

14.3 Clock stops for treatment

An RTT clock will be stopped for treatment in the following scenarios:

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

14.4 Clock stops for non-treatment

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 the patient on a period of active monitoring.
c) A patient declines treatment having been offered it.
d) A clinical decision is made not to treat.
e) A patient DNAs their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient.
f) A patient DNAs any other appointment and is subsequently discharged back to the care of their GP, provided that:
• SSS can demonstrate that the appointment was clearly communicated to the patient.
• discharging the patient is not contrary to their best clinical interests.
• discharging the patient is carried out according to local, publicly available or published policies on DNA.

14.5 Planned patients

All patients added to the planned list will be given a due date by when their planned procedure/test should take place. Where a patient requiring a planned procedure goes beyond their due date, they will be transferred to an active waiting list and a new diagnostic clock (if applicable) and RTT clock will be started

14.6 Reasonableness

'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 a choice of two dates with at least three weeks' notice.

14.7 Uncontactable

Where a patient cannot be reached by the initial phone call, three further attempts on different days at different times (ideally, if possible one out of hours) should be made to contact the patient. If the patient still cannot be reached a letter will be sent giving the patient two weeks to make contact to book their appointment. If the patient does not make contact within those two weeks they will be reviewed and may be returned to their referrer.

14.8 Chronological booking

Patients will be selected for booking appointments or admission dates according to clinical priority. Patients of the same clinical priority will be appointed/treated in RTT chronological order, i.e. the patients who have been waiting longest will be seen first, unless this is not possible for a theatre list due to case mix or equipment constraints.

Patients will be selected using the waiting list management details and patient tracking lists (PTLs) only. They will not be selected from any paper-based systems.

14.9 Communication

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

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.

14.10 Active monitoring

Active monitoring is where a decision is made that the patient does not require any form of treatment currently but is to be monitored in secondary care. When a decision to commence a period of active monitoring is made and communicated with the patient, the RTT clock stops. Stopping a patient's clock for a period of active monitoring requires careful consideration on a caseby-case basis and its use needs to be consistent with the patient's perception of their wait.

14.11 Patient-initiated delays

Non-attendance of appointments/did not attend (DNAs)

Other than at first attendance, DNAs have no impact on reported waiting times. Every effort should be made to minimise DNAs, and it is important that a clinician reviews every DNA on an individual patient basis.

First appointment DNAs

The RTT clock is stopped and nullified in all cases (as long as SSS can demonstrate the appointment was booked in line with reasonableness criteria). The clinician can make the decision to discharge back to the referrer following the first DNA. If the clinician indicates another first appointment should be offered, a new RTT clock will be started on the day the new appointment is agreed with the patient. However, if there is a delay in contacting the patient due to capacity constraints the clock should start on the date that the clinician made the decision for the outpatient appointment to be rebooked. Where an additional appointment is offered following the first DNA, should a

consecutive DNA take place (i.e. 2nd DNA), the patient will be discharged back to their referrer unless the clinician over-rides this decision.

Subsequent (follow-up) appointment DNAs

The RTT clock continues if the clinician indicates that a further appointment should be offered. The RTT clock stops if the clinician indicates that it is in the patient's best clinical interests to be discharged back to their GP/referrer.

Cancelling, declining, or delaying appointment offers

Patients should be ready, willing and able to attend at the time of being referred to secondary care.

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

If a patient makes multiple cancellations, multiple changes or long-term cancellations to an appointment SSS will consider discharge back to the referrer following a clinical review process to ensure this is in the best interests of the patient. SSS will actively engage with patients if there is more than one cancellation to establish reasons for multiple cancellations and to inform the clinical

Cancelling, declining, or delaying admission offers

Patients should be ready, willing and able to attend at the time of being added to a waiting list for a procedure.

If a patient has previously agreed to an admission date which they subsequently wish to change, the cancellation does not stop the RTT clock. However, as part of the rebooking process, the patient should be offered alternative dates for admission. If a patient makes multiple cancellations or multiple changes to an admission resulting in a delay to their treatment pathway SSS will carry out a clinical validation as the appropriateness of the patient remaining on the pathway or whether referral back to the GP is more appropriate. SSS will actively engage with patients if there is more than one cancellation to establish reasons for multiple cancellations and to inform the clinical review.

14.12 Patients who are unfit for surgery

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

Short-term illnesses

If the clinical issue is short-term and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold), the RTT clock continues.

Longer term illnesses

If the clinical issue is more serious and the patient requires optimisation and / or treatment for it, clinicians should indicate to administration staff:

• If it is clinically appropriate for the patient to be removed from the waiting list (this will be a clock stop event via the application of active monitoring).

• If the patient should be optimised/treated within secondary care (active monitoring clock stop) or if they should be discharged back to the care of their GP (clock stop).

If a clinical decision is made to stop the RTT clock for active monitoring, the patient's next steps should be agreed, including timescale for further review or follow up to assess the patient's condition. The pathway should remain visible on the relevant PTL or waiting list report to support ongoing management

15. Vulnerable patients (Safeguarding Children, Young People and Vulnerable Adults)

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

I. Patients with learning difficulties or psychiatric problems
II. Patients with physical disabilities or mobility problems
III. Elderly patients who require community care
IV. Children (as defined in The Children Act (2004)1

Patients must be provided with communications in the appropriate format to access services and the Mental Capacity Act (2005) adhered to. When a patient lacks capacity about their treatment decision, this should be evidenced by a capacity assessment and a best interest discussion held with their next of kin / family or friends and in their absence an independent mental capacity advocate.

SSS have a legal obligation under the Equality Act (2010) to make reasonable adjustments to facilitate the care of people with disabilities. Staff should work in collaboration with the patient, their carer and the team caring for the person when managing their care. By law, if the adjustment is reasonable, then it should be made. Examples of reasonable adjustments may include:

• Offering time appropriate appointments
• Allocating at the beginning or the end of a list / clinic. e.g. early morning may be preferable for patients with dementia.
• Having a trusted person accompany the patient e.g. anaesthetic room.
• Patients subject to a Deprivation of Liberty Safeguard (DoLS) or a section of the Mental Health Act (1983) may require additional support / increased observation.

Cancellations should only be made in exceptional circumstances due to the complex planning required when booking appointments and the emotional distress that it can cause the patient. When safeguarding issues are identified SSS procedures must be followed.

16. Military veterans

In line with the Armed Forces Covenant published in 2015, all veterans and war pensioners should receive priority access to NHS care for any conditions related to their service, subject to the clinical needs of all patients. Military veterans should not need first to have applied and become eligible for a war pension before receiving priority treatment.

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

17. Prisoners

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

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

18. Service standards

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

Key standards for implementation include the following:

- referral receipt and registration within 24 hours of receipt (paper or eRS no slot referral)
- referral triage and accept/reject within 48 hours of receipt
- addition to the day case or inpatient waiting list within 48 hours of decision to admit

19. Governance

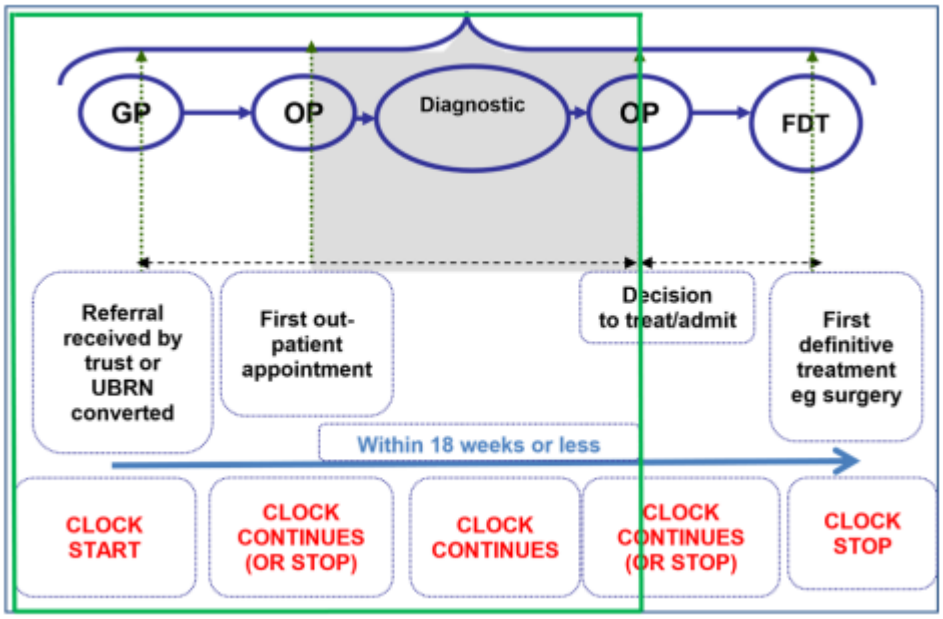
Somerset Surgical Services will have robust Board level reporting of RTT with a Senior Management Team structure to support management, delivery and escalation reporting and action as required.

Section Two

Pathway Specific Principles

Section 2 a) Non-admitted pathways

The non-admitted stages of the patient pathway below comprise both outpatients and the diagnostic stages, as highlighted by the section with the green border around it in the diagram below. It starts from the clock start date (i.e. the date the referral is received) and ends when either a clock stop happens in outpatients (this could be the first, second or a further appointment) or when a decision to admit is made and the patient transfers to the admitted pathway.



20. Referral Management

a) Pre-requisites prior to referral:

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

b) Referral types and sources

Paper-based referrals are still currently accepted, but discouraged, except for services where e-referrals are not possible (such as dental referrals). The NHS e-Referral Service (e-RS) is the preferred method of receiving referrals from GPs and Referral Management Centres (RMCs).

20.1 NHS e-referrals (e-RS)

All NHS e-referrals must be reviewed and accepted or rejected by clinical teams within one working day for urgent referrals or two working days for routine referrals. Where there is a delay in reviewing e-referrals this will be escalated to the relevant clinical/management team and actions agreed to address it. If an NHS e-Referral is received for a service not offered by SSS, it will be rejected back to

the referring GP advising that the patient needs to be referred elsewhere. This will stop the patient's RTT clock.

20.2 Paper-based referrals – Primary Care

All routine and urgent referral letters should be sent to the SSS office. Referrals must be date stamped on receipt. For patients referred by paper from primary care, the referral received date is the point that the RTT clock starts.

20.3 Paper-based referrals – Secondary Care

All Consultant to Consultant Referrals and/or Inter provider transfers (IPTs) will have the received date noted on the referral paperwork. Referrals should be accompanied by an IPT form which will provide RTT pathway details for the patient and will be reviewed for accuracy with any queries made prior to recording electronically to ensure data accuracy.

For any outgoing paper based referrals (IPTs), SSS will ensure that these are processed as quickly as possible to avoid any unnecessary delays in the patient's pathway. An accompanying minimum data set (MDS) pro forma will be sent with the IPT, detailing the patient's current RTT status (the receiving provider will inherit any RTT wait already incurred if the patient has not yet been treated).

20.4 Review of Referrals

All referrals will be triaged to ensure clinical suitability and to ensure that any prior approval has been granted or criteria based access has been demonstrated as part of the referral information provided.

21. First appointment

Where possible, patients will book a first appointment via the NHS e-Referral Service where they will be able to select a convenient appointment date/time from the options available. However if the service is not available via e-RS, or there were no available appointments resulting in an Appointment Slot Issue (ASI), SSS will contact the patient to offer appointments once these are available. In the case of an ASI the RTT clock is ticking from the point at which the patient attempted to book their appointment.

A reasonable offer for a first outpatient appointment is an offer of a date and time three or more weeks from the time that the offer was made by SSS. Should a patient accept an appointment less than three weeks into the future, this becomes a reasonable offer.

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

22. Provider Initiated Appointment Changes

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

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

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

23. Patient Initiated Appointment Cancellations

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

24. Patient Initiated Appointment Changes

RTT Rules continue to apply to pathways where a patient states that due to personal or social reasons, they are not willing to agree a date and no pause or blanket discharge policy can apply. These patients must be reviewed on a case-by-case basis by the relevant clinician. If the clinician is satisfied that the proposed delay is appropriate then SSS should allow the delay, regardless of the length of wait reported. If the clinician is not satisfied that the proposed delay is appropriate, then the clinical risks should be clearly communicated to the patient and a clinically appropriate TCI date agreed

If the patient declines the advice of the clinician, then the responsible clinician must act in the best interest of the patient. If the clinician feels that it is in the best clinical interest of the patient to discharge the patient back to the care of their GP and inform them that treatment is not progressing, then this must be made clear to the patient. This must be a clinical decision, taking the healthcare needs of each individual patient into account. Section 7.1.1 of the guidance on "duration of patient initiated delays" may become relevant if patients could come to harm by repeatedly cancelling or failing to attend appointments:

https://www.england.nhs.uk/statistics/wpcontent/uploads/sites/2/2021/05/Recording-and-Reporting-guidance-April_2021.pdf

It is not acceptable to refer patients back to their GP simply because they wish to delay their appointment or treatment. However, it would be acceptable where referring patients back to their GP is in their best clinical interests. Such decisions should be made by the treating clinician on a case-by case basis.

25. Clinic attendance and outcomes (new and follow-up clinics)

Every patient, new and follow-up, whether attended or not, will have an attendance status and outcome recorded on PAS at the end of the clinic. Clinics will be fully outcomed or 'cashed up' within one working day of the clinic taking place.

Clinic outcomes (e.g. discharge, further appointment) and the patient's updated RTT status will be recorded by the clinician on the clinic outcome sheet and shared with the patient pathway co-ordinator at the end of each clinic.

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

Patients on an open pathway:

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

Patients already treated or with a decision not to treat:

- New clock start if a decision is made regarding a new treatment plan.
- New clock start if the patient is fit and ready for the second side of a bilateral procedure (note: please refer to relevant commissioning policies before proceeding with second side procedures).
- No RTT clock if the patient is to be reviewed following first definitive treatment.
- No RTT clock if the patient is to continue under active monitoring.

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

25.1 Follow Up Appointments

Patients who require a follow up appointment will either have a fully booked appointment when they leave the outpatient clinic or will be contacted by the patient pathway co-ordinator in order to arrange this.

All follow up patients will be recorded on administrative systems and managed by the patient pathway co-ordinator, including those where it has been agreed to transfer onto a Patient Initiated Follow Up (PIFU) pathway.

25.2 Did not attends (DNAs)

All did not attends (DNAs) (new and follow-up) will be reviewed by the clinician at the end of clinic in order for a clinical decision to be made regarding next steps. Vulnerable patient DNAs should be managed with reference to the SSS Safeguarding policy as required.

Any patient who does not attend their agreed appointment (new or follow up) will have a clinical decision made regarding next steps which may include being discharged back to the care of their GP. If this occurs, both patient and GP will be notified of this in writing to ensure the referring GP is aware and can action further management of the patient if necessary. The patient's RTT clock will be stopped. Exceptions to this include:

- when a clinical decision is taken that discharging is contrary to the patient's clinical interests
- clinically very urgent referrals including cancer, or active surveillance for cancer, rapid access chest pain, and other critical illnesses
- Vulnerable adults
- When one of the following can be confirmed:
    i. The appointment was sent to the incorrect patient address
    ii. The appointment was not offered with reasonable notice

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

If a patient DNAs their first appointment following the initial referral which started their RTT clock, their RTT clock should be nullified (i.e. stopped and reported). Should the patient be offered another date this should be done within a period of 14 days, a new RTT clock will start on the date that the patient agrees their appointment. For example, if the patient DNA's an appointment on 4th July and a conversation with the patient happens on 7th July to agree another appointment for 18th July, the new clock starts on 7th July.

If a patient DNAs a rescheduled first appointment their RTT clock should be nullified (i.e. stopped and reported). However, should the decision be made that the patient be offered another date the RTT clock continues. The RTT clock can be stopped if the patient is unsure if they want treatment at all.

Nullification only applies where a patient DNA a first appointment and does not apply to follow up appointments.

The principles for managing cancellations and DNAs for outpatient appointments apply in the same way to non-face-to-face appointments and 'virtual' contacts, including telephone and video consultations.

25.3 Patients requiring thinking time

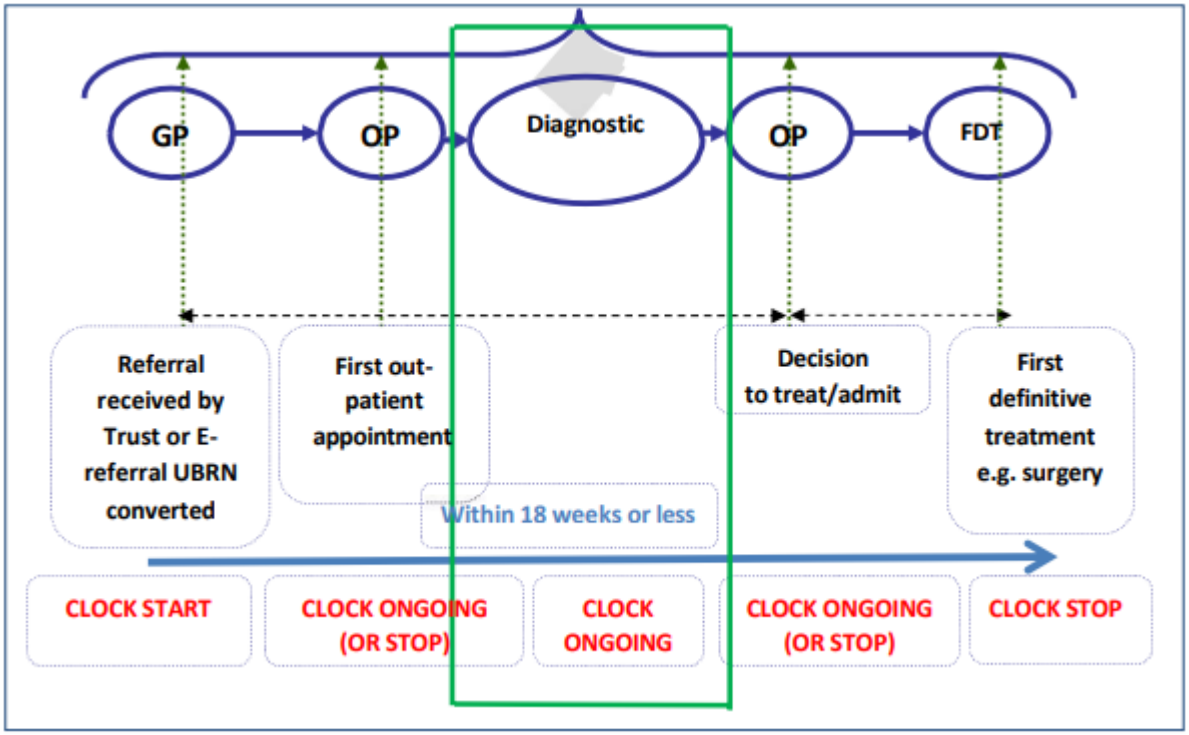
Patients may wish to spend time thinking about the recommended treatment options before confirming they would like to proceed. It would not be appropriate to stop their RTT clock where this thinking time amounts to only a few days or weeks. Patients should be asked to make contact within an agreed period with their decision.

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.

Section 2 b) Diagnostic Pathways

The section within the border on the diagram below represents the diagnostic stage of the RTT pathway. It starts at the point of a decision to refer and ends upon the diagnostic procedure being conducted. Patients waiting for two or more separate diagnostic tests/procedures concurrently should have independent waiting times clocks for each test/procedure.

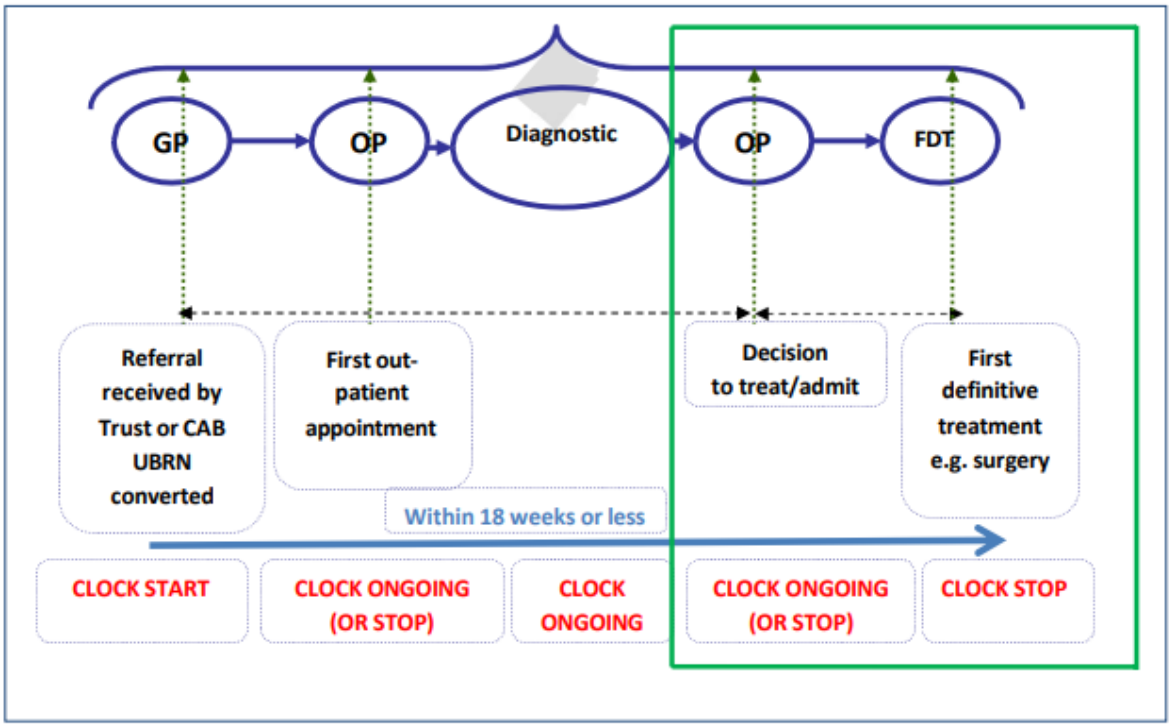


SSS do not typically undertake diagnostic assessments but where this does occur will follow the national standard which relates to the 15 DM01 modalities only – and that the 6-week diagnostic clock starts when the request for a diagnostic test or procedure is made.

In line with good RTT pathway management, SSS will monitor patients awaiting a diagnostic test to ensure that their RTT pathway can be progressed timely.

Section 2 c) Admitted Pathways / Decision to Admit

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



26. Decision to Admit

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

I. There is a sound clinical indication for surgery
II. The patient is clinically fit, ready and available to undergo surgery. Patients who are added must be clinically and socially ready for admission on the day the decision to admit is made, i.e. if there was a bed available tomorrow in which to admit a patient, they are fit, ready and able to come in.
III. The requirements of any commissioning policy in respect of Interventions Not Normally Funded (INNF) or Evidence Based Interventions (EBI) have been complied with in terms of funding approval or meeting criteria.

Turnaround times for funding decisions are guaranteed and detailed in the relevant ICB Exceptional Funding Requests Policy (or equivalent). All patients must be added to the waiting list at the time a Decision to Treat is made and prior approval must be sought thereafter (please note that the RTT clock continues during the time approval is sought). If funding approval is refused or the patient does not meet the criteria to access treatment, the patient must be removed from the waiting list and referred back to the GP with a letter documenting that funding approval was rejected. A copy of the letter must also be sent to the patient.

27. Completion of a Waiting List To Come In (TCI) card

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

28. Pre-operative assessment

Depending on the complexity and anaesthetic requirement, patients may undergo pre-operative assessment immediately following the decision to admit or at a later date.

Careful planning of pre-operative assessment will take into account the need for results to be available ahead of a date for surgery, a pre-operative consent appointment with the Consultant where applicable.

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

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

• Acute conditions (short-term illnesses– temporarily unfit) – if the clinical issue is short term and has no impact on the original clinical decision to undertake the procedure (e.g. cough or cold) the RTT clock continues. Short-term period is defined as a period no longer than 2-3 weeks (i.e. no more than 21 days)

• Chronic conditions (longer-term illnesses) – If the clinical issue is more serious (longer term is defined as anything beyond 21 days) and the patient requires optimisation and / or treatment for it, a clinical review should be carried out and clinicians should indicate to administration staff:

- If it is clinically appropriate for the patient to be removed from the waiting list (this will be a clock stop event via the application of active monitoring) and the patient will not be referred back to the GP but actively monitored and reviewed by the clinician within 3 months
- If the patient should be optimised/treated within secondary care (active monitoring clock stop) or
- If they should be discharged back to the care of their GP (RTT clock stop and discharge of referral)

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

29. Adding patients to the admitted waiting list

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

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

When logging a patient onto the waiting list module of the hospital administration system, SSS staff must ensure all information is gathered and recorded in line relevant policies.

30. Listing patients / Offering TCI dates

Where patients are not fully booked the SSS tracker and PTL must be used in combination as the data source for scheduling admitted patients.

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

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

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

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

If the demographic details are correct and SSS are unsuccessful in making contact with the patient on at least three separate occasions, an invitation to call letter will be sent to the patient asking them to contact SSS. If there is no response from the patient within 14 calendar days of the letter being sent, the Consultant will be notified and the patient may be removed from the waiting list with a clock stop applied as the patient has decline treatment. A 'no reply' letter must be sent to the GP and copied to the patient. This should only happen if in the clinical best interests of the patient as determined by the Consultant.

31. Patients requiring more than one procedure

If more than one procedure will be performed at one time by the same surgeon, the patient should be added to the waiting list with extra procedures noted. If different surgeons will work together to perform more than one procedure, the patient will be added to the waiting list of the consultant surgeon for the priority procedure with additional procedures noted.

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

• The patient will be added to the active waiting list for the primary (1st) procedure.

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

32. Patient Cancellation/Declining of TCI offers

When offering TCI dates, patients may need to decline for a short time for social reasons due to other commitments which cause them to be unavailable, e.g. holidays or exams.

Patients could decline offers immediately during the telephone conversation or cancel / decline at any point between initially accepting and the admission date itself.

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

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

33. The TCI letter

A letter must be generated immediately following the agreement of a TCI date. The TCI letter must contain all the relevant information associated to the attendance and be sent with any enclosures as required on a speciality basis.

If a TCI date is agreed at short notice, a discussion will be had between the SSS staff member and the patient regarding how confirmation of the TCI date is best shared with them.

34. Validation of patients on the elective waiting list

Three-monthly validation of incomplete pathways, i.e. where a clock has started and the patient has not yet received treatment, will be undertaken for patients waiting over 18 weeks in line with national RTT returns. The accurate recording of data within a pathway will support this and enable SSS to provide assurance that, where clinically appropriate, all patients receive treatment within national waiting time standards.

35. Hospital Cancellation of TCI

35.1 Cancellation by the Provider for Clinical Reasons

If the operation is cancelled because the patient is unfit for surgery, they will either remain under the care of SSS for optimisation or be discharged back to their GP (refer to section 28). If the operation is no longer required, the clock stops and the patient will be referred back to their GP.

35.2 Cancellation by the Provider for Non-Clinical Reasons

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

If it is absolutely necessary for the hospital to cancel a patient's surgery, the patient will, wherever possible, be given a new admission date at the time of cancellation. If this is not possible, the patient will be contacted as soon as is reasonably practicable and offered a new date of admission.

It is the responsibility of SSS to ensure that the patient has a new date of admission within 28 days if the patient is cancelled on the day of admission

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

36. Planned Waiting List

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

Patients on planned waiting list are outside the scope of RTT rules. Planned procedures are part of an agreed programme of care, which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.

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

37. Patients who do not attend (DNA) admission

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

Any patient who does not attend their agreed operation date will be contacted to ascertain why the DNA occurred and the reasons recorded to inform the clinical review by the clinician to allow them to advise on the next steps. Some patients may be discharged back to the care of their GP. In such cases both patient and GP will be notified of this in writing to ensure the referring GP is aware and can action further management of the patient if necessary. The patient's RTT clock will be stopped. Exceptions to this are:

- when a clinical decision is taken that discharging the patient is contrary to the patient's clinical interests;
- clinically very urgent patients including cancer, or active surveillance for cancer
- children of 18 years (See Footnote3 below4) and under or vulnerable adults.
- when one of the following can be confirmed:-
    - The operation date was sent to the incorrect patient address
    - The operation was not offered with reasonable notice

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

38. Bilateral Procedures

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

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

Any decision to proceed with surgery for a second side must be made with reference to the appropriate/relevant ICB commissioning policy regarding bilateral procedures

39. Admitting Patients

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

40. Emergency Admissions for an Elective Procedure

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

41. Removals other than for Treatment

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

Section Three

Cancer Pathways

SSS are not commissioned to provide cancer pathways.

Section Four

Reference Information

Glossary

Term	Definition
Active monitoring	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures. Often referred to as 'watchful wait'
Active waiting list	The list of elective patients who are fit, ready and able to be seen or treated at that point in time. Applicable to any stage of the RTT pathway where patients are waiting for hospital resource reasons.
Admitted pathway	A pathway that ends in a clock stop for admission (day case or inpatient)
Appointment Slot Issue (ASI)	A list of patients who have attempted to book their appointment through the national E-Referral Service but have been unable to due to lack of clinic slots.
Bilateral procedures	Where a procedure is required on both the right and left sides of the body.
Breach	A pathway where the period waited to be seen or receive treatment exceeds the access standard, national or local target time, such as: Referral to treatment pathways where the wait for first definitive treatment exceeds 18 weeks, or exceeding long waiting time targets
Chronological booking	Refers to the process of booking patients for appointments, diagnostic procedures and admission in date order of their clock start date.
Clock start	The point at which the RTT pathway starts
Clock stop	The point at which an RTT pathway stops
Consultant-led service	A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse-led clinics which come under the umbrella of consultant-led services.
Day case	Patients who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight
Decision to admit (DTA)	Where a clinical decision is made to admit the patient for either day case or inpatient treatment.
Did Not Attend (DNA)	Patients who give no prior notice of their nonattendance

Decision to treat (DTT)	The date on which the clinician communicates the treatment options to the patient and the patient agrees to a treatment.
Elective care	Any pre-scheduled care which doesn't come under the scope of emergency care.
E-RS	(National) E-Referral Service
First Definitive Treatment (FDT)	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgement in consultation with the patient
Incomplete pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage.
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night
Integrated Care Board (ICB)	An organisation that brings NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS
Interface Service	Any service which involves triage or assessment between primary care and secondary care
Inter-provider transfer (IPT)	Inter-provider transfer is when a patient is transferred to another provider
Minimum Data Set (MDS)	Minimum information required to be able to process a referral either into the cancer pathway or for referral out to other providers.
Non-admitted pathway	A pathway which results in a clock stop for any reason other than an admission for a procedure
Partial booking	Where an appointment or admission date is agreed with the patient close to the time it is due.
Patient Administrative System (PAS)	A patient administration system records the patient's demographics (eg: name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient.
Patient-initiated delay	Where the patient cancels, declines offers or does not attend appointments or admission. This in itself does not the stop the RTT clock. A clinical review must always take place.

Patient Initiated Follow Up	PIFU is when a patient initiates an appointment when they need one, based on their symptoms and individual circumstances
Planned waiting list	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18-week RTT pathway.
Patient pathway identifier (PPID)	A unique identifier which together with the provider code uniquely identifies a patient pathway.
Patient Tracking List (PTL)	A tool used for monitoring, scheduling and reporting on patients on elective pathways
Reasonable offers	A choice of two appointment or admission dates with three weeks' notice.
Referral to treatment (RTT)	The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.
To come In (TCI)	The date of admission for an elective surgical procedure or operation