Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Trust Access Policy

This procedural document supersedes: PAT/PA 1 v.10 – Referral to Hospital Access Policy

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Executive Sponsor(s):	Denise Smith, Chief Operating Officer
Author/reviewer: (this version)	Suzanne Stubbs, Deputy Chief Operating Officer Ben Vasey, Deputy Chief Operating Officer Sonya Granby, Patient Access Manager
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Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
Version 11 (amended March ’24)	Apr 24	Changes made to reflect the ECIST ‘Model Access Policy v3.0’, updated in March ‘24	Ben Vasey
version 10 (amended November 23)	Dec 23	Incorporated CORP/FIN 7 and updated link for Health & Social Care Guidance on Overseas Visitors charging regulations in part 2 3.4 - Extra information added re MDS 4.1.2 – Information regarding chargeable patients declining treatment. 4.4.2 added guidance regarding Veterans. 4.6.1 – slight amendment due to process change in CaMIS 4.6.8 – Clarification of chargeable patients being treated fairly under RTT rules. 5 – amendment to ePPW training for Medical Secretaries 8 – Updated name of Policy CORP/ICT 11 10 – Reference to PIFU SOP added Definition added to Appendix A Armed forces Covenant	Sonya Granby Sonya Granby Sonya Granby Sonya Granby Sonya Granby Anna Mahoney Sonya Granby Anna Mahoney Sonya Granby Sonya Granby Sonya Granby
version 9 (amended June 19)	23 July 2019	Appendix E – wording of letter Appendix G – added to the policy Page 18 – slight amendment to the section patients who lack capacity.	Emma Challans
version 9 [amended March 2019]	7 May 2019	Minor amendments within sections 4.3.1 - Patient Initiated and 4.3.4 – Managing Electronic Referrals. Updated link within Appendix B – Commissioning for value (CfV) policy – Procedures of Limited Clinical Value. Addition regarding referrals for Endoscopy within Appendix C – Diagnostic Referrals.	Emma Challans

		Additional appendix insertion at Appendix E – Example letter for discharge of patients back to the referrer following a review of non-attendance.	
version 9	30 July 2018	Included: Full review of policy in line with the Model Access Policy (Aug 17) Sections A-C reviewed	Emma Challans
October 2015		Included: Section 2 - Pre referral diagnostics 2.1.6 Upgraded referrals) 1.2 Patient information	
		4.3 Internal reporting	
March 20 2015		Included: 5.1.3 Reference to patient/public engagement in the policy. 2.2.1 'Direct Access' Diagnostics 5.5 Active monitoring or Watchful wait. Appendix A – Active monitoring definition	
October 2013 - to August 2014		Policy changed to reflect the transition from Doncaster Primary Care Trust to NHS Doncaster Clinical Commissioning Group (CCG) as statutory body. Updated to reflect latest Planning Guidance, NHS Mandate and Constitution. Heading numbers, paragraph numbers and layout of policy changed to reflect the standard Policy on Procedural Documents approved by NHS Doncaster CCG governing body on 2 April 2013. Clarified: Length of time allowed for treatment delays DNA and CNA's Timescales for prior approval requests The section on Follow up waiting lists Definition of vulnerable patients Timescales for reviewing referrals	

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1.0. Introduction

Doncaster and Bassetlaw Teaching Hospital is committed to ensuring patients receive treatment in accordance with national objectives, planning guidance and appropriate standards, with patients of the same clinical priority treated in chronological order of their waiting time. The purpose of this policy is to outline the Trust and Commissioners requirements and standards for managing patient access to secondary care services from referral to treatment.

This policy sets out the rules and definitions of the Referral to Treatment standard to ensure each patient's 18-week clock starts and stops fairly and consistently and in line with national rules. It does not provide detailed guidance on how the rules should apply to every situation but provides an overarching framework to work within to make clinically sound decisions locally, in consultation with patients, clinicians, providers and commissioners.

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

2.0. Scope of Policy

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

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

The policy sets out the roles, responsibilities, processes and best practice guidelines to assist staff with the effective management of patients who need to attend Doncaster and Bassetlaw Hospitals for treatment as an outpatient, inpatient, daycase or to receive diagnostic care.

This policy covers the processes for booking, notice requirements, patient choice and waiting list management for all stages of a referral to treatment pathway.

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

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

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

The specific needs of PWLD and people with a mental health condition, such as communication, information, use of advocacy services and involving carers according to the patient's wishes must

be taken into consideration when these patients are accessing elective and acute services. All procedures, including consent to treatment will be in accordance with the Mental Capacity Act 2005. Further details can be found in the Trust's safeguarding policies.

3.0. Key Policy Principles

As set out in the NHS Operating Framework and NHS Constitution, by law patients have the right to access certain services commissioned by NHS bodies within maximum waiting times. This includes starting consultant-led treatment within a maximum of 18 weeks (126 days), unless they choose to wait longer, or it is clinically appropriate they wait longer. All the aspects of the patient pathway which lead up to first definitive treatment, including outpatient consultations, diagnostic tests and procedures will be monitored and proactive action taken to reduce waiting times. All other aspects of elective care will also be monitored e.g., follow up of patients following definitive treatment, and those patients waiting for an elective planned procedure etc. The following key principles are pertinent throughout the policy:

a) This policy covers the way in which the Trust will manage administration for patients who are waiting for or undergoing treatment on a Referral to Treatment Pathway, for an admitted, non-admitted or diagnostic referral.
b) This policy does not cover Cancer pathways – a separate policy exists for this cohort of patients.
c) The policy will be adhered to by all staff members who are responsible for referring patients, managing referrals, adding to and maintaining waiting lists (outpatient or elective) for the purpose of advancing a patient through their treatment pathway.
d) The Trust will give priority to clinically urgent patients and treat all other patients in turn.
e) The Trust will work to meet and where possible better the maximum waiting times set by NHS England for all groups of patients.
f) The Trust will mutually agree appointments and admission dates with patients.

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

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

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

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

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

4.0. Roles and Responsibilities

4.1. Chief Operating Officer

The Chief Operating Officer (COO) is accountable for delivery of the referral to treatment (RTT) standards. The COO has overall responsibility for the implementation of this policy and board level accountability for the delivery of elective access standards.

4.2. Clinicians

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

- To review all patient referrals, allocating clinical priority and accepting / rejecting referrals within 2 working days
- To complete accurate and timely clinic outcome forms with clear instructions of next steps e.g., 6 month follow up to be booked and RTT status.
- To produce a clinic letter following outpatient attendance, confirming care plan to GP/Referrer/Patient.
- To communicate with patients to ensure patients' perceptions of their care mirrors clinical decisions made regarding care plans and treatment. (e.g., for clock starts and stops and mutually agreed periods of active monitoring etc.)
- Undertaking clinical review as necessary within 5 working days (e.g., for patient initiated delay or clinical harm review).
- Clinicians should not place a patient on the waiting list to 'reserve a place' against the future possibility that treatment may be necessary or where the patient is not currently ready, willing and able to proceed. Such patients should either be referred back to their GP after clinical review if it is in their best clinical interests, or followed up in clinic, until such time their condition improves / warrants treatment.

4.3. Divisional Directors, Clinical Directors, Divisional General Managers, and Operational Managers

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

4.4. Administration

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

- To maintain accurate up to date waiting lists, i.e., at Outpatient, Diagnostic and Admitted phases.
- To book activity to agreed specialty milestones.
- To highlight capacity short falls in a timely manner to avoid patient wait times being compromised.
- To keep the patient informed of their 18 week RTT status, be open and provide clarity on clock stops and starts within the patient's pathway.
- To validate patient pathways in real time.
- To actively progress patients through their pathways ensuring appropriate measures are taken.
- To keep updated and informed of policies and procedures by ensuring training is completed, policies are read and digested and to make full use of the Trusts communication tools.
- To be competent and compliant in all related elective care and cancer policies.

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

4.5. Integrated Care Board

If maximum waiting time rights under the NHS Constitution cannot be met, the ICB or NHS England, which commission and fund treatment, must take all reasonable steps to offer a commissioned suitable alternative provider, which would be able to see or treat the patient more quickly.

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

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

- Have regard to the need to promote education and training of current or future health service staff.
- Ensure appropriate facilities are made available to any university which has a medical or dental school in connection with clinical teaching or research.

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

4.6. General Practitioners and Referring Clinicians

The Trust rely on all referring clinicians to ensure patients understand their responsibilities and potential pathway steps and timescales when being referred. This will help ensure patients are referred under the appropriate clinical guidelines and are aware of the speed at which their pathway may be progressed and are in the best position to accept timely and appropriate appointments.

Before a referral is made for treatment on an 18 week Referral to Treatment pathway, the patient is ready, willing and able to attend for an appointment and undergo any treatment which may be required. This will include being both clinically fit for assessment and possible treatment of their condition and available for treatment across that pathway. This is the responsibility of the referring clinician, e.g., the GP.

*** Referrers are required to ensure all suspected cancer referrals are made through the agreed 2ww pathway. Referrers must ensure 2ww patients are available to attend an appointment within 14 days from the date of referral.*

- Referrers must provide accurate, timely and complete information within their referral.
- Referrers must comply with national timeframes for referral attachments when referring via NHS e-Referral Service.
- Referrals to secondary care should only be made if all other alternatives have been explored (i.e., agreed patient/clinical pathways have been followed).
- GP referrals to consultant-led outpatient services should be made using the e-Referral System. Paper and Fax referrals will be rejected by the provider unless service exempt from eRS
- To minimise waiting times and to enhance patient access to services, referrers are encouraged to make unnamed referrals (referred to as Dear Doctor referrals) unless there is a specialist requirement for a named consultant or there is a patient history which requires continuity of care. Patient Choice must be taken into consideration when referring.
- When referring children or adults who cannot understand or give consent for their own treatment, the referrer must provide details of who is legally able to act on behalf of the patient.
- Referrers should identify any special communication requirements their patients may have and detail these on the referral letter e.g., literacy problems, need for British Sign Language (BSL) or other language interpreter. Information should be made available in accordance with the Accessible Information Standard.
- Referrers should identify any special access requirements their patients may have, e.g., wheelchair user to allow for access to clinics.

Patients should be referred having already undergone all relevant tests, as outlined in the pathway and Directory of Service of the relevant specialty.

After a referral has been made, the referrer must inform the hospital if the patient no longer wishes or requires to be seen.

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

5.0. Competency and Compliance

As a key part of their induction programme, all new starters to the trust will undergo mandatory contextual elective care training applicable to their role, including training on health inequalities. At DBTH this training is categorised as role specific Training (aligning to specific roles). It is the responsibility of the Administration and Operational Managers to ensure all relevant staff are fully compliant with RTT Training

Each year all relevant staff (those involved in the 18 week pathway) will undergo Role Specific refresher E-Learning training All staff will carry out competency tests that are clearly documented to provide evidence that they have the required level of knowledge and ability. This policy, along with the supporting suite of SOPs, will form the basis of contextual training programmes.

Functional teams, specialties and staff will be performance managed against key performance indicators (KPIs) applicable to their role. RTT Spot Check Audits will be undertaken, and it is the responsibility of the Administration managers to monitor audits and undertake remedial action where identified as necessary. In the event of non-compliance, a resolution should initially be sought by the team, specialty, or individual's line manager. The matter should then be dealt with via the trust's disciplinary or capability procedure

6.0. Governance

6.1. Patient Tracking List (PTL)

A PTL is a list of patients who need to be treated by given dates in order to start treatment within maximum waiting times set out in the NHS Constitution. As well as the RTT PTL, the Trust also has various other PTLs for patients waiting for Diagnostic, Planned Elective treatment, etc.

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

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

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

6.2. Weekly Speciality PTL meetings

Speciality area operational management team must be sufficiently prepared for the PTL meeting to:

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

The PTL meetings are action-orientated and focused upon:

- Performance management and accountability;
- Breaches and prospective management of patients along the 18 week pathway
- Clearing the backlog of patients waiting more than 18 weeks;
- Delivery of the RTT
- Monitoring and managing the number of incomplete pathways.

6.3 Monitoring Compliance with the procedural document

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Adherence and compliance against the overall policy	Divisional Director through the Divisional management and service team	Weekly Monthly	Weekly PTL meetings Daily escalations Monthly performance reports
Regular reporting and escalation of information to Divisional teams	Information Manager	Weekly Monthly	PTL report and WL information at a specialty level Reported to all nominated patient management leads
Training and Education on 18 week policy, CaMIS and other patient management systems. Trust Training Strategy	Head of Applied Information	Ongoing	Progress report against the Trust Training Strategy
Waiting List quality	Internally via DQA Team Externally via 360 assurance audit reports	Daily Annual	Reported to Divisional leads Reported to Trust Audit Committee

7.0. Patient rights

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

The NHS Choice Framework states in Section 3 that patients can choose where they go for their first appointment as an outpatient. Section 4 states a patient can be asked to be referred to a different hospital if they have to wait more than 18 weeks before starting treatment and / or if you wait more than 2 weeks before seeing a specialist for suspected cancer. These are legal rights, there are exceptions to be aware of detailed in the NHS Choice Framework.

As a Trust access to our services will be continually evaluated to establish impacts on health inequalities, with a focus on the Core20PLUS5, and mitigations/improvements implemented as necessary.

7.1. Patient eligibility

The Trust has an obligation to identify patients who are not eligible for free NHS treatment and specifically to assess liability for charges in accordance with Department of Health guidance /rules. All staff have a responsibility to identify patients who are overseas visitors and to refer them to the overseas visitor's office for clarification of status regarding entitlement to NHS treatment before their first appointment is booked or date to come in (TCI) agreed.

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

An ordinarily resident person is anyone:

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

Where the patient's overseas visitor status is unknown in terms of eligibility upon referral, an RTT clock would start. This should continue to tick until their status is ascertained. If they are NOT eligible for treatment funded by an English commissioner, their RTT clock should be nullified. Further information on the management of Overseas Visitors can be found in the Overseas Visitors Policy on the Trusts Intranet sites.

7.2. Military veterans

In line with the Armed Forces Covenant published in 2015, all veterans and war pensioners should receive priority access to NHS care for any conditions related to their service, subject to the clinical needs of all patients.

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

7.3. Prisoners

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

7.4. Vulnerable Adults

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

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

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

For further guidance regarding Vulnerable Adults follow the Safeguarding Adults Policy found on the Trust Intranet sites.

7.5. Children

All Trust staff have a duty to safeguard children from harm and it is expected staff familiarise themselves with their duty in this regard. A person is considered to be a child from pre-birth until their 18th birthday. For further guidance regarding Safeguarding Children Policy found on the Trust Intranet sites.

It is possible children who are not brought to clinical appointments may be at risk of child abuse. When children do not attend for planned care the case notes must be reviewed by a consultant or specialist registrar. The risk to the child will be assessed. Primary care will be informed. Decisions about next steps depend on the clinical situation and are described in the individual Trust policies for the management of children who do not attend outpatient appointments or leave Accident and Emergency before being seen.

8.0. Patients moving between NHS and private care

Patients can choose to move between NHS and private status at any point during their treatment without prejudice. Where it has been agreed, for example, that a surgical procedure is necessary the patient can be added directly to the elective waiting list if clinically appropriate. The RTT clock starts at the point the GP or original referrer's letter arrives in the hospital. Private patients referred to the Trust must be booked in chronological order with the NHS patients, unless clinically urgent.

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

No patient should be referred directly to the Trust from the private service. This includes patients who have been diagnosed with or are suspected to have cancer. The private service should contact the patients GP and the GP can make an urgent referral through to the Trusts Outpatient bookings team or Diagnostic bookings team.

9.0. Commissioner approved procedures and Evidence Based Interventions (EBI)

Patients referred for specific treatments where there is limited evidence of clinical effectiveness, or which might be considered cosmetic can only be accepted with the prior approval of the relevant ICB. Clinicians should be aware of the list of procedures to ensure it is appropriate to offer the procedure prior to listing the patient.

Where an Individual Funding Request (IFR) is required patients will not be added to a waiting list without a prior authorisation number from Commissioners. The patients RTT pathway continues to tick while Individual Funding Requests (IFR) are being processed if the IFR is submitted by the Trust.

10.0. Communication

All communications with patients and anyone else involved in the patient's care pathway (e.g. GP or a person acting on the patient's behalf), whether verbal or written, must be informative, clear and concise. All appointment letters should contain enough detail for the patient to fully understand who the letter is from where and when the appointment is, where to report to on arrival and what will happen to them if they cancel or DNA an appointment. Associated literature about the appointment should also be included.

Copies of all correspondence with the patient must be kept in the patient's clinical notes or stored electronically for auditing purposes.

GPs or the relevant referrer must be kept informed of the patient's progress in writing. Regular two-way communication with the patient is key to ensure that patients are fully informed and aware of any appointments for their care. Where patients are unable to attend or do not attend (DNA) their appointment there should be locally agreed processes to explore the causes.

10.1. Reasonableness

A reasonable offer for any appointment or admission for any service is one that is made with at least three weeks' notice. When offers are made verbally or via email a minimum of two dates with at least three weeks' notice will be offered for patients to choose from. However, if dates at short notice become available these will be offered to patients but can only be considered reasonable if the patient accepts them. If they decline these short notice offers there is no impact on the patient's pathway.

All offers made to the patient should be recorded on PAS.

10.2. Uncontactable

A patient's demographics should always be checked at any appointment or when contact is made. Where a patient cannot be reached by the initial phone call, three further attempts on different days at different times (ideally one out of hours) should be made to contact the patient. There should also be efforts made to contact the original referrer (e.g. GP) to confirm the patient's demographics. If the patient still cannot be reached a letter should be sent giving the patient three weeks to make contact to book their appointment. If the patient does not make contact within those three weeks they can be returned to their referrer if there is a clinical decision to discharge.

10.3. Non-activity related RTT decisions

Where clinicians review test results in the office setting and make a clinical decision not to treat, the RTT clock will be stopped on the day this is communicated in writing to the patient.

10.4. Attendance and outcomes (new and follow-up clinics, diagnostics, and admissions)

Every patient, whether attended or not, will have an attendance status and outcome recorded on PAS at the end of the appointment.

10.5. Chronological booking

Patients will be selected for booking appointments or admission dates according to clinical priority. Patients of the same clinical priority will be appointed/treated in RTT chronological order, i.e. the patients who have been waiting longest will be seen first. However, the holistic needs of patients should still be considered and addressed where possible and when analytical tools for health inequalities are introduced.

Patients will be selected using the trust's patient tracking lists (PTLs) only. They will **not** be selected from any paper-based systems.

11.0. National referral to treatment and diagnostic standards, rules application

Referral to treatment	
Incomplete	92% of patients on an incomplete pathway (ie still waiting for treatment) to be waiting no more than 18 weeks (or 126 days)
Diagnostics	
Applicable to diagnostics tests	99% of patients to undergo the relevant diagnostic investigation within 5 weeks and 6 days (or 41 days) from the date of decision to refer to appointment date

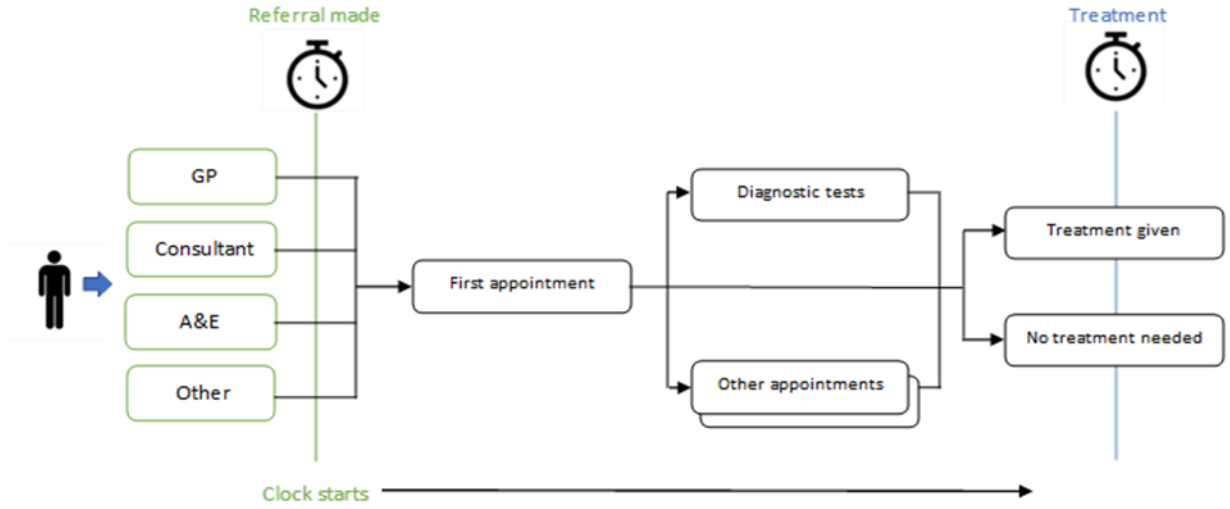
In addition to the elective care standards above, there are separate cancer standards which must be adhered to.

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:** when it is in the patient's best clinical interest to wait more than 18 weeks for their treatment.
- **Choice:** 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.
- **Co-operation:** when patients Do Not Attend (DNA) previously agreed appointment dates or admission offers (TCI) and this prevents the trust from treating them within 18 weeks.

11.1. Overview of national referral to treatment rules

The figure below provides a visual representation of the chronology and key steps of a typical RTT pathway.



The chronology and key steps of a typical RTT pathway

11.1.1. Clock starts (Rules 1- 3)

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

Rule 1: Referrals by care professionals or services

a) A referral is received into a consultant-led service, regardless of setting, with the intention that the patient will be assessed and if appropriate, treated before clinical responsibility is transferred back to the referrer.
b) A referral is received into an interface or referral management assessment centre which may result in an onward referral to a consultant-led service before clinical responsibility is transferred back to the referrer.

Rule 2: Self-referrals

A patient self-refers into a consultant-led service for pre-agreed services agreed by providers and commissioners.

Rule 3: The need for a new clock

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

a) When a patient becomes fit and ready for the second of a consultant-led bilateral procedure.
b) Upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.
c) Upon a patient being re-referred into a consultant-led, interface or referral management or assessment service as a new referral.
d) When a decision to treat is made following a period of active monitoring. Some clinical pathways require patients to undergo regular monitoring or review diagnostics as part of an agreed programme of care. These events would not in themselves indicate a decision to treat or a new clock start. If a decision is made to treat after a period of active monitoring/watchful waiting, a new RTT clock would start on the date of decision to treat (DTT).

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

11.1.2. RTT clock stops (Rule 4 and 5)

Rule 4: clock stops for treatment

a) First definitive treatment starts. First definitive treatment is defined as 'an intervention intended to manage a patient's disease, condition, or injury and/or avoid further intervention'. This could be:

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

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

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

Rule 5: Clock stops for non-treatment

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

a) It is clinically appropriate to return the patient to primary care for any non-consultant led treatment in primary care.
b) A clinical decision is made to start the patient on a period of active monitoring.
c) A patient declines treatment having been offered it.
d) A clinical decision is made not to treat.
e) A patient DNAs their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient[1]
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.

[1] DNAs for a first appointment following the initial referral that started a waiting time clock nullify the patient's clock (that is, it is removed from the numerator and denominator for RTT time measurement purposes).

11.1.3. 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 to a non-consultant led service.
- Referrals for patients from non-English commissioners.
- Genitourinary medicine (GUM) services.
- Emergency pathway non-elective follow-up clinic activity.

11.2. 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 particular 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.

11.2.1. 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 definitely be required), the RTT clock continues when the patient undergoes physiotherapy.

11.2.2. 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.

11.2.3. 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.

12.0. Did Not Attend (DNA)

A clinical review must occur for any pathway DNA. 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.

It is imperative that such arrangements are founded on individual patients' best clinical interests and that they do not include blanket rules for stopping the clock.

12.1. Outpatients

All DNAs will be reviewed by the clinician at the end of clinic in order for a clinical decision to be made regarding next steps. Paediatric and vulnerable patient DNAs should be managed with reference to the Trust's safeguarding policy. Please also section 7.5 on Children for guidance on how to manage patients were not brought to their appointment (WNB).

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12.1.1. First appointment DNAs

The RTT clock is stopped and nullified in all cases (Rule 5e), as long as the trust can demonstrate the appointment was clearly communicated to the patient. If the clinician indicates another first appointment should be offered, a new RTT clock will be started on the date that the patient contacts the trust to rebook their new appointment.

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

12.1.2. Subsequent (follow-up) appointment DNAs

The RTT clock stops if the clinician indicates that it is in the patient's best clinical interests to be discharged back to their GP/referrer. As long as the trust can demonstrate the appointment was booked in line with the criteria listed in the RTT rule suite Rule 5f:

i) The provider can demonstrate that the appointment was clearly communicated to the patient
ii) *Discharging the patient is not contrary to their best clinical interests*
iii) *Discharging the patient is carried out according to local, published, policies on DNAs iv) 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*

The RTT clock continues if the clinician indicates that a further appointment should be offered. If patients wait more than 18 weeks as a result of such delays, the 8% tolerance is in place to account for this.

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

12.2. Admissions

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.

12.3. Appointment cancellations initiated by the patient

It is important that any decision is made by the clinical team on an individual patient basis. Clinicians should strike a balance between the trust's responsibility for acting in the patient's best clinical interests and the fact that patients have a right to choose to delay.

Patients should be made aware of their responsibility to attend agreed appointments. If the patient gives any prior notice that they cannot attend their appointment (even if this is on the day of clinic), this should be recorded as a cancellation and not a DNA.

Cancellations in themselves do not stop clocks. A clock stop should only be applied following a clinical review and decision to discharge (where this is in the patient's best clinical interest) or where there is agreement between the clinician and the patient to initiate a period of active monitoring.

Where a patient cancels at short notice (less than 48 hours before appointment) or where a patient has cancelled two appointments on the same pathway, providers should ensure that reasons are understood and a clinical review undertaken.

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 after a clinical review and the pathway nullified. The patient and GP (or other referrer) will be informed of this.

12.3.1. Patients who cancel or decline TCI offers.

If patients decline TCI offers or contact the trust to cancel a previously agreed TCI, this will be recorded on the PAS. The RTT clock continues to tick until a clinical decision is made about the next steps.

When a patient declines 2 reasonable offers of treatment dates and the second date is within 6 weeks of the first offer, and wishes to delay treatment, the consultant should review the patient. The consultant may agree a period of active monitoring with the patient, which should include an appropriate timeframe for further follow up or review. At the point that the patient indicates their availability, or at the agreed follow up review, if there is agreement to proceed to treatment, a new decision to admit will be recorded and a new RTT clock will start.

Although the patient's clock will start from zero as normal the service will offer a new TCI date in line with clinical prioritisation and act as if the patient is on the waiting list at the point they were prior to the active monitoring period.

12.3.2. 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.

13.0. Active monitoring

Active monitoring is where a decision is made that the patient may not require treatment at this time but should be monitored in secondary care. When a decision by a clinician to begin a period of active monitoring is made, agreed and communicated with the patient, the RTT clock stops.

Where a patient indicates that they wish to delay their appointment or treatment a discussion with their clinician should be arranged.

It is not possible to specifically define compulsory timescales within an access policy and each decision is individual. However, for example, it would be unlikely to make clinical sense to initiate a period of active monitoring and stop a clock for a short period of a few days, nor would this make sense to a patient. Conversely, in instances where patients wish to delay their appointment or treatment for a longer period, trusts should ensure ongoing clinical review to consider whether the best option is to commence a period of active monitoring or whether the patients' clock should remain ticking. Each decision should be made on an individual patient basis.

Stopping a patient's clock for a period of active monitoring requires careful consideration on a case-by-case basis and needs to be consistent with the patient's perception of their wait.

Active monitoring may be appropriate in the following situations:

Hospital initiated:

- When the most clinically appropriate option is for the patient to be actively monitored over a period of time, rather than to undergo any further tests, treatments or other clinical interventions at that time.
- When a patient wishes to delay their treatment (e.g. teacher wishes to wait for treatment in school holidays) and declines 2 offers for reasonable[2] treatment dates the clinician may decide to commence a period of active monitoring, following a clinical conversation and agreement with the patient.
- When a patient[3] declines 2 reasonable offers for earlier treatment dates at an alternative provider – the clinician may decide to commence a period of active monitoring, following a clinical conversation and agreement with the patient. The TCI date offered must include date, provider and team.

Patient initiated:

- Patients may also initiate the start of a period of active monitoring– for example, by choosing to decline treatment to see how they cope with their symptoms.

When patients make a decision to delay their treatment there should be clinical oversight, and steps should be taken to ensure that the patient fully understands the clinical implications of the delay. At the point that a decision to commence a period of active monitoring is made, the RTT clock will stop. In the majority of cases, it will be clear how the rules should apply. However, where there is doubt, or where decisions on the application of the RTT rules is finely balanced, then local clinical decisions should be made within the guidance of national rules.

[2] 'Reasonable' will be defined by each NHS England region recognising the variance in the geography. Provision should be made to support patients with transport or travel costs if required at the discretion of the integrated care board.

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

The discussion with the patient regarding commencing a period of active monitoring should include an appropriate timeframe for further follow up or review. Patients can request delays of any length but should be regularly reviewed in case their condition deteriorates. As a minimum clinical review must take place every 12 weeks. Where active monitoring extends past 12 weeks a clinical review should be undertaken to check the patients' condition and confirm that active monitoring remains appropriate. The pathway should be visible on a relevant PTL or waiting list report for non-RTT pathways.

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.

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, the provider should offer a new treatment date, acting as if the patient is on the waiting list at the point that they previously left.

13.1. Patients requiring thinking time

Patients may wish to spend time thinking about the recommended treatment options before confirming they would like to proceed. It would not be appropriate to stop their RTT clock where this thinking time amounts to only a few days. Where a patient states that they do not anticipate making a decision for a longer period, such as a matter of months, 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.

Trusts are encouraged to ensure a clinical discussion with the patient takes place where more than 14 days have passed without next steps being agreed.

13.2. Patients declaring periods of unavailability while on the inpatient/day case waiting list.

If a patient contacts the trust to communicate a period of unavailability for social reasons (e.g 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.

For any patient request to delay there should be a clinical review to assess the potential impact on the patient's condition and treatment plan. This review is 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.
- **Clinically unsafe length of delay:** clinician to contact the patient with a view to persuading the patient not to 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.

13.3. Appointment changes initiated by the hospital

Hospital-initiated changes to appointments for reasons such as staff availability, suspension of services, equipment failure, will be avoided as far as possible as they are poor practice and cause inconvenience to patients.

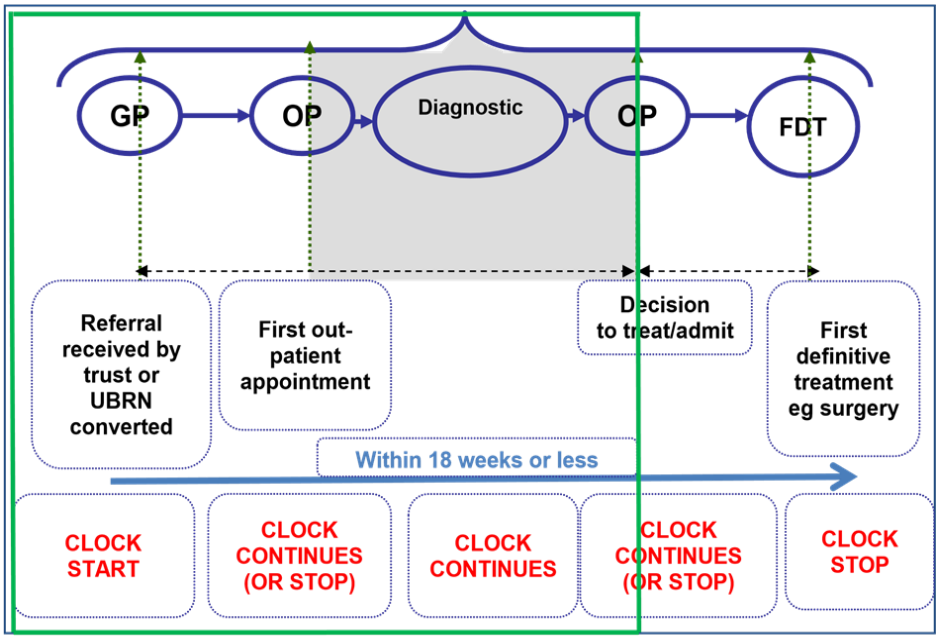
Furthermore, clinicians are actively encouraged to book annual leave and study leave as early as possible. Clinicians must provide 6 weeks' notice if a clinic has to be cancelled or reduced.
Patients will be contacted immediately if the need for the cancellation is identified and offered an alternative date(s) that will allow patients on open RTT pathways to be treated as quickly as possible. Equally, this will allow patients not on open pathways to be reviewed as near to the clinically agreed timeframe as possible.

In these instances, there is no effect on the RTT waiting time and the clock should continue to tick.

14.0. Pathway-specific milestones

14.1. Non-admitted pathways

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



Non-admitted stages of the patient pathway

14.2. Methods of receipt

All referrals from GPs to consultant-led services should be made electronically through the national e-Referral Service (e-RS).

14.2.1. Primary Care Responsibilities

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

14.2.2. Referral Minimum Dataset

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

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

14.2.3. Secondary Care Responsibilities

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

Referrals received at the Trust will be actioned within 48 hours of receipt to ensure the referral detail can be assessed & accessed electronically by consultants and clerical staff as appropriate. Consultants should review all patient referrals, allocating clinical priority and accepting / rejecting referrals within 2 working days of the referral being received at the Trust.

If a consultant deems a referral to be inappropriate, it must be sent back to the referring GP with an explanation provided for the reason for rejection of the referral. If a referral has been made and the special interest of the consultant does not match the needs of the patient, the consultant should cross-refer the patient to the appropriate colleague or sub speciality within the same speciality; the patients RTT clock continues to tick. If a referral has been made to an incorrect speciality, the Trusts Referral Management policy should be followed.

14.3. Referral types

There should be appropriate detail for any unique local referral types or services which may have differing processes and teams must ensure that there is sufficient guidance in the form of an SOP.

14.3.1. Clinical assessment and triage services (CATS), referral management centres (RMCs) and Referral Assessment Centres (RAS)

A referral to a CATS or an RMC starts an 18-week RTT clock from the day the referral is received in the CAT/RMC. If the patient is referred on to the trust having not received any treatment in the service, the trust inherits the 18-week RTT wait for the patient.

A minimum dataset (MDS) form must be used to transfer 18-week information about the patient to the trust.

This is different to Advice and Guidance (A&G) which does not start an 18-week RTT clock unless the consultant converts the request or receives notice of the referral.
The reasons why a clinician may wish to seek advice and guidance include:

- Asking for advice on a treatment plan and/or the ongoing management of a patient.
- Asking for clarification regarding a patient's test results.
- Seeking advice on the appropriateness of a referral for their patient.

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

14.3.2. Inter-provider transfers (IPTs)

Incoming IPTs

All IPT referrals will be received electronically via the trust's secure generic NHS net email account in the central booking office.

The trust expects an accompanying MDS pro-forma with the IPT, detailing the patient's current RTT status (the trust will inherit any RTT wait already incurred at the referring trust if they have not yet been treated) and if the patient has been referred for a new treatment plan for the same condition (where a new RTT clock will start upon receipt at this trust). The patient's pathway identifier (PPID) should also be provided. If the IPT is for a diagnostic test only, the referring trust retains responsibility for the RTT pathway.

If any of the above information is missing, the referral should be recorded on PAS and the information actively chased by the booking office.

Outgoing IPTs

The trust will ensure that outgoing IPTs are processed as quickly as possible to avoid any unnecessary delays in the patient's pathway.

An accompanying MDS pro forma will be sent with the IPT, detailing the patient's current RTT status (the receiving trust will inherit any RTT wait already incurred if the patient has not yet been treated). 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 trust. The patient's patient pathway identifier (PPID) will also be provided.

If the outgoing IPT is for a diagnostic test only, this trust retains responsibility for the RTT pathway.

Referrals and the accompanying MDS will be emailed securely from the specialty NHS net account to the generic central booking office NHS account. The central booking office will verify (and correct if necessary) the correct RTT status for the patient. **If the patient has not yet been treated, the RTT clock will be nullified at the receiving trust.** They will then forward to the receiving trust department within one working day of receipt into the generic email inbox.

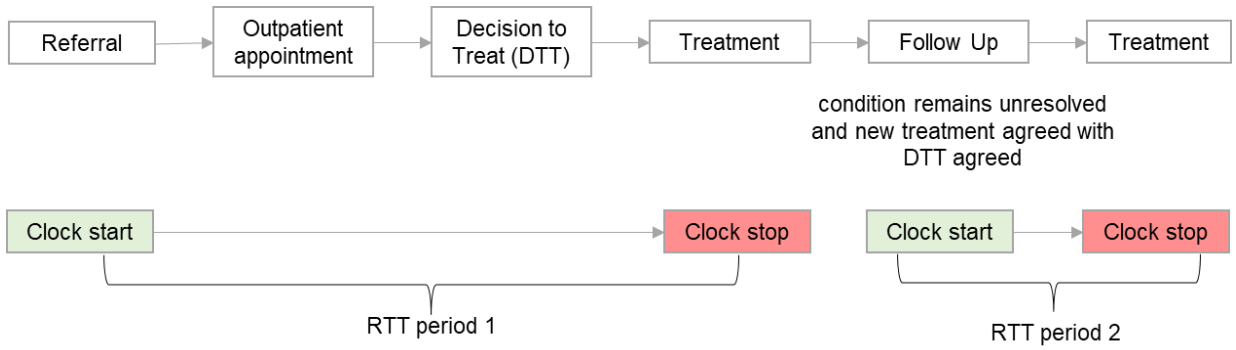
14.4. Appointment Slot Issues (ASIs)

ASIs present a clinical risk as an RTT clock does not start on a provider's patient administration system (PAS) while the patient's referral is on an ASI worklist, and patients may not be visible on the trust PTL (referrals should be either resolved or added to the PAS system within 48 hours). It is important to resolve these ASIs promptly as they will move from the worklist if not actioned after 26 weeks and then only be visible on another report within e-RS.

When patients are unsuccessful in directly booking their first outpatient appointment via e-RS, the RTT clock should be started from the date the patient attempted to book their appointment, for example, when the hospital receives the referral on their ASI worklist.

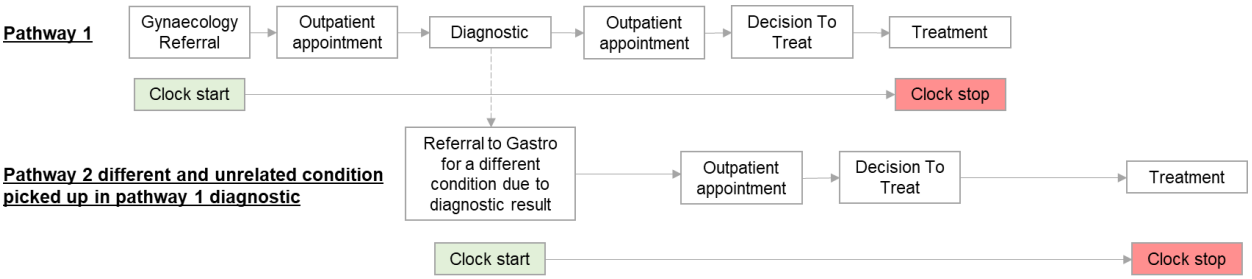
14.5. Multiple RTT periods on the same pathway

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.



14.6. 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. In this instance 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.

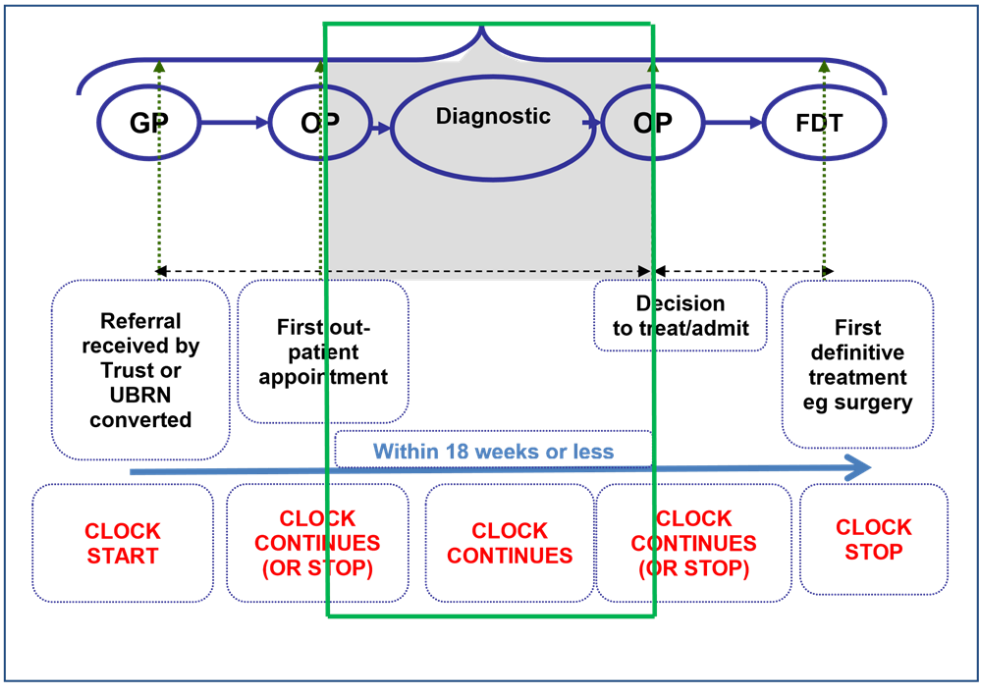


14.7. Diagnostics

This section provides an introduction to the diagnostic phase of the patient pathway. Although a number of patients will already be known to the hospital from outpatients. The following sections cover patients with an RTT and diagnostic clock, straight to test and diagnostic only patients.

The section within the green border on the below figure represents the diagnostic stage of the RTT pathway which forms part of the non-admitted pathways. It starts at the point of a decision to refer for a diagnostic test and ends on the results/report from the diagnostic procedure being available to the requester.

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.



Diagnostic phase of the patient pathway

14.8. Patients with a diagnostic and RTT clock

A large proportion of patients referred for a diagnostic test will also be on an open RTT pathway. In these circumstances, the patient will have both types of clock running concurrently:

- Their RTT clock which started at the point of receipt of the original referral.
- Their diagnostic clock which starts at the point of the decision to refer for diagnostic test.

Where the patient is solely waiting for a therapeutic procedure, for example in the radiology department, there is no six-week diagnostic standard. However, for many patients there is also a diagnostic element to their admission/appointment, and so these patients would still be required to have their procedure within six weeks.

14.9. Straight-to-test arrangements

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

14.10. Direct access diagnostics

Patients who are referred directly for a diagnostic test (but not consultant-led treatment) by their GP, i.e clinical responsibility remains with the GP, will have a diagnostic clock running only. These are called direct access referrals.

14.11. 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.

14.12. Pre-operative assessment (POA)

All patients with a Decision to Admit (DTA) requiring a general anaesthetic will require a pre-operative assessment (POA). Assessment, or as a minimum, initial screening should take place as soon as possible after the DTA to assess the fitness of the patient for surgery. Where necessary, 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.

Many patients can be assessed by the trust's dedicated POA nurse specialists. For patients with complex health issues requiring a POA appointment with a nurse consultant or anaesthetist, the trust will aim to agree this date with the patient before they leave the clinic. The trust will aim to agree an appointment no later than seven working days from the decision to admit. If additional tests are required to ascertain a patient's fitness, the RTT clock continues while these are arranged.

14.12.1. Patients who are unfit for surgery

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

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

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

- If 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).

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

14.13. Admitted pathways

The trust should ensure that admitted patients are captured and monitored on waiting lists. It is worth noting the difference between active RTT patients and planned patients (awaiting admission at a specific clinically defined time).

14.14. Active waiting list

Ideally patients will be fit, ready and available before being added to the admitted waiting list. However, they will be added to the admitted waiting list without delay following a decision to admit, regardless of whether they have undergone preoperative assessment or whether they have declared a period of unavailability at the point of the decision to admit.

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.

14.15. Patients requiring more than one 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.

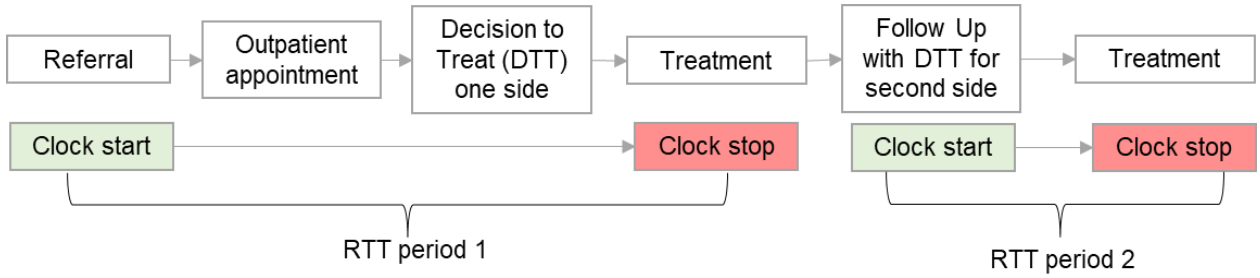
If a patient requires more than one procedure performed on separate occasions such as; first definitive treatment followed by a new decision to treat for a 2nd or subsequent treatment or bilateral procedures that are completed separately. This is an example of multiple RTT periods on the same patient pathway.

• 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 and able to proceed with 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.

NOTE: RTT clocks for bilateral procedures are sequential and not concurrent (nor listed as 'planned') as stated in Rule 3a.

The below figure is an example of a bilateral pathway



14.16. 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.

14.17. Clinical Prioritisation

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:

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

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

14.18. On-the-day cancellations

Where a patient is cancelled on the day of admission or day of surgery for non-clinical reasons, they will be rebooked within 28 days of the original admission date and the patient must be given reasonable notice of the rearranged date. The patient may choose not to accept a date within 28 days. If it is not possible to offer the patient a date within 28 days of the cancellation, the Trust will offer to fund the patient's treatment at the time and hospital of the patient's choice where appropriate.

15.0. Associated Trust Policies

- CORP/FIN 7 – Overseas Visitors/patients Policy
- CORP/ICT 2 - Information Management and Technology (IM&T) Security Policy
- CORP/ICT 7 - Data Protection Policy
- CORP/ICT 8 - Safe Haven Guidelines
- CORP/ICT 9 - Information Governance Policy
- CORP/ICT 10 - Confidentiality - Code of Conduct
- CORP/ICT 11 – Digital Transformation (IT Operations) Business Continuity & Disaster Recovery
- CORP/ICT 14 - Information Records Management - Code of Practice
- CORP/ICT 15 - Freedom of Information (FOI) Policy
- CORP/ICT 20 - Bulk Data Transfer Guidelines
- CORP/ICT 21 - Information Risk Management Policy
- CORP/ICT 22 - 3rd Party Access to the Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust's Network and Core Patient Systems.
- CORP/ICT 27 - Email and Internal Communications Policy
- CORP/ICT 28 - Internet Usage Policy
- PAT/PA 19 – Mental Capacity Act 2005 – Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS)
- PAT/PS 10 – Safeguarding Children Policy

- PAT/PA 28 - Dignity Policy
- Cancer Access Policy – In development

16.0. Glossary

Term	Definition
Active monitoring	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures. Often referred to as 'watchful wait'.
Advice and Guidance (A&G)	By providing a digital communication channel, A&G allows a clinician (often in primary care) to seek advice from another (usually a specialist) prior to or instead of a referral.
Active waiting list	The list of elective patients who are fit, ready and able to be seen or treated at that point in time. Applicable to any stage of the RTT pathway where patients are waiting for hospital resource reasons.
Appointment Slot Issue (ASI)	A list of patients who have attempted to book their appointment through the national E-Referral Service but have been unable to due to lack of clinic slots.
Bilateral procedures	Where a procedure is required on both the right and left sides of the body.
Breach	A pathway where the period waited to be seen or receive treatment exceeds the access standard, national or local target time.
Clinical Assessment and Treatment Service (CATS) Clinical assessment and treatment service	
Clinic Outcome Form (COF)	Used to record the RTT outcome and other clinical information after an outpatient appointment.
Consultant-led service	A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse-led clinics which come under the umbrella of consultant-led services.

Day case	Patients who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight
Decision to admit (DTA)	Where a clinical decision is made to admit the patient for either day case or inpatient treatment.
Direct access	Where GPs refer patients to hospital for diagnostic tests only. These patients will not be on an open RTT pathway.
Did Not Attend (DNA)	Patients who give no prior notice of their nonattendance.
Elective care	Any pre-scheduled care which doesn't come under the scope of emergency care.
E-RS	(National) E-Referral Service
First Definitive Treatment (FDT)	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgement in consultation with the patient
Fixed appointments	Where an appointment or admission date is sent in the post to the patient without the opportunity to agree a date.
Full booking	Where an appointment or admission date is agreed either with the patient at the time of the decision or within 24 hours of the decision.
Incomplete pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage.
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night

Integrated Care Board (ICB)	An organisation that brings NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS
Inter-provider transfer (IPT)	Inter-provider transfer is when a patient is transferred to another provider
Minimum Data Set (MDS)	Minimum information required to be able to process a referral either into a trust or for referral out to other trusts.
Nullified	Where the RTT clock is discounted from any reporting of RTT performance.
Partial booking	Where an appointment or admission date is agreed with the patient close to the time it is due.
Patient Administrative System (PAS)	A patient administration system records the patient's demographics (eg: name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient.
Patient-initiated delay	Where the patient cancels, declines offers or does not attend appointments or admission. This in itself does not the stop the RTT clock. A clinical review must always take place.
Patient Initiated Follow Up	PIFU is when a patient initiates an appointment when they need one, based on their symptoms and individual circumstances
Planned waiting list	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18-week RTT pathway.
Patient pathway identifier (PPID)	A unique identifier which together with the provider code uniquely identifies a patient pathway.

Patient Tracking List (PTL)	A tool used for monitoring, scheduling and reporting on patients on elective pathways (covering both RTT and cancer).
Reasonable offers	A choice of two appointment or admission dates with three weeks' notice.
Referral management centre (RMC)	The Referral Management Centre (RMC) provides a single point of access for professionals to make referrals into providers.
Referral to treatment (RTT)	The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.
Straight To Test (STT)	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an RTT pathway
To come In (TCI)	The date of admission for an elective surgical procedure or operation

17.0. References and further reading

Title	Publication date	Link
Referral to treatment consultant-led waiting times Rules Suite	Oct-22	https://www.gov.uk/government/publications/right-to-start-consultant-ledtreatment-within-18-weeks
Recording and reporting referral to treatment (RTT) waiting times for consultantled elective care	Feb-24	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2024/02/Recording-and-reporting-referral-to-treatment-RTT-waiting-times-for-consultant-led-elective-care-v4-1.pdf
Recording and reporting referral to treatment (RTT) waiting times for consultant led elective care: frequently asked questions	Oct-23	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2023/10/20231020-Accompanying-FAQs-v7.34-October2023-Choice-Update-Final-2.pdf
Evidence-based interventions	N/A **programme**	NHS England » Evidence-based interventions programme
The NHS Constitution	Aug-23	https://www.gov.uk/government/publications/the-nhs-constitution-for-england
The NHS Choice framework	Aug-23	https://www.gov.uk/government/publications/the-nhs-choice-framework
Diagnostics waiting times and	N/A **activity**	https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waitingtimes-and-activity/ https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/datacollections/diagnostics-waiting-times-and-activity-dm01

Guidance on completing the 'diagnostic waiting times & activity' monthly data collection	Mar-15	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01guidance-v-5.32.pdf
Diagnostics FAQs	Feb-15	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01FAQs-v-3.0.pdf
Supplementary Diagnostics FAQ	Oct-22	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2022/11/Supplementary-FAQ-v1.0.pdf
Equality Act 2010	Jun-15	https://www.gov.uk/guidance/equality-act-2010-guidance
Armed Forces Covenant	Jun-16	https://www.gov.uk/government/publications/armed-forces-covenant-2015-to2020/armed-forces-covenant
How charges for NHS healthcare apply to overseas visitors	Dec-20	https://www.gov.uk/government/publications/how-the-nhs-charges-overseasvisitors-for-nhs-hospital-care/how-the-nhs-charges-overseas-visitors-for-nhshospital-care
NHS England Did Not Attends (DNAs)	N/A	https://www.england.nhs.uk/outpatient-transformation-programme/did-notattends-dnas/
Good communication with patients waiting for care	Oct-23	https://www.england.nhs.uk/long-read/good-communication-with-patientswaiting-for-care/#introduction

18.0. APPENDICES

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

APPENDIX A

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

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

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

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

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

Inter Provider Minimum Data Set (IPTAMDS)

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

If a tertiary referral is submitted with conflicting 18 week IPTAMDS information, then the team member recording the referral must contact the department/hospital/Triage Centre and challenge the information. This process will ensure accurate recording of 18 week clock start information. It is best practice for the RTT history to tell a story of the patient's journey, including activity attended, results requested, results received, and clock stops. There can be multiple clock starts and stop on one referral.

Patients on a 20 code showing on the incomplete report must be progressed through their pathway. This may involve checking diagnostic tests have been booked, attended, or reported. A follow up appointment may need to be booked to discuss a diagnosis or care plan or a letter may need to be typed confirming the test is clear and no follow up required, the patient is being discharged from our care.
Delays with progressing patients through their pathway can impact the ability to treat within 18 weeks.

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

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

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

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

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

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

APPENDIX ? - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Trust Access Policy	Corporate	Ben Vasey	Existing Policy	07/05/24

1) Who is responsible for this policy? Corporate Division – COO's Office

2) Describe the purpose of the service / function / policy / project/ strategy? To guide Trust colleagues and Primary Care colleagues on the management of referral to treatment pathways.

3) Are there any associated objectives? It is a national expectation for an organisation to have an Access Policy

4) What factors contribute or detract from achieving intended outcomes? –

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Yes

- **If yes, please describe current or planned activities to address the impact:** The policy identifies and addresses guidance on managing the pathways of different patient groups and aims to help support the reduction of inequalities.

6) Is there any scope for new measures which would promote equality?

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	N	
b) Disability	N	
c) Gender	N	
d) Gender Reassignment	N	
e) Marriage/Civil Partnership	N	
f) Maternity/Pregnancy	N	
g) Race	N	
h) Religion/Belief	N	
i) Sexual Orientation	N	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: 07/05/25

Checked by: **Date:**