# Suffolk & North East Essex (SNEE) Elective Access Policy
# Draft v0.6

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| **For use in:** | The SNEE system, comprising:<br><br>• West Suffolk Hospital NHS Foundation Trust (WSFT) including community services<br>• East Suffolk and North Essex NHS Foundation Trust (ESNEFT) |
| **For use by:** | All staff |
| **For use for:** | Management of elective care waiting lists, comprising:<br><br>• Referral to Treatment (RTT)<br>• Diagnostics<br>• Non-RTT<br>• Community services (as appropriate) |
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## Section 1 Introduction

### 1.1 Policy Statement and Rationale

All providers within the SNEE system are committed to delivering high quality and timely elective care to patients.

This policy sets out the SNEE (subsequently referred as 'the system') elective access policy covering the core principles of Referral to Treatment (RTT). This policy:

- Sets out the rules and principles under which the trusts manage elective access to outpatient appointments, diagnostics and elective inpatient or day case treatment.
- Is designed to ensure the management of elective patient access to services is transparent, fair, and equitable and managed according to clinical priorities.
- Gives staff clear direction on the application of the NHS Constitution and NHS choice framework in relation to elective waiting times. Including the right of all patients to start consultant-led treatment within the RTT target of the date of receipt of their referral. If we do not meet these obligations that patient has the right to ask us to resolve the situation.

The trust's elective access policy was developed following consultation with staff, Integrated Commissioning Boards (ICBs) and clinical leads. It will be reviewed and ratified at least annually or earlier if there are changes to national elective access rules or locally agreed principles.

This policy will be read by all applicable staff once they have successfully completed the relevant elective care training. It will not be used in isolation as a training tool.

The access policy is underpinned by a comprehensive suite of detailed standard operating procedures (SOPs). All clinical and non-clinical staff must ensure they comply with both the principles within this policy and the specific instructions within SOPs.

The trust is committed to promoting and providing services which meet the needs of individuals and does not discriminate against any employee, patient or visitor. As such the system will ensure:

- That patients' treatment is in line with other local and national policies, including the Overseas Patient Policy, Evidence Based Intervention (EBI) Clinical Policies and any other relevant guidance in relation to the treatment of serving military personnel, their immediate families, war veterans and reservists as per the Armed Forces Covenant 2022. **Armed_Forces_Covenant_Duty_Statutory_Guidance.pdf (publishing.service.gov.uk)**
- All patients are to be treated fairly and equitably in accordance with The Equality Act 2010.

The system recognises the importance of good quality data and legal responsibilities for all NHS Hospital Trusts over data quality. As part of the False or Misleading Information (FOMI) legislation, it is an offence to provide information that is false or misleading.

## 1.2 Key Principles

The system relies on GPs and other referrers to ensure patients understand their responsibilities (including providing an accurate address and contact details) and potential pathway steps and timescales when being referred. This will help ensure that:

- Patients are referred under the appropriate clinical guidelines, or via self-referral where appropriate (mostly in community settings).
- Referrals include information relating to the need for translators or other issues relating to accessible information needs.
- Pre-referral diagnostics have been completed as part of the referral process by the GP or referring practitioner.
- Patients are aware of the speed at which their pathway may be progressed.
- Any patients potentially needing EBI or individual funding request procedures have been informed of the criteria, and initial assessment where appropriate, has taken place prior to referral.
- Patients are in the best position to accept timely appointments throughout their treatment including, the patient being clinically fit for assessment, possible treatment of their condition, and ready to start their pathway.
- Everyone involved in patient access should have a clear understanding of their own roles and responsibilities.
- The policy is applied consistently and fairly across all services provided by the system. Communications with patients should be timely, informative, clear, and concise, preferably in writing to the patient's address provided by the referrer, but there is also a requirement to be mindful and to meet the different accessible information and communication needs of patients that will arise such as the need for large font, text to speech, easy read, interpretation, and translation etc. as appropriate.
- The process of waiting list management is transparent to patients.
- The system has a responsibility to ensure no patient is added to a list inappropriately.
- Patients have responsibilities, e.g., for keeping appointments and giving reasonable notice to the system if unable to attend as well as providing the system with up-to-date demographic details such as address and contact numbers.

## 1.3 Overarching Roles and Responsibilities

Although responsibility for achieving standards lies with the Divisional Management teams and ultimately the trust boards, all staff with access to and a duty to maintain elective care information systems are accountable for their accurate upkeep.

For example:

- The Head of Information Services is responsible for the timely production of patient tracking lists (PTLs) which support the divisions in managing waiting lists and RTT standards
- Associate Directors of Operations (ADOs) or equivalent roles are accountable for implementing, monitoring, and ensuring compliance with the policy within their divisions.
- Data Quality team responsible for day-to-day validation and updating patient pathways.

- Divisional teams, including secretaries and divisional managers are responsible for day-to-day RTT tracking.
- Clinicians with responsibility for patient pathways must have an appropriate level of understanding of RTT rules and application with specific focus on clinic outcoming.
- Waiting list administrators, including clinic staff, secretaries and booking clerks are responsible to ADOs, or equivalent roles, for compliance with all aspects of the systems elective access policy.
- Waiting list administrators for outpatients, diagnostic and elective surgery are responsible for the day-to-day management of their lists and are supported in this function by the ADOs who are responsible for achieving access standards
- ADOs and/or equivalent service leads are responsible for ensuring data is accurate and services are compliant with the policy.
- General practitioners (GP's) and other referrers play a pivotal role in ensuring patients are fully informed during their consultation of the likely waiting time for a new outpatient consultation and for the need to be ready, willing and able to attend when contacted.
- Integrated Care Board (ICB) are responsible for ensuring all patients are aware of their right to treatment at an alternative provider in the event that that their RTT wait goes beyond 18 Weeks or if it is likely to do so.
- In the event that patients' RTT wait goes beyond 18 Weeks, ICBs must take all reasonable steps to offer a suitable alternative provider, or if there is more than one, a range of suitable alternative Providers, able to see or treat patients more quickly than the provider to which they were referred. A suitable alternative provider is one that can provide clinically appropriate treatment and is commissioned by an Integrated Care Board or NHS England.
- GP's and other referrers should ensure quality referrals are submitted to the system first time.

## 1.4 Competency and Compliance

As part of their induction programme, all new starters with undertake mandatory contextual and technical elective care training applicable to their role.

All existing staff will undergo mandatory contextual elective care training on an annual basis.

Functional teams, specialties and staff will be performance managed against key performance indicators applicable to their role. Role specific KPI's are based on the principles set out in this policy and specific aspects of the systems standard operating procedures.

In the event of non-compliance, resolution should be sought by the team, specialty, or individual's line manager. Staff should then be dealt with in accordance with the systems disciplinary or capability policy.

## 1.5 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. Further detail can be found

through The NHS Constitution for England - GOV.UK (www.gov.uk).

### 1.5.1 UK and EU Citizens

The NHS provides healthcare for people who are ordinarily resident in the United Kingdom. People who are not ordinarily resident in the United Kingdom are not automatically entitled to use the NHS free of charge – regardless of their nationality or whether they hold a British passport or have lived in and paid National Insurance contributions and taxes in this country in the past.
All NHS Trusts have a legal obligation to identify patients who are not eligible for free NHS treatment and specifically:

- Ensure patients who are not ordinarily resident in the UK are identified;
- Assess liability for charges in accordance with Department of Health overseas visitor guidance
- Charge those liable to pay in accordance with Department of Health overseas visitor guidance.

Patients registered with a GP in either Northern Ireland, Scotland or Wales are also eligible for elective treatment, subject to prior approval from their local health board.

An NHS Number does not give automatic entitlement to free NHS treatment. Therefore, at first point of entry, patients must be asked questions which will assist the systems in assessing 'ordinarily resident status'. The only exception to this is being in an emergency.

The Human Rights Act 1998 prohibits discrimination against a person on any ground such as race, colour, language or religion.
Some visitors from abroad, who are not ordinarily resident, may receive free healthcare such as those that:

- Have paid the immigration health surcharge;
- Have legally come to work or study in the UK; or
- Have been granted or made an application for asylum

### 1.5.2. Patients Moving Between NHS and Private Care

Patients can choose to convert between an NHS and private status at any point during their treatment without prejudice.
The NHS Constitution does not apply to private patients however should a private patient move to NHS funded services (and if the patient is yet to receive first definitive treatment and their treatment is applicable to RTT rules) then the RTT clock will start when the referral is received by the hospital.
The elective RTT pathway of a patient who notifies the system of their decision to seek private care will be closed as a pathway stop event on the date of this being disclosed by the patient.

### 1.5.3 Commissioner-approved Procedures & 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.

### 1.5.4 Armed Forces Community

In line with the Armed Forces Covenant Duty, the Trust will ensure that members of the Armed Forces Community (including those serving, reservists, their families and veterans) are supported, treated equally and receive the same standard of and access to healthcare as any other UK citizen in the area they live.

Referrers should make it clear that the patient is a member of the Armed Forces Community.

Armed Forces Community should retain their relative position on any NHS waiting list, if moved around the UK due to the Service person being posted, however they should not be given priority over other patients with more urgent clinical needs. To enable this Inter-provider transfers should accompany the referral.

Veterans receive their healthcare from the NHS, and should receive priority treatment where it relates to a condition, which results from their service in the Armed Forces, subject to clinical need. A veteran is defined as someone who has served at least one day in the UK armed forces.

### 1.5.5 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. In the instance of patient initiated cancellations or non-compliance, this would be managed in accordance with all other elective standard rules.
Providers will work with staff in the prison services to minimise delays through clear and regular communication channels and by offering a choice of appointment or admission date in line with reasonableness criteria.

### 1.5.6 Vulnerable Patients

Patients who are vulnerable and/or require additional support may require additional communication between the system clinician and the GP or other referrer. Such patients should be identified at the outset at the point of referral.

Staff should always refer to related policies and resources relating to vulnerable or at-risk patients.

Patients with specific information or communication needs because of a disability, impairment or sensory loss must be identified at the outset at the point of referral and relevant details provided as part of the minimum data set, in accordance with the Accessible Information Standard.

### 1.5.7 Children and Young People

The Children Acts 1989 and 2004 define a child as anyone who has not yet reached their 18th birthday. The fact that a child has become sixteen years of age, is living independently or is in further education, the armed forces or is in hospital, prison or young offenders institute does not change their status or their entitlement to services or protection under the Children Act 1989.

Please see the system's Safeguarding Policy for further guidance around when children are not brought in.

### 1.5.8 Communication

All communication 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. 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, the agreed processes as per section 2.5 will be enacted, at all times, the responsible clinician will be advised so they can make an informed decision about the patient's RTT pathway and whether it is appropriate to offer further appointments.

### 1.5.9 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 digital routes (e.g. text, patient portal) 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.

### 1.5.10 Uncontactable

A patient's demographics should always be checked at any appointment or when contact is made. Where a patient cannot be reached by initial phone call, two further attempts on different days at different times will be made to contact the patient. If the patient can still not be reached a letter will be sent giving 2 weeks' notice to make contact to book their appointment/diagnostic/TCI, alternative an appointment/TCI with 3 weeks' notice will be sent to the patient, which would be deemed a reasonable offer. If the patient does not make contact within those two weeks they will be returned to their referrer if there is a clinical decision to discharge.

## Section 2 National Referral to Treatment and Diagnostic Standards, rules application

### 2.1 Overview

The current national operational standards for elective care are provided below [of note cancer standards are managed by each site within their individual Cancer Access Policies]:

| **Referral to Treatment** | |
|---|---|
| Incomplete | 92% of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 Weeks from Referral |
| **Diagnostic Waiting Times** | |
| Applicable to diagnostic tests | 99% of patients will wait no longer than 6 weeks for a diagnostic test, investigation, or image |

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.

Patients may have more than one RTT clock ticking simultaneously. Each one must be measured separately.

RTT waiting time clocks only start or stop. There are no suspensions or pauses.

### 2.2 Clock Starts

The RTT waiting time clock starts when a referral is made by any care professional or service permitted by an English NHS Commissioner to make such referrals to:

- A consultant-led service (regardless of setting) with the intention to assess and if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner.
- An interface or assessment service which may result in an onward referral to a consultant-led service before responsibility is transferred back to the referring health professional or GP
- A consultant-led service where a patient self-refers as part of pre-agreed pathways.

The RTT clock start date is the date that the system receives the referrals. For referrals received through NHS e-Referral Service, the RTT clock starts when the unique booking reference number (URBN) is converted into an appointment.

Where no appointments are available the referral will be deferred, the UBRN will immediately appear as an Appointment Slot Issue (ASI) work list. The date on which the UBRN appears on this work list is the consultant-led RTT clock start. If there has been any previous activity against the UBRN (for example, a booking

into a Clinical Assessment Service) it is the earlier date that starts the consultant-led RTT clock.

For referrals that are not made via the NHS e-Referral Service, the clock starts on the date that the referral is received by the provider organisation.

Upon completion of a consultant-led referral to treatment period, a new RTT clock may also start for the circumstances below:

- when a patient becomes fit and ready for the second of a consultant-led bilateral procedure;
- upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan;
- upon a patient being re-referred into a consultant-led, interface or referral management or assessment service as a new referral;
- when a decision to treat is made following a period of active monitoring;
- when a patient rebooks their appointment following a first appointment 'did not attend' (DNA) that stopped and nullified their earlier clock, this is providing the system can evidence the appointment was appropriately communicated with reasonable notice. A new RTT clock would start from the date of the new rebooked appointment if the Clinician wished to give the patient another appointment, the alternative is that the routine patient will be discharged back to their GP.

### 2.2.1 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 therefore 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.

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.

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.

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.

## 2.3 Clock Stops

### 2.3.1 First Definitive Treatment

A clock stops when 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

Alternatively, a clock stops when 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.

### 2.3.2 Clock Stop – Non-treatment

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

- It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care;
- A clinician decision is made to start a period of active monitoring;
- A patient decision is made to start a period of active monitoring;
- A patient declines all treatment offered. This does not include when a patient feels they have insufficient information to proceed with treatment. Patients may delay treatment while they seek further information or a clinical review, patients should be given a 4-week timeframe for this. This does not stop the clock and the pathway continues;
- A clinical decision is made not to treat;
- A patient DNAs their first appointment following the initial referral that started their waiting time clock, provided that the appointment was clearly communicated to the patient and reasonable notice given (as per 2.2.3 above);
- A patient DNAs any other appointment and is subsequently discharged back to the care of their GP, provided that (i) the appointment was clearly communicated to the patient (as per 2.2.3 above) (ii) discharging the patient is not contrary to their best clinical interests; (iii) decisions have been clinically led
- The RTT clock also stops when a patient declines two reasonable offers of inpatient treatment and there is a clinical decision to either discharge the patient back to their GP or agree a specified period of active monitoring.

### 2.3.3 Clock Stop - Active Monitoring

An RTT clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without further clinical intervention or diagnostic procedures at that stage. This can include periods when the patient is receiving

symptomatic support. The clock stops on the date that the clinical decision is made and communicated with the patient.

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

Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to discharge the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such and stops an RTT clock. Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made.

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 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 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. This would include for example patients declining earlier offers at one of the alternative SNEE Hospitals deciding to delay care in order to be treated at a specific site.

- When a patient declines 2 reasonable offers for earlier treatment dates across ESNEFT multi-site i.e. where the provider is able to offer reasonable offers at Ipswich or Colchester site however the patient declines this earlier treatment and opts to wait longer at a preferred site.

**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 must 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.

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.

**Thinking Time**
Patients may wish to spend time thinking about the recommended treatment options before confirming they would like to proceed. In these instances 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.

In instances a patient takes more than 14 days of thinking time and no steps agreed clinical decisions should be made on active monitoring options.

## 2.4 Exclusions

The following patient pathways are excluded from the RTT reporting target:

- Emergency Department activity
- Emergency admissions from the Emergency Department
- Elective patients undergoing planned procedures
- Activity in fracture clinics
- Antenatal and maternity appointments
- Direct Access diagnostics referred by GPs which are not 'straight to test'
- referrals
- Patients receiving on-going care for a condition whose first definitive treatment has already occurred
- Patients whose RTT clock has stopped for active monitoring and has not been re-instated, even though they may still be followed-up by their consultant
- Referrals into non-consultant led services.

## 2.5 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.

### 2.5.1 First appointment DNAs

The RTT clock is stopped and nullified in all cases when a patient DNAs their first appointment provided that the appointment was clearly communicated to the patient and reasonable notice given (as per 1.5.9 above).

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.

### 2.5.2 Subsequent (follow-up) appointment DNA

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 provided that the appointment was clearly communicated to the patient and reasonable notice given (as per 1.5.9) above).

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.

### 2.5.3 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.

## 2.6 Appointment cancellations initiated by patient

Patients will be made aware of their responsibility to attend agreed appointments. Is the patient gives any prior notice that they cannot attend their appointment (even if this is on the day of the 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.

Letters to patients will confirm that where a patient cancels at short notice (i.e. less than 48 hours before appointment) or where a patient has cancelled two appointments on the same pathway, subject to clinical decision, there is a chance they will be discharged back to their referrer.

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. If following clinically review there is a decision to reappoint the patient, the RTT clock continues and they will receive one further appointment offer.

### 2.6.1 Patients who arrive late for their appointment

The system asks all patients to keep their appointments and arrive in good time.

If a patient arrives after their appointment time, every effort will be made to see them for their consultation, for example, if delayed arrival is the responsibility of the Patient Transport Service. Patients who arrive late may have to be seen last or it may need another member of the team seeing the patient, if clinically appropriate.

If the patient arrives too late to be seen and cannot be accommodated within the scheduled time of the clinic, i.e. 30 minutes beyond their appointment time, their appointment should be cancelled and another appointment should be made. This will be treated as a patient cancellation and as such follow that part of the policy (it is important that the appointment is cancelled and not rescheduled). Details of this action and reason for delay should be recorded on the PAS system.

### 2.6.2 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 (as per section 2.3.3).

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.

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

It may be necessary to offer patients choice to be treated at another provider, in these instances the same process and clock rules apply as above (Patients who cancel or decline TCI offers). 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.

### 2.6.4 Patients declaring periods of unavailability while on the inpatient/daycase waiting list

If a patient contacts the trust to communicate a period of unavailability for social reasons (e.g. .holidays, exams), this period will 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 will 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.

## 2.7 Appointment changes initiated by the hospital

The system will avoid cancelling outpatient appointments wherever possible for reasons such as staff availability, service suspension, equipment failure etc.

If a patient's appointment has to be rescheduled due to a hospital cancellation, the patient will be rebooked to as close to the original appointment date to enable treatment to take place within the RTT breach date. If the appointment is under 7 days, the patient will be contacted by telephone and letter. The reason for

cancellation should be recorded on the PAS system. The RTT clock continues to tick during this time.

Clinicians are actively encouraged to book annual leave and study leave requests as early as possible and ideally the year ahead.

Clinicians should follow the 'Consultant Leave Policy' when cancelling clinics and provide as much notice as they, in all but exceptional circumstances, to cancel or reduce any outpatient or diagnostic session for reasons due to annual, study leave or on-call commitments. If it is necessary, in exceptional circumstances, to cancel or reduce any outpatient sessions, the relevant Assistant Service Manager or dedicated operational lead for that specialty must authorise and where practical, agree a re- provision of lost capacity to ensure patients are not disadvantaged and wait times do not increase.

All short notice (less than 6 weeks) clinic cancellations must be authorised by the appropriate operational lead. Short notice cancellations without appropriate authorisation will not be actioned.

## Section 3 Pathway specific milestones

### 3.1 Non-admitted pathways

The non-admitted stages of the patient pathway comprise both outpatients and the diagnostic stages. 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.

### 3.2 NHS e-Referral System

The NHS e-Referral Service (eRS) is a national electronic referral service that gives patents a choice of provider for their first consultant outpatient appointment. The patient is allocated a Unique Booking Reference Number (UBRN).

The RTT clock starts when the UBRN is converted into an appointment by the patient's referring health professional or by the patient themselves.

If an NHS e-Referral is received for a service not provided by the system, it will be rejected back to the referring GP advising that the patient needs to be referred elsewhere. This will stop the patient's RTT clock.

As of October 2018, in line with NHS England referrals from GP practices to Consultants will only be accepted if sent via eRS. Paper referrals will be returned to the GP practice with the exception of 2Week Wait, Urgent referrals and other services on the exemption list.

Across the system Trusts have SOPs detailing the process of referral booking processes and KPIs, these can be found on the relevant organisations intranet for staff.

## 3.3 Advice and Guidance

GPs can request individual consultants to provide advice and guidance under the NHS eRS. Advice and Guidance does not start an RTT clock. Any advice and guidance requests must be reviewed by the clinician to whom they are directed and responded to as soon as possible within clinically appropriate time frames. Where a consultant converts an advice and guidance request to an appointment referral in eRS, this starts the RTT clock for the patient. **Advice and guidance changes implemented in early 2021 - NHS Digital**

## 3.4 Prioritisation and Clinical Review of Referrals (triaging)

Once referrals have been received, the referral is either managed by the Cancer 2 Week Wait Team for immediate booking (for suspected cancer or breast symptomatic referrals for eRS) or directed to the appropriate consultant or clinical team for triaging.

For referrals to be triaged, referral letters must be passed to the consultant within 2 working days of receipt:

- Urgent referrals should be triaged within 3 working days
- Routine referrals should be triaged within 5 working days of receipt by the consultant or a nominated clinician to whom the patient has been referred.

### 3.4.1 Upgrading or downgrading a referral

Where a consultant to clinical team suspect the possibility of cancer, the referral should be upgraded from routine to 2WW. The GP or other referrer must be informed at this time by the person triaging the referral that the clinical priority of their patient has changed. The change will be adapted and managed within the PAS system (see cancer operational policy for further detail on upgrades).

Non-2WW referrals can be downgraded by the receiving consultant following triage. Cancer referrals cannot be downgraded and the management of this process is detailed below within section 6.7.

### 3.4.2 Redirecting Referrals

Where the referral has been made to the incorrect clinical team or consultant, the receiver should redirect the referral to the correct clinical service. This redirection occurs within eRS. This does not affect the patient's RTT pathway and the clock should continue to tick from the referral received date.

### 3.4.3 Rejecting Referrals

At the point of clinical triaging, referrals deemed inappropriate will be returned to the GP or other referrer with an explanation as to why it has been rejected. It is then the referrer's responsibility to notify the patient that the referral was rejected to ensure the patient does not attend a previously arranged appointment. The duty of care rests with the referrer until such time as the referral is accepted by the system. The RTT clock will be nullified.

The referring clinician has the responsible of ensuring any referral criteria is adhered to and pre-referral diagnostics are complete prior to undertaking the referral. Patients who do not meet pre-referral criteria will have the referral rejected and the referring clinician will be informed. The referring clinician is responsible for informing the patient in these instances. The RTT clock will be nullified.

### 3.4.4 Consultant to Consultant Referrals

Consultant to consultant referrals must follow the guidelines agreed locally by the ICB. Patients can be referred to another consultant in a different specialty in the patient's best interest without the need for the patient to be re-referred back to the hospital via the GP.

A clinician must not refer a patient to another clinician where the presenting conditions are unrelated to the original referral from primary care except where the referrals are classed as clinically urgent by a referring consultant.

As such, patients will be returned to primary care where a presenting condition is not classed as clinically urgent or related to the original referral.

In cases where the patient is identified as having suspected cancer, the patient must be transferred to the care of the appropriate service with 48 hours. It is the responsibility of the referring clinician to inform the patient's GP or other referrer that the patient has been referred to another team.

When this occurs and the patient is still awaiting treatment, the RTT clock continues from the original referral date.

### 3.4.5 Rapid Access Chest Pain Clinic Referrals

RACPC patients must be seen by a specialist within 14 days of the system receiving the referral. To ensure this is achieved:

- RACPC referrals should be made via eRS only
- GPs should ensure that appropriate information regarding the RACPC referral is provided to the patient.

### 3.4.6 Appointment Slot Issues (ASI)

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 the patient is not visible on the RTT PTL.

ASIs lists are pulled from ERS on a daily basis and cross checked against speciality worklists for action. These referrals are manually added to PAS and the RTT clock started from the date the patient attempted to book their appointment, for example, when the hospital receives the referral on their ASI worklist.

## 3.5 Cross Site Transfers

Where patients are referred from one site to another for treatment as part of mutual aid, an Intra-Provider Trust form is to be completed providing agreement Minimum Data Sets (MDS), this MDS includes clinical information and RTT clock start date and RTT clock status.

The transfer should be agreed with the patient and sent electronically as per the site processes.

The RTT clock continues from the original referral.

Once the referral is active on the receiving Trust's PTL, the pathway RTT code is updated to a 21 – transfer to alternative provider, once the patient has a clock stop at the receiving site documentation of this will be sent on the referring site to the RTT pathway can be stopped.

## 3.6 Inter-Provider Transfers (including community services)

In order to support our patients' care there are occasions where a patient will need to be transferred from one hospital to another, this could be transfer into the organisation or transfer out of the organisation. The system accepts referrals from other secondary care Trusts for both urgent (including suspected cancer) and routine tertiary care and community providers.

### Incoming IPTs

All IPT referrals will be received electronically via the relevant trust's secure generic NHS net email account.

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 this trust.** They will then forward to the receiving trust within one working day of receipt into the generic email inbox.

### 3.7 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.

### 3.8 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.

### 3.9 Patient Initiated Follow Up (PIFU)

PIFU is established for certain pathways where patient have stable long-term conditions requiring regular follow ups or acute conditions that infrequently require follow up in the hospital. Instead of being offered regular clinic visits or routine check-ups, patients can (if agreed between themselves and their clinician) request an appointment by telephone only when / if required for an agreed time frame. If no further appointment is requested within the agreed timeframe, the pathway will be closed. Any further appointment will require a new GP referral, unless the service has a planned review after the end of the PIFU period. Please see PIFU Standard Operating Procedures for further details on managing patients on PIFU.

### 3.10 Clinic Outcomes

Every patient, new and follow-up, whether attended or not, will have an attendance status and outcome recorded on the PAS system.

Every attendance must have a defined clinical outcome and RTT status recorded as part of the clinic outcome on the PAS system directly after the patient's attendance. The RTT status must relate to the outcome of the current activity not next activity.

## Section 4 – Diagnostics

The diagnostic stage of the RTT pathway forms part of the non-admitted pathway. It starts at the point of a decision to refer for a diagnostic test and ends on the results/report from the procedure being available to the requester.

### 4.1 Diagnostic Booking Process

Referrals for diagnostic tests / procedures are accepted from the following sources:

- GPs, other referrers, or direct access
- Consultant referral (internal)
- Consultant referral (tertiary).

Patients should only be referred for a diagnostic if they are ready and available to attend their appointment in the next 6 weeks unless the diagnostic test is planned for a specific time. It is the responsibility of the referrer to ensure the patient is made aware of this.

Once diagnostic tests are requested as an order on the PAS system or on ICE for primary care direct access the request is triaged and prioritised. Requests can be upgraded, downgraded or rejected.

### 4.2 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:

(1) Their RTT clock which started at the point of receipt of the original referral.
(2) 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.

### 4.3 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 start on receipt of the referral. These are called straight-to-test referrals.

### 4.4 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.

## 4.5 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.

### 4.5.1 Diagnostic Cancellations Hospital Initiated

Every attempt will be made not to cancel diagnostic tests / procedures, however if the system cancels a diagnostic appointment, the patient's appointment should be rebooked as close as possible to their original appointment and within the 6-week target date, with consideration to RTT target dates where applicable. The diagnostic clock continues and is not restarted.

### 4.5.2 Patient Initiated Cancellations and DNA's

The same rules apply for diagnostics for patient cancellations and DNAs as for any other clinical appointment where the patient has been given reasonable notice.

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 will 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.

The new diagnostic appointment should be a reasonable offer and ideally as close to their cancelled or DNAd appointment as possible, and within the new / recalculated 6-week target date, with consideration to RTT target dates where applicable.

If the patient was not given reasonable notice the diagnostic clock would continue to tick and a new appointment should be offered if clinically appropriate.

Where a diagnostic test is rebooked following a patient cancellation or DNA (as long as the appointment was reasonable), a new diagnostic clock is started on the date of the cancellation / DNAd appointment.

If a clinical decision is taken that the patient no longer requires the diagnostic test, the patient will be removed from the diagnostic waiting list and a letter will be sent to the original referrer (for the diagnostic). Where there is an RTT clock this will continue.

## 4.6 Diagnostic Booking Standards

General principles and standards for diagnostic booking:

- Tests are booked in order of clinical priority (urgent over routine) and then in chronological order.
- Clinicians or administrator inform patients of the likely waiting time for diagnostic appointments.
- The decision to add patients to the diagnostic waiting list must be made by the consultant or designated clinical member of the team. It is the responsibility of the clinician or designated clinical member of the team to place the order for the patient to enable them to be added to the waiting list.
- Every effort is made to contact the patient directly to agree the diagnostic test or procedure date.
- If the patient cannot be contacted (following unsuccessful telephone contact and checking with the GP or other referrer that the system has the correct contact details) the patient will be given the next available appointment date and sent an appointment confirmation letter.
- Where individuals have specific communication needs, services will provide help and information in formats that they can understand.
- The system requires patients to be offered a choice of 2 appointment dates with at least 3 weeks' notice of the appointment (reasonableness criteria). This does not preclude offering patients the choice of an earlier date if they agree.
- The appointment must be booked before the 6-week target. The cancer and RTT clock and status should always be checked.
- If a patient turns down reasonable appointment, i.e. two separate dates with three weeks' notice, the diagnostic waiting time for that test / procedure can be set to zero from the first date offered. The RTT clock continues to tick.

## 4.7 Pre-operative assessment (POA)

All patients with a Decision to Admit (DTA) requiring a general anaesthetic will require a pre-operative assessment (POA). Pre-operative assessment establishes whether a patient is fit for surgery including anaesthesia and confirms that the patient is available, fully informed and wishes to proceed with surgery. Patient information leaflets will be available to issue to the patient at the time of the appointment. Patients should be booked for their pre-op assessment as soon

as possible once there has been a DTA.

The following sets outpatient scenarios following pre-operative assessment. It is important to note that all decisions regarding the RTT clock (whether it continues or stops) should be a clinical one. This decision can be made by the POA nurse, an anaesthetist or any other consultant who is involved in assessing the patient's fitness for surgery. In the event of a clock stop, this decision should always be made by the anaesthetist or another consultant.

MRSA swabs should be obtained from all eligible patients when attending for pre-operative assessment. Where patients are found to be colonised they are treated immediately in line with Trusts MRSA policy. This does not stop the RTT clock.

Across specialities there are pre-operative investigations/tests/swabs as part of a patient's work up, a clock does not stop for these tests. If a patient refuses to undertake these tests or is non-compliant in undertaking within set timescales this will be highlighted to the responsible consultant for a clinical decision to either proceed (meaning the clock will continue or) discharge back to the patient's GP.

If after anaesthetic review a patient is deemed fit for surgery, the patient will be informed that they can proceed and offered dates for surgery by the Waiting List Office.

### 4.7.1 Patients who are unfit for surgery

If the patient is identified as unfit for the procedure, the nature and duration for the clinical issue should be ascertained. The following scenarios are guidance to support with clinical decisions regarding the application of the rules:

**Short-term illnesses**
If the clinical issue is short-term (i.e. below 4 weeks) 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:

(i) 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.
(ii) 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

If a patient requires additional investigations or they should be clinically reviewed and a decision made as to whether they remain on the waiting, are removed from the waiting list, or actively monitored.

If a decision is made that the patient should be removed from the waiting list or placed on active monitoring, the GP will be informed of the decision and will be provided with relevant information to support the GP in managing the patient's health to a level, if possible, where they can proceed with surgery. The patient will also be informed that they cannot proceed with the agreed surgery. The RTT clock will stop.

Patients who are returned to the care of their GP but are subsequently re-referred in within the next 6-month period should be added back onto the elective waiting list using the date the letter was received as the new clock start date. The consultant should complete an order for surgery on the PAS system as per the normal process. A new RTT clock will start.

### 4.7.1 Patient initiated cancellation or DNA

If a patient fails to attend a pre-operative assessment appointment, then the patient should be contacted by the pre-assessment team to discuss the reason. It is expected that one of two outcomes will occur:

- A further date for a pre-operative assessment should be agreed. The RTT clock will continue; or
- Discharged back to the care of the GP following review from listing consultant. This will stop the RTT clock.

### 4.7.2 Patient non-contactable

Where a patient cannot be reached by initial phone call, three further attempts on different days at different times will be made to contact the patient. If the patient can still not be reached a letter will be sent giving 3 weeks' notice to make contact to book their POA. If the patient does not make contact within those three weeks they will be returned to their referrer if there is a clinical decision to discharge.

## Section 5 – Admitted Pathways

The system will 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 date).

### 5.1 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.

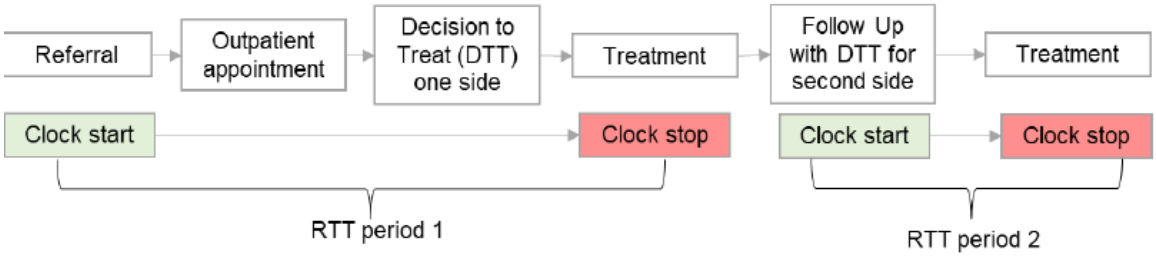
The RTT clock will stop upon admission.

## 5.2 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 (as per 3.8 above). In these instances the patient should 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.

RTT clocks for bilateral procedures are sequential and not concurrent (nor listed as planned), below is an example of a bilateral pathway:




## 5.3 Planned patients

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 (also 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.

## 5.4 Clinical Prioritisation / Priority Coding (P Codes)

When a patient is added to the waiting list they will be assigned a clinical prioritisation code by the clinician. This clinical validation of waiting lists allows lists to run effectively by:

- Prioritising access to procedure based on individual patient needs, while considering the need of the population
- Facilitating good communication between the patient, GP and secondary care provider
- Producing a validated waiting list that is up to date and that allows procedures to run effectively
- Minimising waits where possible, but particularly those with immediate need
- Recognising that for less urgent or routine procedures, some patients may experience a delay.

All patients who are listed for surgery should have a clinical priority decision at the point of listing a patient for surgery. The criteria for each elective speciality is agreed by clinical leads following guidance from respective Royal Colleges. This is based on the clinical urgency and the options that can be selected are:

| 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).

### 5.5 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.

## Section 6 Training and Education

This policy will be actively promoted and distributed to all employees who are involved with managing patient pathways and especially all those employees working within the Outpatient Department, the Waiting List Office, the MDT and Cancer offices and all Medical Secretaries. It will also be available to all employees on the intranet.

Any new members of staff appointed to the above-mentioned departments will be made aware of this policy as part of their local induction.

Additional training is provided by the RTT Team for both clinical and non-clinical staff to support this policy during the course of their employment with the system.

It will be incorporated into elective care training and for all appropriate staff it will be a requirement to read this policy as well as complete the online e-learning training, see appendix 008 for e-learning matrix.

## Section 7 Monitoring

| **Elective Access Policy** | | | | |
|---|---|---|---|---|
| WHAT | HOW | WHO | WHEN | WHICH GROUP |
| Policy is to ensure that patients are treated promptly, efficiently and consistently in line with national guidance and good practice. | Regular review of performance and continuous spot checks by data quality team. | Head of Elective Access | Annual | Insight |

**APPENDIX 1**
**Scheme of Delegation**

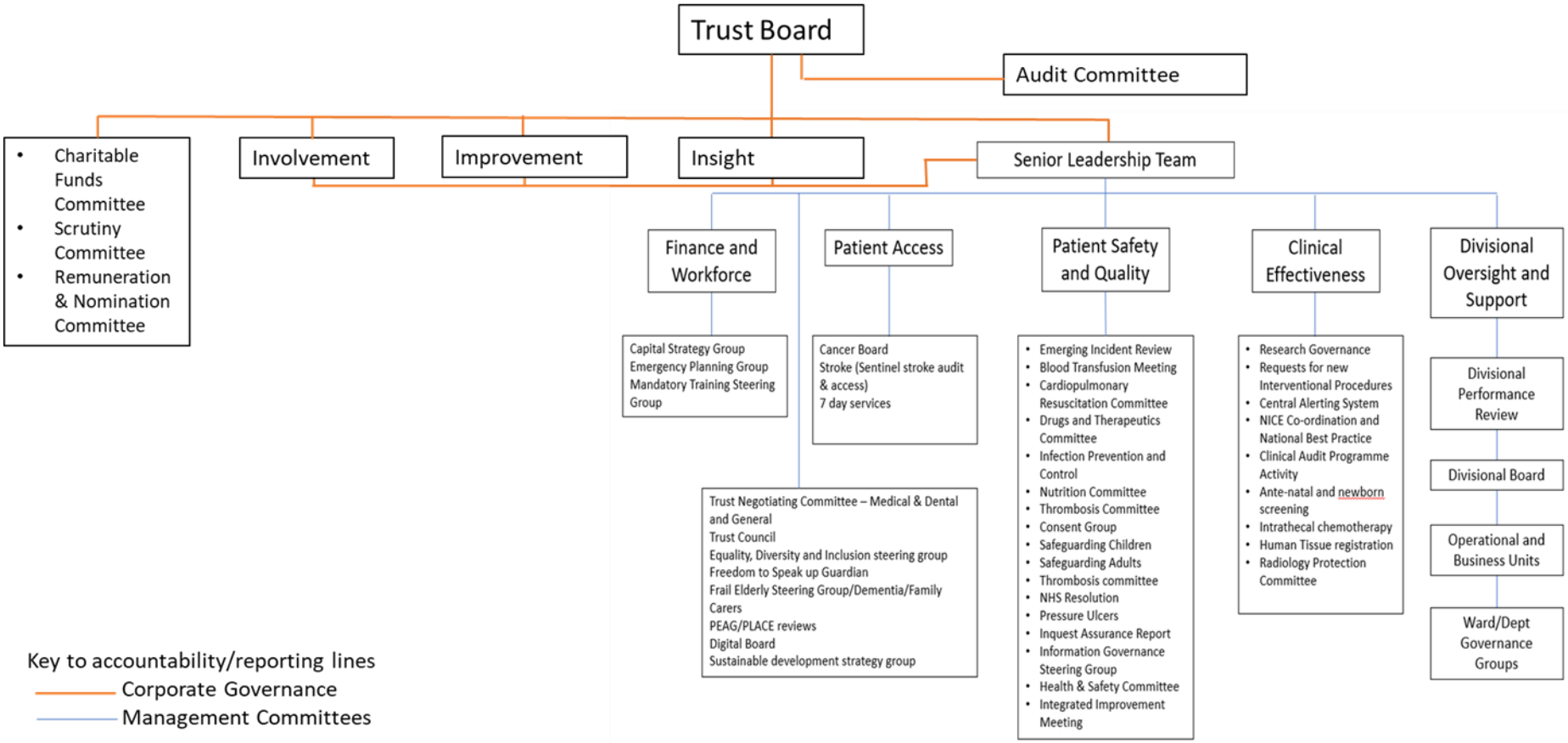
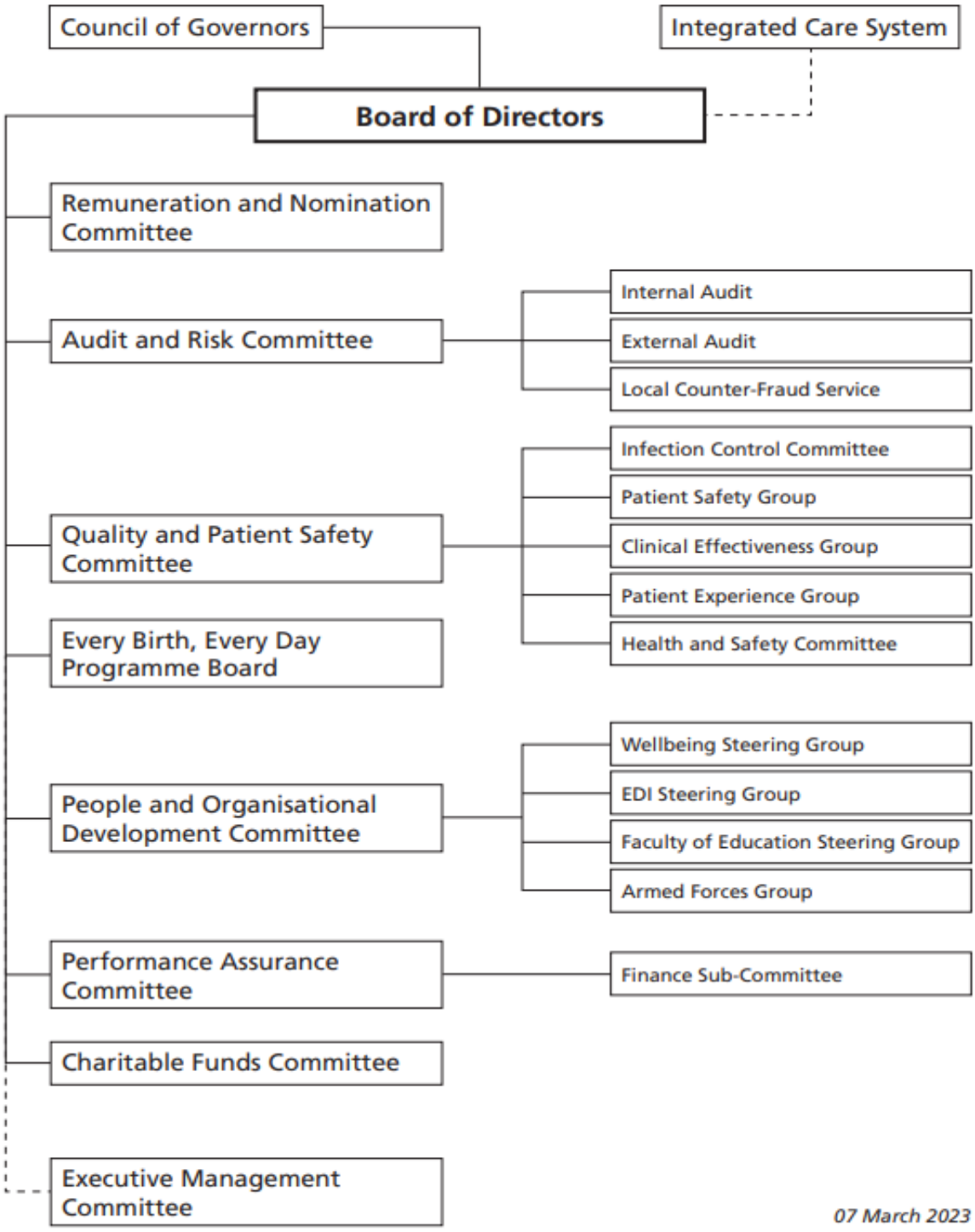



*Figure 1 WSFT Delegation*

# Overview of ESNEFT

NHS
East Suffolk and
North Essex
NHS Foundation Trust




*07 March 2023*

**Appendix 2**

## EQUALITY/DIVERSITY ASSESSMENT TOOL

| | |
|---|---|
| **Title of Document** | Elective Access Policy |
| **Date of assessment** | 19/01/2023 |
| **Date for review** | 19/01/2026 |
| **Division** | Corporate |
| **Completed by** | Hannah Knights |
| **Date** | 19/01/2023 |

| | **Yes/No** | **Rationale** |
|---|---|---|
| Does the document affect one group less or more favourably than another on the basis of: | | |
| • Race | N | |
| • Gender | N | |
| • Sexual orientation | N | |
| • Age | N | |
| • Disability | N | |
| • Marriage and Civil Partnership | N | |
| • Pregnancy and Maternity | N | |
| • Culture | N | |
| | | |
| Does this document affect an individual's human rights? | n | |

| **If the answer to any of the above is 'yes' then:** | **Tick** | **Rationale** |
|---|---|---|
| Demonstrate that such a disadvantage or advantage can be justified | | |
| Adjust the policy to minimise the disadvantage identified or better promote equality | | |
| If neither of the above is possible, submit to Trust Council for review | | |

## Appendix 3
## Glossary and Acronyms

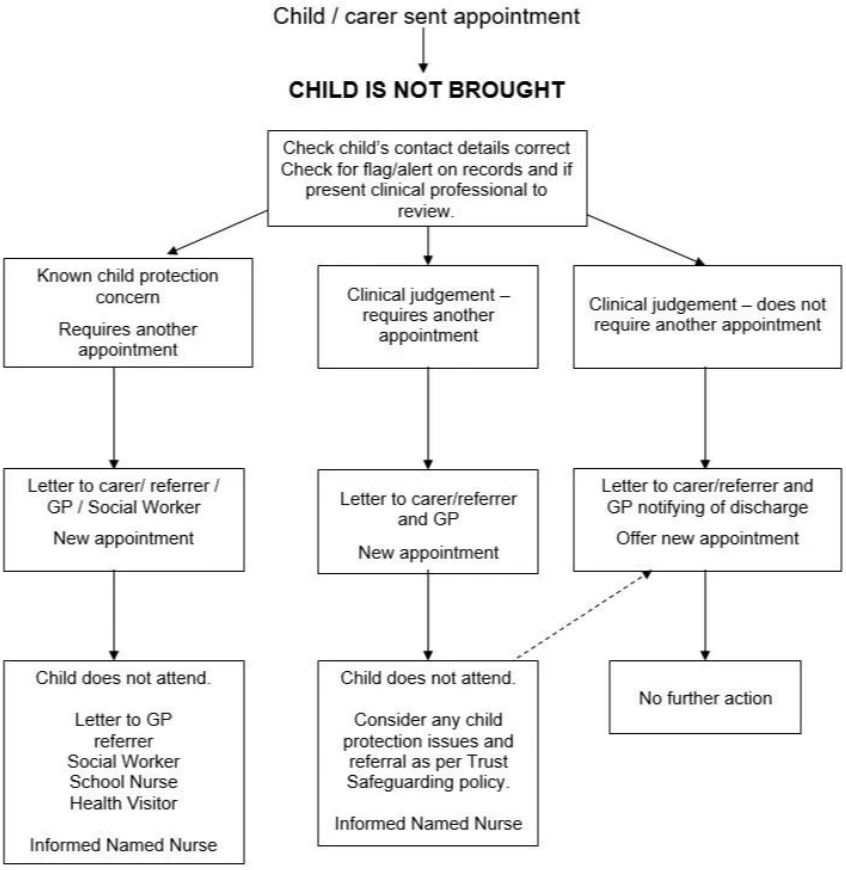
Common terms and abbreviations used i

## Appendix 4
## Patients who are unfit SOP

SOP for unfit patients.docx

## Appendix 5
## Children who are not brought in

**Management of non-attendance to appointments / child was not brought to an appointment**




## Appendix 6
## Learning Disability PTL SOP

ESNEFT SOP LD PTL.pdf