BNSSG ICS Elective Care Access Policy

- North Bristol Hospitals NHS Trust
- University Hospitals Bristol and Weston NHS Foundation Trust
- BNSSG ICB
- Other providers of elective care (e.g. AQP and ISTC)

Version 13.2: 24th November 2022 **Review Date: 24th November 2025**

APPROVALS

ORGANISATION	DATE	NAME	DESIGNATION	SIGNATURE
BNSSG ICB				
UHBW NHS Trust				
North Bristol Trust				

VERSION HISTORY

VERSION	DATE	AMENDMENTS
0.1	10.07.14	
1.1	31.07.14	
1.2	07.08.14	Agreed changes and comments from the meeting held on 7th August 2014 between commissioners and acute Trust providers.
3.0	12.09.14	Cancer added to main document
4.0		
5.0	30.09.14	Final Draft incorporating comments following 2nd working group meet held 25th September 2014.
6.0	22.10.14	
7.0	15.02.16	Refresh following publication of two national DoH document's: - - 'National Cancer Waiting Times Monitoring Dataset Guidance – Version 9.0' - 'Referral to Treatment consultant led waiting times'. The BNSSG 'Non GP referral policy' has been reviewed and incorporated.
8.0	01.04.16	Outputs of consultation with providers, CCGs and Local Medical Committee (LMC) are recognised in this refresh.
9.0	15.04.16	IMAS review. Updates assert requirement for ensuring actions are in the clinical best interests e.g. DNA discharge
10.0	22.6.2018	Review and refresh
11.0	01.04.2019	Reviewed and refreshed including; - Updated INNF guidance - Addendum 1
12.0	14.10.2021	Reviewed and refreshed, removed Cancer Referrals to separate guidance, included Covid 19 guidance around pts seeking to delay treatment,
13	30.03.2022	Updated to reflect removal of P5
13.1	10.09.2022	Updated following feedback and recommendations from IST. Amendments include: • ICB replaced with ICB and Trusts with 'Providers' where applicable to ensure broader application across all Provider types • Patients transitioning from Paediatric to Adult age whilst waiting • Mutual aid • Guidance on financial support for travel
13.2	24.11.22	Updated to include national changes to Choice guidance – see Addendum 2

CONTENTS

1) **STATEMENT OF INTENT**

All organisations within this BNSSG Access Policy are united in their commitment as a Local Health Economy (LHE) to ensure patients all patients requiring access to outpatient appointments, diagnostics and elective inpatient or day case treatment are managed equitably and consistently in line with national waiting time standards and the NHS Constitution. The purpose of this policy is to outline the LHE's expectations and requirements in terms of managing patients referred into elective non urgent care pathways. It provides guidance on elective care principles, key administration processes, timeframes and referral to treatment rules for managing patients along their elective care pathways.

2) SCOPE OF POLICY

This policy applies to the principles and procedures for the management of the different groups of patients encompassing elective pathways. These are categorised as follows:

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

Note: For patients on the cancer pathway, the "South West Cancer Access Policy Version 12 – July 2020" is followed and these patients are not subject to this policy for their cancer treatment.

3) STRUCTURE OF POLICY

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

1. **General Principles**
2. **Pathway Specific Principles**
3. **Cancer Pathways**
4. **Reference Information**
5. **Standard Operating Procedures**

Section One

General Principles

4) KEY POLICY PRINICPLES

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

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

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

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

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

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

5) ROLES & RESPONSIBILITIES

a) BNSSG

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

b) BNSSG ICB

I. Promote the rights and pledges enshrined in The NHS Constitution 2021

II. Develop and manage the local health market to provide plurality and patient choice

III. Ensure that all patients needing planned elective care are offered clinically appropriate choices of provider

IV. Ensure that patients are treated within clinically appropriate, commissioned pathways and maximum treatment times

c) Referrers Responsibilities

Referrers will:

I. Ensure that the patient is clinically suitable for their referral and intended pathway of care. There are tools and information on Remedy to assist with understanding of relevant clinical pathways: https://remedy.bristolICB.nhs.uk/

II. Ensure that patients are ready, willing, fit and able to attend for any necessary outpatient appointments and/or treatment.

III. Ensure patients are given sufficient information about the purpose of the referral and are supported to fully understand the implications of any surgery or other treatment which may be necessary

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

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

VI. Ensure that where appropriate, funding for interventions not normally funded has been obtained by the referrer prior to referral.

VII. Ensure that the patient meets the criteria set out in any relevant commissioning policies for that procedure; these procedures can be accessed on the BNSSG Website; Commissioning Policy Development - NHS BNSSG ICB . It is expected that each clinician involved in managing a patient assures themselves and clearly records in the patient records how it can be demonstrated that a patient meets the criteria as patients can and do improve or deteriorate during their care pathway.

d) Provider Responsibilities

i) Chief Executives / Chief Operating Officers

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

ii) **Clinicians**

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

iii) General Managers / Operational Managers

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

It is the responsibility of the management teams in conjunction with clinicians to ensure that the Directory of Services (DoS) is up to date in terms of the service specific criteria and that clinics are mapped to the relevant services.

iv) Administration Staff

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

v) Patients

- Attend agreed appointments and give sufficient notice in the event of the need to change an agreed date and time.
- Make every effort to accept an available appointment
- Respond to hospital communications in a timely manner
- Communicate immediately to the hospital or general practitioner if treatment and/or appointments are no longer required
- Consider the choice options that are available to them
- Immediately communicate to the hospital and general practitioner any changes in personal contact details

6) NATIONAL ELECTIVE CARE STANDARDS

The table below provides the current national elective care standards.

Referral to Treatment	
Incomplete Pathways	92% of patients on an incomplete pathway (ie still waiting for treatment) to be waiting no more than 18 weeks (or 126 days)
Diagnostics	
Applicable to specific diagnostic 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: 1. Imaging - Magnetic Resonance Imaging 2. Imaging - Computed Tomography 3. Imaging - Non-obstetric ultrasound 4. Imaging - Barium Enema 5. Imaging - DEXA Scan 6. Physiological Measurement - Audiology - Audiology Assessments 7. Physiological Measurement - Cardiology - echocardiography 8. Physiological Measurement - Cardiology - electrophysiology 9. Physiological Measurement - Neurophysiology - peripheral neurophysiology 10. Physiological Measurement - Respiratory physiology - sleep studies 11. Physiological Measurement - Urodynamics - pressures & flows 12. Endoscopy - Colonoscopy 13. Endoscopy - Flexi sigmoidoscopy 14. Endoscopy - Cystoscopy 15. Endoscopy – Gastroscopy

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

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

b) Choice – applicable where 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. (See Addendum 2 for interim guidance on management of choice and the use of C categorisations that replace previous P6)

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

7) 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.

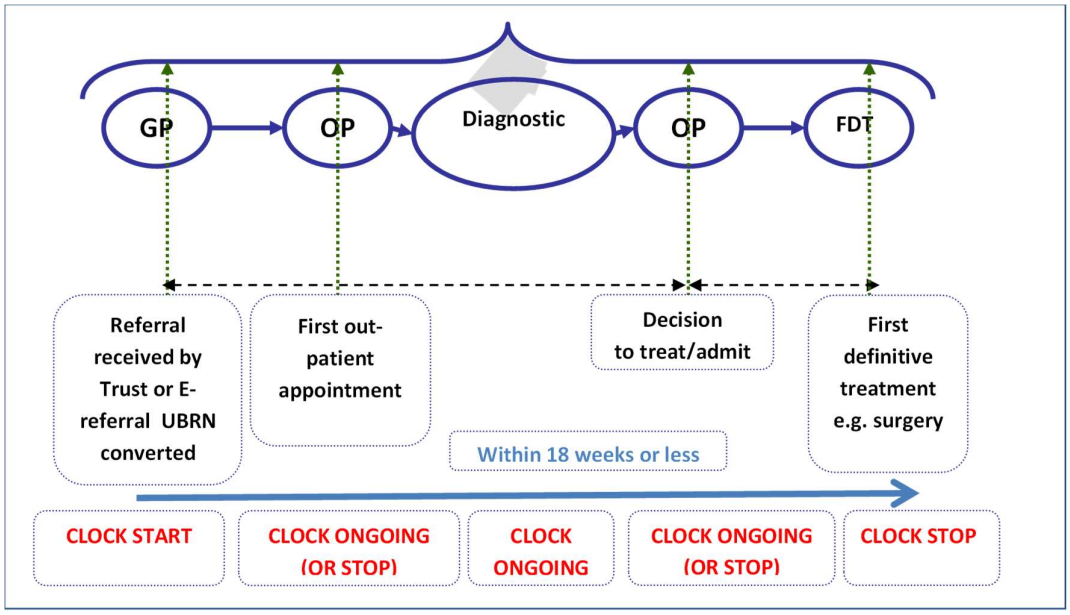
The clinical review of key cohorts of patients ensures that they are prioritised with regard to the length of time they can wait for treatment without significant detrimental effect.
Categories of P1 to P4 have been introduced in addition to the Routine, Urgent, 2 week wait and Cancer priorities for clinical prioritisation and waiting lists have been re-prioritised to ensure that all patients waiting for inpatient treatment are visible to be booked in priority order and to enable timely clinical review.

- P1 Relates to emergency
- P2 < 1 month
- P3 < 3 months
- P4 > 3 months

In October 2022 Interim Operational Guidance on the Management of patients on the waiting list choosing to decline offered treatment dates at current provider or an alternative provider was released. This Guidance introduced C coding to replace P6 (patients who had chosen to delay treatment). Addendum 2 provides the Guidance and describes the application of C coding and an approach to be considered where a patient wishes to delay their treatment.

8) OVERVIEW OF NATIONAL RTT RULES

The full national RTT rules suite (Released October 2022) can be accessed here [Referral to treatment consultant-led waiting times: rules suite (October 2022) - GOV.UK (www.gov.uk)](). Detailed local application of the rules is provided in the standard operating procedures within section five at the end of this policy. An overview of the rules however is shown using the diagram and narrative below.



a) Clock Starts

The RTT clock starts when:

- A referral is received into a consultant led service, regardless of setting, with the intention that the patient will be assessed and if appropriate, treated before clinical responsibility is transferred back to the referrer
- A referral is received into an interface or referral management assessment centre which may result in an onward referral to a consultant led service before clinical responsibility is transferred back to the referrer.
- For referrals received through NHS e-Referral, the RTT clock starts the day the patient converts their unique booking reference.
- A patient self refers into a consultant led service for pre-agreed services agreed by providers and commissioners.

b) Clock Stops

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

i) treatment provided by an interface service

ii) treatment provided by a consultant-led service

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

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

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

c) <u>Patients Who Do Not Attend (DNA)</u>

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.

i) <u>First Appointment Following Initial Referral</u>

If a patient DNAs their first appointment following the initial referral the RTT Clock is stopped and nullified in all cases (as long as the trust can demonstrate the appointment was booked in line with reasonableness criteria). If the clinician indicates another first appointment should be offered, a new RTT clock is started on the day the new appointment is agreed with the patient. Where an additional appointment is offered following the first DNA, should a consecutive DNA take place (i.e. 2nd DNA) in an adult service, the patient will be discharged back to the GP unless the clinician over-rides this decision (see Section 23)

ii) <u>Subsequent (follow-up) appointment DNAs</u>

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 the GP/referrer.

d) Patient Reschedules of Outpatient & Diagnostic Appointments

If a patient chooses to reschedule their outpatient or diagnostic appointment, their RTT clock should continue to tick, even if they wish to reschedule their first appointment following initial referral. If a patient makes multiple cancellations, multiple changes or long-term cancellations to an appointment the trust will consider discharge back to the GP following a clinical review process to ensure this is in the best interests of the patient. The trust will actively engage with patients if there is more than 1 cancellation to establish reasons for multiple cancellations and to inform the clinical review process.

e) Patient Reschedules of Admission Dates

If a patient has previously agreed to a reasonable admission (i.e. three weeks' notice and a choice of two dates) offer which they subsequently wish to change, the cancellation does not stop the RTT clock. However, as part of the rebooking process, the patient should be offered alternative dates for admission. If a patient makes multiple cancellations or multiple changes to an admission resulting in a delay to their treatment pathway the Trust 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. The trust will actively engage with patients if there is more than 1 cancellation to establish reasons for multiple cancellations and to inform the clinical review

f) Active Monitoring

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

g) Mutual Aid

There are occasions when Providers will be unable to provide the treatment required by a long waiting patient but is able to arrange for the treatment to be given by another Provider, via a mutual aid arrangement. In these cases:

- Patients should be contacted and offered the transfer of care to another provider where a shorter wait is made possible through a mutual aid arrangement
- A patient has a right to decline transfer to another trust and may remain with their current provider until they can be treated. Their RTT clock is not affected by this decision.

- If a patient accepts an offer to transfer but declines dates offered at another provider for treatment due to their unavailability, the patient may be categorised as a C category until they are available.
- Mutual aid through subcontracting should include provider-to-provider agreement that clearly stipulates the arrangements for reporting patient waiting times and therefore any waiting time standard breaches. Where there are long waiting patients that would be disadvantaged due to an alternative provider being unwilling to take on these patients because of the impact on their performance, then the originating provider can continue to report the patients RTT wait on an exceptional basis. See Section 10.1.2 of the RTT recording and reporting guidance for further information on subcontracting relationships and RTT reporting: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/05/Recording-and-Reporting-guidance-April_2021.pdf

h) <u>Transport support for transfer to another provider</u>

It is recognised that for some patients accepting a transfer to another Provider would require travel and accommodation support.

Travel support requirements should first be checked for eligibility under The Healthcare Travel Cost Scheme (HTCS) Healthcare Travel Costs Scheme (HTCS) - NHS (www.nhs.uk) which allows eligible patients to claim the costs incurred for their travel to get to certain types of appointments with their own/original Provider also – note this is not restricted to Mutual Aid transfers of care.

In some Mutual Aid transfer circumstances reasonable costs can be reimbursed by the transferring Provider. The costs that the Trust will reimburse and the method by which reimbursement is made will be detailed in Trust level SOPs.

8) PATHWAY MILESTONES

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

- Diagnostics
- First outpatient appointment
- Treatment decision
- Treatment

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

a. Patients transitioning from paediatric to adult services while on the waiting list

Patients who are referred appropriately into paediatric services (age between 0-15 years), but who transition from childhood to adulthood whilst waiting, should be accepted and seen initially by the paediatric service as an outpatient. Where surgery or ongoing care management is required, the Trust will internally transfer the patient to the adult service.

No patient will be disadvantaged in terms of continuity of care and waiting time by being referred back to GP from paediatric services to then be re-referred to adult services for the same condition. This applies also to the continuation of a pathway where a paediatric patient will be in future seen by the adult service, for ongoing management of the same condition. Where this occurs and particularly when the patient may not need to be seen for some time, the emphasis should be on agreeing clinically appropriate review dates, ensuring pathways are visible through waiting list reports, with clear clinical responsibility under the correct service, and ensuring access to clinical and pathway information to support the transition from paediatric to adult services. This applies within the same organisation or Trust, and for patients that are transferred onwards to services in another organisation or Trust.

It is recognised that the process will be managed according to specialty pathway, and the point at which a patient should be transitioned to an adult service may depend on their age, their size, or their stage in a specific pathway. This may be dependent on the structure of local services, which can also vary by specialty, and which are detailed in service level SOPs.

It is important that patients (and their carers) are fully informed of which service is responsible for managing their care at any time.

9) INTERVENTIONS NOT NORMALLY FUNDED (INNF) INC. Exceptional Funding Requests (EFR), Prior Approval (PA) and Criteria Based Access (CBA)

INNF Guidance including commissioning policies referenced in the INNF list must be adhered to – any procedures undertaken without prior funding authorisation (EFR or PA), or who do not meet the CBA criteria set out in the Commissioning policy will not be authorised by the Commissioners. In these circumstances the 18-week clock will begin when the GP proceeds to make a formal referral, either with or without funding approval having been secured at the outset.

The majority of treatments or conditions require funding approval to be secured prior to referral to secondary care for assessment and treatment. There is however a small number of specialist treatments as set out on the INNF list where funding approval can only be sought by a secondary care

Consultant. In these cases, the 18-week clock will not stop whilst funding approval is sought from the Commissioner.

The current list of INNF Procedures which are part of the contract schedule agreed between providers and the ICB can be found at Commissioning Policy Development - NHS BNSSG ICB

Where patients have been referred to BNSSG providers from other ICB areas in England, including Associate Commissioners, patients will be funded and treated in line with BNSSG Commissioning Policies. Where required, funding approval will need to be secured from the patient's host commissioner.

Where patients have been referred to BNSSG providers from other constituent parts of the United Kingdom including Wales and Scotland, providers are advised to ensure that patients have been referred with appropriate approvals from their host commissioner to ensure that they receive payment for assessments and treatments.

Where there is uncertainty around diagnosis, or further advice is required to manage a patient and support via Advice and Guidance schemes is not available or appropriate, GPs may refer patients to secondary care in order to access this support even where a commissioning policy normally requires funding approval prior to referral. Should secondary care recommend surgery, funding approval will be secured in accordance with the "Who Applies" guidance published on the ICB website.

Armed forces personnel and their families are subject to the NHS England non-specialised INNF.

10) 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:

a) Patients with learning difficulties or psychiatric problems
b) Patients with physical disabilities or mobility problems
c) Elderly patients who require community care
d) Children (as defined in The Children Act (2004)[1].

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

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

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.

Providers 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 maybe 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 Provider procedures must be followed.

11) ACCESS TO HEALTH SERVICES FOR MILITARY VETERANS

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

It is important for GPs or other referrers to notify the Trust of the patient's condition and its relation to military service when they refer the patient. This so that the Trust can ensure that it meets the current guidance for priority service over other patients with the same level of clinical need. In line with clinical advice patients with more urgent clinical needs will continue to receive priority.

12) PRIVATE PATIENTS

If a patient has been seen privately and wishes to be treated at one of the BNSSG Trusts, by the same consultant as an NHS Patient, the patient must first obtain an NHS referral letter from their GP or referring consultant. On receipt of this letter the patient may then be treated as a new referral in

outpatients or placed on a waiting list for investigations or treatment but will be treated according to their NHS medical priority. The RTT clock starts at receipt of referral to the NHS. 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.

Patients can choose to move between NHS and private status at any point of their pathway 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 in the hospital.

The RTT pathways of patients who notify the trust of their decision to seek private care and no longer require treatment as an NHS patient will be closed with a clock stop applied on the date of this being disclosed by the patient.

13) OVERSEAS PATIENTS

Trusts will ensure they assess patient's eligibility for NHS care in line with the Guidance on implementing the overseas visitor charging regulations

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1077186/overseas-nhs-visitors-charging-regulations-guidance.pdf

14) COMMUNICATION WITH PATIENTS

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

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

Providers will ensure that patients receive information in formats that they can understand and receive appropriate support to help them to communicate (Accessible Information Standard 2015). GPs should be informing the trust of the patient's communication needs on referral and the Trust should be asking the patient whether they have a communication need and recording this on PAS.

15) ELECTIVE CARE GOVERNANCE STRUCTURE

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

16) INFORMATION, MONITORING & REPORTING

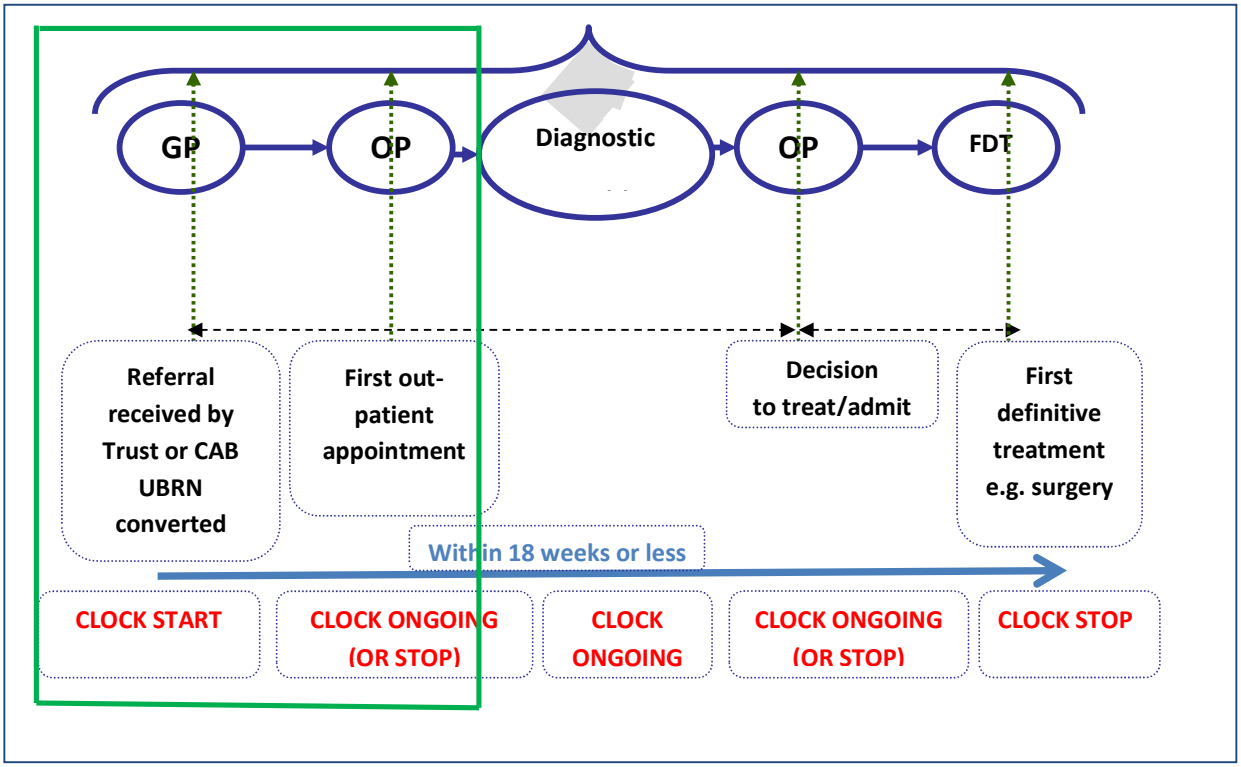
a) RTT monitoring and reporting will be managed through the information schedule of provider's acute contract. In addition, other statutory returns to NHS England and monitor will be provided as required.

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

Section Two

Pathway Specific Principles

Section 2 a) Referral, Outpatient Booking and Appointments



17) REFERRAL MANAGEMENT

a) Pre-Requisites Prior to Referral

i) **Primary Care**

In line with national RTT rules, before patients are referred, GPs and other referrers should ensure that patients are ready, willing, 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.

ii) **Secondary Care**

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

b) Referral Sources

i) **General Practitioners**

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

- To maximise the choice opportunities for patients in terms of provider, date and time of appointment.
- To contribute to the management of secondary care capacity by ensuring only those genuinely needing secondary care receive it, and in a more timely way as part of an RTT pathway.

ii) **Non-GP Referrals**

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

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

If the referral is asking for an opinion about a different condition, he/she shall write back to the referring GP detailing this opinion so that the patient and their GP can agree a further management. It is the responsibility of the clinician to ensure that the patient understands that decision on further referral should be made on the clinical assessment and decision of the GP and exercise caution of recommending referrals to other services

Where there are agreed clinical pathways which are agreed by the ICB and trust or mandated nationally then referral to another specialty can be made.

iii) **External Consultant to Consultant Referrals / Inter Provider Transfers**

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

Patients Referred from Other Providers (including Primary Care Interface Services) should be accompanied by a completed IPTAMDS (Appendix 1). Where the IPTAMDS does not accompany the referral it must follow within 48 hours.

Whether an IPTAMDS is received or not, the identity of the referring Trust and Referral to Treatment Time information must be recorded as per the Standard Operating Procedures. Information sent on an Inter-Provider transfer should be sent securely via email and not by a fax machine in order to protect the confidentiality of the patient information within.

iv) **Referral Support Service (RSS)**

The RSS supports the management of referrals and signposting of new services to patients. To ensure these services can successfully support referral processes, referrers must ensure a full data set is provided when referring. In addition all referrals on an RTT pathway will start the RTT clock at the point the referral is received by the RSS, who will then share this date with any onward referral.

c) Referral Methods

Unless by local agreement with the ICB, all referrals from primary care to a consultant led clinic will be made using e-referrals. The only exception to this is for prison referrals which are still paper based. There are currently three recognised methods of referral for non-cancer referrals as described below:

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

ii. **Directly Bookable Services -** Directly Bookable Services (DBS) via eRS enables the GP to book a first outpatient appointment slot while their patient is in the surgery, or will give the patient a Unique Booking Reference Number (UBRN) and a password so the patient can use The Appointment Line (TAL) or go online to book a slot at the hospital of their choice. Trusts will ensure that sufficient capacity is available for patients to directly book their first appointment. Patients who have been directly

booked will have a referral automatically created on PAS by the E-Referrals software and the RTT clock start will be automatically triggered from the referral received date on PAS i.e. when the patient first attempts to book their appointment. Exceptions to this are where the patient has experienced an Appointment Slot Issue (see section 18b) where the clock starts at the point that the patient attempts to book directly and a slot issue is experienced, or when the referral has been sent on from a Primary Care Interface Service, when the referral should be treated as an Inter-Provider Transfer.

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

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

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

If the referral relates to a condition or treatment included in the INNF list, evidence should be provided demonstrating funding has been secured from the ICB or how the patient meets the criteria to access treatment in line with a CBA commissioning policy.

ii) Referrals should be addressed to a speciality rather than a named consultant and the patient will be offered an appointment with the consultant with the shortest waiting time. Named referrals will be allocated to the relevant consultant but if they do not have sufficient capacity to accept the referral then a decision will be made in conjunction with the consultant and the speciality operational / service manager to allocate the referral to an appropriate alternative consultant. Exceptions to this would be where denying access to a sub-speciality opinion would compromise clinical care or patients choose to wait to see the consultant they had requested.

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

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

18) FIRST APPOINTMENT

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

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

a) Booking appointments via the NHS eReferral Service

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

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

b) Appointment Slot Issues (ASIs)

If booking via eRS is not possible due to lack of capacity, the UBRN will be directed to the Trust via the 'Defer to Provider' function on the eReferral Service for local management to resolve. This is referred to as an ASI. The RTT clock is ticking from the point at which the patient attempted to book their appointment even though they will not be visible on the Trust's patient administration system at this point. Appointment staff will then call the patient to offer an appointment within two working days for those clinically categorised as urgent and 5 working days for routine.
ASIs result in a poor patient experience and time-consuming administrative workarounds.
Sufficient capacity must therefore be made available via eRS to ensure patients can book directly

into services. This is the responsibility of the operational / service management team responsible for the speciality.

c) <u>Referral Assessment Service (RAS)</u>

eRS referrals made into a RAS service require triage to ensure that the referral is processed into the correct service/speciality. Where referrals are held on a RAS list, the RTT clock is ticking from the point at which the referral was made. Where triage is required before accepting or rejecting the referral, triage should be completed within 7 days. If triage results in the acceptance of the referral, the patient should be contacted and offered an appointment within 5 working days for a routine referral and two working days for an urgent referral.

19) HOSPITAL INITIATED APPOINTMENT CHANGES

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

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

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

20) PATIENT INITIATED APPOINTMENT CANCELLATIONS

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

21) PATIENT INITIATED APPOINTMENT CHANGES

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 will be classified according to the '*Interim Operational Guidance: Management of patients on the waiting list choosing to decline offered treatment dates at current provider or an alternative provider*' as provided in Addendum 2 and 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 the Provider 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/wp-content/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. For further detail see Recording-and-Reporting-guidance-April_2021.pdf (england.nhs.uk).

a) Clinic Outcomes

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

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

b) Follow Up Appointments

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

ii) Patients, who require an outpatient follow up appointment in more than six weeks' time, will be appointed e.g. pending list/partial booking waiting list. It is the responsibility of the provider to develop a standard operating procedure for the management of "follow up" patients to ensure that these patients are not placed at clinical risk by administrative error.

Where clinically agreed, patients can be transferred onto a Patient Initiated Follow Up (PIFU) pathways – please refer to Provider SOPs that detail the different PIFU arrangements that include time limited follow-ups, long team follow ups as well as PIFU 6 and 12 months. These arrangements are intended to empower the patient to access a service at the point of need. (NB: this does not replace clinically determined follow up appointments).

c) <u>Patient thinking time</u>

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 28 days or longer. 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.

(Note this section does not apply where patients choose to delay

22) DID NOT ATTEND (DNA)

a) Any patient who does not attend their agreed appointment (new or follow up) will be managed in line with 7.c above which may include being discharged back to the care of their GP. Both patient and GP will be notified of this in writing to ensure the referring GP is aware and can action further management of the patient if necessary. The patient's RTT clock will be stopped. Exceptions to this are:

- when a clinical decision is taken that discharging the patient 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
- Children of 18 years and under or vulnerable adults (See Footnote2 below[2]).
- 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

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

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

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

d) If a patient DNAs their first appointment following the initial referral which started their RTT clock, their RTT clock should be nullified (i.e. 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

e) 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.

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

g) 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. See Section 4.4.1.3 of the RTT recording and reporting guidance https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/05/Recording-and-Reporting-guidance-April_2021.pdf

23) CLINIC MANAGEMENT

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

- Consultants, medical staff and other health professional staff must give at least six weeks' notice of annual leave. Where this is not given, the Consultants team or alternative health professional should make every effort to cover the clinic. Leave should be given as early as possible to minimise the effect on clinics.
- The Trust is committed to offering certainty to patients as well as choice in arranging care. As such, every effort will be made to avoid cancelling patient's appointments. Every effort will be made to backfill absent clinicians by the speciality. Cancellation will be a last resort.

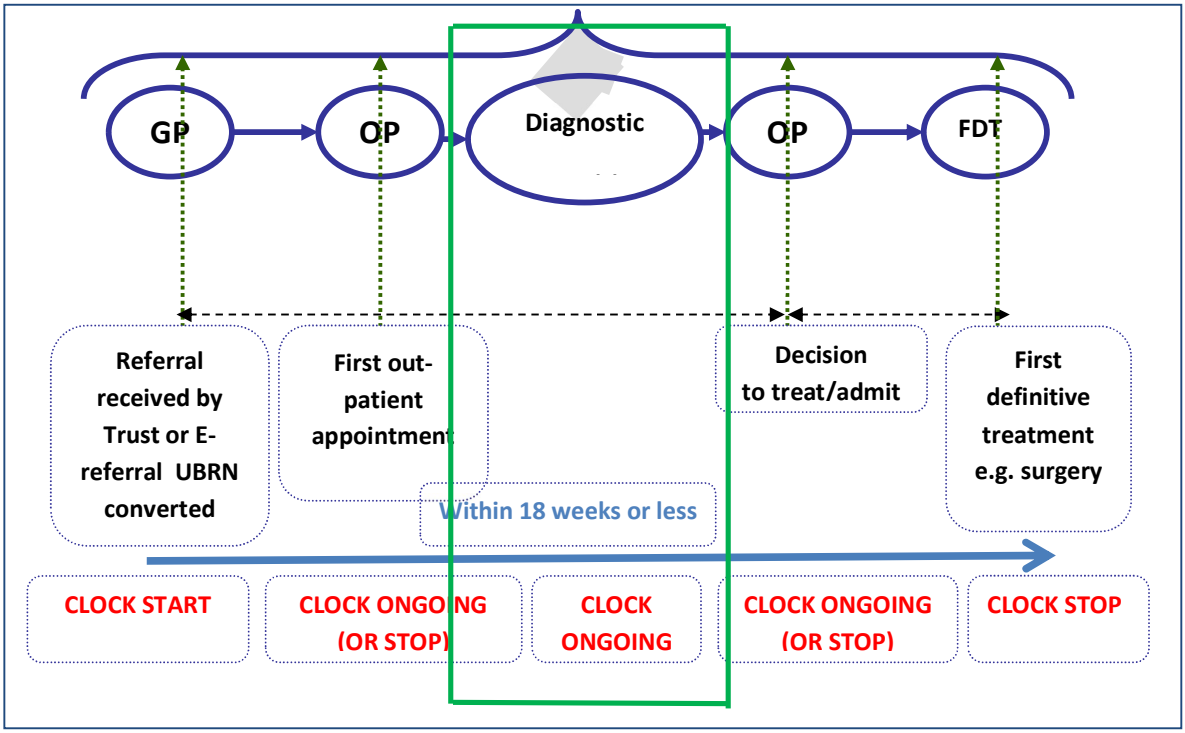
- Clinics should not be cancelled or reduced for any purpose unless there are exceptional circumstances.

b) **Outpatient Clinic Capacity**

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

Section 2 b) Diagnostic Pathways

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



24) DIAGNOSTIC PATIENTS

The diagnostic stage of the pathway can be the start of an RTT clock (e.g. STT), continuation on an RTT pathway, or not be on a RTT pathway, for example direct access for diagnostics only, where the GP retains responsibility for the patients care.

The national standard – which relates to the 15 DM01 modalities only, however other diagnostic areas may follow the same principles - is that the 6-week diagnostic clock starts when the request for a diagnostic test or procedure is made.

The Provider should seek to fulfil "reasonableness" criteria when offering patients appointments for diagnostic tests/procedures. This means they should be offered two appointment dates with at least 3 weeks' notice of the appointment. The three weeks requirement can be overridden if the patient agrees to a shorter notice appointment.

- Diagnostic cancellations, declines and/or DNAs for patients

If a patient declines, cancels or does not attend a diagnostic appointment, The diagnostic 'clock' waiting time starts again from the date of the appointment that the patient cancelled or DNA'd.

However the Provider must be able to demonstrate that the patient's original diagnostic appointment fulfilled the reasonableness criteria for the diagnostic clock to start to be reset. Resetting the diagnostic clock start has no effect on the patient's RTT clock. The RTT clock will continue to tick from the original clock start date.

Where a patient has cancelled their appointment, declined and/or not attended their diagnostic appointment and a clinical decision is made to return them to the referring consultant, the RTT clock should continue to tick. Only the referring Consultant can make a clinical decision to stop the RTT clock, if this is deemed to be in the patient's best clinical interests, by discharging the patient or agreeing a period of active monitoring.

- Planned Diagnostic Appointments

Patients who require a diagnostic test to be carried out at a specific point in time for clinical reasons are exempt from the diagnostic clock rules and will be held on a planned waiting list with a clinically determined due dated identified. If the patient's wait goes beyond the due date for the test, they will be transferred to an active waiting list and new diagnostic clock and RTT clock will be started.

If the planned diagnostic is related to one of the 15 DM01 modalities, then if the patient becomes overdue for their procedure, they will also be added to the DM01 active waiting list for their procedure to be completed within 6 weeks.

- Additional Items to note:

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

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

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

25) SUBSEQUENT DIAGNOSTICS

Where the patient has received first definitive treatment for a condition they were referred for and subsequent new treatment plan is agreed following the result of a 'check' diagnostic, a new RTT pathway/clock should commence. A new diagnostic pathway/ clock may also commence for any follow up diagnostics.

26) STRAIGHT TO TEST

'Straight to Test' is used by a GP where there is an expectation that the patient will go on to be reviewed afterward by a consultant and if appropriate treatment within a consultant service. A RTT

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

27) DIRECT ACCESS

Direct Access referrals are when a GP refers a patient for a diagnostic test but not a consultant-led treatment, and as such the GP retains clinical responsibility for the patient and makes a decision regarding referral on the basis of the results; this does NOT constitute an RTT pathway. An RTT clock only commences if the GP subsequently makes a referral to a consultant led service. The diagnostic clock of 6 weeks applies.

28) PRIVATE PATIENTS TRANSFERRING INTO THE NHS AT THE POINT OF DIAGNOSTICS

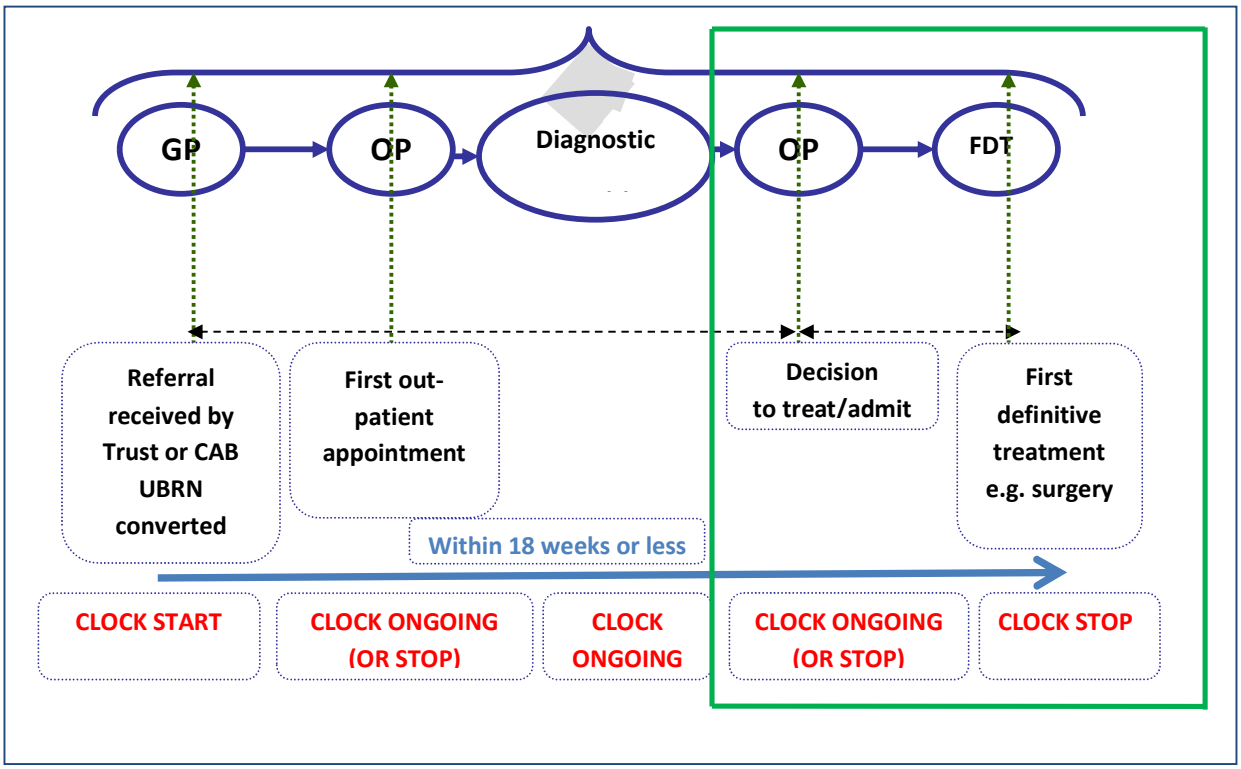
A patient that has been seen privately for an Outpatients 1st appointment may wish to transfer to one of the BNSSG Trusts from the point of the diagnostic step in their pathway. To do so the patient must first obtain an NHS referral letter from their GP or referring consultant. On receipt of this letter the patient may then be treated as a new referral in outpatients or placed on a waiting list for diagnostic investigations according to their NHS clinical priority. Patients are not given priority to earlier diagnostic tests because they have sought the clinical advice privately.

In circumstances where a GP requests a diagnostic test recommended in a private facility, the GP is clinically responsible for receiving and dealing with the results. Diagnostics departments should ensure good justification of all such requests and clinical priority.

GPs cannot refer for all test types so any recommendations from a private consultation that fall outside the GPs scope (specialist imaging for example) will require referral into the Trust for a consultation where the consultant will make decisions about any test type required. This may or may not match the recommendations from the private consultation. This must be clearly explained to patients before a referral is made.

29) DECISION TO ADMIT

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



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

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

b) **The patient is clinically fit, ready and available to undergo surgery.** Patients who are added must be clinically and socially ready for admission on the day the decision to admit is made, i.e. if there was a bed available tomorrow in which to admit a patient, they are fit, ready and able to come in.

c) **The requirements of the INNF list have been complied with in terms of funding approval or meeting criteria** as set out in section 9 above

Turnaround times for funding decisions are guaranteed and detailed in the Exceptional Funding Requests Policy. All patients must be added to the waiting list at the time a Decision to Treat is made and prior approval must be sought thereafter (please note that the RTT clock continues during the time approval is sought). If 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.

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

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.

Please refer to Provider SOPs.

31) PRE-ANAESTHETIC & PRE-OPERATIVE ASSESSMENT

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

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

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

c) Patients who are medically not fit for treatment should be 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 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)

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

32) ADDING PATIENTS TO THE ADMITTED WAITING LIST

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

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

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

33) LISTING PATIENTS/OFFERING TCI DATES

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

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

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

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

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

If the demographic details are correct and the patient does not respond to the partial booking letter for a first outpatient appointment within 14 calendar days of the letter being sent, the case will be subject to clinical review and may be removed from the waiting list. In such cases any RTT pathway will be 'nullified' and the patient referred back to the GP or referring clinician. This should only happen if in the clinical best interests of the patient as determined by the hospital clinical lead. A 'no reply' letter must be sent to the referrer or GP. Exceptions to this would be patients on a Cancer pathway, vulnerable adults, children and prisoners.

- **Patients choosing to delay for personal or social reasons**

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

Providers must record patient-initiated delays for audit and RTT rules application purposes. Patients choosing to delay, or who are otherwise unavailable for admission must have an appropriate clinical prioritisation recorded.

Individual patient circumstances must be considered when applying RTT rules to pathways where patients have chosen to delay treatment. Mechanisms should be in place to protect patients who may come to harm by choosing to delay their treatment. This applies equally to those patients who may come to harm by repeatedly cancelling or failing to attend appointments.

Patients requesting an extended delay should be reviewed by their clinician to decide if this delay is appropriate, considering the best clinical interests of the patient. If the clinician is satisfied that the proposed delay is appropriate and within guidelines, then the provider should continue with treating the patient.

It is not acceptable to refer patients back to their GP simply because they wish to delay their appointment or treatment. However, there are situations when referring a patient 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 and following discussion and agreement with the patient.

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/wp-content/uploads/sites/2/2021/05/Recording-and-Reporting-guidance-April_2021.pdf

In October 2022 Interim Operational Guidance on the Management of patients on the waiting list choosing to decline offered treatment dates at current provider or an alternative provider was released. This Guidance introduced C coding to replace P6 (patients who had chosen to delay treatment). Addendum 2 provides the Guidance and describes the application of C coding and an approach to be considered where a patient wishes to delay their treatment as described below:

- Following declining a 1st TCI, the patient should be recorded on the WLMDS as a 'C-code'.
- TCIs offered should be reasonable (with 3 weeks-notice)[3]

[3] Please note this interim guidance suggests a 2nd TCI should be offered within 6 weeks of the first TCI offer. BNSSG providers should however, act in line with the main body of this policy and provide a reasonable offer which is three weeks' notice and a choice of two dates.

- 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.

34) CLINIC ATTENDANCE

Arrival of Patients

- Patient demographic details should be checked at every clinic attendance and amended as necessary on the Trust's PAS system. The status of overseas visitors will be checked at this time. The relevant manager must be notified where it is suspected that there is an overseas visitor.
- All patients must have an attendance / arrival status recorded, i.e. Attended or Did Not Attend.

35) 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.

36) 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 seeking longer delays should be classified as with a C coding, as described in Addendum 2. Patients could decline offers immediately during the telephone conversation or cancel / decline at any point between initially accepting and the admission date itself.

Patient choice to delay their treatment should be accommodated as long as in the view of the responsible clinician, it is in their best clinical interest to do so. An end date to their unavailability should be agreed with the patient and details of the dates that could have been offered should be recorded on PAS for audit purposes. Where possible this should be established in primary care and clinical risks discussed with the patient where known. It is recognised that in cases of diagnostic uncertainty that this may not be possible.

37) THE TCI LETTER

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

38) 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 the Trust to provide assurance that, where clinically appropriate, all patients receive treatment within national waiting time standards.

39) HOSPITAL CANCELLATION OF TCI

a) **<u>Cancellation by the Trust for Clinical Reasons</u>**

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

Cancellation may be necessitated where patients require a period of recovery following COVID infection prior to surgery, in line with clinical guidelines. The timing of elective surgery following patient infection with COVID-19 should include evaluation of clinical risk, taking into consideration the urgency of the required procedure, but for most surgical treatment a 7-week period applies. In most circumstances the patient would be considered 'temporarily unfit' and the RTT clock will continue to tick.

b) **<u>Cancellation by the Trust for Non-Clinical Reasons</u>**

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

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

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

40) PLANNED WAITING LIST

a) This is an admission where the date of admission is determined by the clinical needs to the treatment. Examples of these would be follow up chemotherapy sessions, or a removal of internal fixation, three months post operation, check cystoscopy or repeat colonoscopies. These patients will be held on a 'planned waiting list', separate from the other waiting list, however, will be subject to the same monitoring and validation process.

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

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

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

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

If the planned diagnostic procedure was to become overdue, then this would also require the patient to be added to the DM01 active Waiting List also.

41) PATIENTS WHO DO NOT ATTEND (DNA) ADMISSION

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

b) Any patient who does not attend their agreed operation date will be 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 below[4]) 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

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

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

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

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

42) BILATERAL PROCEDURES

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

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

43) ADMITTING PATIENTS

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

44) 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.

45) REMOVALS OTHER THAN TREATMENT

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

Section Three

Cancer Pathways

Cancer Access Targets in BNSSG will be managed in accordance with the current national Cancer Waiting Times guidance, available at this website. This national guidance is supported by the South West Cancer Access Policy, produced by the Somerset, Wiltshire, Avon and Gloucestershire and Peninsula Cancer Alliances. The South West Policy provides further clarity on complex areas of the national guidance and ensures that the rules are consistently applied across the South West region. The policy is signed off by the Cancer Alliance Board which includes the cancer leads from BNSSG commissioners and providers, as well as all by all Cancer Managers in the region. As such BNSSG providers and commissioners will follow the rules laid out in the national guidance and the South West Policy (available at this website).

Where changes to the national guidance occur, should these contradict the South West Policy, the national guidance will take precedence until the policy is updated to reflect the new rules.

Where changes to the national guidance occur, these will be considered effective from the month of publication, for activity in that month. Rule changes will not be retrospectively applied to patients treated in previous months but not yet reported. However only one set of rules will be used in any given calendar month i.e. if guidance is published mid-month, the change would be effective from the next month's activity. This approach has been previously confirmed as correct by NHS England (via email correspondence following publication of version 10 of the national guidance).

Section Four

Reference Information

Definitions

A

Active monitoring

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

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

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

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

Admission

The act of admitting a patient for a day case or inpatient procedure

Admitted pathway

A pathway that ends in a clock stop for admission (day case or inpatient)

B

Bilateral (procedure)

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

C

Care Professional

A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

Clinical decision

A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements.

Consultant

A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. Consultant-led waiting times exclude non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.

Consultant-led

A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.

Convert(s) their UBRN

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

D

DNA – Did Not Attend

DNA (sometimes known as an FTA – Failed to attend). In the context of consultant-led waiting times, this is defined as where a patient fails to attend an appointment/ admission without prior notice.

Decision to admit

Where a clinical decision is taken to admit the patient for either day case or inpatient treatment.

Decision to treat

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

F

First definitive treatment

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

Fit and ready (in the context of bilateral procedures)

A new RTT clock should start once the patient is fit and ready for a subsequent bilateral procedure. In this context, fit and ready means that the clock should start from the date that it is clinically appropriate for the patient to undergo that procedure, and from when the patient says they are available.

H

Healthcare science intervention

See Therapy or Healthcare science intervention.

I

Interface service (non consultant-led interface service)

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

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

The definition of the term does not also apply to:

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

N

NHS e-Referral Service

A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic.

Non-admitted pathway

A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment'.

Non consultant-led

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

Non consultant-led interface service

See interface service.

P

Patient pathway

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

Planned care

An appointment /procedure or series of appointments/ procedures as part of an agreed programme of care which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.

R

Reasonable offer

An offer is reasonable where the offer for an outpatient appointment, diagnostic appointment or an offer of admission is for a time and date three or more weeks from the time that the offer was made. Or if the patient accepts an offer with shorter notice, then this is also considered reasonable.

Referral Management or assessment service

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

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

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

Referral to treatment period

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

S

Straight to test

A specific type of direct access diagnostic service whereby a patient will be assessed and might, if appropriate, be treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional.

Substantively new or different treatment

Upon completion of a consultant-led referral to treatment period, a new waiting time clock starts upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.

It is recognised that a patient's care often extends beyond the consultant-led referral to treatment period, and that there may be a number of planned treatments beyond first definitive treatment.

However, where further treatment is required that did not form part of the patient's original treatment plan, a new waiting time clock should start at the point the decision to treat is made.

Scenarios where this might apply include:

- where less ‘invasive/intensive’ forms of treatment have been unsuccessful and more ‘aggressive/intensive’ treatment is required (for example, where Intra Uterine Insemination (IUI) has been unsuccessful and a decision is made to refer for IVF treatment);
- patients attending regular follow up outpatient appointments, where a decision is made to try a substantively new or different treatment. In this context, a change to the dosage of existing medication may not count as substantively new or different treatment, whereas a change to medication combined with a decision to refer the patient for therapy might.

Ultimately, the decision about whether the treatment is substantively new or different from the patient’s agreed care plan is one that must be made locally by a care professional in consultation with the patient.

T

TCI

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

Therapy or Healthcare science intervention

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

Thinking time

Patients may wish to spend time thinking about the recommended treatment options before confirming they would like to proceed.

U

UBRN (Unique Booking Reference Number)

The reference number that a patient receives on their appointment request letter when generated by the referrer through the NHS e-Referral Service (Choose and Book). The UBRN is used in conjunction with the patient password to make or change an appointment.

Section Five

Standard Operating Procedures

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

Referring organisation name:	Referring organisation code:
Referring clinician:	Referring clinician registration code:
Referring treatment function code:	Contact name:

Contact phone:	Contact e-mail:
Patient Details:	
Patient's family name:	Patient's forename:
Title:	Date of birth:
NHS number:	Local patient identifier:
Correspondence address: Post code:	Contact details: Patient is lead contact ☐ Lead contact if not the patient: ☐ Lead contact name: Contact home tel no: Contact work tel no: Contact mobile: Contact e-mail:
GP Details:	
GP Name:	GP practice code:
Referral To Treatment Information:	
Patient Pathway Identifier:	Allocated by (organisational code):
Is the patient on an 18 Weeks RTT pathway: Yes ☐ No	
Is this referral the: Start of a new pathway – (New condition or change of treatment) ☐ Continuation of an active pathway – (1st definitive treatment not given) ☐ Continuing treatment for a stopped pathway (1st definitive treatment given) ☐	

Is this referral for: Diagnostic test only ☐ Opinion only ☐	
Date of decision to refer to receiving organisation:	Clock start:
List all organisations involved in the 18 Weeks pathway	
Receiving Organisation Details:	
Receiving organisation name:	Receiving organisation code:
Receiving clinician:	Receiving treatment function code:
Date IPTAMDS sent:	
For Receiving Organisation:	
Date received:	

Appendix 2: - GP Referral Letter Information Requirements

Minimum Data Set (MDS) – in bold

- **Referring GP**
- **Practice Address including postcode**
- **Telephone number**
- **Fax Number**
- **Practice code**
- **NHS Number**
- **Patient Surname**
- **Forename(s)**
- **Date of Birth and Age**
- **Sex**

- **Address**
- **Postcode**
- **House telephone**
- **Mobile telephone**
- **Specialty/Department**
- **Date**
- **Presenting complaint**
- **Reason for referral**
- **Expected outcome**
- **Treatments tried and outcomes**
- **Significant PMH**
- **Relevant investigations**
- **Current medication**
- **Allergy history**
- **Interpreter required? If so which language?**
- **Ambulance or other transport needed**

Optional Data items

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

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

Clock Starts

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

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

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

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

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

a. when a patient becomes fit and ready for the second of a consultant-led bilateral procedure;
b. upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan;
c. upon a patient being re-referred in to a consultant-led; interface; or referral management or assessment service as a new referral;
d. when a decision to treat is made following a period of active monitoring;
e. when a patient rebooks their appointment following a first appointment Did Not Attend (DNA) that stopped and nullified their earlier clock.

RTT Clock Stops

Clock stops for treatment

4) A clock stops when:

a) First definitive treatment starts. This could be:

i) Treatment provided by an interface service;

ii) Treatment provided by a consultant-led service;

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

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

Clock stops for 'non-treatment'

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

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

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

c) A patient declines treatment having been offered it;

d) A clinical decision is made not to treat;

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

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

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

- The provider 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/published, policies on DNAs;
- These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g. children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders.

Addendum 1

2019/20 Addendum to the BNSSG Elective Care Access Policy

April 2019

The purpose of this addendum is to complement the policy around paediatric patients who make multiple cancellations or who DNA multiple appointments.

In the event of a paediatric patient making multiple (more than one) cancellations, multiple changes or if they DNA on multiple occasions - in addition to the clinical review process and active engagement with the patient the trust will write to the patient's GP to establish if there are any particular circumstances, including safeguarding concerns, why the patient might not be attending.

Addendum 2

Addendum to the BNSSG Elective Care Access Policy

Interim Operational Guidance

Management of patients on the waiting list choosing to decline offered treatment dates at current provider or an alternative provider

Context

Thanks to the hard work, dedication and innovation of our staff, the NHS recently delivered the first milestone in our Elective Recovery Plan: virtually eliminating the very longest waits of more than two years for scans, checks, surgical procedures, and other routine treatment that have been delayed because of the Covid-19 pandemic.

The NHS is now well underway with the next phase, focussing on patients waiting longer than 18 months, based on the key principle of prioritising people in order of clinical priority. To help recovery we have to make the best use of clinical and operational resources whilst giving patients more choice over their own care. Partly this is about ensuring anyone waiting longer than necessary is given the option to travel to a different hospital if they can be treated quicker. But equally, patients can choose to delay or decline treatment if they wish.

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

- the circumstances when it is appropriate to offer patients the choice to travel elsewhere and how it should be recorded and managed on Referral to Treatment (RTT) waiting list.

- that when patients make a decision to delay their treatment there should be clinical oversight, and the patient fully understands the clinical implications of the delay.

- for a number of patients who wish to continue to delay their treatment it may be appropriate for them to not remain on the waiting list until such time as they are available to have their treatment.

The NHS' RTT rules guidance will be updated to reflect this guidance, which will be kept under constant review.

Interim Operational Guidance

Management of patients on the waiting list choosing to decline offered treatment dates at current provider or an alternative provider

Background

The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (the "Standing Rules"), regulations 45 and 46 describe the basis for meeting the maximum waiting time standards. The duty to meet the minimum waiting time standards remains a statutory responsibility of the NHS. However, in recognition of the pressures caused by the pandemic, it is appropriate to issue interim operational guidance to support Providers to schedule care efficiently and prioritise patients who are available to receive their care. The RTT rules guidance has been updated to reflect the interim guidance.

As with all patients on the waiting list, patients should be treated according to clinical need and according to general public law principles of fairness.

Below describes the interim guidance for the management of patients on the waiting list choosing to decline a treatment date at their current provider or an alternative provider. Guidance will be kept under constant review and re-issued as required.

Guidance

Below is a guideline structure for clinicians on how they may wish to manage patients on the waiting list choosing to decline a treatment dates at current provider or an alternative provider, through placing then into a period of active monitoring

Patients wishing to delay treatment (currently P6)

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 on the WLMDS as a 'C-code'.
- A 2nd TCI should be offered which is within 6 weeks of the 1st TCI.
- 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.

TCI date offered must include date, provider, and team. It is not appropriate to start a period of active monitoring and stop the clock on the basis of a patient declining earlier treatment at a provider for which the detail has not been confirmed.

Patients declining earlier treatment at an alternative provider (currently choice category)

Patients included within this cohort should be clinically validated to be appropriate (clinically and socially) to be offered earlier treatment at a reasonable[1] alternative provider.

In circumstances where a patient declines earlier treatment at an alternative provider the following approach may be considered:

- Following declining a 1st TCI at an alternative provider, the patient should be recorded on the WLMDS as a 'C-code'.
- A 2nd TCI should be offered which is within 6 weeks of the 1st TCI.
- TCIs offered should be reasonable (i.e. 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 active monitoring.
- 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.
- Should a patient decline the subsequent offered TCIs at the existing provider, the guidance relating to cohort (a) above should be followed.

TCI date offered must include date, provider, and team. It is not appropriate to start a period of active monitoring and stop the clock on the basis of a patient declining earlier treatment at a provider for which the detail has not been confirmed.

Reasonable will be defined by each region recognising the variance in the geography. Provision should be made to support patients with transport/travel costs if required.

Updated 11.10.22

Management of patients on the waiting list choosing to decline offered treatment dates at current provider or an alternative provider

Version 2 11.10.22

Frequently Asked Questions

1. **Where does a new clock start for those wishing to stay on the waiting list (following Active monitoring)?**
   The new clock should start at zero but 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 within the context of clinical priority.

2. **When does the clock stop for Active Monitoring i.e. is it when the 2nd TCI is turned down or when the discussion is had with the patient?**
   The clock should stop when there is a conversation with the patient and the clinician has agreed the duration of active monitoring. It is anticipated that this will be within a very short period of time from the 2nd TCI being declined.

3. **How should providers actively review the active monitoring list?**
   Active monitoring is not a new process. It is anticipated that as part of existing good waiting list management that all providers will have, providers will have robust existing processes in place which can be utilised. There will be a requirement to capture locally the period of active monitoring which is appropriate for each patient with an end date identified to enable providers to contact patients at the end of that period if the patient has not contacted the hospital.

4. **Is active monitoring being used in a similar way to PIFU way?**
   Active Monitoring is able to be applied if it is clinically appropriate and a patient has an opportunity to come back onto the waiting list after or during that period. That may be initiated by the patient or the provider.

5. **If at the end of the maximum 12-week active monitoring period a patient still does not wish to go ahead with their treatment is the patient discharged from the waiting list?**
   If following a clinical conversation with the patient to ensure that the patient understands the clinical implications of further delays it is deemed to be appropriate to be discharged from the waiting list, then this can be enacted. Local access policies should be utilised.

6. **Can we be clear on what a 'reasonable' alternative offer is in terms of location.**
   A reasonable offer will be determined by each region based on the geography of the region.

7. **Can this approach be retrospectively applied?**

   A TCI offered must include the details of the provider, date and team. Where a 1st TCI (including details) has been previously recorded the 1st TCI offer can be applied retrospectively. The 2nd TCI cannot be applied retrospectively as there will need to be a conversation with the patient to ensure that they understand the implications of declining that 2nd TCI, what it means to them in terms of active monitoring and the process for coming back onto the waiting list.

8. **Should we offer TCI's at alternative providers if patients have already said they do not wish to move?**

   Yes, this should be considered if it is clinically appropriate. Our experience of offering an alternative provider is that patients often re-consider the option for moving when they have the details available to make an informed decision. This should be done by a member of the team who has the skills and knowledge to be able to provide information on the risks and likely impact of further delays, the offer of any travel support and support with relatives etc.

9. **Does the guidance only apply when a patient is added to waiting list?**

   No, this will also apply to existing patients on the waiting list.

10. **How should the patient on active monitoring be recorded on the WLMDS?**

    Following feedback from providers last week we were asked to simplify the process for recording patients choosing to decline TCIs in the context of the patients' clinical priority. We are therefore updating the guidance to reflect the following methodology to support the single reporting requirement and minimise changes to PAS/EPRs. This will also simplify the process for moving patients back onto the waiting list after the period of active monitoring.

    - **Clinical Priority - Existing P2 - P4 categories should be used. We should see P6 as a category deplete.**
    - **Patients declining 2 TCIs (for both social reasons and at alternative providers) These should be recorded as C2-C4. 'C' relates to the patient 'choosing' to decline TCIs, and the 2-4 should be aligned with the clinical priority.**

11. **Is this guidance only to be applied for long waiters?**

    No, it should be applied to all patients as clinically appropriate who are offered a TCI.

12. **Does any of this apply to long waiting patients on a non-admitted pathway?**

    The guidance principles can also be applied to non-admitted patients if deemed appropriate. We would however encourage providers to focus on those patients on an admitted pathway.

13. **Are C codes a drop down on the clinical prioritisation list or separate?**
    C2-C4 should be added as a drop down on the clinical prioritisation fields .

14. **Is the intention that patients currently on P6 who have asked to delay for over 12 weeks will be contacted and put on active monitoring?**
    No, not automatically, they will need to follow the process detailed in the guidance relating to the offer of 2 TCI dates first. Please also refer to Q7.

15. **Will there be an ask to report on the active monitoring cohort nationally?**
    We will monitor those who have been moved onto active monitoring through the C code data and STT status outcome code of 32 recorded within the clock stops data in the WLMDS. Providers will likely wish to monitor this locally too to enable the waiting list to be effectively managed.

16. **Do we need to change the data dictionary definition for active monitoring as this is a different use?**
    As this is interim guidance only we do not anticipate making substantive changes to the data dictionary.

17. **How will you be communicating this to providers?**
    National webinars will take place w/c 3rd October to share the detail with systems and providers. Additional sessions will be arranged at system or regional level if requested.

18. **What is the expected impact on the volumes of long waiting patients?**
    We anticipate that there will be a significant increase in patients being classified as a C-code from existing numbers of P6 patients as this now incorporates two different patient cohorts. However, we anticipate that volumes of patients being moved onto active monitoring will be relatively low given that this needs to be agreed as appropriate by the clinician. Providers should continue to work towards reducing the number of long waiting patients in line with the nationally set ambitions.

19. **What happens if a patient refuses the TCIs and refuses to go onto active monitoring?**
    Existing local processes for applying active monitoring and local access policies should be applied. It is anticipated that through a clinical conversation with the patient and involving shared decision an agreement can be reached with the patient. If a patient ultimately declines the TCI and refuses to be placed on active monitoring, there will need to be a decision as to whether the patient should remain on the waiting list.

20. **Patient ownership - who will be responsible for patients when they come off and re-join the pathway?**

Existing clinical governance arrangements for patients on active monitoring should be applied.

21. What is the status of P6 patients going into using this new guidance?

P6 patients should be reviewed at the end of their current unavailability period or at the time which their clinical review is due and the new guidance should be applied including assigning the C code where appropriate.

22. Can trusts decide not to adopt this guidance?

The requirement to record patient cohorts differently is mandated e.g., using C codes rather than P6 however the remainder of the guidance is subject to local implementation.

23. Should the patient's GP be advised of the decision to place the patient onto active monitoring?

Existing processes should be applied when patients are placed on active monitoring. It would be good practice to advise primary care of the outcome.

24. If the patient states that they are unavailable for a period of time do you have to offer the second TCI?

The second TCI should be offered when the patient is available. If the second TCI is then declined, it could be considered to place the patient on active monitoring.

25. How are you advising Trusts to manage allocating a TCI in line with the RTT wait at the point of clock stop...for example, if the patient was at 30 weeks and they have been on a stopped clock for 12 weeks, how would Trusts/bookers know the previous wait? Is the expectation that Trusts need to develop some form of manual tracking system to manage this? Record it in the medical record somewhere depending on the functionality of the EPR system?

Yes, this will be subject to implementation at a local level depending on EPR/PAS functionality.

26. What is the anticipated approach if a patient declines TCIs and does not wish to go on active monitoring?

The decision to place a patient on active monitoring is at the discretion of the clinician. It is anticipated that through the clinical conversation with the patient this scenario would be resolved by the clinician.

27. Ideally, we should have an agreed TCI date for the patient when they start a period of active monitoring. This keeps the process tight, minimises the patient being disadvantaged. That should be our local approach.

This is a very sensible approach which we would fully support.

28. **What happens after 12 weeks? As others have mentioned there are genuine reasons for delay beyond 12wks (in fact it's common).**
    It may be appropriate for a further active monitoring period to be agreed; however, this will require a clinical conversation with the patient prior to being set.

29. **If you're offering a patient a TCI 14 weeks out and they decline, then they are making themselves unavailable longer than the active monitoring period of 12 weeks?**

    We would encourage pragmatic interpretation of the guidance in line with local operational processes.

30. **If a patient declines a first TCI in 2 weeks and second TCI in 14 weeks into the future on the same call is it ok to be put on active monitoring (following clinical Conversation)?**
    The guidance states that the 2 TCIs should be offered 6 weeks apart. If it is not operationally possible to make the 2nd TCI offer until 14 weeks after, active monitoring should not be considered until after the 2nd TCI has been declined.

31. **If active monitoring is being recorded as the reason should this be patient issued rather than hospital issued?**

    The guidance details that code 32 (hospital initiated active monitoring) should be utilised for these cohorts as the decision to commence active monitoring is with the hospital.

32. **Where a patient was offered an alternative provider and declined as the reason for being a C-code but after 12 weeks we still don't have capacity would the recommendation be to repeat the process and ultimately extend the active monitoring period?**
    Yes, if it has been clinically agreed as appropriate.

33. **If a decision is made to offer surgery but patient is not clinically ready- can we apply active monitoring from clinic appointment (in theory patient should not be on the waiting list if not ready)?**

    Existing active monitoring rules/guidance should apply to this scenario.

34. **If patients return to the active waiting list is the intention that there will be a clinical review and the priority status will be reviewed/revised?**

    It is the responsibility of the clinician to determine if this is required. The national surgical validation programme details that there should be regular reviews of patients (circa every 3 months).

35. **The guidance will result in us having to manage 2 different waiting lists.**

Hospitals will need to ensure that there are processes in place to manage the waiting list including moving those placed in active monitoring on and off the waiting list.

36. Implementation of this approach will appear as the provider booking out of turn relative to their current RTT length.

We are sighted on this as a potential issue. It is important that there is local recording of previous clock start/stop dates as an audit trail if needed.

37. Do patients remain on our inpatient waiting list but not on our PTL whilst on active monitoring, as when they are put back on the PTL the decision to admit date would be before the RTT start date?

The patient remaining on the inpatient waiting list would seem to be sensible from an operational perspective. It is acknowledged that the recorded DTA will be before the RTT start date for those patients who have been on active monitoring.

38. Does the active monitoring clock stop have to be a communicated and jointly agreed between the patient and the clinician?

Yes, there should be a conversation between the clinician and the patient prior to placing the patient on active monitoring.

39. Is there a view about timescales for reinstating Patient Access Policies such that patients are discharged back to their GP if they decline two reasonable TCIs and it is clinically safe to discharge them?

Patients should only be discharged back to the GP if it is clinically appropriate to do so in line with the existing guidance. The implementation of the local access policy is at provider discretion.

40. Current PAS and EPR systems will not easily allow the management of patients according to the proposed process. Has this been considered?

We acknowledge that there is significant variance with PAS/EPR capabilities. Providers will need to work through any changes with PAS/EPR suppliers required to support delivery.

41. How should we record a patient who we know is unavailable but has not yet had a TCI.

Patients should be recorded as a 'C' code as soon as you become aware that they are not available but should remain on the active waiting list until they have been offered TCIs.

42. Is C-code a replacement for P6 or is it in addition?

No, C-codes supersedes P6 to be used for patients declining TCIs in both circumstances.

43. How do we differentiate these patients from others on an active monitoring list?

The combination of RTT Status Outcome Code 32 and Clinical Priority Code C-code will enable this cohort of patients to be identified on the WLMDS clock stops data submission.

44. How should we report those that have been placed on active monitoring in these cohorts?

Patients moving onto active monitoring should be reported as a RTT Status Code 32 on the WLMDS clock stops data set with a C-code clinical priority.

45. **When is this to be implemented?**

As the guidance has been issued this should be implemented with immediate effect recognising that there will be a period of time to establish the administrative processes.

46. Is there a cut-off date in WLMDS for move from P6 to C-code?

Taking into consideration the frequency which patients should be clinically and administratively validated we would anticipate that there are no patients categorised as P6 beyond 31st January 2023.

47. What about patients already on a P6? E.g. if they declare they are unavailable for a period of time and we aren't in a position to offer a TCI?

These patients should be contacted and if they remain unavailable recorded as a C-code but remain on the active waiting list until they have been offered 2 TCIs

48. Can you confirm that this applies to patients at any stage of their waiting time and not just to "long-waiters"?

Yes, this should be applied to all patients as appropriate irrespective of their waiting time.

49. Does this mean that patients can be on an active TCI list but at the same time be on a closed pathway?

Patients can be on a closed RTT pathway but remain on a local PTL to enable them to be managed from an active monitoring perspective.

50. When patients are reinstated following active monitoring, are we expected to update the clock start for the new pathway to incorporate previous weeks' wait, or just record this locally and keep them at week 0?

The patient should be recorded from an RTT perspective as at week 0; but managed as if they have re-entered the waiting list at the point they left.

51. **I understand the move from P6 to C-code is mandatory however is the active monitoring element also mandatory?**
    No, active monitoring is not mandatory. This is subject to clinical determination.

52. **Just for absolute clarity - when these patients' clocks are restarted, while they are treated as long waiters, are they reported on the RTT monthly submission at their original weeks wait or starting from 0?**
    They should be reported as starting from 0 on the RTT submission.

53. **Is there a reason why we cannot keep them on the PTL (without applying active monitoring) and change the P6 to a C-code? Our reporting would then be easily identifiable, and we still maintain visibility.**
    This option is available however the RTT clock would not stop if active monitoring is not applied.

54. **Reviewing patients at the end of active monitoring could consume large volumes of clinical capacity. How do we manage this when we are already under significant clinical resource pressures?**
    We have aligned the maximum 12-week period with the national guidance on clinical validation which details that patients on an admitted waiting list should be regularly reviewed eg. every 3 months. We do not therefore anticipate additional clinical capacity being utilised over and above that which is already being consu med for clinical validation of those on the waiting list.

55. **Is there a minimum requirement for time between first and second TCI offered? I know maximum is 6 weeks, but what happens if we offer two dates in same week which is when patient is on holiday - do they still go onto active monitoring?**
    We would encourage pragmatic application of the guidance. It would not seem reasonable to offer a patient 2 TCIs within the same week that they are on holiday then suggest that they move onto active monitoring.

56. **Does this guidance apply when someone on behalf of the patient declines these offers i.e. children, prison inmates?**
    Existing approaches should be applied with regards to making decisions on behalf of children. Local decisions should be applied with regards to the other reasons for declining TCIs for prison inmates.

57. **When should active monitoring start? Would it be from now or from the TCI date they have declined (could have been offered six weeks in advance).**
    Active monitoring start date should be set as the date on which the clinician has the conversation with the patient, and it is agreed that active monitoring commences.

58. Will the WLMDS template be updated? From a WLMDS reporting perspective would these patients drop off the 'RTT Open Pathways' section and move on to the Non-RTT Open Pathways' section?

There is no need to update the WLMDS template - the existing fields should be used. For any patients who are placed on active monitoring they should be transferred from the open pathways WLMDS submission to the clock stop WLMDS submission.

59. Are cancer pathways included in this guidance?

No, it is not clinically appropriate to apply this to patients who are on a cancer pathway or awaiting treatment for cancer.

60. Will there be any additional data returns required?

No, the WLMDS data submissions will be used. There is significant importance in ensuring that there is good data quality and completion in the WLMDS submissions which will avoid the need to introduce any additional data returns. We will monitor each provider's clock stop data over the coming weeks/months.

61. How can we ensure that patients do not move onto an unsighted PT and any implications this may have for patients with regards to risk?

Providers should adapt local administrative processes for patients On active monitoring to ensure that they are suitable and appropriate for this cohort of patients.

62. Do we need to record the TCI offers made to a patient?

The evidencing of TCI offer dates is not a reporting requirement. Providers should have existing mechanisms for being able to ensure access policies are applied with regards to number of TCI offers being made.

63. Is there any reason we cannot book these patients into a telephone review at the end of the active monitoring period so that they remain visible?

This would be a very sensible way of managing this process that we would be fully supportive of.

64. Is this going to be a permanent change? If it is beneficial to patients, Why isn't it going to be permanent?

The guidance will be kept under constant review at future intervals based on feedback. While we are in this period, we have badged the guidance as 'interim'.