Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

# BNSSG ICS Elective Care Access Policy

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

**Version 14.1 August 2024** **Review Date: August 2025**

## CONTENTS

## 1) POLICY PURPOSE AND SCOPE

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

Through this policy the system upholds the Human Rights Act 1998 and the Equality Act (2010) promoting equality of opportunity for all.

This policy provides guidance on:

- Rules and principles under which BNSSG ICS manages elective patient access to outpatient appointments, diagnostics and elective inpatient or day case treatment and through their elective care pathways.
- Application of the NHS Constitution and NHS choice framework in relation to elective waiting times.
- Demonstrating that elective access rules are applied transparently, consistently, fairly and equitably and managed according to clinical priorities.
- Key administration processes.

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 an appointment or 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: Patients on a cancer pathway are not in scope of this policy. The current "Southwest Cancer Access Policy" should be followed (see Section 3).*

The policy is split into the following sections:

1. **General Principles**
2. **Pathway Specific Principles**
3. **Cancer Pathways**
4. **Appendices and Addendums**

# Section One
# General Principles

## 2) KEY POLICY PRINCIPLES[1]

This policy covers the way BNSSG will collectively manage administration for patients who are waiting for, or undergoing treatment on an elective care RTT or diagnostic pathway. The policy adheres to national best practice and provides a framework to ensure that patients are treated transparently, fairly and reasonably. The overarching principles include:

- Providing fair and equitable access to services for all patients.
- Promoting choice, as set out in the NHS Constitution for England (The NHS Constitution for England - GOV.UK (www.gov.uk)), the Handbook to the NHS Constitution for England (Handbook to the NHS Constitution for England - GOV.UK (www.gov.uk)) and The Department of Health and Social Care NHS Choice Framework (NHS Choice Framework - what choices are available to you in your NHS care - GOV.UK (www.gov.uk))
- Promoting patients' right to start consultant led treatment within maximum waiting times, as set out in the NHS Constitution (The NHS Constitution for England - GOV.UK (www.gov.uk)).
- Supporting Providers to achieve and improve the maximum waiting times set by NHS England for all patients.
- Providers ensuring priority to clinically urgent patients and treating everyone else in chronological order.
- Providing reasonable adjustments in waiting list management to ensure that vulnerable groups are not disadvantaged or experiencing increased wait times.
- Providers engaging with patients to agree reasonable[2] appointment and admission dates and times.
- Shared commitment of responsibility for ensuring that referrals are clinically appropriate and follow BNSSG system defined pathways.

## 3 ROLES AND RESPONSIBILITIES

Delivery of the principles and standards described above are a shared commitment across the BNSSG footprint, with clear roles and responsibilities as described below.

### 3.1 BNSSG ICS

The ICS 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 to action.

### 3.2 BNSSG ICB

BNSSG ICB will:

- Promote individual patient rights as set out in the NHS Constitution and NHS Choice Framework.
- Develop and manage the local health market to support the provision of patient choice.
- Ensure that all patients requiring planned elective care are offered clinically appropriate choices of provider.

[1] The principles within the policy are applicable across all organisations comprising the BNSSG area, as detailed on the covering page. SOPs are in place to underpin the access policy principles. There may be a number of these are they are typically specific to each individual organisation.

[2] Reasonable' is a term applicable to all stages of the elective pathway and refers to specific criteria which should be adhered to when offering routine appointments and admission dates to patients to demonstrate that they have been given sufficient notice and a choice of dates. A reasonable offer is defined as a choice of two dates with at least three weeks' notice. Or if the patient agrees and accepts an offer with shorter notice, then this is also considered reasonable.

- Ensure that patients are treated within clinically appropriate, commissioned pathways and maximum treatment times.
- Ensure that patient facing communications, such as the ICB webpages inform patients of their right to treatment at an alternative provider in the event that their RTT wait goes beyond 18 weeks or if it is likely to do so. If a patient requests to move provider, the ICB will take all reasonable steps to identify and offer a suitable alternative provider, or if there is more than one, a range of suitable alternative providers, able to see or treat patients more quickly than the provider to which they were referred. A suitable alternative provider is one that can provide clinically appropriate treatment and is commissioned by an ICB or NHS England.
- Provide accurate, accessible waiting time data on the Remedy platform, to support referrers in their consultations with patients and choice discussions[3].

The ICB Referral Service will receive referrals through eRS and:

- Aim to shortlist on average five clinically appropriate choices from local providers from which the patient may choose, where these are available, where this is practicable, clinically appropriate and preferred by the patient.
- Ensure that where appropriate, funding for Interventions Not Normally Funded (INNF) or Prior Approval has been obtained by the referrer and is attached to the referral OR ensure that the patient meets the criteria set out in any relevant Criteria Based Access (CBA) commissioning policies and that this is evidenced within the referral. These procedures can be accessed on the BNSSG Website; Commissioning Policy Development - NHS BNSSG ICB .

### 3.3 Referrers Responsibilities

All referrers, including but not limited to, General practitioners (GPs), Consultants and Professions allied to medicine, play a pivotal role in ensuring patients are informed during their consultation of the likely waiting times[4] for a new outpatient consultation and of the need to be contactable and available when referred.

Referrers[5] will**:**

- Utilise Advice and Guidance (A&G) services where appropriate and available.
- Ensure that the patient is clinically suitable for their referral and intended pathway of care. Tools and information are available on Remedy relating to the relevant clinical pathways: Referral Home (Remedy BNSSG ICB)
- Ensure to the best of knowledge that patients are ready, willing, fit and able to attend for any necessary outpatient, diagnostic appointments and/or treatment.
- 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 necessary.
- Ensure patients are communicated with in a way that meets their needs and is accessible.
- Initiate the referral using the NHS eReferral Service, where this is applicable (where the Referral Service will, where appropriate identify clinically appropriate services for the patients up to an average of 5 choices from local providers)[6]. Note. Not all referrals are via the Referral Service.

[3]Note that there are currently several sources of information regarding waiting times. The BNSSG website, that provides the 90th centile waits. Remedy, which provides both 50th and 90th centile. There is also My Planned Care and the NHS App quoting mean waits.

[4] Local waiting time information can be found on Remedy Hospital waiting times (Remedy BNSSG ICB) or via the ICB website How long will I wait for a hospital appointment? - NHS BNSSG ICB

[5] Responsibility for the referral sits with the referrer and this needs to be via eRS and include appropriateness of referral, meeting CBA, funding etc. It is recognised that private GPs do not have access to eRS so are unable to refer into the NHS.

[6] It is recognised that there are challenges with the Choice process where a GP has requested Advice & Guidance and the provider uses Convert to Referral function. Similarly there is a work underway nationally regards RAS and choice.

- Ensure that where appropriate, funding for interventions not normally funded has been obtained by the referrer prior to referral. Or ensure Prior Approval application is attached to the referral or essential criteria is evidenced within the referral and sent to the BNSSG Referral Service for approval and processing on.
- Ensure that the patient meets the criteria set out in any relevant commissioning policies for that procedure; this can be accessed on the BNSSG Website; Commissioning Policy Development - NHS BNSSG ICB . It is expected that the clinician managing a patient provides assurance and clearly documents in the patient records that a patient meets the criteria. Patients can and do improve or deteriorate during their care pathway and may require re-assessment.
- Provide the national minimum core data set (detailed in the Appendix) when transferring care to another provider.
- Include information to enable the Accessible Information Standard (AIS) Accessible Information Standard Specification - version 1.1 and reasonable adjustments to improve patient safety, experience and outcomes.

## 3.4 Acute Provider Responsibilities

Providers are responsible for ensuring patient communication is timely, in a way that meets the patient needs and is accessible. Communications should be provided in the patient's preferred format (wherever possible) to improve patient safety, experience and outcomes. Providers should provide patients with information on how to contact them if they need to change or cancel their appointment or change their personal contact details.

### 3.4.1 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.

### 3.4.2 Clinicians

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

### 3.4.3 General Managers / Operational Managers

General Managers and Operational Managers are responsible for ensuring that staff are 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) remains up to date in terms of the service specific criteria and that clinics are mapped to the relevant services.

### 3.4.4 Administration Staff

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

## 3.5 Patients

Patients are asked to:

- Help providers by sharing information about any communication or reasonable adjustments that the provider can offer to support them in attending appointments.
- Respond to hospital communications as quickly as possible.
- Consider the choice options that are available to them.
- Accept an available appointment if they can.

- Attend agreed appointments and give as much notice as possible in the event of the need to change an agreed date and time.
- As soon as is possible communicate to the hospital or general practitioner if treatment and/or appointments are no longer required.
- As soon as is possible communicate with the hospital if they are no longer able to attend a booked appointment or treatment.
- As soon as is possible communicate to the hospital and general practitioner any changes in personal contact details or communication requirements.

### 3.6 Information, Monitoring and Reporting

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

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 monitoring will be provided as required.

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

## 4 ELECTIVE CARE ACCESS STANDARDS

The principles in this policy are rooted in the standards and requirements set out nationally. In England, the NHS has set standards for access to elective care, related to two key areas:

- The individual patient rights (as described in the NHS Constitution and NHS Choice Framework).
- The standards by which individual providers and ICBs are held accountable by NHS England, these are also described as waiting-time standards.

### 4.1 Individual patient rights: Patient Choice

The NHS Constitution for England sets out the principles and values of the NHS in relation to patient choice. The Handbook to the NHS Constitution describes in more detail the rights in relation to informed patient choice and The Department of Health and Social Care NHS Choice Framework sets out some of the nationally determined choices available to patients, to which this policy complies.

The pledges and rights set out in these documents explain what patients can expect from the NHS. For example, when referred for consultant-led treatment, a patient can choose which provider they would like to receive care from for a first appointment as an outpatient and can also choose the clinical team who will be in charge of their care within that provider organisation.

These choices only apply at the point of referral (from for example, GP, dentist or optometrist) to providers that have an NHS contract to provide the service required and the service is led by a consultant who has overall responsibility.

These are legal rights, however, there are circumstances when a patient may not have a legal right to choose where their outpatient appointment will take place. These include when a patient is:

- Already receiving care and treatment for the condition for which they are being referred and this is an onward referral.
- Under the care of urgent, emergency or crisis services
- Requiring emergency or urgent treatment, such as cancer services[7]
- A prisoner, on temporary release from prison, or detained in 'other prescribed accommodation' (such as a court, secure children's home, secure training centre, an immigration removal centre or a young offender's institution)
- Resident in a secure hospital setting under the Mental Health Act 1983
- A serving member of the armed forces
- Using maternity services

A patient also has the right to access certain services commissioned by NHS bodies with maximum waiting times. For example, a patient has a right to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions. If this is not possible, the ICB or NHS England, whichever commissions and funds the treatment, must take all reasonable steps to offer a suitable alternative provider, or if there is more than one, a range of suitable alternative providers, that would be able to see or treat more quickly than the provider to which originally referred. A suitable alternative provider is one that can provide clinically appropriate treatment and is commissioned by an ICB or NHS England. A patient would need to contact either the provider they were originally referred to, or their local ICB to initiate the process for looking for alternatives.

There are circumstances when the right to treatment within 18 weeks from referral does not apply, for example when:

- The patient chooses to wait longer.
- Delaying the start of treatment is in the patients' best clinical interests, for example where smoking cessation or weight management is likely to improve the outcome of the treatment.
- It is clinically appropriate for the patients' condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage.
- The patient fails to attend appointments which they had chosen from a set of reasonable options
- The treatment is no longer necessary
- The patient is on a transplant list

The following services are not covered by the right:

- Services that are not consultant-led
- Maternity services
- Public health services provided or commissioned by local authorities

[7] Note: the guidance still includes reference to a maximum waiting time of 2 weeks for cancer services, this has been superseded by the changes to cancer waiting time standards that came into effect in Oct 2023. NHSE Choices team have confirmed that this has been raised with DHSC to ensure it is changed in the next update.

## 4.2 Elective Care Waiting Time Standards

The elective care waiting time standards by which individual providers and ICBs are held accountable by NHS England are described in the table below[8].

<table>
<tr><th colspan="4">Referral to Treatment</th></tr>
<tr><td>Incomplete Pathways</td><td colspan="3">92% of patients on an incomplete pathway (i.e. still waiting for treatment) to be waiting no more than 18 weeks (or 126 days)</td></tr>
<tr><th colspan="4">Diagnostics</th></tr>
<tr><td rowspan="2">Applicable to specific diagnostic investigations</td><td colspan="3">99% of patients to undergo the relevant diagnostic investigation within 6 weeks (42 days) from the date of decision to refer to appointment date. Also considered as: Less than 1% of patients should wait 6 weeks or more for a diagnostic test from the date of referral to appointment date.<br>This applies to the following diagnostic tests:</td></tr>
<tr><td>Imaging<br>Magnetic Resonance Imaging<br>Computed Tomography<br>Non-obstetric ultrasound<br>Barium Enema<br>DEXA Scan</td><td>Physiological Measurement<br>Audiology - Audiology Assessments<br>Cardiology - echocardiography<br>Cardiology - electrophysiology<br>Neurophysiology - peripheral neurophysiology<br>Respiratory physiology - sleep studies<br>Urodynamics - pressures & flows</td><td>Endoscopy<br>Flexi sigmoidoscopy<br>Colonoscopy<br>Gastroscopy<br>Cystoscopy</td></tr>
</table>

While the aim is to treat all elective patients within 18 weeks, the national elective access standards are set at less than 100% to allow for the following scenarios:

- Clinical exceptions: applicable to RTT pathways, when it is in the patient's best clinical interest to wait more than 18 weeks for their treatment.
- Choice to extend pathway: when patients choose to extend their pathway beyond 18 weeks by declining reasonable offers of appointments, rescheduling previously agreed appointment dates/admission offers, or specifying a future date for appointment/ admission. This could be due to personal or social reasons[9].
- Co-operation – applicable where patients do not attend previously agreed appointment or admission offers (TCI) and this prevents the trust from treating them within 18 weeks.

# 5 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 was set up to ensure that all patients are 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.
P categories were introduced in addition to the Routine, Urgent, and Urgent Suspected Cancer categorisations for clinical prioritisation. Waiting lists have been re-prioritised to ensure that all patients waiting for inpatient treatment are visible to be booked in priority order, reflecting clinical urgency, and to enable timely clinical review.

When a patient is added to the waiting list they should be assigned a clinical prioritisation code by the clinician. Clinical prioritisation criteria for each elective speciality should be agreed by clinical leads following by guidance from respective Royal Colleges. These follow a standard format as detailed below:

[8] Note-In addition to the elective care standards, there are cancer waiting time standards. These are described in the specific cancer access policy, see Section 3.
[9] See Addendum 2 for interim guidance on management of patients who choose to extend their pathway

| P code | Booking timescale | Review timescale |
|---|---|---|
| P2 | Procedures to be performed in <1 month | 1 month |
| P3 | Procedures to be performed in <3 months | 3 months |
| P4 | Procedures to be performed in >3 months | 6 months |

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

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

In addition to the above there may be additional considerations for clinical prioritisation. For example, where professional guidelines or service standards exist, for example cleft lip and/or palate. In such cases, factors such as developmental and psychological impacts are considered[10].

## 5.1 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.

## 5.2 PLANNED WAITING LIST

Planned waiting lists are admissions where the date of admission is determined by the clinical needs of the treatment. Examples of these would include removal of internal fixation, three months post operation, check cystoscopy or repeat colonoscopies. Although a 'planned waiting list' is separate to other waiting lists, it is subject to the same monitoring and validation process.

Operational managers are responsible for reviewing the planned list 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.

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'. However please also note that not all surveillance procedures are undertaken in a planned manner – as an example, these maybe requested within 6-8 weeks.

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 removal of metal work.

Patients who wait beyond their clinically defined interval between appointments or 'planned by date' should be transferred to the active RTT waiting list and/or Diagnostic (DM01/non-DM01) waiting lists, with a new clock start date. i.e. a planned second procedure, diagnostic or therapeutic.

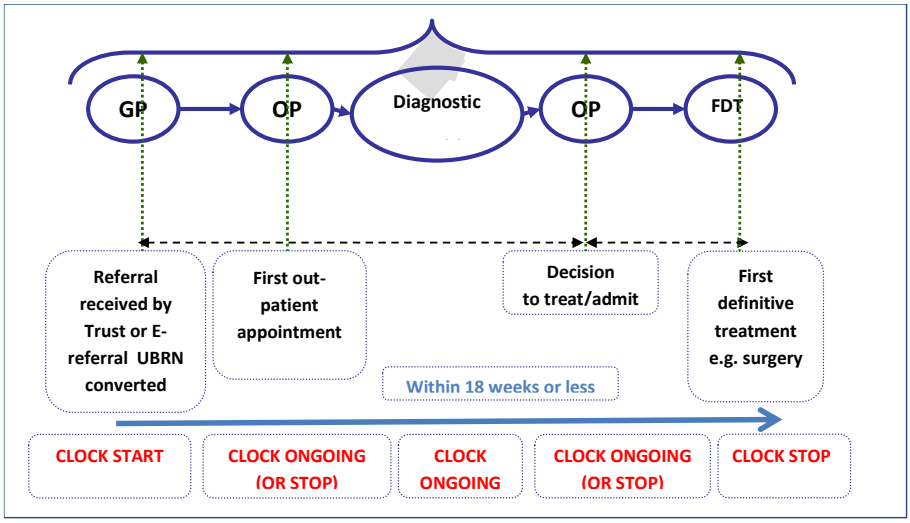
If the planned diagnostic procedure was to become overdue, this would require the patient to be added to a diagnostic (non-DM01) or DM01 active Waiting List with a new clock to ensure that the procedure be completed within 6 weeks.

[10] Within the BNSSG system there is a programme utilising C2AI to support risk stratification of the waiting lists and support clinical prioritisation.

# 6 OVERVIEW OF NATIONAL RTT RULES AND GUIDANCE

The full national RTT rules suite can be accessed here [Referral to treatment consultant-led waiting times: rules suite (October 2022) - GOV.UK (www.gov.uk)](). This is accompanied by guidance on recording and reporting [Recording-and-reporting-referral-to-treatment-RTT-waiting-times-for-consultant-led-elective-care-v4-1.pdf (england.nhs.uk)]()

An overview of the rules is demonstrated in the diagram and narrative below.




## 6.1 Clock Rules

### 6.1.1 Clock Starts (Rules 1-3)

**Rule 1: Referrals by care professionals or services**

Rule 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 (GP)

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 GP

**Rule 2: Self-referral**

Rule 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.

**Rule 3: The need for a new clock**

Rule 3: upon completion of a consultant led RTT period, a new waiting time clock only starts:

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

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

c) upon a patient being re-referred into a consultant-led, interface or referral management or assessment service as a new referral

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

e) when a patient rebooks their appointment following a first appointment 'did not attend' (DNA) that stopped and nullified their earlier clock

### 6.1.2 Clock Stops (Rule 4 and 5)

**Rule 4: Clock stops for treatment**

Rule 4: a clock stops when first definitive treatment starts – this could be:

a) treatment provided by an interface service;
   treatment provided by a consultant-led service
   therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions
b) a clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list

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 (Patient Administration System). 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.

**Rule 5: Clock stops for 'non-treatment'**

Rule 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
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 or published policies on DNA; these local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (for example, children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders

Clock stops must be captured in the Provider's PAS. A full list of clock starts and stops is documented in Appendix 3.

### 6.1.3 Exclusions

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

- Obstetrics and midwifery.
- Planned patients*.
- Referrals for patients from non-English commissioners.
- Genitourinary medicine (GUM) services.
- Emergency pathway non-elective follow-up clinic activity.

### 6.1.4 Other circumstances for removal from the elective waiting list

There are circumstances where a patient can be removed from the waiting list other than through receiving treatment. This includes patients who state that they do not wish to receive treatment and circumstances when a patient has an emergency admission for their 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. The referral should be removed from / cancelled on e-RS.

### 6.1.5 Non-consultant-led pathway and RTT clocks

Referrals to therapy or healthcare science interventions (e.g. physiotherapy, dietetics, orthotics, and surgical appliances) can be:

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

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

- Example 1: Physiotherapy - For patients on an orthopaedic pathway referred for physiotherapy as first definitive treatment the RTT clock stops when the patient begins physiotherapy.
- For patients on an orthopaedic pathway referred for physiotherapy as interim treatment (as surgery will be required), the RTT clock continues when the patient undergoes physiotherapy.
- Example 2: Surgical appliances - Patients on an orthopaedic pathway referred for a surgical appliance with no other form of treatment agreed. In this scenario, the fitting of the appliance constitutes first definitive treatment and therefore the RTT clock stops when this occurs.
- Example 3: Dietetics - If patients are referred to the dietician and receive dietary advice with no other form of treatment, this would constitute an RTT clock stop. Equally, patients could receive dietary advice as an important step of a particular pathway (e.g. bariatric). In this pathway, the clock could continue to tick.

## 6.2 Missed Appointments

Other than at first attendance, missed appointments (often described as DNAs – Did Not Attend) have no impact on reported waiting times. Missed appointments for children and young people are sometimes described as ‘Was Not Brought’ (WNB).

Every effort should be made to minimise missed appointments, and it is important that a clinician reviews every missed appointment on an individual patient basis. A clinician can decide to discharge the patient back to the original referrer (stopping the clock) where this is not contrary to the patients best clinical interests. Where another appointment is offered, the RTT clock continues to tick.

Patients could come to harm by repeatedly failing to attend appointments. Further information can be found here: Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care (england.nhs.uk) and NHS England » Did Not Attends (DNAs)

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

Pathway specific information about missed appointments is in later sections.

### 6.3 Patient Initiated Appointment Changes: Delays, Reschedules and Cancellations

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)[11]
- 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, at which point there should be a clinical review to determine whether the patient is ready, willing and able to proceed with treatment or whether the patient should be given the option of Patient Initiated Follow-up. Repeated periods of active monitoring should be avoided unless clinically indicated, rather than due to patient choice.
- If a patient is placed on active monitoring the RTT clock should be stopped.

RTT Rules continue to apply to pathways where a patient states that due to personal or social reasons, they are not able to agree a date. 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. This applies to all types of appointment, not just treatment dates. It is important that the Provider practice is from a trauma-informed approach and engages with the patient to understand the personal context of patients request to delay.

Cancellations or delays have no impact on reported RTT waiting times. If the patient is on an open RTT pathway, the clock continues to tick. If the patient requires a further appointment, this will be booked with the patient at the time of the cancellation. If there are insufficient appointment slots within the agreed pathway milestones, the issue must be escalated to the relevant speciality management team and the patient contacted to agree an alternative date. It is important to note that cancellations in themselves do not stop clocks. Clock stops should only be applied following a clinical review and where discharge is in the patient's best clinical interest.

Patients can request to delay any aspect of their RTT pathway for social or personal reasons (e.g. work commitments, holidays, exams), this period should be recorded on PAS and a clinical decision taken as to the next best step, which may be active monitoring - See Section 6.5). 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

[11] 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.

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.

If as a result of a patient requested extended delay or through the patient cancelling, a delay is incurred which is equal to or greater than a clinically unsafe period of delay (as indicated in advance by consultants for each specialty), the patient's pathway should be reviewed by their consultant to assess the potential impact on the patient's condition and treatment plan and to determine if the delay is appropriate, considering the best clinical interests of the patient and that no harm is likely to result from the patient waiting longer for diagnosis or treatment (clinicians may indicate in advance, for each specialty or pathway, how long it is clinically safe for patients to delay their treatment before their case should be reviewed). If the clinician is satisfied that the proposed delay is appropriate and within guidelines, then the provider should continue with treating the patient. Upon clinical review, the patient's consultant should indicate one of the following to support the clinical decision on next steps, of which the following may be considered:

- Clinically safe for the patient to delay: Planning for the patient's treatment may continue if only a short delay is requested, or active monitoring may be appropriate where agreed with the patient, including regular review. Continue progression of pathway. The RTT clock continues.
- Clinically unsafe length of delay: Clinician to contact the patient and engage in a Shared Decision-Making conversation. The RTT clock continues with agreed timescale to proceed or discussion with the patient about options or the impact on clinical outcome if continued delay. In exceptional circumstances if a patient decides to delay their treatment it may be appropriate to place the patient under active monitoring (clock stop) if the clinician believes the delay will have a consequential impact on the patient's treatment plan. If there is a shared decision made by the clinician and the patient to start active monitoring this should include a future date for review within at least 12 weeks, so that the patient's condition and treatment options can be re-assessed following the period of active monitoring.
- Clinically unsafe length of delay: clinical assessment that it is in the patient's best clinical interests to return the patient to their GP. The patient is discharged and their RTT clock stops on the day this is communicated to the patient and their GP.

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.

It is important to ensure the patient understands the risks of declining an appointment, particular consideration should be given to those patients that require additional communication support, including where translation services are required.

If the patient has never been seen and advises they do not wish to progress their pathway, they will be removed from the relevant waiting list and a clock stop and nullification applied. The patient will be informed that their consultant and GP will be informed of this.

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. The cancellation reason should also be clearly noted on the e-RS by the provider.

If a patient makes multiple cancellations, multiple changes or long-term cancellations to an appointment the Provider should actively engage with the patient to understand the reasons. This should inform a clinical review process that will consider whether discharge back to the GP is in the best interests of the patient. Section 8.1 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 Recording-and-reporting-referral-to-treatment-RTT-waiting-times-for-consultant-led-elective-care-v4-1.pdf (england.nhs.uk)

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.

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.

Pathway specific descriptions are in later sections.

### 6.4 Patients declining earlier treatment at an alternative provider

It may be necessary to offer patients choice to be treated at another provider. The same process and clock rules apply as above (Patients who cancel or decline TCI offers). However, TCI offers must include date, provider and team, and meet reasonableness criteria. This includes situations where a patient is offered an appointment with a private provider as part of an outsourcing arrangement.
It is important to fully understand both social and clinical factors in order to assist patients in making a decision to move to an alternative provider. This may include access to transport, carer assistance etc.
Further information can be found here: 8.5 Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care (england.nhs.uk)

### 6.5 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.

Active monitoring may be appropriate in the following situations:

- When a period of monitoring is appropriate before further action is needed, and the patient does not require any form of diagnostic or clinical intervention within the next few weeks.
- When a patient declines two reasonable offers of appointment dates and wishes to delay. In this situation, the patient should be reviewed by the consultant who may agree a period of active monitoring with them. This discussion with the patient should include an appropriate timeframe for further follow up or review, with the maximum being 12-weeks. Where it is appropriate to place a patient on active monitoring, this should be for a maximum period of 12 weeks, at which point there should be a

clinical review to determine whether the patient is ready, willing and able to proceed with treatment or whether the patient should be given the option of Patient Initiated Follow-up (PIFU). Repeated periods of active monitoring should be avoided unless clinically indicated rather than due to patient choice – repeated delays due to patient choice are likely better manged on a PIFU pathway, unless this is deemed to be clinically unsafe.

- A clinical review should take place every 12-weeks; this ensures that patients are reviewed regularly in case their condition deteriorates while they are waiting.

The pathway should be visible on a relevant PTL or waiting list report for non-RTT pathways. In all scenarios a new waiting time clock will start when a new decision to treat is made with the patient following a period of active monitoring. For patients who have been placed on active monitoring due to unavailability, once the patient wishes to go ahead with treatment, they should be reinstated on the waiting list with a new RTT clock starting at zero. The provider should offer a new offer for treatment date, acting as if the patient is on the waiting list at the point that they previously left.
When a patient is placed on active monitoring, they should be provided with written contact details and a clear process for two-way communication between them and the clinician in the event that their condition or circumstances change.

### 6.6 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 provider 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 11.2 of the RTT recording and reporting guidance for further information on subcontracting relationships and RTT reporting: Recording-and-reporting-referral-to-treatment-RTT-waiting-times-for-consultant-led-elective-care-v4-1.pdf (england.nhs.uk)
- Mutual aid can be facilitated via the national Digital Mutual Aid system (DMAS)

### 6.7 Inter-provider transfers (IPTs)

Referrals between providers must be accompanied by the national Inter-Provider Transfer Administrative Minimum Dataset (IPTAMDS). All fields must be completed as fully as possible (Appendix 1).
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.

Information sent on an Inter-Provider transfer should be sent via secure email e.g. nhs.net to protect the confidentiality of the patient information within.

- Incoming IPTs

All IPT referrals should be made electronically via Providers secure email, for e.g. NHS.net. The IPT referral must be accompanied by the IPTAMDS, detailing the patient's current RTT status (a receiving provider will inherit any RTT wait already incurred at the referring provider. The patient's pathway identifier (PPID) should also be provided. If the IPT is for a diagnostic test only, the referring provider retains responsibility for the RTT pathway (and the DM01/diagnostic pathway), so the results for the diagnostic test should be sent back to the referrer. If any of the information is missing on the IPT, the referral should be recorded on PAS and the information actively chased.

- Outgoing IPTs

The Provider will ensure that outgoing IPTs are processed as quickly as possible to avoid any unnecessary delays in the patient's pathway. The IPTAMDS should detail the patient's current RTT status (the receiving provider will inherit any RTT wait already incurred). If the patient has been referred for a new treatment plan for the same condition, a new RTT clock will start on receipt at the receiving provider. The patient's patient pathway identifier (PPID) will also be provided. If the outgoing IPT is for a diagnostic test only, this provider retains responsibility for the RTT pathway (and the DM01/diagnostic pathway). Referrals and the accompanying MDS will be sent from secure email to secure email.

### 6.8 Transport support for transfer to another provider

It is recognised that for some patients accepting a transfer to another Provider would require travel, subsistence 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 a Provider will reimburse and the method by which reimbursement is made will be detailed in Provider level SOPs.

## 7 COMMUNICATION WITH PATIENTS

The rules and principles within which the BNSSG system will operate to deliver elective care to all patients, 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 and at a minimum include information about the department and speciality the communication relates to (be that for example, about an appointment offer or change to booked appointment) and where possible, the clinician or clinical team and procedure (if applicable).

Providers will ensure that patients receive information in formats that they can understand and receive appropriate support to help them to communicate (see Accessible Information Standard 2015 NHS England » Accessible Information Standard).
It is important that information about a patients' communication needs is shared by the GP to the acute provider at the point of referral and the Providers should also ask patients about any communication needs they have or support they need, and this should be recorded on the PAS.

### 7.1 Unsuccessful contact attempts and non-response

Patients may be contacted by a partial booking or 'invite to call' letter, or by telephone to book their appointment. All attempts to contact a patient, guardian or carer will be documented clearly and concisely within the patient's health record[12].

If by phone call, and a patient cannot be reached by the initial phone call, two further attempts on different days at different times (ideally one out of hours) should be made to contact the patient. If the patient still cannot be reached a partial booking or 'invite to call' letter should be sent after the first phone call attempt, giving the patient two weeks to make contact to book their appointment. If the patient does not make contact within those two weeks, it may be clinically appropriate to discharge back to the referrer.

If by letter, the partial booking or 'invite to call' letter will provide information on how and by when a response is required. The letter may ask the patient to make contact by QR code or telephone to book their appointment, noting that some appointments in specialist areas can only be booked by telephone when speaking with the patient/ guardian/ carer directly. Otherwise, if possible, the provider may book the appointment by letter if they have received the response from the patient within the specified timeframe requested. Therefore, if a patient responds to the letter that they would like to be booked in for their appointment, they should be contactable by telephone to arrange this within the week (5 working days) that follows this. If the patient advises that they still require their appointment and cannot be booked in by letter, the provider will make at least two attempts to call and arrange the appointment by telephone. Attempts to contact the patient will be made on different days at different times (ideally one out of hours). The provider will ensure they have made reasonable attempts to contact the patient by telephone, where booking by letter is not possible. These attempts should be documented within the patient's health record.

If the patient is not contactable, to enable the provider to book them into a clinically appropriate slot, and has not advised by text, email or voicemail that they will be uncontactable, the provider may review that it is clinically appropriate to discharge the patient back to the referrer. The patient, GP and referrer should be notified of this.
N.B. If the patient is discharged as non-contactable and if the procedure is still clinically required, the referrer may be required to re-request the referral or procedure but this re-request should only be made once the referrer has discussed with the patient and they have agreed to attend. Any re-referral would usually generate a new waiting time, as the provider has made reasonable attempts to contact the patient and book them according to the previous request.

Paediatric patients and patients who are vulnerable for any reason that has been identified to the provider at the point of referral, may be contacted by letter for a second time after the first non-response, in a further attempt to book them for their requested appointment or procedure.

Please see provider SOPs for specific details of methods of contact.

## 8 PATIENT GROUPS

### 8.1 Patients transitioning from paediatric to adult services while on the waiting list

Patients who are referred appropriately into paediatric services[13] (age between 0-15 years), but who transition from childhood to adulthood whilst waiting, should be accepted and seen

[12] A patient may also receive communications through digital means – for example, by email, text or through the patient app.
[13] This also applies to mental health pathways such as those for ADHD / autism and CAHMs.

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 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. In most cases paediatric patients should be transitioned to adult services prior to their 18th birthday, and as soon as practical and possible following their 16th birthday.

### 8.2 Vulnerable Patients and patients with additional care and support needs

It is essential that patients who have additional care and support needs or are vulnerable for any reason have their needs identified at the point of referral. This should be clearly identifiable in the referral information received. This group of patients might include, but is not restricted to:

a) People with learning disabilities
b) Autistic People
c) People with a Severe Mental Illness
d) People with physical disabilities or mobility problems
e) People with dementia
f) Elderly or frail people who require community care
g) Children (as defined in The Children Act (2004)[14].
h) People experiencing homelessness
i) People that are refugees
j) Detained Estate patients

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

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

[14] 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.

law, if the adjustment is reasonable, then it should be made. Examples of reasonable adjustments may include:

- Adjusting waiting times to acknowledge that additional time will be required to ensure reasonable adjustments are met.
- 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.

### 8.3 Detained Estate Patients

All elective standards and rules are applicable to prisoners. Delays to treatment incurred as a result of difficulties in prison staff being able to escort patients to appointments or for treatment do not affect the recorded waiting time for the patient.
Providers will work with staff in the prison services to minimise delays through clear and regular communication channels and by offering a choice of appointment or admission date in line with reasonableness criteria.

### 8.4 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 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 means that the Trust can meet 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.

### 8.5 Private Patients

Patients can choose to move between NHS and private status at any point during their treatment without prejudice.

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

Private patients wishing to transfer into the NHS, must first obtain a referral that demonstrates that patient is eligible for NHS referral and that there has been provision of appropriate choice[15]. Criteria Based Access and Prior Approval policies apply and should be reviewed and confirmed before a referral is made. All of the above is the responsibility of the referring consultant.
The RTT clock starts at the point the referral is accepted into the NHS.

[15] It has been raised during the review process v.14/14.1 that in addition to patients wishing to transfer from private to NHS status during a pathway, there may be referrals private GPs want to initiate. Referrals should be made through the commissioned referral route i.e. e-referral ERS (or the agreed, designated referral pathway if e-referral is not available for the required service), but we are aware that private GPs do not have access to eRS currently. While this is considered further referrals indicated by a private GP will need to be made via a NHS GP.

On receipt of the referral the patient will be treated according to their NHS clinical priority, as a new referral in outpatients or placed on a waiting list for investigations.
Patients transferred from private providers are not given priority to earlier treatment and cannot avoid required steps on the care pathway even 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 a referral is made.

**8.6 Overseas Patients**

Providers will ensure they assess patient's eligibility for NHS care in line with the Guidance on implementing the overseas visitor charging regulations
NHS cost recovery – overseas visitors (publishing.service.gov.uk)

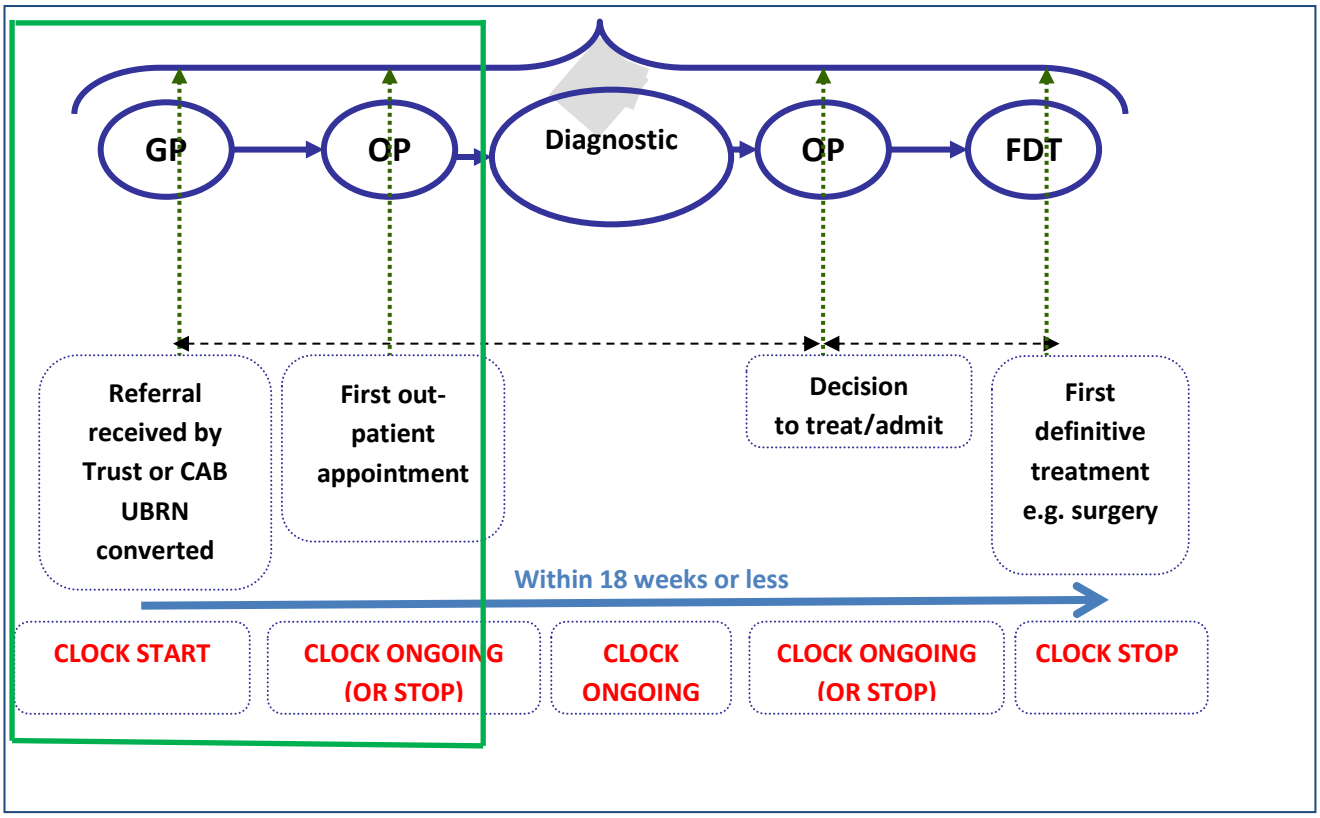
# Section Two
# Pathway Specific Principles

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

- First Outpatient Appointment
- Diagnostics
- Treatment decision
- Treatment

Providers should 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.

## Section 2 a) Referral, Outpatient Booking and Appointments




## 9 REFERRAL

### 9.1 Pre-Requisites Prior to Referral

- **Primary Care and other referrers –** In line with national RTT rules, before patients are referred, all referrers (usually but not limited to, General practitioners (GPs), Consultants and Professions allied to medicine) should ensure that patients are ready, willing, fit and able to attend for any necessary outpatient appointments and/or treatment and that they explain to the best of their knowledge the implications of any surgery or other treatment which may be necessary. Please refer to section on vulnerable groups and other patient cohorts to ensure communications are accessible and fully comprehensible by the patient.
- **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. If referral is directed to the wrong clinic, the hospital will try to amend this where possible, or if they are unable to, they should contact the Referral Service to action as needed.

- The management teams should also inform the Referral Service and Remedy Team of any changes to the DoS and ensure that this is in keeping with existing referral pathways across BNSSG.

## 9.2 Referral Sources

### 9.2.1 Primary and Community Practitioners

Referrals into Secondary Care come from various sources, including although not limited to community and primary providers (e.g. GP, optician, approved AHP).
Within BNSSG referrals may also be received from Services, such as through the MSK Interface.
For some services there is also the functionality established for Advice and Guidance requests to be converted to referral.

### 9.2.2 Consultant to Consultant Referrals

It is appropriate for onward or consultant to consultant referrals when a consultant or member of their team determines that the opinion of another consultant/service should be sought. It is expected that the consultant will complete the referral when: -

- The onward referral is for the same presentation/symptom as the originating referral or is directly related to the condition for which the original referral was made. This could also include a manifestation of the originally presenting condition, a side effect of drugs or treatment, or a complication of surgery or treatment.
- The patient has an urgent, immediate need for an investigation or treatment (for e.g. urgent suspected cancer, life or organ threatening, function reduction/loss, significant disease progression affecting prognosis/outcome)
- A pathway of care was critically dependent on it (e.g. a new murmur/heart failure detected by a surgeon pre-operatively)
- The referral prevents an urgent admission.

A new, non-related condition not fitting criteria above should be communicated in a letter back to the patients GP detailing this opinion so that the patient and their GP can agree 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 in accordance with local guidance on Remedy, and exercise caution of recommending referrals to other services.

### 9.2.3 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 and should only be sent via secure email, for example nhs.net email, to protect the confidentiality of the patient information within.
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.
Exceptions may apply in certain circumstances, and it may be appropriate for the BNSSG Referral Service to support and generate onward referrals through the NHS e-Referral system as a result.

### 9.2.4 Referral Service (RS)

The BNSSG Referral Service (RS) supports GPs and practices with optimising the best referral pathways and referral advice for their patients whilst adhering to local and national NICE guidelines and ICB funding policies. RS help referrers to navigate through the referral processes and ensures patients are given choice where they wish to be treated. The RS support to referrers helps to maximise the Getting It Right First Time (GIRFT) principles, ensuring only complete and appropriate referrals reach secondary care.

Referrers must ensure a full data set is provided when referring.

All referrals on an RTT pathway will start the RTT clock at the point the referral is converted into an appointment or added onto a waiting list.

## 9.3 Referral Methods

Unless by local agreement with the ICB, all referrals from primary care to a consultant led clinic must be completed using the NHS e-Referral System. The only exception to this is prison referrals which are still paper based. It is expected that prison referrals will move to eRS in 2024. There are currently three recognised methods of referral for non-cancer referrals as described below:

- **E-referrals -**Trusts will endeavour to give patients their choice of site within their Trust where this is available, however, 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.
    - BNSSG also offers several Referral Assessment Service (RAS) and A&G services, and for a subset of the latter functionality to convert to referral has been established. 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.
- **Directly Bookable Services –** Directly Bookable Services (DBS) via eRS enables the GP to book the first outpatient appointment slot whilst their patient is in the practice or will give the patient a Unique Booking Reference Number (UBRN) and a password so the patient can contact The Telephone Appointments Line (TAL) or go online to book a slot at /or select 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, where the clock starts at the point that the patient attempts to book directly and a slot issue is experienced, or when the referral has been sent on from a Primary Care Interface Service, when the referral should be treated as an Inter-Provider Transfer.
- **Indirectly Bookable Services –** GP referrals booked under the Indirect Booking rules are 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.

### 9.4 Referral Criteria / Minimum Data Sets

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 and sufficient clinical data to enable the appropriate appointment to be arranged. The letter should also state the patient's current drug regime, clinical question to be answered and significant past medical history and where the patient was previously treated if applicable. It is important that the referral clearly articulates any vulnerabilities, communication needs of the patients or reasonable adjustments required.

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.
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, however, if the consultant does 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.

### 9.5 Interventions Not Normally Funded (INNF), Exceptional Funding Requests (EFR), Prior Approval (PA) and Criteria Based Access (CBA)

Funding Approvals should be secured prior to referral to secondary care for assessment and treatment for the majority of treatments or conditions that require funding. There are 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.
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. The current list of INNF Procedures which are part of the contract schedule agreed between providers and details of BNSSG policies can be found here Commissioning Policy Directory – 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[16] 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.

It is recognised that there are routes to referral that bypass Referral Service, where checks against funding are typically conducted. For example, the 'convert to refer' function in Advice and Guidance. When this occurs the "Who Applies for Funding" guidance published on the ICB website Exceptional Funding Requests (EFR) Guidance: Who Applies for Funding? – NHS BNSSG ICB, should be followed.

[16] Note - Choice only applies for patients registered with an English GP practice – so Choice would not apply in Welsh/Scottish/NI cases.

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

### 9.6 Expediting Referrals

A patient may request their referral expedited. Requests from patients to expedite referrals that do not meet the below scenarios or circumstances should be politely declined, and the patient advised that this will not speed up the process.

Expedition of a referral may be required if a patient has been referred and is waiting to be seen but symptoms have significantly deteriorated. In such cases the referrer should consider the following actions in the first instance:

- If symptoms develop that could indicate a diagnosis of cancer, then the referrer should consider a referral on an appropriate Urgent Suspected Cancer pathway.
- If there are new symptoms that could possibly be managed in primary care, consider using advice and guidance services (if available). Advice and guidance should be requested from the provider where the patient has been referred or where they are on a waiting list. Advice and guidance should not be used to directly request that an appointment is expedited.

If the above options are not appropriate, the referrer should email or write to the provider directly explaining why the referral should be expedited and include a copy of the original referral to help the clinicians in hospital triage appropriately.

Referrers should not send a new referral on e-RS. This creates a duplicate referral, resulting in additional administration and paradoxical delays in patient care (e.g., multiple appointment dates, patient confusion and DNAs). If this is noticed during the triage process, the duplicate referral will be returned.

In cases where a patient is already under the care of a hospital, including those under lifelong follow up, and there are concerns that a condition or symptoms have significantly deteriorated and expedited follow up may be required, a patient can contact their consultant via the consultants secretary. Alternatively, if the patient reaches out to their GP or originating referrer, the GP/referrer can send a letter directly to the patients named clinician secretary as detailed on previous communication/clinic letters. This communication should clearly state the clinical reasoning for the required expedition. The consultant will review the information to determine whether the follow up requires expediting.

Patients who have health inequalities and who are likely to be at increased risk due to a significantly delayed appointment may also be suitable for an expedited appointment. In such circumstances, a letter should be sent to the patients named clinician secretary as detailed on previous communication/clinic letters, clearly stating the circumstances.

## 10 Clinical Assessment / Triage and Booking First Appointment

Referrals should be clinically assessed or triaged to ensure patients are clinically suitable and received by the most clinically appropriate service. It is good practice to assess/triage all referrals, unless there are clear guidelines and evidence that demonstrates patients are all typically referred correctly first time.

If a referral is addressed to a named consultant, the referral may be held within their team, rather than guaranteed to the consultant named. If the consultant no longer works with the provider, the referral will be allocated to another appropriate clinician.

### 10.1 First Appointment

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.

Patients may be contacted by phone or receive a letter to arrange their appointment. A patient can use the Telephone Appointments Line or go online to make their appointment, or

select their preferred provider if appointments are not available, using their Unique Booking Reference Number (UBRN) and password via the NHS eReferral Service.

It is essential that sufficient appointment capacity is available to book patients within their clinical priorities and specialty specific milestones for first appointments. 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 Provider's sites. Should a patient accept an appointment less than three weeks into the future, this becomes a reasonable offer.

### 10.2 Appointment Slot Issues (ASIs)

If booking via eRS is not possible due to lack of capacity, the UBRN will be directed to the Provider 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 contact the patient to offer an appointment.

### 10.3 Outpatient Appointment Changes

- **Hospital initiated appointment changes** – There may be circumstances when a provider needs to change an appointment. Every effort should be made to avoid this, however, when it is unavoidable the patient should be contacted and informed, with an apology and rationale for the cancellation explained. The patient will be contacted to arrange an alternative appointment date and time. If the cancellation is within two weeks of the appointment date, the patient should be informed of the cancellation by telephone by the relevant hospital team. In the event of a hospital-initiated cancellation, the patient's RTT clock continues to tick from the original referred received date.
- **Patient Initiated Changes for Appointments –** If a patient chooses to reschedule their outpatient appointment, their RTT clock should continue to tick, even if they wish to reschedule their first appointment following initial referral. When a patient cancels an appointment, a provider will contact the patient to understand the reasons. The reasons for cancellation will inform whether the patient is offered another appointment and may also inform a clinical review, if this is required. The provider will ensure the next steps are in the best interests of the patient. This may be rebooking, active monitoring, patient-initiated follow-up or may be discharge back to the referring clinician. If a patient is discharged following multiple reasonable appointment refusals, cancellations, missed appointments or prolonged periods of non-engagement, the provider will ensure that a discharge letter is sent to the referrer/GP and copied to the patient.

## 11 CLINIC ATTENDANCE AND OUTCOMES

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

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.

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.

### 11.1 Follow Up Appointments

Patients who require an appointment within six weeks should be fully booked prior to them leaving their outpatient appointment.

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 (SOP) 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 term 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).

## 12 Missed Outpatient Appointments

### 12.1 First Appointment Following Initial Referral DNA

When a patient misses a first appointment, the RTT clock is stopped and nullified[17] (Rule 5e), if the Provider can demonstrate the appointment was booked in line with reasonableness criteria and communicated in a way that meets the patients' needs.

It is important to consider vulnerable groups as part of this process – including, but not limited to those with a Learning Disability, experiencing homelessness, from a Traveller Community, or with a severe mental health diagnosis.

In paediatric services, any missed appointment should be reviewed by the clinician and consideration should be given as to whether the patient requires a further review (considering safeguarding principles and practices).

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. If the patient is unable to book an appointment due to capacity pressures or lack of available appointment slots, the clock should start when there is a decision to add the patient to a waiting list as an alternative to booking their appointment.

### 12.2 Subsequent (follow-up) appointment DNAs

The RTT clock stops if there is assurance that the appointment was booked in line with the criteria listed in the RTT rule suite and that the clinician indicates that it is in the patient's best clinical interests to be discharged back to their GP/referrer.

The RTT clock continues if the clinician indicates that a further appointment should be offered.

If the subsequent DNA is within a support service e.g. pre-operative assessment and or diagnostics, the decision for rebooking should be made by the requesting clinician.

In paediatric services, any patient DNAs should be reviewed by the clinician and consideration should be given as to whether the patient requires a further review (considering safeguarding principles and practices).

[17] Note - nullification only applies where a patient DNA a first appointment and does not apply to follow up appointments.

Any patient who does not attend their agreed appointment (new or follow up) may be discharged back to the care of their GP. Both the patient and GP will be notified 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:

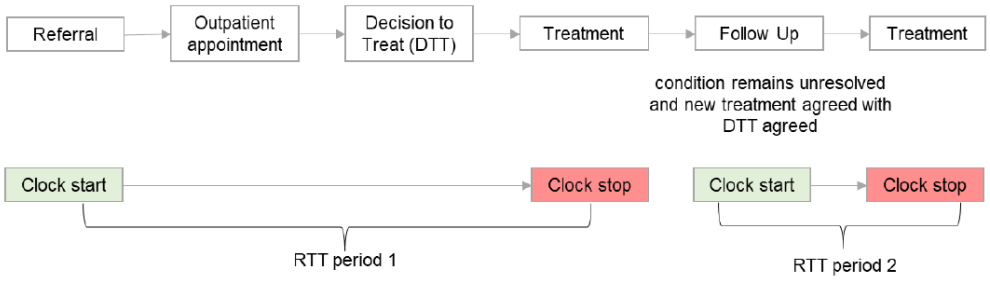
- When a clinical decision is taken that discharging the patient is contrary to the patient's clinical interests
- Clinically very urgent referrals including cancer, or active surveillance for cancer, rapid access chest pain, and other critical illnesses.
- Children[18] of 18 years and under or vulnerable adults.
- When one of the following can be confirmed:
    - If the patient did not receive the letter/ digital notification of the appointment including the appointment being sent to incorrect patient address / contact number
    - The appointment was not offered with reasonable notice.
    - If reasonable adjustments or patients' needs have not been supported – for example, accessible communications, translation, transport needs.

Where circumstances were beyond the patient's control, the Provider will endeavour to be as flexible as possible. The patient must first be contacted to ascertain the reasons for their missed appointment and supported, where required, to attend a rescheduled appointment. For paediatric patients after the reason for a missed appointment (also sometimes referred to as 'Was Not Brought') 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.

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.

## 13 Multiple RTT Periods on the Same Pathway

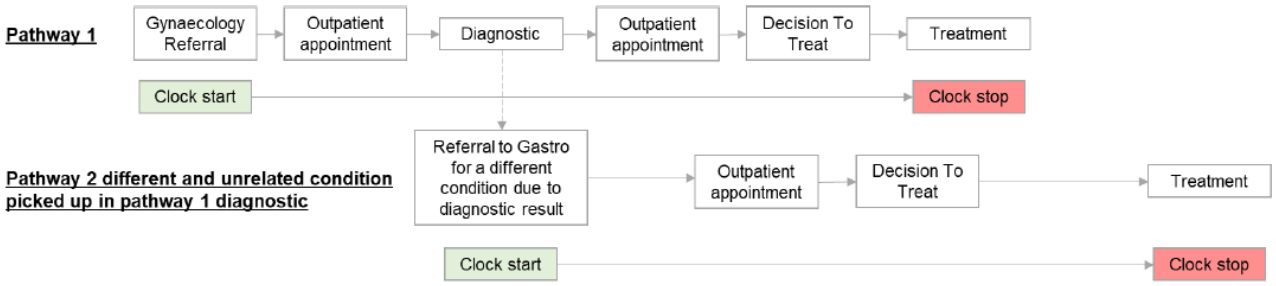
A patient can have multiple RTT periods along one patient pathway with the same original referral. This is where it relates to the same underlying condition (e.g.: chronic or recurrent) where the patient pathway will continue beyond the point at which first definitive treatment starts, as it will include further treatment for the same condition. In this instance the RTT clocks are not concurrent and instead sequential following one after each other as new treatment decisions and plans are made. There may also be some periods of active monitoring between these decisions.




[18] 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.

## 14 Multiple RTT Pathways

Where a patient has more than one referral for unrelated clinical reasons, each referral will have its own patient pathway and separate RTT clocks. It is important to understand any impact on the management of their different conditions, for example where treatment for one condition affects the planning of another treatment, or where a period of recovery is needed before undergoing treatment for another condition. Clinical and operational teams should implement co-ordinated care pathways as appropriate for patients on multiple pathways. There may be cases where it's appropriate for a period of active monitoring to be agreed on one pathway while the patient undergoes and recovers from treatment on another pathway that's considered to be the clinical priority.




## 15 Clinic Management

### 15.1 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.

### 15.2 Outpatient Clinic Capacity

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

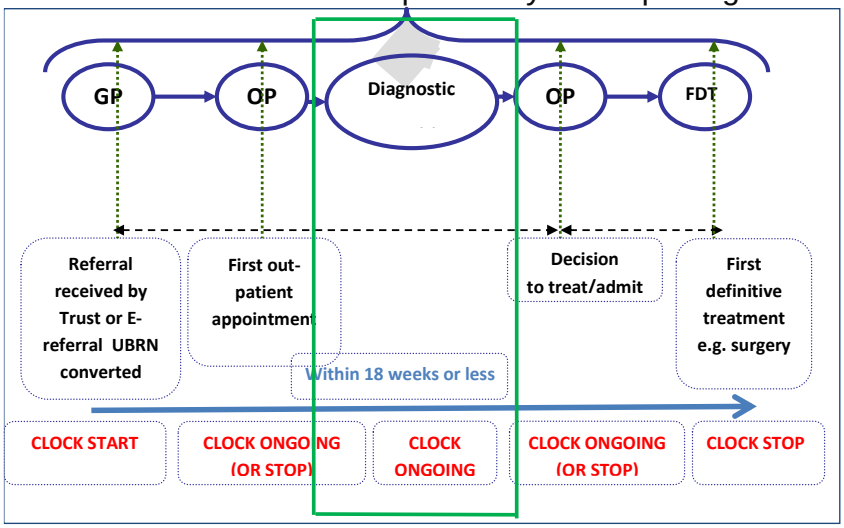
## Section 2 b) Diagnostic Pathways

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 for a diagnostic test and ends on the completion of the diagnostic procedure, or if the patient is removed from the active waiting for another appropriate reason, e.g. the procedure is no longer required or declined by the patient. The diagnostic scan or procedure should be completed within 6 weeks of the request being made, unless otherwise specified, e.g. patients planned to be seen beyond 6 weeks in a specific month and year. The scan/ procedure report is to be completed and made available to the referrer after the procedure or scan is completed, according to the clinical urgency of the request. For example, tests that are requested or deemed to be clinically urgent have a quicker reporting turnaround time than routine test reports. Similarly to the diagnostic test prioritisation, reporting turnaround times are prioritised by clinical and then date order. Therefore, referrers should request a diagnostic test or procedure as soon as they know it is required and the patient is fit, willing and able to attend, to avoid any delay within the patient's wider pathway. In general, a diagnostic test or report cannot be

expediated ahead of other clinically urgent patients, for non-clinical reasons, but services will aim to complete diagnostic tests and reports as soon as possible within the appropriate timeframes requested, triaged and in date order.
Patients waiting for two or more separate diagnostic tests/procedures concurrently should have independent waiting times clocks for each separate test/procedure. However, if multiple procedures/tests are to be completed within the same appointment, then these requests will constitute as one wait. For example:

- Patient requires a colonoscopy and an MRI scan – these would be two diagnostic requests with two waiting times as per their respective request dated.
- Patient requires a gastroscopy and colonoscopy, and these are requested to be completed within the same appointment/session, sometimes referred to as a 'top and tail' endoscopy. These procedures would be classed as one wait as it has been requested in the patient's best interest to have the procedures in one session.

Where a patient is referred to another provider for a diagnostic test whilst on an active RTT pathway, the host trust will retain overall responsibility and reporting.




## 16 National Diagnostic Clock Rules

All patients referred for a diagnostic test that is not planned or part of a screening programme are expected to be dated within 6 weeks of referral.

- Diagnostic clock start: the clock starts at the point of the decision to refer for a diagnostic test by either the GP or the consultant (day 0).
- Diagnostic clock stop: the clock stops at the point at which the patient undergoes the test.

Patients referred for planned diagnostics must be offered a date by their due date, patients that are not dated by their due date will have a 6-week clock started on their due date.
If a patient declines a reasonable offer, cancels an appointment offered with reasonable notice or misses an appointment offered with reasonable notice the diagnostic 6 week waiting time clock can be re-set to zero and the waiting time starts again from the date of the appointment declined, cancelled or missed. This has no effect on the RTT clock and so all patients should be offered the next available appointment.

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.

## 17 Diagnostic Patients

The diagnostic stage of the pathway can be the start of an RTT clock (e.g. Straight to Test - 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 referrer should ensure that the patient is fit/able, willing and ready to attend their diagnostic procedure within this timeframe, at the time of the request being made. If the patient is not ready, able or willing to attend, then the referrer may choose to either delay requesting the diagnostic procedure until the patient's circumstance change, or request for the procedure to be completed at a planned date in the future. For example, if a patient is undergoing an operation which requires a recovery period, the patient should be referred once they are fit to attend, or the referrer can request for the test to be done at specific date in the future – a specified month and year is required for such requests. If a future planned date is not requested, the trust will aim to book the patient within 6 weeks of the request date, appointment offers will be made with reasonable notice.
A patient may commence on a 6-week diagnostic or a planned wait and their circumstances may change to either delay their procedure, remove the planned waiting time and bring the patient in sooner. In all cases, such changes must be subject to agreement with either the referrer or a clinician reviewing triaging/vetting the procedure. Even if requested by the patient, the change request must be agreed by a clinician before the change is actioned on the patient's record. All changes should be clearly and concisely recorded on the patient's PAS record for reference and validation. For example:

- Patient is requested to have a scan within 6 weeks (i.e. their active diagnostic wait has commenced from completion within 6 weeks), but their circumstances change and they request to be delayed for 3 months – this request must be approved by the referrer or another clinician. Only once this is completed and agreed should the patient's PAS record be adjusted according to this review.
- Patient is on a planned or pending pathway for a procedure in 1 years' time – but it is requested that the patient is seen sooner. This request must be approved by the referrer or another clinician. Only once this is completed and agreed should the patient's PAS record be adjusted according to this review. Once this decision is made by a clinician, that the patient is to be seen sooner then either their planned admission should be adjusted on PAS, or an active clock is started from the date of the decision to complete the diagnostic test within 6 weeks.

If a patient/ carer or guardian requests for a change in timescale from that requested or vetted on their diagnostic request, they should be advised that this will be reviewed by an appropriate clinician and actioned if/ once agreed. This should be noted clearly and concisely on the patient's PAS record.

### 17.1 Straight to Test

'Straight to Test' is used by a GP where there is an expectation that the patient will receive a further review 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.

### 17.2 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 and therefore the GP

should ensure the patient is contactable, fit, able and willing to attend within 6 weeks of the request being made. If the patient is not able to attend, the GP should defer referring the patient until such a time that they are able to attend.

### 17.3 Open Access Diagnostic Requests

Open access requests are not suitable or available on all pathways or for all tests. But there are some diagnostic requests which are requestable by a GP or Clinician as 'open access'. This means that referrer will request the diagnostic test as per agreed BNSSG referral pathways, but the clock specifically starts once the patient has initiated the referral and contacts the provider to arrange their procedure. It is the requester's responsibility to ensure the patient understands the open access pathway, and that they are fit, able and willing to attend as per the clinician's request. This type of request is not widely used in every modality and should only be used by referrers if within the agreed clinical pathways for that specific procedure type/modality, and suitable to the patient's clinical circumstances, i.e. that a procedure or scan is required at a certain point in time that is only known to the patient (e.g. day X in their menstrual cycle).

Once the patient has contacted the provider, the active waiting clock starts and the patient should be seen with 6 weeks of this date, and/or as per the clinician request. The same diagnostic rules will apply for reasonable notice offers, patient choice resets for appointments that are declined, not attended or cancelled by the patient. If the provider cancels the patient's appointment, the clock does not reset and the patient should be booked in to be seen as soon as possible within their ongoing waiting time and as per the request.

N.B. inappropriate or incorrect open access requests will be returned to the referrer for re-request under the correct pathway, if still required. In such cases a new waiting time will start with the new/ corrected request.

### 17.4 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 date 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 (and from this point are no longer 'exempt' from the diagnostic clock rules).

If the planned diagnostic is related to one of the 15 DM01 modalities, and 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 of becoming overdue. However, even if it is not a DM01 test, the same diagnostic principles apply for booking, cancelling, resets etc to non-DM01/ other diagnostic pathways.

The Provider should book the patient in for their planned procedure as per the clinical request i.e. for the date or month/year requested. Clinically planned procedures and the expected date/ month year that the patient is due should be clearly documented on the patient's health record as per the diagnostic request or any subsequent clinical reviews or triage. Evidence of any clinical review/triage should also be documented on the system/ patient's record, ideally within the specific diagnostic test listing/entry.

### 17.5 Diagnostic test/procedure requests which cannot be acted upon as per the clinician's initial request

Requests that do not align to the agreed BNSSG clinical pathways or are missing vital information which means that the provider is unable to book the patient, may be returned to

the referrer. This should be completed by the receiving provider without undue delay, with the reasons clearly stated.

In most cases, if the diagnostic test/procedure is still required, a new diagnostic test request will be required (generating a new waiting time). However, if minor (but critical) information clarification is required, the provider will request this clarity from the referrer – which must be received within 2 weeks of clarification being requested. If not received, the request will be returned to the referrer since the provider is unable to book the patient as requested without this critical information. N.B. even if clarification is requested, the active diagnostic waiting time/clock continues and does not pause or reset. Therefore, if the information is received within 2 weeks/ 10 working days, then the patient should be booked in as soon as possible as per the request information received so that they are still seen within 6 weeks of this request.

If the diagnostic request is for a planned procedure – the same process should be followed, and the patient should only be put on a planned or pending wait once all relevant information is received. If the critical information is not received after the 2-week clarification window has passed, then the request may be returned to the referrer.

This should all be documented clearly and concisely on the patient's health record on the procedure's listing/ entry. Referrers should be advised why the request has been returned to them.

***Additional Items to note***:

- Some diagnostic tests will be undertaken on an admitted basis.
- Patients who are referred for diagnostics as part of an RTT pathways need also to be seen within the current diagnostic waiting time.
- Providers should work to establish one-stop appointments with outpatient and diagnostic elements occurring concurrently wherever clinically appropriate.
- Patients should only be added to the planned waiting list where this has been clinically requested by the referrer or approved by the referrer or a clinician. This also may occur if the patient's clinical circumstances have changed since the original request was made and a clinical review is undertaken to agree the new planned date for the procedure.

## 18 Diagnostic Appointment Offers

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, however this should be documented within on the request listing.

There are different approaches to booking in diagnostic pathways. Diagnostic appointments may be booked by letter, without speaking with the patient. These will be booked with reasonable notice and the patient will have the option to contact the Provider to rebook if needed. Patient requests for specific day/ times will be offered wherever possible, noting that some appointment types are very specialist and can only be performed on certain lists on certain days.

NHS diagnostic tests within BNSSG are delivered in various NHS and agreed non-NHS locations. These may be booked by an NHS provider, or another provider that is working in

collaboration with the Trust/s where the test has been requested, as BNSSG providers are endeavouring to ensure that patients do not wait longer than needed for their appointments.

Patients will be offered a choice of location – only if this is available for the diagnostic test/ procedure requested. All appointments, regardless of location, should fulfil “reasonableness” criteria. The provider will endeavour to offer the patient a reasonable appointment at the location with the shortest wait. If the patient declines this location with reasonable notice and chooses to be seen in another location which may have a longer wait, the patient’s diagnostic waiting clock will reset from the reasonable notice offer that they have declined, cancelled or not attended. Generally, unless the patient has declined to be seen in a specific location, they will be rebooked to the same location, unless there is a shorter wait elsewhere within BNSSG. Please refer to the BNSSG Remedy pages for up-to-date details on where tests/procedures types are completed for each DM01 modality within BNSSG.

If a patient is clinically unsuitable or unable to attend in a certain location, e.g. due mobility or transport needs, this should be clearly stated within the original request. This will prevent the provider offering appointments which are unsuitable for the patient’s needs. If the patient advises the provider of such needs in retrospect – for example if their circumstance have changed since the request was made – especially for planned procedures, the provider/s will make every effort to ensure that the patient is not delayed unduly.

Some diagnostic appointments are more complex or need to be booked within certain criteria and therefore can only be booked by telephone with a letter sent to confirm the agreed appointment, if required. In some cases, the provider will call the patient to book their appointment – this call may be from a withheld number. If the patient cannot answer the call, then if available, a voicemail will be left requesting the patient to call back. If the patient does not answer, then a partial booking or ‘invite to call’ letter will be sent requesting the patient to contact within 2 weeks to arrange their appointment. If the patient does not respond to the partial booking or ‘invite to call’ letter by telephone or QR code within 2 weeks, then they may be discharged back to their referrer as appropriate. A discharge letter should be sent to the referrer and copied to the GP and patient.

A minimum of one telephone call and/ or partial booking or ‘invite to call’ letter will be sent to the patient to offer them appointments with reasonable notice. Additionally, the provider may also make up to 2 further phone calls on different days and times to try and reach the patient (ideally one out of hours). All telephone attempts to reach a patient should be recorded on the clearly and concisely on the patient’s health record.

## 19 Patient Initiated decline, cancellation or missed diagnostic appointment

If a patient declines, cancels or does not attend a diagnostic appointment made with reasonable notice, the diagnostic ‘clock’ waiting time resets and starts again from the date of the appointment that the patient declined, cancelled or missed.
Reasons for cancellations will be recorded where these are provided, the provider will endeavour to make reasonable contact with the patient to understand why they did not attend their appointment and rebook them if appropriate.

If a patient chooses to reschedule their diagnostic appointment, their RTT clock should continue to tick.
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.
Patients who state that they do not wish to receive a diagnostic test will have their request removed and returned to their referrer. Their diagnostic clock will be stopped. A letter should

be sent to the referrer and copied to the GP and patient advising them of this action and the reason. If after further discussion with the patient, the referrer or GP still requires the patient to have their diagnostic procedure and the patient agrees, then a new diagnostic referral will be required and a new diagnostic clock from this request will be started. If the patient has refused/ declined the procedure, the patient should not be re-referred without further discussion and agreement with them. Any associated RTT clock will continue.

## 20 Hospital initiated cancellations on diagnostic pathways

Hospital/ provider-initiated cancellations i.e. cancellations that are not specific to the patient being unable or unwilling to attend, are not reset. Reasons may include equipment unavailability/ breakage, staff sickness or another provider related matter. When a provider cancels an appointment, the diagnostic wait/ clock continues and the provider should make every effort to rebook the patient as soon as possible within the ongoing diagnostic clock. No action is needed from the patient, GP or referrer to initiate this.

This applies to all NHS patients on diagnostic pathways, regardless of which NHS or non-NHS location the patient was booked to. Generally, the patient will be rebooked to the same location, unless there are suitable appointments with shorter waits available elsewhere within the BNSSG area.

## 21 Subsequent Diagnostics

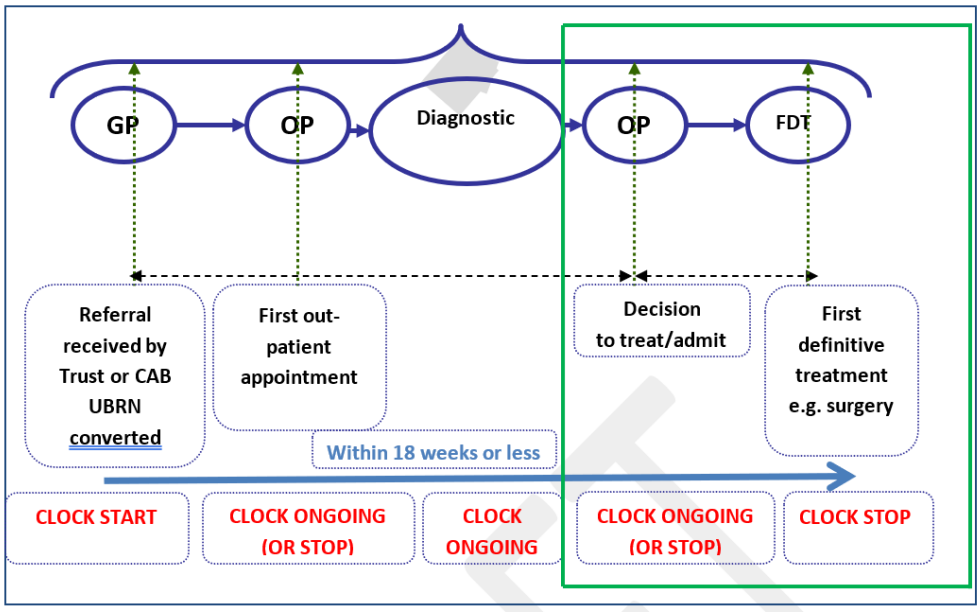
Where the patient has received first definitive treatment for a condition they were referred for and a subsequent new treatment plan is agreed following the result of a 'check' diagnostic, a new RTT pathway/clock should commence. A new diagnostic pathway/ clock may also commence for any follow up diagnostics. Follow up diagnostics may occur with a new diagnostic clock (i.e. to be completed within 6 weeks of the request) or, for a future clinically planned date as per request or triage – the requested date/ month and year should be clearly documented on the diagnostic referral.
N.B. This differs from NHS patients that have been referred to the NHS from their GP or another NHS referrer for diagnostics but may receive their diagnostic test/procedure in an independent sector/ private provider location as an NHS patient on an NHS referral.

## 22 Private Patients Transferring into the NHS at the Point of Diagnostics

Patients can choose to move between NHS and private status at any point during their treatment without prejudice.
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 a referral into the NHS. This is the responsibility of the referring consultant. 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.

## Section 2 c) Decision to Admit

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




## 23 Decision to Admit

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

- There is a sound clinical indication for surgery.
- The patient is clinically fit, ready, willing, able and available to undergo surgery[19].
- The requirements of the INNF list have been complied with in terms of funding approval or meeting criteria as set out 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.

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.

## 24 Patient Thinking Time

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

[19] Aligned to the national commitment to strengthening perioperative care pathways to support patients' preparation, BNSSG commits to progressing programmes of early screening, risk assessment and health optimisation for all adult service users waiting for inpatient surgery. NHS England » Earlier screening, risk assessment and health optimisation in perioperative pathways: guide for providers and integrated care boards

clinical discussion with the patient takes place where more than 14 days have passed without next steps being agreed.
Where a patient states that they do not anticipate deciding for a longer period, it may be appropriate to agree a period of active monitoring with the patient. This decision can only be made by a clinician and on an individual patient basis with their best clinical interests in mind.
(Note this section does not apply where patients choose to delay)

Further information can be located 4.4.1.4 and 8.3 Recording-and-reporting-referral-to-treatment-RTT-waiting-times-for-consultant-led-elective-care-v4-1.pdf (england.nhs.uk)

## 25 Adding Patients to the Admitted Waiting List

Patients must be added to the admitted waiting list within two working days of the decision to admit. From the point of adding the patient to the admitted waiting list, the patient transfers from a non-admitted pathway to an admitted pathway.
The active inpatient or day case waiting lists/PTLs includes all patients who are awaiting elective admission. The only exceptions are planned patients, who are awaiting admission at a specific clinically defined time. Adding a patient to the inpatient or day case waiting will either:

- Continue the RTT clock from the original referral received date.
- Start a new RTT clock if the surgical procedure is a substantively new treatment plan which did not form part of the original treatment package, providing that either another definitive treatment or a period of active monitoring has already occurred.
- Start a new RTT clock if the patient's previous clock had been stopped for active monitoring.

The RTT clock will stop upon admission.

### 25.1 Planned waiting lists.

Patients will only be added to an admitted planned waiting list where there is a clinical reason requiring them to undergo a procedure at a specific time or repeated at a specific frequency e.g.: such as a repeat colonoscopy.
The due date (sometimes locally known as Guaranteed Admission Date, GAD) for their planned procedure will be included in the planned waiting list entry. Patients on planned waiting lists will be scheduled for admission at the clinically appropriate time and they should not have to wait a further period after this time has elapsed.
When patients on planned lists are clinically ready for their care to begin and reach their due date for their planned procedure, they will either be admitted for the procedure or be transferred to an active waiting list and a new RTT clock will start.
Patients who require a diagnostic test to be carried out at a specific point in time for clinical reasons (such as for post-treatment surveillance) are exempt from the diagnostic clock rules and will be held on a planned waiting list with a clinically determined due date identified. However, if the patient's wait goes beyond their due date for the test, they will be transferred to an active waiting list and a new diagnostic clock and RTT clock will be started.

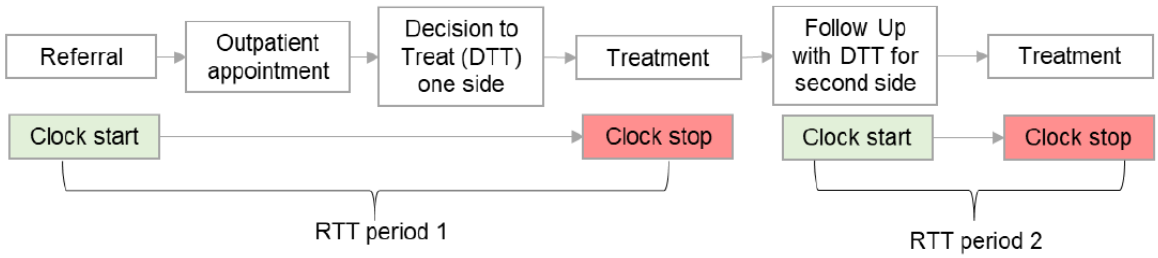
## 26 Patients requiring more than one procedure

Sometime patients require more than one procedure, these might be concurrent or sequential. This might be a result of a first and follow up procedure for the same condition or it might be a need for two procedures, related to the same condition but at different sites, such as cataracts in both eyes, for example.
Where the initial referral makes clear that there are two procedures required (i.e. two cataracts) the patient can be re-listed by the provider as described below. If the initial

referral does not, the patient should return to their GP after their first procedure, to ensure their right to choice is enabled for the decision of the provider for their second procedure.

If more than one procedure will be performed in the same scheduled slot 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) such as; first definitive treatment followed by a new decision to treat for a 2nd or subsequent treatment or bilateral procedures that are completed separately. This is an example of multiple RTT periods on the same patient pathway (see diagram below)

- 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.




Patients will only be put onto the admitted waiting list for one procedure at a time.
The RTT clock will stop when first definitive treatment for the first side begins. A second new clock starts once the patient is fit and ready to proceed with the second procedure.
NOTE: RTT clocks for bilateral procedures are sequential and not concurrent (nor listed as 'planned') as stated in Rule 3a.

## 27 Offering TCI dates and Listing Patients

Listing must be undertaken by selecting patients firstly by their clinical priority and then within chronological order of RTT wait time.
Patients must be contacted to have the opportunity to agree their TCI date. This may be by telephone or letter.
Patients should be offered two separate dates with at least three weeks' notice for day case or inpatient admissions. Where available, patients can be offered dates with less than three weeks' notice and if they accept, this then becomes a 'reasonable' offer.
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).

## 28 Patient Unavailability While on the Inpatient or Day Case Waiting list and Patient Initiated Changes

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.
Patient choice to delay their treatment should be accommodated if the responsible clinician agrees it is in their best clinical interest. An end date to their unavailability should be agreed with the patient and details of the dates that could have been initially offered should be recorded on the PAS. Patients can decline offers immediately during the telephone

conversation or cancel / decline at any point between initially accepting and the admission date itself.
Patients seeking longer delays, pending clinical review and agreement with the patient, might be appropriate for active monitoring and in such cases should be classified as with a C coding, as described in Addendum 2.

### 28.1Patient Initiated Reschedules of Admission Dates

If a patient has previously agreed to a 'reasonable' admission 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 Provider will actively engage with patients to establish reasons and to inform a clinical validation and review process to assess the appropriateness of the patient remaining on the pathway or whether referral back to the GP is more appropriate.

## 29 Pre-Anaesthetic and Pre-Operative Assessment

Elective Patients should be screened and risk assessed at decision to admit and optimised in line with trust guidelines prior to a pre assessment or anaesthetic assessment appointment. The purpose of these assessments is to ensure that all patients benefit from appropriate optimisation in order to reduce surgical risk.

Urgent and cancer patients should be offered optimisation advice where appropriate, however, these patients should be given a pre assessment appointment immediately a decision to admit is made.

- **Anaesthetic assessment**: - This assessment is required to ensure that patients with higher risk factors (due to co-morbidities or intended procedures) can be optimised and be involved in joint decision making with the clinician to ensure that all risks have been considered. Once the clinician declares the patient fit then a date for surgery can be given.
- **Pre-operative assessment (POA):** - This assessment takes place with a specialist pre assessment nurse to ensure that the patient is fit for the intended procedure.

For both assessment types the patient may be required to undergo further tests prior to being declared fit for surgery and the RTT clock continues while these are arranged.

All patients with a Decision To Admit (DTA) requiring a general anaesthetic will require a pre-operative assessment (POA) and/or an anaesthetic assessment. Where possible, urgent and cancer patients, should be made aware in advance of their outpatient appointment that they may need stay longer on the day of their appointment for attendance in POA.

### 29.1 Patients who are unfit for surgery or treatment

If the patient is identified as unfit for the procedure /treatment (irrespective of whether it is a day case, an inpatient stay or in a clinic setting*)*, the nature and duration of the clinical issue should be ascertained and should be managed dependent on the nature of their condition as below: -

- 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, cold, UTI or chest infection) the RTT clock continues, and the patient rescheduled when fit. Short-term period is defined as a period no longer than 2-3 weeks (i.e. no more than 21 days). Where appropriate this should be managed as part of the preoperative process,

unless in exceptional circumstances, referral back to GP is required for treatment of the Acute issue.

- Longer-term illnesses (longer term is defined as anything beyond 21 days) – If the clinical issue is more serious, such as a chronic or a long-term condition, and the patient requires optimisation and / or treatment for it, a clinical review should be carried out and clinicians should indicate next steps as per the following:
    - If the patient requires optimisation within secondary care or treatment for another condition or a period of recovery before proceeding, they should be placed on active monitoring.
    - If the patient is being optimised or otherwise managed within primary care they should be discharged back to the care of their GP (clock stop). Communication with the GP should provide information from the anaesthetist including an indication of what treatment targets or levels of control would be acceptable for the patient's condition.
    - If a clinical decision is made to stop the RTT clock for active monitoring, the patient's next steps should be agreed, including timescale for further review or follow up to assess the patient's condition. The pathway should remain visible on the relevant PTL or waiting list report to support ongoing management.

The clinical review and subsequent decision whether to proceed with these patients in such cases is the responsibility of the consultant anaesthetist and/or consultant surgeon.

## 30 Provider Cancellation of a TCI

### Cancellation by the provider for Clinical Reasons

If the TCI is cancelled because the patient is unfit for surgery, they will either remain under the providers care for optimisation or be discharged back to their GP. If the treatment is no longer required, the clock stops, and the patient should be referred back to their GP.

### Cancellation by the provider for Non-Clinical Reasons

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

If it is necessary for the hospital to cancel a patient's admission, 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 longest waiters.

## 31 Missed Admission Appointments

Patients who do not attend for admission will have their pathway reviewed by their consultant. If the patient's consultant decides that they should be offered a further admission date, the RTT clock continues to tick. Should the patient's consultant decide that it is in their best clinical interests to be discharged back to the GP, the RTT clock is stopped.

It is important that the patient has been given instructions of whom to notify and how if they subsequently cannot come in for their operation / procedure and that the letter clearly states the consequences of not attending for their appointment date.
Any patient who does not attend their agreed appointment (new or follow up) will be managed in line with Section 8.2 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[20] of 18 years and under or vulnerable adults.
- When one of the following can be confirmed:
    - If the patient did not receive the letter/ digital notification of the appointment including the appointment being sent to incorrect patient address / contact number
    - The appointment was not offered with reasonable notice
    - If reasonable adjustments or patients needs have not been supported – for example, accessible communications, translation, transport needs

Where circumstances are 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 their missed appointment and supported, where required, to attend a rescheduled appointment. For paediatric patients after the reason for a missed appointment (also sometimes referred to as 'Was Not Brought') 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.

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

# Section Three
# Cancer Pathways

Cancer Access Targets in BNSSG will be managed in accordance with the current national Cancer Waiting Times guidance, available at Cancer Waiting Times Data Collection (CWT) - NHS Digital. This national guidance is supported by the Southwest Cancer Access Policy. The Southwest Policy provides further clarity on complex areas of the national guidance and ensures that the rules are consistently applied across the Southwest region. The policy is signed off by the SWAG Cancer Alliance Board which includes the cancer leads from BNSSG commissioners and providers, as well as all by all Cancer Managers in the footprint. As such BNSSG providers and commissioners will follow the rules laid out in the national guidance and the Southwest Policy (available at Home - SWAG Cancer Alliance).

Where changes to the national guidance occur, should these contradict the Southwest 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
# Appendices and Addendums

## Appendix 1: 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.
**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)
**Advice and Guidance (A&G)** services in secondary care are available through eRS and provide primary care with access to specialist clinical advice, enabling a patient's care to be managed in the most appropriate setting, strengthening shared decision making and avoiding unnecessary outpatient activity.

**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. They 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.

**D**

**DNA – Did Not Attend -** In the context of consultant-led waiting times, this is defined as where a patient does not 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.

**E**

**e-Referral**
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.

**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.

**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.

**N**

**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.

**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 -** Reasonable' is a term applicable to all stages of the elective pathway and diagnostics also. It refers to specific criteria which should be adhered to when offering routine appointments and admission dates to patients to demonstrate that they have been given sufficient notice and a choice of dates. A reasonable offer is defined as a choice of two dates with at least three weeks' notice. Or if the patient accepts an offer with shorter notice, then this is also considered reasonable.
**Referral service -** Referral 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.
**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.

**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.
**Trauma Informed -** A Trauma-informed approach is based on a framework for human service delivery that centres on knowledge and understanding of how trauma affects people's lives, their service needs and service usage.

**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.

# Appendix 2: - INTER-PROVIDER TRANSFER ADMINISTRATIVE DATA TEMPLATE

**Referring Trust**

| | | | |
|---|---|---|---|
| Referring organisation name: | | Referring organisation code: | |
| Referring clinician: | | Referring clinician registration code: | |
| Referring treatment function code: | | Contact name: | |
| Contact phone number: | | Contact email address: | |

**Patient details**

| | | | |
|---|---|---|---|
| Surname: | | Local Patient Identifier: | |
| Forename: | | NHS Number: | |
| Title: | | Home telephone number: | |
| Date of Birth: | | Mobile telephone number: | |
| Correspondence address: | | Work telephone number: | |
| | | Email address: | |
| | | Is patient lead contact? | |
| | | Lead contact name if not patient: | |
| Postcode: | | Lead contact relation to patient: | |
| | | Does this patient have a need for language or interpreting? | Yes / No<br>(if yes, please include further details) |
| | | Does the patient have a disability or require reasonable adjustments to be made? | Yes / No<br>(if yes, please include further details) |

**GP details**

| | | | |
|---|---|---|---|
| GP name: (in full) | | GP Practice organisation code: | |
| Practice name: | | | |

**Receiving organisation details**

| | | | |
|---|---|---|---|
| Receiving organisation name: | | Speciality/Treatment required for patient: | |
| Receiving clinician (in full): | | | |
| Date IPTAMDS sent: | | | |
| Is this referral for a diagnostic test only? | Yes / No | | |
| Is this referral for an opinion only? | Yes / No | | |

**Further comments to be included in the box below by the referrer e.g clinic letter attached:**

| | | | |
|---|---|---|---|
| Is this patient on an active 18 week RTT pathway? (Ongoing) | | Clock start date: | |
| | | Current RTT status? | |
| Is this a new condition? (New pathway) | | Unique pathway identifier (if available): | |
| Is this no RTT activity? (After treatment, patient transfer) | | Date of decision to refer to other organisation: | |

**For receiving organisation**

| | |
|---|---|
| Date received: | |

**Appendix 3: - GP Referral Letter Information Requirements**

Minimum Data Set (MDS) requirements are:

- 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
- Ethnicity (to support Health Inequalities workstream)

## Appendix 4 – Policy Governance

### Ratification

| | DATE | NAME | DESIGNATION | SIGNATURE |
|---|---|---|---|---|
| **ERODG** | | | | |
| **BNSSG Acute Health and Care Improvement Group** | | | | |
| **BNSSG Primary Care Health and Care Improvement Group** | | | | |

### Organisation approval record

| ORGANISATION | DATE | |
|---|---|---|
| BNSSG ICB | | |
| University Hospitals Bristol and Weston NHS Foundation Trust | | |
| North Bristol Hospitals NHS Trust | | |
| OneCare or GPCB | | |
| Sirona | | |
| LMC | | |

### VERSION HISTORY

| VERSION | DATE | AMENDMENTS |
|---|---|---|
| 1.0 | 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: -<br>• 'National Cancer Waiting Times Monitoring Dataset Guidance – Version 9.0'<br>• 'Referral to Treatment consultant led waiting times'.<br>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 and 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:<br>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 around Choice to delay guidance – see Addendum 2 |
| 14<br>14.1 | Review period Nov 2023 – August 2024 | Reorganisation and reformatting of existing content to remove duplication.<br>4.1 Patient Choice section detail added<br>5 Clinical Prioritisation updated<br>5.2 Surveillance examples added<br>6.3 and 6.5 Additional detail added on Active Monitoring<br>6.3 and 10.3 - Clarity on patient-initiated changes<br>7.1 Unsuccessful contact attempts and non-response clarified<br>9.5 includes link to 'Who applies for funding' guidance<br>9.8 - Expediting referrals updated to include life long follow up expedition<br>17. Additional detail in Diagnostics, including new open access (17.3); appointment offers (18); hospital-initiated cancellations (20)<br>24. Patient thinking time updated<br>29. Pre-Anaesthetic and Pre-Operative Assessment updated including clarification to patients unfit for surgery (29.1)<br>Section 3 - Updated Cancer Access policy noted<br>Footnote 15 recognises referrals from private GPs as an area for further consideration |

## 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. October 2022

**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 mile-stone 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

**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.

[1] 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.**

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 consumed 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 PTL 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'.