Elective Access Booking and Choice Policy

	POLICY		
Reference	G/EAB&CPiCA		
Approving Body	*Planned Care Steering Group, Clinical Chairs*		
Date Approved	*22 August 2023*		
For publication to external SFH website	***Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:***		
	YES	**NO**	**N/A**
Issue Date	*22 August 2023*		
Version	*3.0*		
Summary of Changes from Previous Version	*Changes to content relating to National Guidance and Best Practice examples. Replace Medway PAS – CareFlow PAS Remove DCOO Elective Care*		
Supersedes	*Version 2.0*		
Document Category	*Governance*		
Consultation Undertaken	*Planned Care Steering Group, Clinical Chairs, Medical Managers, Heads of Service, Patient Services Divisional Representatives.*		
Date of Completion of Equality Impact Assessment	*30 June 2023*		
Date of Environmental Impact Assessment (if applicable)			
Legal and/or Accreditation Implications	*Developed in line with best practice Model Access Policy. Elective Care Improvement Support Team NHSE/NHSI*		
Target Audience	*This policy applies to any staff involved in the management of all cancer, urgent and routine patients at the Trust irrespective of who is making the booking and where the activity is scheduled. The policy does not apply to emergency care.*		
Review Date	*30 June 2025*		
Sponsor (Position)	*Deputy Chief Operating Officer*		
Author (Position & Name)	*Head of RTT*		
Lead Division/ Directorate	*Corporate*		
Lead Specialty/ Service/ Department	*Elective Care*		
Position of Person able to provide Further Guidance/Information	*Head of RTT*		
Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**		

APPENDICIES

1 INTRODUCTION

The Trust is committed to delivering high quality and timely elective care to patients; and to promoting and providing services which meet the needs of individuals and does not discriminate against any employee, patient, or visitor.

This policy is issued and maintained by the Chief Operating Officer (the sponsor) on behalf of the Trust, at the issue defined on the front sheet, which supersedes and replaces all previous versions.

This document defines the Elective Access, Booking & Choice Policy for Sherwood Forest Hospitals NHS Foundation Trust (hereafter referred to as 'the Trust').

This policy:

- Sets out the rules and principles under which the Trust manages elective access to outpatient appointments, diagnostics and elective inpatient or day case treatment.
- Gives staff clear direction on the application of the NHS Constitution and the NHS Choice Framework in relation to elective waiting times.
- Demonstrates how elective access rules should be applied consistently, fairly, and equitably.

The Trust's Elective Access Booking and Choice Policy has been developed following consultation with key stakeholders including the Clinical Commissioning Groups, GP'S, Clinical Leads, Divisional General Managers, and other relevant Trust Staff.

The Policy will be reviewed and ratified bi-annually; unless changes to the National Elective Care Access Rules are introduced or locally agreed principles are developed.

The Access Booking and Choice Policy must be read in full by all staff involved in elective patient care and staff should attend any relevant Trust Elective Care training sessions provided.

The Access Booking and Choice Policy will be supported and underpinned by a comprehensive suite of Standard Operating Procedures (SOPS) that are available to read and print from the Trusts Data Quality Web page. All clinical and administrative staff must ensure compliance with the principles contained within this document and specific guidance contained within the SOPS.

Top Tip - The link to suite of Standard Operating Procedures is:
http://sfhnet.nnotts.nhs.uk/admin/webpages/preview/default.aspx?recid=1373&pid=1373

2 PURPOSE

The purpose of this policy is to ensure that all patients requiring access to outpatient appointments, diagnostics and elective inpatient or day-case treatment are managed equitably and consistently, in line with national waiting time standards and the NHS Constitution and the NHS Choice Framework. (See document links pg. 53)

The policy:

- Is designed to ensure the management of elective patient access to services is transparent, fair, equitable and managed according to clinical priorities
- Sets out the principles and rules for managing patients through their elective care pathways
- Applies to all clinical and administrative staff and services relating to elective patient access at the trust.

The policy covers those responsible for referring patients, managing the receipt of referrals, booking outpatient activity, management of diagnostics and maintenance of the elective waiting list for the purpose of taking a patient through their referral to treatment pathway.

This policy applies to the management of all patient groups, excluding non-elective, maternity/obstetric patients, and patients on a suspected or confirmed cancer pathway at the Trust irrespective of who and where the booking and scheduling of patient's activity is undertaken.

Arrangements for suspected or confirmed cancer patient pathways are set out specifically within the Cancer Access Policy. Cancer Access Policy

Top Tip - There may be situations which are not covered by this document. If you require further assistance or clarification on any aspects of this policy, please contact your direct line manager for any general issues in the first instance or the RTT and Data Quality Educator for more specific queries. Contact the Cancer Management Team for queries relating to the application of cancer waiting times standards.

Equality Impact Assessment

The Trust is committed to ensuring that none of its policies, procedures and guidelines discriminate against individuals directly or indirectly based on gender, colour, race, nationality, ethnic or national origins, age, sexual orientation, marital status, disability, religion, beliefs, political affiliation, trade union membership, and social and employment status. An EIA of this policy/guideline has been conducted by the author using the EIA tool developed by the Diversity and Inclusivity Committee. (22/12/15).

Related Policies and Guidelines and/or Other Documents

- Cancer Access Policy
- Overseas Visitor Policy
- Restricted Procedures Policy
- Private Patient Policy
- Management of Children who do not attend appointments Policy
- Elective Care Training Strategy

Top Tip – Definitions and Acronyms can be found in the appendices

3 ROLE AND RESPONSIBILITIES

Whilst the Chief Executive has overall responsibility for achieving the Trusts national standards as the accountable officer, all staff with access to the elective care patient administration systems (PAS - The Trust use CareFlow) have a duty to maintain the information held within and are accountable for their accurate data input.

- The Chief Operating Officer is responsible for ensuring patient access through the operational delivery of the waiting times standards described in this policy and responsibility for the governance and performance monitoring processes that underpin the Policy.

- The Deputy Chief Operating Officer is responsible for ensuring that this Policy is implemented across Trust services and that operational systems and processes are developed, coordinated and monitored.

- Divisional Clinical Chairs and Divisional Managers have a shared responsibility for implementation of the Elective Access, Booking & Choice Policy within their Division's clinical and management teams and for ensuring compliance with the arrangements set out within this policy. They also have joint responsibility for ensuring clinical teams within their division have awareness of all patients on the RTT and Cancer PTL, and for the management of these patients through their pathways.

- Hospital Consultants, Clinical Nurse Specialists along with the divisional teams have a shared responsibility for managing patients waiting times.

- The Chief Digital Information Officer is responsible for the timely provision of operational information to support delivery of patient pathways and for the reporting of information within and external to the organisation including the production of Patient Tracking Lists (PTLs) which support the Divisions in managing waiting lists and RTT standards.

- The Medway Patient Administration System (PAS) Manager is responsible for the management of the CareFlow system on which patient information and waiting lists are held.

- Waiting list administrators for outpatients, diagnostics, elective inpatient, or day care services are responsible for the day-to-day management of their lists and are for compliance with all aspects of the Trusts Elective Access Policy. They are supported in this function by the general managers and divisional directors who are responsible for achieving all access standards.

- Operational managers are responsible for ensuring the NHS e-referral service directory of services (DOS) is accurate and up to date and available to referrers.

- General practitioners (GPs) and other referrers play a primary role in ensuring patients are fully informed of the likely waiting times for a new outpatient consultation and of the need to be contactable and available to be seen once referred. GPs should ensure quality referrals are submitted in line with the DOS to the appropriate provider first time. Inappropriate referrals, including those which do not meet agreed referral criteria, will be rejected, and returned to the referrer with an explanation, or forwarded on to the appropriate department.

- ICBs are responsible for ensuring all patients are aware of their right to treatment at an alternative provider if their RTT wait goes beyond 18 weeks. In this instance, CCGs 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 a clinical commissioning group or NHS England.

- The Trust is responsible for providing information to the CCG relating to the DOS and referral criteria and providing relevant feedback when GP's have not followed guidance, which can then be shared with GPs.

- The Trust is responsible for a providing a robust mechanism of receiving feedback when this or other trust policies are breached.

- The CCGs are responsible for ensuring there are robust communication links for feeding back information to GPs.

Top Tip - The Information Manager, The Head of RTT and Data Quality and the Cancer Management Team are responsible for providing subject matter expert advice and guidance in the application of the national pathway management rules, this policy, and its application throughout the Trust.

The NHS Constitution recommends the following actions patients can take to help in the management of their condition:

- Patients can make a significant contribution to their own, and their families, good health, and wellbeing, and should take personal responsibility for it.
- Patients should be registered with a GP practice as this is the main point of access to NHS care as commissioned by NHS bodies.
- Patients should provide accurate information about their health, condition, and status.
- Patients should keep appointments or cancel within a reasonable timeframe.

4 STAFF COMPETENCY & COMPLIANCE

Competency

- The Trust will provide the necessary training for staff in the use of CareFlow PAS and specific functions within the system relating to each individual member of staff's job role, ensuring a clear understanding of expectations is communicated.
- As a key part of their induction programme, all appropriate new starters to the Trust will undergo role specific mandatory elective care training applicable to their role.
- Existing staff will undergo role specific mandatory elective care training on an annual basis, both classroom based and e-learning.
- All staff will undertake competency tests and the outcomes will be clearly documented to provide evidence that the required level of knowledge and ability has been attained. There will be at least 2 assessors in each division and the assessor's competency will be assessed by the Data Quality Team.
- Performance and capability will be monitored and managed as part of the DQ Errors Escalation Process.
- This policy, along with the supporting suite of Standard Operating Procedures and PAS User guides, will form the basis of all training programmes.

Top Tip – Further details are available in the Elective Care Training Strategy or by contacting the RTT and Data Quality Educator.

Compliance

- Clinicians, functional teams, specialties, and staff will be performance managed against key performance indicators (KPIs) applicable to their role. Role specific KPIs are based on the principles in this policy and specific aspects of the Trust's standard operating procedures.

- In the event of non-compliance with the Policy, a solution should 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 if continues.

5 SCOPE OF POLICY

This policy applies to the management of all cancer, urgent and routine patients at the Trust irrespective of who is making the booking and where the activity is scheduled. **The policy does not apply to emergency care.**

6 CONSULTATION

The policy was formally ratified at the following committees:

Contributors:	**Communication Channel:**	**Date:**
Operational Management	For information	
Medical Managers	For information	
Clinical Chairs	For information	
Planned Care Steering Group	For Ratification	
CCG	For input	

7 GENERAL ELECTIVE PRINCIPLES

Elective Access Principles and General Rules

The NHS has set maximum waiting time standards for elective access to healthcare. In England, waiting-time standards for elective care (including cancer) come under two headings:

- The individual patient rights (as in the NHS Constitution).

- The standards by which individual providers and commissioners are held accountable by NHS Improvement and NHS England.

The NHS Choice Framework states in Section 3 that patients can choose where they go for their first appointment as an outpatient and Section 4 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.

Individual Patient's Rights:

The NHS constitution clearly sets out a series of pledges and rights stating what patients, the public and staff can expect from the NHS. A patient has the right to the following:

- The choice of care provider and clinician
- For routine conditions it is expected that the patient will commence their treatment following a referral into a consultant-led service, within a maximum waiting time of 18 weeks to treatment
- For urgent referrals where cancer is suspected it is expected that the patient will be seen by a cancer specialist within a maximum of two weeks from a GP referral

Where this is not possible, the Trust must take all reasonable steps to offer a range of alternatives.

The right to be seen within the maximum wait time does not apply in the following circumstances:

- If the patient chooses to wait longer (the patient's RTT clock continues to tick)
- If delaying the start of the treatment is in the best clinical interests of the patient, (RTT clock continues to tick)
- If it is clinically appropriate for the patient's condition to be actively monitored in secondary care without clinical intervention or further diagnostic procedures at that stage (the RTT clock should stop)

Patients must be treated within the above national waiting time standards and in line with the NHS Operational Planning and Contracting Guidance.

Attached is the Guidance 23/24. Additionally attached is the Delivery Plan for Tackling the COVID-19 backlog of Elective Care (the Delivery Plan) which sets out key ambitions in recovery for the next 3 years.

Top Tip - The NHS Operational Planning and Contracting Guidance for 23/24:
PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf (england.nhs.uk)
2022/23 priorities and operational planning guidance: Elective recovery planning supporting guidance:
2022/23 priorities and operational planning guidance: Elective recovery planning supporting guidance

A summary of the key points from the 2023/2024 Operation Planning and Contracting Guidance are:

- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
- Deliver the system- specific activity target (agreed through the operational planning process)
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
- Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
- Deliver an appropriate reduction in outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024
- Increase productivity and meet the 85%-day case and 85% theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings

- Offer meaningful choice at point of referral and at subsequent points in the pathway, and use alternative providers if people have been waiting a long time for treatment including through the Digital Mutual Aid System (DMAS)

The deliverables for cancer are:

- Implement and maintain priority pathway changes for lower GI (at least 80% of FDS lower GI referrals are accompanied by a FIT result), skin (teledermatology) and prostate cancer (best practice timed pathway)

- Increase and prioritise diagnostic and treatment capacity, including ensuring that new diagnostic capacity, particularly via community diagnostic centres (CDCs), is prioritised for urgent suspected cancer. Nationally, we expect current growth levels to translate into a requirement for a 25% increase in diagnostic capacity required for cancer and a 13% increase in treatment capacity

- Expand the Targeted Lung Health Checks (TLHC) programme and ensure sufficient diagnostic and treatment service capacity to meet this new demand.

- Commission key services which will underpin progress on early diagnosis, including non-specific symptoms pathways (to provide 100% population coverage by March 2024), surveillance services for liver; and work with regional public health commissioners to increase colonoscopy capacity to accommodate both the extension of the NHS bowel cancer screening programme to 54 year olds and the inclusion of Lynch patients, and to increase capacity within the NHS breast screening programme for patients with BRCA.

Patient Eligibility - NHS Treatment

Overseas Patients

The Trust has a legal obligation to identify patients who are not eligible for free NHS treatment and to assess liability for charges incurred because of care provided in accordance with Department of Health Rules.

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

- have paid the immigration health surcharge

- have come to work or study in the UK

- have been granted or made an application for asylum

- Citizens of the European Union (EU) who hold a European Health Insurance Card (EHIC), PRC or S2 are also entitled to free healthcare, although the trust may recover the cost of treatment from the country of origin.

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.

Top Tip
The contact number for the Overseas Department is ext. 4211.
The Overseas Visitors Policy is: f-17-001-osvp-policy-june-2021.pdf (sfh-tr.nhs.uk)

Patients Moving Between NHS and Private Care

Patients can choose to move between NHS and Independent Sector (IPS) Care at any point during their pathway without prejudice. (Either from NHS to IPS or IPS to NHS) For example' where it has been agreed that a patient requires a surgical procedure the patient can be added directly to the elective waiting list of either provider if clinically appropriate to do so.
When transferring to NHS care, the RTT clock starts at the point the GP or original referrer's letter is received into hospital. A new GP referral is not needed at the time care is transferred to the trust from the IPS provider - the original GP referral to the private healthcare provider can be transferred to the trust. This also includes patients transferring from NHS to private care a new referral is not required.

The RTT pathways of patients who notify the Trust of their decision to transfer to IPS care will be closed with a clock stop applied on the date of the transfer. NB this does not apply to patients transferred to IPS under NHS care for Mutual Aid purposes.

Top Tip
Link to Private Patient Policy https://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=51596

Link to Private Practice & Fee-Paying Policy
https://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=51602

Evidence Based Interventions (EBI)

These are procedures where there is limited evidence of clinical effectiveness, or which might be considered cosmetic and therefore can only be accepted with the prior agreement by the ICB Commissioners through a clear set of criteria and an appropriate assurance process. A number of these procedures were either restricted through the Procedures of Limited Clinical Value Policy 2015 or the East Midlands Cosmetics Policy 2015:

Clinicians should be aware of the list of procedures particular to their service to ensure it is appropriate to offer the procedure prior to listing the patient

In addition to these restrictions the Commissioners we will not fund interventions identified in the "do not do" recommendations database which is maintained by NICE.

https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/interventional-procedures-guidance/recommendations

Prior Approval Process

Where prior approval is required, the following will apply:

a) At the point of decision to refer for a specific procedure, which requires prior approval, the referrer will ensure that the clinical criteria are met. The referrer must then apply for prior approval, informing the patient of the prior approval process.

b) A consultant who wishes to undertake a procedure covered by this policy must seek approval in the same way and using the same criteria as their GP colleague. This process applies regardless of the hospital at which the patient may be treated and only applies to NHS commissioned secondary care but is applicable in all provider settings where that care is provided. Providers should ensure that the prior approval code is recoded in the free text field in the SUS entry to ensure that the procedure is not queried.

On receipt of the prior approvals request the CCG, or those conducting triage on their behalf, will ensure that the requests receive appropriate clinical review to confirm compliance with policy and equity with other approval decisions.

The CCG will have a 10-working days turnaround from date of receipt for all Primary Care requests. For the purposes of patient confidentiality only e-mail requests are accepted which should be sent to Maccg.ifrteam-nottscountyccgs@nhs.net

Secondary Care

Ideally the patient will only be added to the waiting list for the requested treatment once prior approval has been received. Providers should ensure that the prior approval code is recorded in the free text field in the SUS entry to ensure that the procedure is not queried. All information relating to the prior approval status will be recorded on the waiting list addition within PAS. The approval system in use in Nottinghamshire is Blueteq.

Military Veterans

The Armed Forces Covenant, published in 2015, states that all veterans and war pensioners should receive priority access to NHS care for any conditions which are related to their military service. Veterans should not need first to have applied and become eligible for a war pension before receiving priority treatment.

The GP should notify the Trust of the patient's condition and how this relates to their military service when they refer the patient. This will ensure that the Trust can meet the current guidance for priority service over other patients with the same level of clinical need, patients with more urgent clinical needs will continue to receive priority.

Top Tip - An alert must be added to CareFlow, and the patient's case notes to identify the patient's Military Veteran status.

Prisoners

All elective standards and rules are applicable to prisoners. Delays to treatment incurred because 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.

The Trust will work with staff within 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.

Interpreter Requirements

Where a patient requires an interpreter for an appointment or admission this must be highlighted within the referral or request and must also clearly state the type of interpreter required. GP to provide this on e-referral.

The Trust offers the following interpreting services:

- Interpreting Telephone Service
- Interpreting Face to Face Service
- Document Translations
- British Sign Language Face to Face interpretation

When considering the use of interpretation services, the telephone service is the most accessible and cost-effective method of translation. However, in the following situations face to face interpreting is recommended:

- Giving bad news
- Mental health patients / meetings
- Children appointments
- Procedures i.e. endoscopy, therapy, surgery, scans.
- Giving consent
- Appointments longer than 30 minutes
- British Sign Language requests
- Clinic 14 (Breast Services)
- Clinic 9 (Pain Clinic)
- Rheumatology appointments.
- Clinic 3 (Pre-op)
- Lymphedema (Clinic 3/10)
- 2 week wait Dermatology clinic

Top Tip – Interpreting Services Information Link is:
https://sfhnet.nnotts.nhs.uk/admin/webpages/default.aspx?recid=5431&pid=5431

Disabilities or Special Needs

The Trust is committed to providing a flexible booking system to support the requirements of individuals with disabilities; wherever possible. This may involve for example booking an appointment time that is more suitable to the patient's needs. GP to provide this information on e-referral.

Best Interest Meeting

Best Interest meetings will take place when a patient has complex needs that need to be addressed outside the normal situation. A clinician will decide if a best interest meeting is required.

Top Tip – Useful Links

Mental Capacity Policy.pdf

Consent Policy.pdf

Safeguarding Adults Policy.pdf

Religion and Ethnicity

The Trust is committed to providing, a flexible booking system to support the ethnic or religious requirements of the service user wherever possible.

We will continually work towards ensuring that individuals with ethnic or religious requirements are not disadvantaged by this Policy; we will, through the impact assessment process identify areas of concern and work to eliminate these issues wherever possible.

Patient Transport

Trust staff are no longer able to book patient transport. Patients need to contact their GP to arrange transport.

Governance

The following governance structure is in place:

- Systemwide Planned Care Board
- Monthly Planned Care Steering Group
- Monthly Board of Directors meeting (Chief Operating Officer)
- Monthly Divisional Performance meetings (Chief Operating Officer)
- Monthly CCG Performance meeting (Deputy Chief Operating Officer)
- Monthly Senior Leadership Team meeting
- Weekly Corporate PTL meetings (Bi-weekly for divisions - Week 1 W&C & Surgery, Week 2 Medicine & Therapies) (Associate Director of Operations – Planned Care)
- Weekly Specialty PTL meetings (Senior PPCs and PPCs)

Supporting Tools, Monitoring Systems and Application of the Policy

The Trust has a responsibility to record accurate information regarding the RTT start date and stop date for all RTT applicable patient pathways.

An RTT status must be recorded at each stage of the patient journey be this any outpatient appointment, admission, contact or intervention.

The Trust's primary patient administrative system (PAS) for recording RTT information is CareFlow. Other bespoke systems exist for Radiology, Endoscopy and Cardiorespiratory. The Infoflex system is utilised for tracking and monitoring cancer pathways which is covered in the **Cancer Access Policy**.

All waiting lists must be held and managed on the CareFlow PAS system and/or other agreed Trust systems. e.g. PRISM, CRIS

Any patient lists held in/on books, cards, spreadsheets, or databases or in any other non-Trust system form are not permitted and must be transferred to CareFlow and/or another agreed Trust system. If any lists are found, please notify the Head of RTT and Data Quality or the Deputy Data Quality Manager. Anyone found to be holding any patient lists on a non-Trust system will be performance managed as appropriate.

Patient Tracking Lists

Information Services provide a self-service RTT PTL that is refreshed daily to support the management validation and tracking of patient pathways. The RTT PTL is created from RTT entries made on the CareFlow system.

All patient related activities such as referral receipt, decision to admit and outpatient clinic outcome must be entered onto MEDWAY in a timely manner and in accordance with this policy and related standard operating procedures.

Failure to add patient activities to waiting lists in a timely manner is a serious matter that can delay patient care unnecessarily and non-compliance with this policy may result in action being taken. PTL output will be subject to an internal audit cycle.

It is the role of the PPC to generate a self-service PTL daily for validation, tracking, updating CareFlow as necessary and engaging with the lead clinician for next steps for patient when appropriate.

Top Tip -Link to self-service PTL Dashboard
https://sfh-qliksense-1.notts-his.nhs.uk/sense/app/ccd99ba7-ef49-49c3-b862-92939f9cce53/sheet/f981c7d9-f928-429a-a80a-7bc3c7cbc12b/state/analysis

Chronological Booking

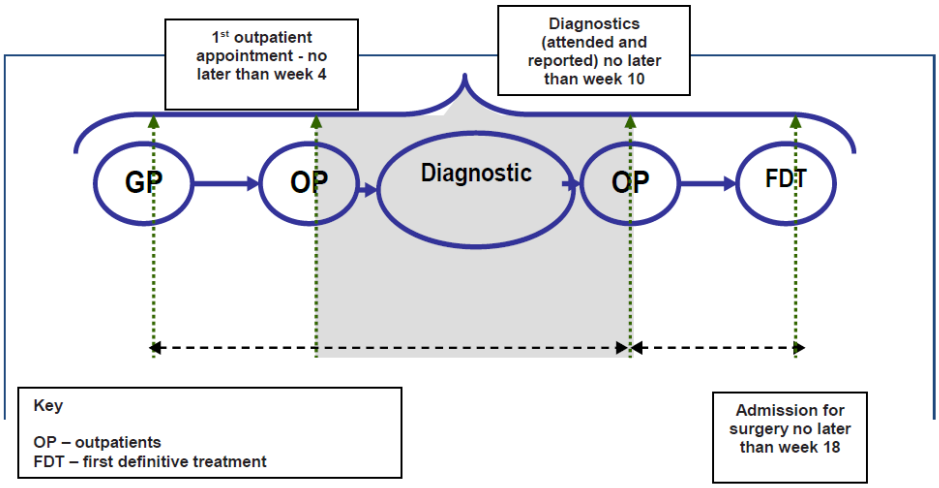
Patients will be selected for booking appointments or admission dates according to their clinical priority (e.g. P/D Code). Patients of the same clinical priority will be appointed / treated in RTT chronological order i.e. the longest waiting patients will be seen first. Patients will be selected using the Trust's PTLs only. Patients will NOT be selected from any paper-based systems.

Pathway Milestones

The monitoring of the Trust's Elective Access Policy is an essential part of ensuring patients do not wait unnecessarily for elective care at the Trust and the access to the Trust's services is equal and fair. Information Services will routinely provide reports detailing compliance against key areas within the policy which will be provided to the relevant operational and clinical teams.

Operational teams will regularly and continuously monitor levels of capacity for each pathway milestone to ensure any shortfalls are addressed in advance, thus avoiding a poor patient experience, resource intensive administrative workarounds and ultimately breaches of the RTT standard.

An example of a Milestone Map can be seen below:



Overarching Monitoring/Standards/Key Performance Indicator's

It is a Trust aim to have key business processes that support access to care and that have clearly defined service standards, which will be regularly monitored. Compliance with each service standard will support effective and efficient service provision, and the achievement of referral to treatment standards. Key standards for implementation include the following:

Standard	Description
Outpatient referral receipt and registration within 24 hours (Paper and ICR referrals)	Electronic referrals will automatically be registered on CareFlow PAS through the E-Referral system. Therefore, this standard applies to all other referral sources including internal referral and external where the E-Referral system is not in use.
Outpatient referral receipt and registration within 8 days (ASI List)	Electronic referrals will automatically be registered on CareFlow PAS through the E-Referral system. Where there are no directly bookable slots available the referral will go onto the Appointment Slot Issues (ASI) list. Where the referral has been on this list for 8 days with no appointment booked the patients, referral must be move onto CareFlow PAS.
Outpatient referral vetting and triage within 72 hours of registration	This applies to services where grading of their referrals is required prior to appointment booking. (Not services that are directly bookable) Wherever possible referrals should be vetted on the E-referral system and appointments booked or redirected to most suitable service as required.
All patients to be added to the relevant elective waiting list on CareFlow within 48 hours of a Decision to Admit (DTA)	This applies to all additions to the elective waiting list whether diagnostic or therapeutic procedure.
All patients added to the elective waiting list for a procedure listed as 2WW or Urgent will be contacted by the Trust within 24 hours	As Standard
All patients added to the electronic elective waiting list for a procedure listed as routine will be contacted by the Trust within 2 weeks	As Standard
All diagnostic reporting for investigations listed as 2WW or Urgent will be completed within 48 hours	As Standard
All diagnostic reporting for investigations listed as Routine will be completed within 10 working days	As Standard
All 2WW and Urgent appointment outcomes will be recorded electronically within 24 hours of the clinic appointment	As Standard
All Routine appointment outcomes will be recorded electronically within 5 days of the clinic appointment	As Standard
Operational Management DQ reports will be monitored on at least a weekly basis	
RTT DQ reports will be monitored daily	
Capacity Escalation Process – Operational teams will regularly and continuously monitor levels of capacity	Underpinned by the IST D&C model on a quarterly basis.
All offers of TCI dates will wherever possible meet the Reasonable standards*	This applies to all additions to the elective waiting list whether diagnostic or therapeutic procedure.

***Reasonableness**

'Reasonableness' is a term applicable to all stages of the elective pathway. Reasonableness refers to specific criteria which should be adhered to when offering routine appointments and admission dates to patients to demonstrate that they have been given sufficient notice and a choice of dates. A reasonable offer is defined as a choice of two dates with at least three weeks' notice.

These offers must be recorded on the appropriate Trust system. Where patients are offered and verbally accept a mutually agreed appointment that is offered with less than three weeks' notice this appointment is considered reasonable.

Communication

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

GPs or the relevant referrer must be kept informed of the patient's progress in writing. When clinical responsibility is being transferred back to the GP/referrer, (e.g. when treatment is complete and patient is

discharged), this must be made clear in any communication. Any outstanding clinical problems that have not been managed by the discharging clinician but are highlighted in a discharge communication should be directed to the GP for assessment or inform the GP that a consultant-to-consultant referral has been made (if appropriate). It is not appropriate to advise or request a GP to make a new referral which could be made in line with the consultant-to-consultant referral policy**.**

8 OVERVIEW OF ELECTIVE CARE NATIONAL STANDARDS

National Target	Description
Referral to Treatment RTT	92% of patients on an incomplete pathway (i.e. still waiting for treatment) to be waiting no more than 18 weeks (or 126 days)
Diagnostics	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
Direct Access Audiology	95% of Direct access audiology patients will wait no more than 18 Weeks (126 days) for their clock to stop
Cancer Standards	Patients referred on a suspected cancer pathway will be managed as per the Trust Cancer Access Policy (see Appendices). The RTT pathway does not replace the Cancer waiting time standards. Cancer Access Policy

In addition to the elective care standards above, there are separate cancer standards which must be adhered to. The cancer standards are listed within the Cancer Access Policy.

The RTT pathway does not replace or override other waiting time standards where these are shorter than 18 weeks. This includes waiting times for patients with suspected cancer or waiting times for Rapid Access Chest Pain clinics.

Patients may have more than one RTT waiting time running simultaneously if they have been referred to more than one consultant led care pathway for separate conditions. Each RTT pathway will be measured and monitored separately and will have a unique patient pathway identifier in CareFlow.

While the overall aim is to treat all elective patients on a Referral to Treatment pathway within 18 weeks, the national elective access standards are set at 92% (not 100%) to allow for a tolerance for unavoidable scenarios such as listed below:

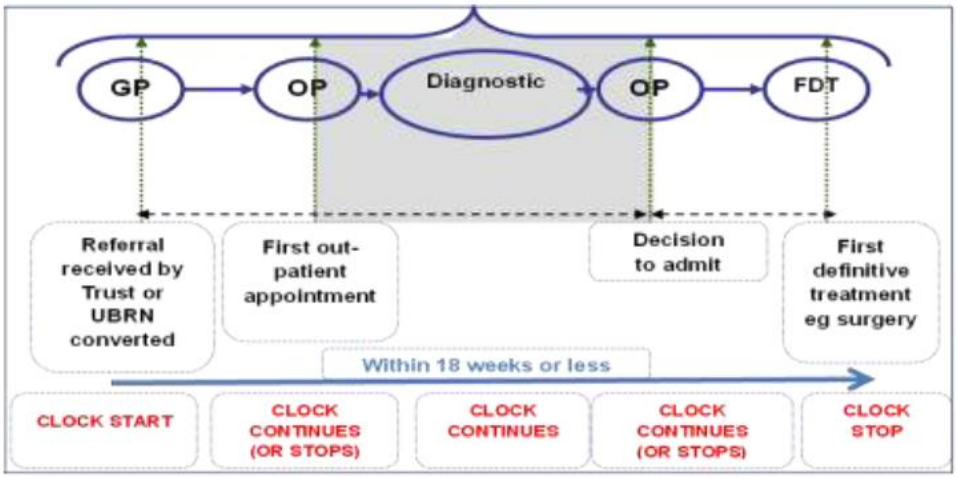
- Clinical exceptions – situations where it is in the patient's best clinical interest to wait more than 18 weeks for their treatment i.e. where the patient is clinically complex, or it is not clinically appropriate to treat the patient within 18 weeks.

- Patient Choice – when patients choose to extend their pathway beyond 18 weeks by declining reasonable offers of appointments or admission, or rescheduling previously agreed appointment dates / admission offers, or making themselves unavailable for an extended period beyond their 18 week period.

- Patient Co-operation – when patients do not attend previously agreed appointment dates or TCI dates (i.e. DNA) and where this prevents the Trust from treating them within 18 weeks.

Overview of National Referral to Treatment Rules

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



Key

OP – outpatients
FDT – first definitive treatment

Clock Starts

The RTT clock starts when any healthcare professional (or service permitted by an English NHS commissioner to make such referrals) refers to a consultant-led service. The RTT clock start date is the date the trust receives the referral.

1 A referral is received through the NHS e-Referral system and the patient converts their unique booking reference (UBRN) electronically into an appointment within the PAS system, or the referral hits the ASI list where there is no slot availability to book into.

2 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. This could include a paper referral where the referrer does not have access to e-RS or an Interconsultant Referral (ICR)

3 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.

4 A patient self-refers into a consultant-led service for where this referral route is agreed by service providers and commissioners.

Top Tip - The UBRN is the reference number that a patient receives on their appointment request letter when generated by the referrer through the NHS e-Referral Service.

Exclusions to the RTT Pathway

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

- Obstetrics and midwifery
- Planned patients – Where the wait for appointment or procedure has not exceeded the clinically appropriate date
- 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.

New Clock Starts for the Same Condition

Patients may have more than one RTT waiting time on a pathway i.e. the RTT clock can restart following a previous clock stop under the following circumstances:

1. Following Active Monitoring

When a decision to treat is made following a period of active monitoring;(The concept of active monitoring applies where the patient may not have received 1st definitive treatment, but it is clinically appropriate to monitor the patient in secondary care without further clinical intervention or diagnostic procedures, or secondly where a patient themselves wishes to be reviewed as an outpatient currently without progressing to more invasive treatment)

If after a period of active monitoring, the patient and/or care professional makes the decision that treatment is now appropriate; a new RTT clock would start on the date of the new decision to treat, and the patient shall receive their first definitive treatment within a maximum of 18 weeks from that date.

2. Following A Decision to Start a Substantively New Treatment Plan

Upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan; a new RTT pathway clock starts at the point the decision is made regardless of setting and the patient shall receive their first definitive treatment within a maximum of 18 weeks from that date.

3. For Second Side of Bilateral Procedure

When a patient becomes fit and ready for the second stage of treatment for a bilateral procedure within a consultant-led pathway.

4. For A Rebooked New Outpatient Appointment (Following A DNA)

When a new appointment is rebooked following a first appointment DNA that stopped and nullified their earlier clock. The RTT clock re-starts on the day a new appointment is agreed with the patient.

5. For an Overdue Review Appointment or Procedure (Planned Patients)

All patients added to the planned list either for a review appointment (follow-up) or procedure, will be given a clinically determined due date by when their planned procedure/test/appointment should take place.

Where a patient requiring a planned procedure/test/appointment goes beyond their due date, they will be transferred to an active RTT wait and DMO1 active wait (where applicable).

The detailed process for management of planned patients is described in the relevant standard operating procedure.

RTT Pathway Clock Stops for Definitive Treatment

A RTT pathway stops for treatment under the following circumstances:

1. First definitive treatment provided within an interface service e.g. physiotherapy

Where the patient has been treated within an interface service such as the MSK pathway

2. First definitive treatment provided within a consultant led service

First definitive treatment can be administered through a procedure or given/prescribed pharmacologically within the outpatient clinic, as an elective admission or in some circumstances as a decision made outside of clinic.

3. Therapy or healthcare science intervention provided within secondary care

Where this is the treatment plan that the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further intervention. This might be through many of the varied allied Health Professional services such as physiotherapy, occupational therapy, audiology, or dietetics for example.

4. A clinical decision is made and has been communicated to the patient and their GP or referring practitioner to add the patient to the transplant list

RTT Pathway Clock Stops for Non-Treatment

An RTT waiting time clock can stop for non-treatment where appropriate, so long as this is evidenced within the patient's clinical documentation and communicated to the patient and GP or referring practitioner.

1. It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment

This could be to a service provided with primary/community care such as a therapy service or for treatment of a condition ordinarily managed within Primary Care by the GP.

2. A clinical decision is made not to treat

Following initial first appointment or diagnostics it may become apparent that treatment is not required either by lifestyle advice and guidance, an intervention or pharmacologically.

3. The patient Did Not Attend (DNA) their first appointment following the initial referral that started their RTT wait for the pathway. In this instance the Pathway is 'Nullified'.

4. A patient Did Not Attend (DNA) any other activity which results in a clinical decision to discharge the patient back to the GP.

This DNA could be any activity including an outpatient appointment, a diagnostic procedure, or an admission

NB 3&4 can only apply provided that the Trust can demonstrate that the DNA'd activity was reasonably booked, clearly communicated to the patient, and discharging the patient is not contrary to their best clinical interests and follows local, publicly available or published policies on DNA. These local policies must be 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

5. A decision is made to start the patient on a period of active monitoring either by the clinician responsible for the patients care or by the patient themselves.

Active Monitoring – see examples below

Active monitoring can be applicable where a decision is made that the patient does not currently require or want to go ahead at present with definitive treatment but should continue to be monitored in secondary care. Treatment may be available, but the patient may wish to be managed conservatively rather than proceed with invasive treatment. This decision to monitor can be reversed at any point if the clinician and/or patient wish to proceed with treatment. Active monitoring may apply at any point in the patient's pathway and when a decision to commence a period of active monitoring is made and communicated with the patient, the RTT clock stops.

It is not appropriate to stop a clock for a period of active monitoring if some form of diagnostic or clinical intervention is required; however, it is appropriate if a longer period of active monitoring is required before further action is needed.eg for thinking time prior to a decision about invasive non-invasive treatment. Stopping a patient's clock for a period of active monitoring requires careful consideration on a case-by-case basis and its use needs to be consistent with the patient's perception of their wait.

6. A patient declines treatment having been offered it

A patient can choose to decline any treatment offered whether this is invasive e.g. surgical or pharmacological. In this instance the clock would stop on the date the patient declines the offer of treatment after consideration.

Scenario 1- Patient has diagnosis of an aortic aneurysm. Patient and consultant discuss the possibility of surgery, but it is agreed that at this stage it is too small for surgery. The patient is therefore put on a period of active monitoring. During this time regular ultrasound tests will be carried out to measure the size of the aneurysm if the aneurysm increases in size, then surgery will be required and at this point a new decision to treat would be made and the clock would restart.

Scenario 2 – Patient is referred with undefined disease. The consultant has no clear plan of treatment and wants to monitor the patient before any intervention. Option is to start a period of active monitoring, with the patient having a follow up appointment in three to six months, but to contact the hospital before if her condition deteriorates.

Scenario 3 – Patient requires a surgical procedure but currently is unfit to be listed. For example, the patient might need to lose weight or have cardiac/respiratory conditions managed to reduce operative risk to the patient. It is reasonable to actively monitor the patient until they are fit to list

Patient-Initiated Delays/Compliance

Non-Attendance of Appointments/Did Not Attend (DNAs)

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

First Appointment DNAs

The RTT clock is stopped and nullified in all cases (if the Trust can demonstrate the appointment was booked in line with reasonableness criteria). If the clinician indicates another first appointment should be offered, a new RTT clock will be started on the day the new appointment is agreed with the patient**.**

Subsequent (Follow-Up) Appointment DNAs

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

Top Tip - The clinician will review after any DNA and a decision will be made for one of the following outcomes:

- The patient will be discharged back to the GP
- The patient MUST be offered another appointment
- The patient should be offered another appointment – the patient will be contacted and if after 2 weeks there is no response the patient will be referred back to the GP

Cancelling, Declining or Delaying Appointment and Admission Offers

A patient cancellation should be recorded when the patient gives any prior notice that they cannot attend their appointment (even if this is on the day of clinic), Patients who attend but are unable to wait for their appointment are included in this category.

There will be occasions where the patient will need to rearrange a previously agreed appointment regardless of the resulting waiting time. Such cancellations or delays have no impact on reported RTT waiting times. As a Trust we will make every effort to book a mutually agreeable date and time in the first instance, if the patient contacts the Trust to change this appointment, we will endeavour to accommodate this requirement a further appointment, will be booked with the patient at the time of the cancellation. However, clinicians will be informed of patient-initiated delays to ensure that no harm is likely to result from the patient waiting longer for. Where necessary, clinicians will review each patient's case on an individual basis to determine whether:

- The requested delay is clinically acceptable (**clock continues**)
- The patient should be contacted to review their options – this may result in agreement to delay (**clock continues**) or to commence a period of active monitoring (**clock stops**)
- The patient's best clinical interest would be served by discharging them to the care of their GP (**clock stops**)
- The requested delay is clinically acceptable, but the clinician believes the delay will have a consequential impact (where the treatment may fundamentally change during the period of delay) on the patient's treatment plan - active monitoring (**clock stops**)

Patient initiated delays

Patients who wish to delay their wait for a period longer than 3 months will be reviewed by the clinician to decide if this delay is clinically acceptable. If the clinician is satisfied that the proposed delay is appropriate, a decision will be made to continue the wait. Patients should not be discharged to their GP, or otherwise removed from the waiting list, unless it is for clinical reasons.

When a patient declines 2 reasonable offers of treatment dates and wishes to delay treatment. In this situation following a clinical review the patient may be suitable for a period of active monitoring.

This shared decision-making discussion with the patient should include an appropriate timeframe for further follow up or review.

Patients can request delays of any length but the maximum period between monitoring appointments should be 12 weeks after which a clinical review should take place, this ensures that patients are reviewed regularly in case their condition deteriorates while they are waiting.

The pathway should be visible on a relevant PTL or waiting list report for non-RTT pathways.

In all scenarios a new waiting time clock will start when a new decision to treat is made with the patient following a period of active monitoring. For patients who have been placed on active monitoring due to unavailability, once the patient wishes to go ahead with treatment, they should be reinstated on the waiting list with a new RTT clock starting at zero. The provider should offer a new offer for treatment date, acting as if the patient is on the waiting list at the point that they previously left.

When a patient is placed on active monitoring, they should be provided with written contact details and a clear process for two-way communication between them and the clinician if their condition or circumstances change.

Patient Cancellations

Patients who cancel one appointment should be given an alternative date at the time of the cancellation.

Patients Who Cancel Two or More Routine Appointments

A report is in place to identify patients who have cancelled two consecutive routine new or follow-up appointments. The clinician will review after two consecutive routine cancellations and will decide the following:

If the patient has not yet been seen in clinic as a first attendance and advises that they do not wish to progress their care pathway, they will be removed from the relevant outpatient waiting list and a clock stop/nullification will be applied to the RTT pathway. The patient will be informed that their consultant and GP will be notified will be notified of this decision.

If because of the patient cancelling an appointment and wishing to rebook, a delay is incurred which is greater than a clinically acceptable period of delay i.e. potentially unsafe, the patient's pathway should be reviewed by their consultant. Upon clinical review, the patient's consultant should indicate one of the following:

- It is clinically safe for the patient to delay their appointment. (**clock continues**).

- It is clinically unsafe length of time to delay the appointment: the clinician must contact the patient with a view to persuading the patient not to delay. (**clock continues**).

- It is a clinically unsafe length of time to delay the appointment and is in the patient's best clinical interests to return the patient to their GP. (**clock stops** on the day this is communicated to the patient and their GP.)

For Urgent, Cancer, Vulnerable adults or children, there should be a clinical review and a decision made on the individual patient level about whether to offer the patient another appointment or whether discharging them is in their best clinical interest.

Top Tip – There is a separate policy for cancelations and DNAs for Children.

Patients who decline dates because they are fearful about coming into a hospital setting (Covid-19)

Patients may still be fearful of attending the hospital due to concerns regarding Covid -19, the patient's pathway will not be affected as the usual rules on patient choice apply in this scenario. If patients repeatedly cancel or fail to attend their appointments an assessment of patient harm should be undertaken and a conversation with the patient take place and agreement to the best course of action.

Uncontactable Patients

Where a patient cannot be reached by an initial phone call, three further attempts on different days at different times (ideally one out of hours) should be made to contact the patient. If the patient still cannot be reached, a 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 will be returned to their referrer.

Patient Non-Compliance Providing Samples

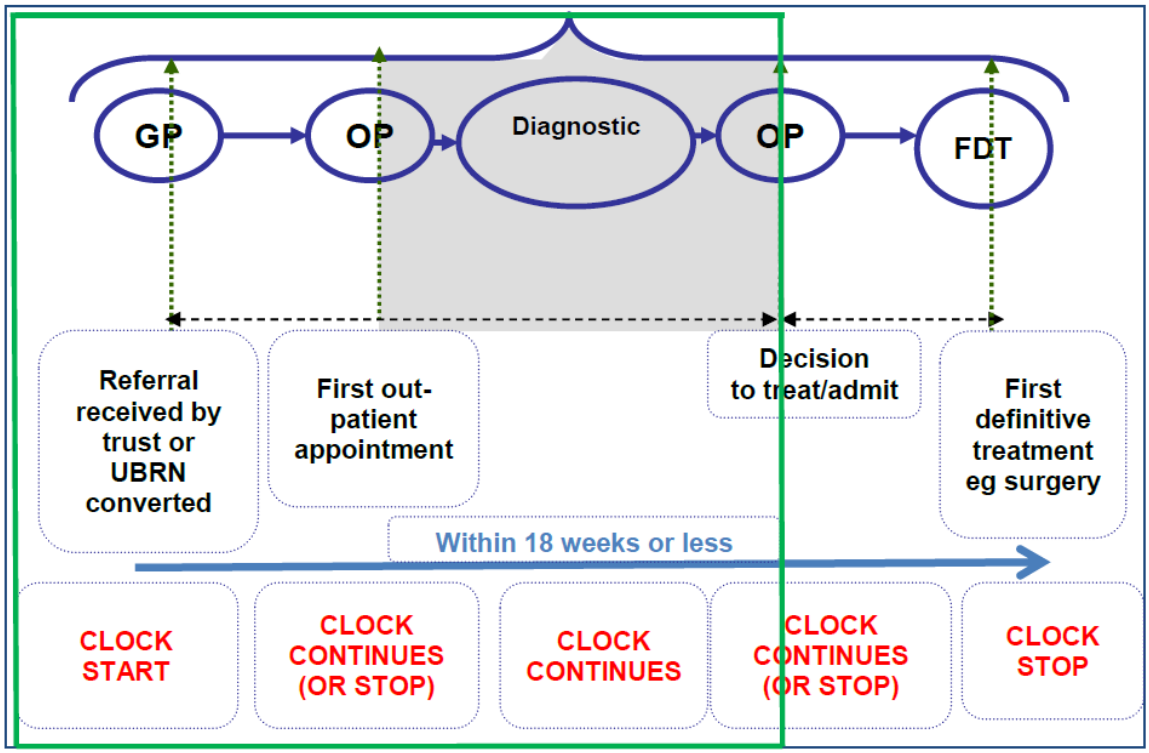
The patient has 3 weeks to provide a sample (e.g. urine, semen, stool samples) unless there is a clinical exception. If a patient fails to provide a sample within this period, the clinician will review.

Pathway-Specific Principles Referral to Treatment and Diagnostic Pathways

Non-Admitted Pathways

Non-admitted patient pathways comprise of either or both outpatients and diagnostics, as highlighted by the section shaded in the diagram below.
The pathway starts on 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 as a decision made outside of clinic following tests and investigations.

If a decision to admit is made, the patient transfers to the admitted pathway.



Key

OP – outpatients
FDT – first definitive treatment

The Referral Process

A referral is a decision made by a Health Care Professional to refer a patient to a particular Health Care Provider and to a particular Service.

It is the referring Care Professionals responsibility to inform the patient of the intention to refer into secondary care and ensure that the patient is both clinically fit and prepared to receive potential treatment and be available within 18 weeks from referral. Where the referring Care Professional knows that the patient is unavailable for example on a tour of duty, extended holiday or has work or study commitments, and the referral is for a routine clinical condition, the referral should not be made until a more appropriate time when the patient can fully engage with their care.

The NHS e-Referrals Service system is the nationally recommended referral route, allowing the patient choice over Provider, date, and time of their appointment. The Trust operates 100% compliance for electronic referrals and therefore expects all referrals to be made via the NHS e-Referrals Service System unless the referring Care Professional does not currently facilitate the use of NHS e-Referrals Service.

In exceptional circumstances paper-based referrals will be sent to a central point of referral and all referrers will be informed of this requirement and its location. These are held in the Appointments Office, Office Suite 2.5. ALL new referrals must go via the Central Booking Team.

Routine practice will see referrals made to a service rather than an individual. This will improve waiting times across consultants and services to ensure patients are seen in a timely manner. Services have agreed clinical criteria to support triage and vetting, and patients will then be allocated to the most appropriate clinician, in consideration of waiting times.

As set out within the NHS Operating framework, the Trust will work to ensure patients see the Consultant of choice where a preference is expressed.

It is the Trust's responsibility to ensure:

- Accurate, clear, and up to date information about Outpatient, Advice and Guidance and Direct Access services provided by the Trust are included on the NHS e-Referrals Service Directory of Services (DOS). This is to ensure patients are referred into the most appropriate service thus reducing the need to redirect referrals.

- Named clinician services are available on NHS e-Referrals Service for Commissioners to refer into.

- It is the Division's responsibility to monitor slot availability and forward plan for any identified capacity constraints.

- All clinically appropriate referrals made to them are accepted. Patients choosing the Trust must be treated by that provider if this is clinically appropriate and in accordance with the patient's wishes.

It is the Referring Care Professional's Responsibility to:

- Refer and book the patient into the most appropriate clinical service by utilising the information contained within the DOS.

- Ensure that all referral letters, whether paper based or sent via the NHS e-Referrals Service System are clear and concise, stating the clinical priority and reason for the referral request.

- To ensure no elective referral letters are handwritten.

- To ensure a minimum set of patient information is contained within the referral

    1. The GP Practice
    2. HS Number
    3. ethnicity
    4. Full patient Demographics including evening or daytime and/or mobile telephone number
    5. Current drug regime and significant past medical history
    6. Requirement for an interpreter and the patient's language of choice
    7. Any special requirements needed for example vulnerable patients

- Generate and attach (e-RS) or send (Paper) urgent referral letter within one working day and a routine referral letter within three working days of the date decision to refer.

- Ensure a Unique Booking Reference Number (UBRN) is generated for all NHS e-Referrals Service referrals and where possible an appointment booked before the patient leaves the GP surgery. At the point the UBRN is converted into an appointment, an RTT clock start will electronically generate.

If it is necessary to send a paper referral i.e. the care professional does not have access to NHS e-Referrals Service, then these must be addressed to:

KINGS MILL HOSPITAL – Clinic Admin Department, Office Suite 2.5, King's Mill Hospital, Mansfield Road, Sutton in Ashfield, Nottinghamshire, NG17 4JL

Key performance indicators for monitoring the referral process include the following:

NHS E-Referrals

- All NHS e-referrals must be reviewed and accepted or rejected by clinical teams within one working day for urgent referrals or two working days for routine referrals.

- Where there is a delay in reviewing e-referrals this will be escalated to the relevant clinical / management team, including Heads of Service, and actions agreed to address it.

- If an NHS e-Referral is received for a service not provided by the Trust, 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.

Paper-Based Referrals

The Trust operates a 100% compliant e-RS service in line with national requirements and hence paper referrals are only accepted in exceptional circumstance, such as emergency and ambulatory clinics. If e-RS was unavailable to the GP for a prolonged period due to technical issues paper referrals would be accepted. All routine and urgent pooled and consultant-specific referral letters should be sent to the Trust's centralised booking office.

Referrals must be date stamped upon receipt at the Trust. Should a paper-based referral be received directly into a specialty, the specialty must date stamp the referral and forward to the centralised booking office within one working day of receipt. For patients referred by paper, the referral received date is the point that the Referral to Treatment (RTT) clock starts.

Once paper-based referrals have been recorded on MEDWAY, they will be directed to one of the following:

- 2WW team in central booking office for immediate booking of an appointment where the referral is suspected cancer or breast symptomatic. No vetting is required.
- A consultant or clinical team for vetting. This will be undertaken within 72 hours of receipt for the referrals to be returned to the central booking team for booking as early as possible in patient's RTT pathway.

Other Referral Types

Rapid Access Chest Pain Referrals (RACPC)

Rapid Access chest pain patients must be seen by a specialist within 14 days of the Trust receiving the referral.

To ensure this is achieved:

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

Every referral from GPs is reviewed and if there is not appropriate information or they do not fit the RACPC criteria they will be declined.

Patients referred from ED or from other wards for RACPC are required to fit the exact same criteria as e-referrals. These referrals would also be seen within 14 days. If these patients are not appropriate, they will either be declined and would go back to the referrer or if appropriate they would be pulled into the ACS clinic

Dental Electronic Referral Service (powered by REGO)

As dental practitioners do not have access to e-RS their referrals are accepted into the Trust via the REGO system. Once vetted by the clinician the booking team will contact the patient to arrange a suitable appointment.

Diabetic Retinopathy Access Screening

Patients referred from the Diabetic Eye Screening Programme are made direct to the Head & Neck Outpatient Booking team via email; these do not go via the GP.

The Screening Programme must meet the following national standards regarding referrals into the hospital eye clinic:

- Urgent referrals – patient must be seen within 6 weeks of their screening appointment (Preferably in Medical Retina/Diabetic clinics)

- Routine referrals – patients must be seen within 13 weeks of their screening appointment (Preferably in Medical Retina/Diabetic clinics)

All diabetic patients referred by the screening programme need to be offered a second appointment in the event of a DNA or cancellation.

Consultant to Consultant Referrals (ICR's)

There are times when consultants in secondary care refer patients to another colleague, either within the same specialty or in another specialty. The NHS Standard Contract states that where a patient has been referred to one service within a provider by the GP, or has presented as an emergency, the provider clinician is allowed to make an onward outpatient referral to any other service, without the need for a referral back to the GP where:

- Either onward referral is directly related to the condition for which the original referral was made, or which caused the emergency presentation- The RTT clock starts at the point of the initial referral and will continue if the patient has not received definitive treatment prior to the ICR
- Urgent referrals for new condition. A new RTT clock on a separate RTT pathway will start at the point the ICR referral is received.

- Suspected cancer referral - this will be vetted and dated by the receiving consultant and upgraded if deemed necessary. Once upgraded the patient will be treated within 62 days of the date the referral was received by the consultant. A new RTT clock on a separate RTT pathway will start at the point the ICR referral is received.

For clarity, if following review of the referral or assessment of the patient it is apparent that the patient has been referred to the wrong specialty, then a consultant referral should be made to the correct specialty rather than return the patient to their GP / referrer.

Top Tip - The Consultant-to-Consultant Referral Policy is:

ICS Consultant to Consultant Referral p

Clinical Assessment, Interface, and Triage Services (CATS/CAS) and Referral Management Centres (RMCs)

These services provide intermediary levels of clinical triage, assessment, and treatment between traditional primary and secondary care.

A referral to a CAS or an RMC starts an 18-week RTT clock from the day the referral is received in the CAS/RMC. If the patient is onward referred to the Trust having not received definitive 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 where onward referral is unable to be completed through e-RS (which is the preferred choice).

The Trust receives referrals from this type of service as described above these are:

- Musculoskeletal (MSK) referral pathway to Orthopaedics, Pain Management, Rheumatology
- Ophthalmology and Dermatology

To manage the RTT pathway, the referral into the CAS/RMC generates an RTT clock start either by the conversion of the UBRN if booked through NHS e-Referrals Service or on the receipt of the paper referral if manual.

Urgent GP Orthopaedic/Fracture Appointment Referrals

GP's can refer to a consultant led fracture clinic. This referral type may be urgent but would not be classed as an emergency attendance and therefore the referral process will generate an RTT pathway clock start on the date of the GP telephone referral. A referral letter must also accompany the referral prior to the patient being seen.

Emergency Outpatient Appointments Referrals

The Trust accepts emergency referrals from care professionals for patients needing to be seen same day in an outpatient environment or ambulatory care setting. These referrals will be made by telephone and be supported by a paper referral accompanying the patient when they attend. Trust examples of this type of service include **emergency ENT, maxillofacial, ophthalmology, diabetic foot clinic and surgical and medical ambulatory clinics.** These patients are classed as **genuine emergency referrals** and are therefore not applicable to an RTT Pathway.

Inter Provider Transfers (IPT's) - Incoming

Patients may be referred into the Trust from other care providers; these are classed as **Inter Provider Transfers (IPT's).**

The referring Trust is mandated to complete an accompanying minimum dataset form (MDS) containing the relevant 18-week information where applicable.

Any patient transferred from another provider will be managed in line with their RTT waiting time. And the Trust will inherit any RTT wait already incurred at the referring Trust if they have not previously been treated.

If the referral into the Trust is for a new condition this would result in the generation of a new RTT pathway and clock start on receipt of the referral.

If the referral into the Trust is for a condition that the patient is already being seen for at the referring provider, then the referring Hospital must provide the relevant RTT information including:

- Name
- Date of Birth
- NHS No
- Address
- Patient Pathway Identifier (PPI)
- Current RTT position- e.g. Treated/Not yet treated
- Current RTT start date
- Date decision to refer

Incomplete RTT data is not an acceptable reason for delaying the acceptance of an appropriate referral If any of the above information is missing, the referral should be recorded on PAS and the information actively chased by the central booking office. The Trust CareFlow PAS system must be updated within 24 hours of receipt of the referral.

Inter Provider Transfers (IPT's) – Outgoing

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

An accompanying minimum dataset form (MDS) will be sent to the receiving organisation detailing mandated patient information which will include the current RTT wait and clock status. This will be accessed from the Trusts PAS system to ensure that the correct RTT information is sent to the receiving Provider. The referral letter will be attached to the MDS and will be sent in a secure manner via an encrypted email address (e.g. NHS.net to NHS.net) and to a central inbox identified by the receiving provider for the receipt of referrals. Referrals will never be sent to unmanned or isolated/personal inboxes

If the outgoing IPT is for a diagnostic test only, this Trust retains responsibility for the RTT pathway and will continue to track the patients care until treatment is given or a decision not to treat is made.

SFH will no longer report the patients wait on the PTL only once confirmation has been received that the referral has reached the onward Trust, the RTT wait will transfer to the receiving organisation who will inherit any RTT wait already incurred if the patient has not yet been treated.

Booking First Attendance (New) Appointments

Referrals for Advice and Guidance

This service utilises e-RS to support GPs to manage conditions in primary care and reduce the number of outpatient referrals. A referral for Advice and Guidance (A&G) 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.

A&G can improve patient experience as the patient does not need to make an unnecessary trip to the hospital and support consultants to see only the most appropriate GP referred patients in secondary care. The Trust is responsible for ensuring that the service list is up to date and clear for GPs to access advice. A&G turnaround times and quality monitoring should be used as measures to monitor KPI's.

Referrals Via - NHS e-Referral Referral Assessment Services (RAS)

A Referral Assessment Services (RAS) allows a provider to review the Clinical Referral Information without the need for an appointment to have been booked. This allows the provider to assess the referral information from the GP/referrer, decide on the most appropriate onward clinical pathway and arrange an appointment, telephone consultation or diagnostics if required. It is also possible for the provider to return the triage request to the original referrer with advice, should an onward referral not be needed at that time. A referral into a RAS service, results in an RTT clock start once the referral letter is received by the Trust via e-RS.

Referrals Via - Clinical Assessment Service (CAS)

Currently SFH has Clinical Assessment Service (CAS) in place for some specific services where referrals are reviewed by a clinician to enable them to decide if the patient is to be seen as a first attendance outpatient or straight to test. Referrals are booked into an appointment on CareFlow (These are often referred to as either dummy appointments or ghost clinics at present). A referral into a CAS service results in an RTT clock start once the referral letter is received by the Trust via e-RS. This service is most utilised for 2WW suspected cancer referrals.

Directly Bookable appointments received via the E-referral service

Patients who have been referred via e-RS should be able to choose, book and confirm their appointment before the Trust receives and accepts the referral. The GP initially grades the referral with the appropriate priority such as Two Week Wait, Urgent or Routine And using the information supplied by the Trust within the Directory of Services (DOS) an appropriate appointment slot is selected by the GP in line with the patient's choice.

The Trust consultant should then review their referrals on the NHS e-Referrals Service system to ensure the patient is booked into the correct service and allocated the correct urgency. Consultants or a designated member of the team should review their referrals daily.

If patients are booked into the incorrect service, the referral must be re-directed within the NHS e-Referrals Service system processed by the Central Booking Team. A confirmation letter of the appointment change will be sent to the patient. The patient's RTT clock will continue to tick from the original date when they converted their UBRN. Any inappropriate referrals received into a service will be returned to the referrer via the rejected referral option within NHS e-Referrals Service.

Appointment Slot Issues (ASIs)

When no clinic appointment is available for patients to book into via the NHS e-Referrals Service due to slot capacity, the referral is deferred, and it will appear on the Trusts ''Appointment Slot Issues' (ASI) worklist. ASIs present a clinical risk as an RTT clock does not start on the Trust patient administration system (PAS) while the patient's referral is on an ASI worklist as the referral is held on the separate system.

After 14 days patients who appear on the ASI worklist will receive a letter from the e-RS system advising them to call the hospital they have not been contacted to arrange an appointment. The booking team will contact the patient to arrange an appointment as soon as clinic capacity is available.

The date the UBRN appears on the ASI worklist is the Consultant-led RTT Clock Start. (i.e. the RTT clock starts from the point at which the patient attempted to book.) and the patients wait will be recorded on the RTT PTL.

If an appointment slot does not become available within 8 days of the referral being received into the Trust, the patient's referral will be transferred onto the CareFlow PAS system to ensure clear visibility of the patients wait on the RTT PTL and to enable the referral to be recorded in the monthly referrals received (MRR) data.

Wherever possible services must ensure that patients are booked into a slot before 26W following referral received, at which point the referral may potentially 'drop-off' the e-RS worklist. Information Services provide a solution to ensure that ASI 'drop-off' patients are monitored to ensure visibility and to prevent referrals being lost due to this eventuality.

ASI information is available to all services through the PTL and a daily report for monitoring purposes and long waits will be discussed at the weekly corporate PTL meetings

Paper-Based Referrals

All non-e-RS Referrals will be managed, and appointments booked in order of clinical priority (urgent before routine) and then chronologically in order of referral received date. Patients will be selected for booking from the trust's patient tracking list (PTL) only.

Any non-NHS e-Referrals Service referrals made to specialities where the clinical agreement is that the referral must be graded by a clinician prior to the new appointment being made will be sent for grading to the required department within 24 working hours of the date request received. This triage process is to ensure the patient is allocated to the correct clinic within the correct time frame and that any pre-existing referral criteria agreed with the commissioning CCGs are met.

Clinicians should review referrals **within 72 working hours of receipt** to ensure the patient is booked to the appropriate speciality and with the correct urgency.

Any inappropriate referrals manually received will be returned with an explanation as to why they were inappropriate. It is the referring Care professional's responsibility to notify the patient of any rejected referrals to ensure the patient does not attend a previously booked appointment.

An 'invitation to call' letter will be generated from PAS, asking patients to make contact by day seven of their RTT pathway.

Should the patient not make contact, the demographic details should be confirmed with the GP. Three attempts will then be made to contact the patient, one of which made in the evening. If still unsuccessful, a second 'invitation to call' letter will be sent to the patient and a copy sent to their GP.

Patients will be offered a choice of at least two dates with three weeks' notice within the agreed first appointment milestone for the specialty concerned. Appointment dates can be offered with less than three weeks' notice and if the patient accepts, this can then be defined as 'reasonable'.

Where there is insufficient capacity to offer an appointment within the required milestone, this should be escalated to the relevant service manager.

Any appointment offers declined by patients should be recorded on PAS. This is important for two reasons: full and accurate record keeping is good practice, and the information can be used later to understand the reasons for any delays in the patient's treatment, e.g. hospital or patient initiated. This information is also essential to accurately report waits for the DM01 diagnostic return

Rejected Referrals

The Trusts and clinical Commissioning Groups will continue to work together to ensure all referrals are appropriate for the services that the Trust provides.

The duty of care for the patient rests with the referrer until such time as the referral is accepted by the Trust or by an authorised Clinician within the CAS/RAS where this will then pass to the responsible clinician at the Trust.

Outpatient Booking Processes

Delivery of the Elective Care Access Standards is the responsibility of the Divisions through the engagement with their clinical teams and as such capacity management to achieve all waiting time standards sits within the Divisions, with the support of the Booking Team.

The utilisation of outpatient clinics must be monitored daily and any empty slots which become available should be filled with 2 Week Wait, urgent or the next longest waiting patients thereby appointments will be booked in order of clinical priority and then in chronological order of referral received date.

Discussions regarding capacity will take place with divisional reps at the Corporate PTL meeting and through capacity meetings held between the services and the central booking teams escalating where there is insufficient clinic capacity to offer appointments within the required milestones.

Every patient must be sent or given a letter confirming that he or she has an outpatient appointment including instructions on where to attend, bring any medication, any special instructions relating to the appointment and details of how to contact the Trust regarding the outpatient attendance.

The ‘outpatient’ letter should be an agreed template generated from CareFlow and sent out in the name of the Appointments Clerk.

Patient information should be made available or can be made available in a variety of languages and formats such as large print, Braille and audio as required.

Booking Follow-up appointments

It may not always be clinically required to consult with the patient in a face to face follow up appointment and bringing the patient to the Trust unnecessarily can be avoided by discussing likely treatment plans at the first outpatient appointment and using follow-up telephone consultations and written communication with the patient and GP.

- **Patients On an Active Pathway**

However, if a follow- up appointment is required, such appointments must be booked within a timeframe that permits treatment by the 18W breach date (unless the patient chooses a later date). The date of the appointment should wherever possible be agreed with the patient prior to leaving the clinic (fixed appointments)**.** This will be booked by the Outpatient Receptionist at the desk.

In the instance that there is no clinical capacity within the time frame requested by the clinician, the Receptionist must obtain authorisation to overbook or add the patient to the relevant Capacity Review list which is monitored managed by the Divisional PPCs and BSUs.

- **Patients Not on An Active Pathway**

Patients who have already been treated or who are under active monitoring (i.e. on an inactive RTT pathway) and require a follow-up appointment within 6 weeks (12 weeks for Rheumatology) should be given a fixed

appointment booked by the Outpatient Receptionist at the desk prior to leaving the Outpatient Department. This will be booked on the Trust CareFlow system and the patient will be given a record of the date either by appointment card or posted letter to follow.

In the instance that there is no clinical capacity at the time frame requested the Receptionist must obtain authorisation to overbook or add the patient to the relevant Capacity Review list which is monitored at the managed by the Divisional PPCs and BSUs.

Patient appointments requested greater than 6 weeks will be added to the Trusts Review List appropriate to that Clinician/service/specialty. **No patient should be added to the review list on an active RTT pathway these patients must be booked within to a timeframe that permits treatment by the 18W breach date (unless the patient chooses a later date).**

The partial booking process will be clearly explained to the patient before they leave clinic.

Once added to the Partial Booking Outpatient waiting list:

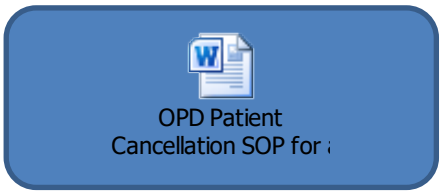
- Near to the time that the patient's appointment is due, the patient will be sent a text message or 'invitation to book' letter. The patient will be requested to contact the call centre within 21 days to arrange their OPD follow up appointment at a time convenient to them.

- Should the patient fail to contact the call centre within 14 days, they will receive a reminder text or letter. Between day 14 and 21 the call centre will attempt to contact the patient at three different times of the day, and on alternative days, one of which will be after 5 pm. If still unsuccessful, a second 'invitation to call' letter will be sent to the patient and a copy sent to their GP.

- If unable to make contact, a clinical review will take place to decide on the best course of action (except for orthopaedic patients where it has been agreed to discharge the patient).

To ensure the clinical safety of patients who may request discharge form outpatients either by telephone or via envoy, any adult patient who requests discharge from an outpatient appointment pathway including from the Partial Booking List will be referred to the responsible clinician to assess the implications of the patient's discharge from the pathway.

If necessary, the clinician will contact the patient and /or GP and advise of the implications of their request and any possible risks. Clinicians will be required to follow up in a letter of discharge where applicable so that a record is made of the advice given to patient and GP to provide on-going support in the community setting.



For Children & Young People and Vulnerable Adults, a notes review will be conducted at day 21 by the clinician responsible for the patient and an attempt made to contact the patient / carers directly by Telephone/Letter. Following which a decision made regarding sending a fixed appointment or to discharge the patient back to the GP.

Follow-Up Appointments Following a Ward Discharge

Appointment Required Less Than 6 Weeks

Every effort must be made to book this appointment by the Ward Receptionist by contacting the relevant Patient Pathway Coordinator prior to the patient leaving the ward on discharge. Where this is not feasible, the Ward Receptionist will contact the Patient Pathway Coordinator at the earliest possible time to book the appointment. The follow-up appointment must be booked within the RTT Breach date where this is applicable.

In the instance that there is no clinical capacity at the time frame requested the PPC must obtain authorisation to overbook or follow the Trust's Escalation Policy to resolve the issue. The appointment will be booked on the Trust CareFlow system and the patient will be given a record of the date either by appointment card or posted letter to follow.

Appointment Required Over 6 Weeks

The ward receptionist will use the in-house electronic system to request an appointment ensuring all fields on the request form are completed. The booking team will add these patients to the relevant partial booking list ensuring the timeframe requested by the clinician is accurately recorded.

Failure to Attend an Outpatient Appointment (Did Not Attend/Was Not Brought)

As a Trust we will make every effort to book a mutually agreeable date and time for all Outpatient Appointments and that to ensure that the booking has been clearly communicated to the patient.

If the patient does not attend their appointment, and given no advance warning of a cancellation, the patient should be recorded on CareFlow did not attend (DNA) or WNB (was not brought – used for children and vulnerable adults)
Failure to attend results in the inability to offer the appointment slot to another patient and is therefore a wasted opportunity to treat a patient and therefore all possible actions should be taken to reduce the incident of DNA's.

If the patient arrives more than 20 minutes after their appointment time it is at the clinician's discretion whether, they will see the patient. The patient will need to be informed that they may have to wait until the end of the clinic session to be seen. If the patient chooses not to wait, they will be classed as a DNA. If the patient is a child or vulnerable adult every effort should be made to see the patient due to the clinical risk associated with their nonattendance.

All did not attend (DNA/WNB) (new and follow-up) will be reviewed by the clinician during clinic for a clinical decision to be made regarding next steps. A DNA/WNB sticker will be placed in the case notes for the clinician to record their decision regarding the patient's next steps. This will include an assessment of safeguarding risks. Children's WNBs should be managed with reference to the Trust's safeguarding policy.

Top Tip - The clinician will review after any DNA and a decision will be made for one of the following outcomes:

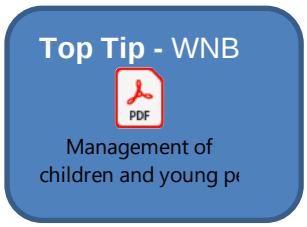
- The patient will be discharged back to the GP
- The patient MUST be offered another appointment
- The patient should be offered another appointment – the patient will be contacted and if after 2 weeks there is no response the patient will be referred back to the GP

Was Not Brought Paediatric Outpatient Appointment

Specific rules apply to the management of Children's WNB's, and these can be viewed in the **Policy for the Management of Children who Fail to Attend Appointments** via the link below**.**

As a rule it is at the Clinician's discretion after risk assessment whether to request further appointments following a WNB. The Clinician may wish after a risk assessment to make the referring Care Professional aware of the failure to attend.

A risk assessment must be undertaken to plan around the fact that a child was not brought to the appointment and the WNB sticker must be completed showing whether a further appointment is offered, what communication has been undertaken and what other actions may be required.



Hospital Clinic Cancellations

Hospital-initiated changes to appointments will be avoided as far as possible. However, this may occur in exceptional circumstances. Clinicians are actively encouraged to book annual leave and study leave as early as possible and they must provide 6 weeks' notice if a clinic must 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 an active RTT pathway to be treated within 18 weeks. Equally, this will allow patients not on active pathways to be reviewed as near to the clinically agreed timeframe as possible. However, if capacity is not available at the time of cancellation, patients will be added to the capacity list, until such time the appointment can be rebooked.

Patients who have appointments cancelled because a service has been suspended: Where a clinical assessment has been made and considers it is safe to temporarily suspend a service for some patients, the usual rules on provider-initiated cancellations will apply and the RTT waiting time clock should continue to tick.

Patients who have appointments cancelled because staff are unavailable: If a provider cancels an appointment at any point in the RTT pathway, this has no effect on the RTT waiting time. The RTT clock should continue to tick.

Children and Young People Under 18 Years - Appointment Cancellations

A patient cancellation is where a patient **or a proxy for the patient** contacts the Trust in advance of their appointment (including on the day cancellations) stating that they are unable to attend the appointment.

Children and young people who attend their appointment, but their parent/proxy are unable to wait for their appointments due to clinic delays are included in this category.

There will be occasions where the patient **or proxy for the patient** will need to rearrange a previously agreed appointment. As a Trust we will make every effort to book a mutually agreeable date and time in the first instance. If the patient contacts the Trust to change this appointment, we will endeavour to accommodate this requirement within the arrangements set out below.

**The important aspect regarding children and young people's appointment changes is that the consultant with overall responsibility for the patient MUST be kept up to date and consulted in the event of repeated appointment changes and/or appointment cancellations to decide on the correct course of action to be taken. Example of appropriate decisions may be i.e. discharged to GP, reappointment agreed, referral to another service, safeguarding procedures followed, other professionals involved. The child should not be discharged without this plan being agreed by the consultant.*

Clinic Attendance and Outcomes (New and Follow-Up Clinics- All Consultation Media)

Top Tip - It is essential that accurate patient demographic data is always held on CareFlow, therefore it is paramount that at every opportunity this information is confirmed with the patient to confirm the patient demographic details. Clinic attendances are a prime opportunity to update this information
This will include:

- Patient Name
- Date of Birth
- Patient Address and postcode
- GP details
- Telephone contact details
- Next of Kin
- Religion
- Ethnicity

If any patient details have changed since the patients last attendance this information must be amended on CareFlow and new medical notes front sheet and labels produced.

Every patient, whether new or follow-up, whether attended or not, will have an attendance status and outcome recorded on CareFlow by the end of a face-to-face clinic. All consultation media clinics will be fully reconciled / outcomed, within 5 working days.

The clinical outcome and appropriate RTT status must be recorded by the responsible clinician using the specialty specific reconciliation slip, **this is a mandated process**.

It is the responsibility of the clinician to complete all relevant information including any outpatient procedures or diagnostics tests that have taken place and to ensure the reconciliation slip is returned to the clinic receptionist on the outpatient reception desk prior to the face-to-face clinical session ending or as soon as feasible for all other consultation media.

Every outpatient attendance must have one defined clinical outcome recorded on the slip and this must relate to the next steps for the patient on the care pathway under the clinic specialty. The attendance must also generate an RTT status. Any delays in this process will result in potential clinical delays for the patient and therefore must be addressed.

Patients will attend clinic at any point on their RTT pathway i.e. still active RTT pathway (i.e. not yet treated) or on a previous clock stop (having previously received 1st definitive treatment or following a decision to actively monitor the patient).

A daily un-reconciled clinic report will be circulated to the Operational Managers, Outpatient Clinic Supervisors and Team Leaders for action and escalates where there are delays. This is a mandated process and will be monitored through internal audit processes. It is the responsibility of the Divisional Manager to ensure patient appointments have an outcome.

Options for RTT outcomes following an outpatient consultation include

Patients on an open pathway

1. Clock stops for treatment. Either via a procedure performed in the outpatient setting, pharmacologically or via lifestyle advice and guidance
2. Clock stops for non-treatment. e.g. a decision not to treat or to commence active monitoring
3. Clock continues if requiring diagnostics, therapies or being added to the admitted waiting list.

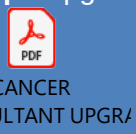
Patients already treated or with a decision not to treat

1. New clock start if a decision is made regarding a substantively new treatment plan.
2. New clock start if the patient is fit and ready for the second side of a bilateral procedure.
3. No RTT clock if the patient is to be reviewed following first definitive treatment.
4. No RTT clock if the patient is to continue under active monitoring.

Consultant Upgrade

Where it is decided to upgrade the patient's priority to a 62 Day Cancer Pathway following Outpatient consultant, the consultant will telephone the Cancer Upgrade Line to upgrade the patient and will also complete the Upgrade Template. For patients upgraded to treatment within 62 days, these patients will have a 62 day start on the date of the upgrade.

Top Tip - upgrade helpline 6478 /email sfh-tr.SFHFT-CancerPathwayTeam@nhs.net



CANCER
CONSULTANT UPGRA

Awaiting Reports

Patients can be classed as awaiting reports where the clinician does not routinely want to see the patient again in the Outpatient Department as a follow-up but has requested tests or investigations to be completed prior to deciding on the next course of action.

To identify these patients and to aid further management of the patient's pathway the Awaiting Reports report is provided as a self-service report that is refreshed daily. The Patient Pathway Co-ordinator will monitor the patients on the report on a weekly basis to ensure all tests and investigations are completed. The results are returned to the department to be viewed by the consultant and a decision made as to further plan of action. Patients will be removed from the list once they have a further appointment booked or their referral is discharged. This outcome will ordinarily mean the RTT clock will continue to tick.

It is the Patient Pathway Co-ordinators responsibility to monitor the Awaiting Reports report alongside the Patient Tracking List for all patients allocated to their consultant/specialty and therefore to manage the patients RTT pathway. This will require validation and CareFlow to be updated with the relevant administrative event/contact where necessary. These activities are referred to as 'decisions made outside of clinic'.

Patient Initiated Follow Up (PIFU)

PIFU is an initiative that allows patients to access follow-up appointments on an as and when required basis rather than on a routine follow-up basis thus giving patients autonomy over when and where they are seen and allows for outpatient capacity to be used for those patients most clinically needed

PIFU enables patients to make an appointment to see us if they have an exacerbation or flare -up of their condition.

A defined criteria and period is set.

Discharge

The patient has been discharged from the Trust back to the care of the referring care professional and no further consultation is required. If further consultation is required a new referral must be sought from the referring care professional which will start a new RTT pathway and clock.

Add to Elective Waiting List (Diagnostic or Treatment)

Patients can either be added to a diagnostic, therapeutic/treatment or planned waiting list as a Day-case or Inpatient Admission. Patients are to be added to the Waiting List within 48 hours of the decision to admit. Patient's outcome as 'Add to Diagnostic Waiting list' will appear on the 'Awaiting Reports report' as above to be managed by the Patient Pathway Co-ordinator. Please refer to the Elective Admissions section for further guidance.

Refer Other Consultant This Provider (Inter Consultant Referrals)

It is appropriate that consultants will directly refer patients to other specialties when the reason for that inter specialty referral is the ongoing management or investigation of the problem for which the patient was initially referred or a directly related medical condition.

When there is an immediate need for investigation it is appropriate that consultants will refer patients directly to other specialties. These patients will require urgent referral and rapid assessment and will usually be within two weeks.

Patients that are referred between consultant specialties will fit one of the following criteria:

The referral is:

- Clinically urgent and delay would be detrimental to the patient. These referrals will be assessed within two weeks.
- For investigation of suspected cancer and will be referred as a "two week wait referral" or part of a proven cancer pathway.
- Necessary for the on-going management and investigation of the condition for which the initial referral was made.
- For the investigation and / or management of a condition linked to the original condition for which the initial referral was made.

Patients where the clinical referral criteria for inter specialty consultant referral is met and therefore can be made consultant to consultant should not be discharged to the GP, as this will create further delays in patient care. However, if the clinical criteria for inter specialty consultant referral is not met, patients should be referred back to the GP for a primary care assessment.

Top Tip – Consultant to Consultant Referral Policy:

Refer Other Consultant Other Provider

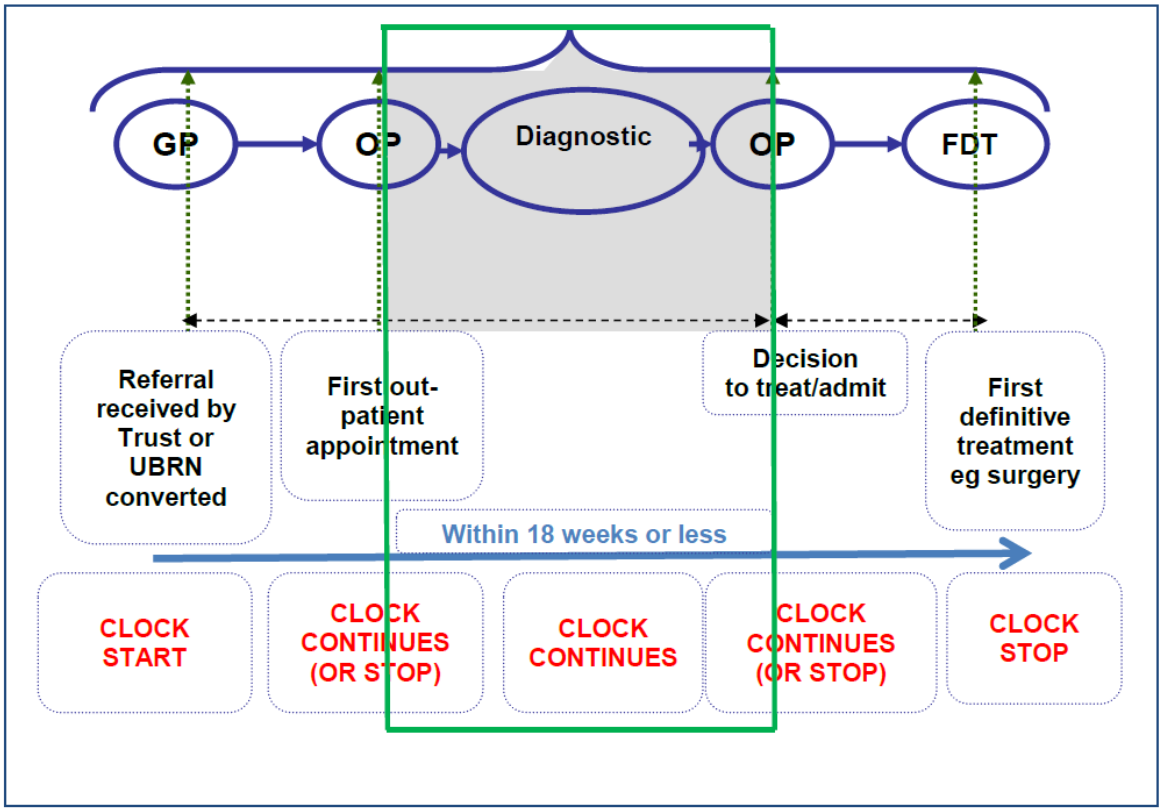
During consultation there may be a requirement to refer the patient to a service at another provider for a diagnostic investigation or treatment that will be to be performed at the other provider e.g. Nottingham University Hospitals. This decision must be clearly documented within the patient case-notes and the clinical letter digital dictation marked as urgent. To ensure monitoring of the RTT pathway continues **it is mandatory that an Inter Provider Transfer Minimum Data Set (MDS) form is completed** when transferring patients between organisations and that these referrals are sent securely through NHS mail.

All Inter-Provider Transfers must be **completed within 48 working hours** of the decision to refer being made and the relevant administrative event entered onto the CareFlow system which details the organisation the patient is being referred to and if it is for diagnostics or treatment. The MDS contains the Referral to Treatment (RTT) data items that need to pass between providers including the Patient Pathway Identifier, NHS Number, Organisation Code, RTT Start Date (where applicable) and RTT Clock Status. Receipt of these RTT data items will allow the receiving provider to measure RTT waiting times.

When waiting for a response from another organisation use read receipt. If no further response is received escalate through the Divisional Management Teams,

DIAGNOSTIC BOOKINGS

Many patients require diagnostics to determine the appropriate diagnosis and their subsequent treatment. Diagnostic tests can be for example in the form of a blood test, an endoscopy procedure, ECG, patch test or x-ray.



Key

OP – outpatients
FDT – first definitive treatment

The process above represents the diagnostic stage of the RTT pathway which forms part of the non-admitted pathway. The diagnostic period starts at the point of a decision to refer for a diagnostic test and ends on the results/report from the diagnostic test being available and actioned by the requester.

It is important to note that patients can also be referred for some diagnostic investigations directly by their GP where they might not be on an 18-week RTT pathway. (Direct Access Diagnostics Referrals)

Direct Access Diagnostics Referrals

The Trust operates a Direct Access Diagnostic Service for patients who are referred directly for a diagnostic test (but not consultant-led treatment) by their GP with the intention that the clinical responsibility for the patient remains with the GP. Trust examples of this type of service include direct access arrhythmia, non-obstetric ultrasound referrals and direct access gastroscopy services. RTT rules are not applicable to direct access diagnostics. The diagnostic test request does not start an RTT clock.

List of services supplied by SFH:

- Echocardiogram
- Gastroscopy
- Lung (direct access CT scan)

If the GP chooses to refer the patient to a consultant led service in secondary care based on the direct access test results the receipt of the new GP referral would start an RTT pathway.

Straight-To-Test Diagnostics

For patients who are referred to a consultant led service it may be appropriate for a diagnostic test to be completed prior to the patient being seen in clinic or to negate the need for an outpatient consultation at all. This service helps to streamline and expedite patient care. An RTT clock will start on receipt of the referral and a diagnostic wait will start on the decision to send for the diagnostic. These are called straight-to-test referrals and are sometimes managed via a RAS or CAS.

Patients with both a Diagnostic and an RTT Waiting Time Target

It is very common to have a patient with a concurrent RTT and diagnostic pathway. The diagnostic period is a significant milestone within the RTT pathway and can significantly impact the overall wait if patients are not managed in a timely manner. It is important that there are no undue delays to the diagnostic test taking place, and the clinician decision on next steps to enable the patient to be treated within the 18-week target.

The start dates for the two waiting time targets differ in that:

- The RTT clock starts at the point of receipt of the original referral i.e., the conversion on the UBRN in e-RS (Referral to treatment consultant-led waiting times 18W Standard)

- The diagnostic clock starts at the point of the decision to refer for a diagnostic test (this can be on referral i.e., the conversion on the UBRN in e-RS or at any point in the patient's care pathway e.g., at the first outpatient consultation). (DM01: Monthly Diagnostics Waiting Times and Activity standard)

Inactive RTT Pathways – Diagnostic Referrals

Patients on an inactive consultant-led pathway may also only have a diagnostic clock running. For example, where treatment has been given previously or a decision to actively monitor a condition has previously been made on the RTT pathway. Further diagnostic procedures may be required at later date to monitor the patient i.e., a check scan or scope. The RTT clock may have already stopped but diagnostic clocks must still be adhered to.

However, where a patient is referred for diagnostics with a view to further treatment it may be more appropriate to start a new RTT clock from the point that the decision that diagnostics or specialist opinion is made – i.e., when it is decided to start the patient on a new treatment pathway.

National Diagnostic Clock Rules - DM01

- **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. For Choose and Book referrals, this is the time that the UBRN is converted, i.e., when the patient has accepted an appointment.

- **Diagnostic clock stop:** the diagnostic clock stops at the point at which the patient undergoes the diagnostic test however the RTT clock will continue to tick until the patient has received definitive treatment or a decision not to treat is made.

Diagnostic Booking and Scheduling

Diagnostic waiting lists and PTLs are managed on a day-to-day basis by individual services such as Endoscopy, Radiology, Audiology and Cardio-Respiratory. Clinical ownership and delivery of access standards is the responsibility of the Divisions. Responsibility for ensuring that there is sufficient capacity to

achieve the necessary waiting time lies solely with the Divisions. Where a diagnostic procedure is unable to be booked due to capacity the Trusts Escalation Policy should be followed.

The appointment will be booked directly with the patient at the point that the decision to refer for a test was made where possible (e.g. the patient will leave Outpatients and go to the Endoscopy Department with the referral and will get an appointment before leaving the hospital).

Otherwise the teams that undertake diagnostics booking should contact the patient by telephone in the first instance to agree and book the date for the diagnostic procedure following locally agreed processes

All appointments agreed and confirmed with patient on the telephone should be confirmed in writing giving clear details of the date, time, and location of the diagnostic appointment along with appropriate information relating to the procedures and any necessary preparations the patient should take.

Where the patient is unable to be contacted by telephone the diagnostics and/or admissions booking team will attempt to contact the patient on the number provided throughout the working day a minimum of three times over two days. (and ideally one out of hours).

If the diagnostics booking team still cannot contact the patient by telephone, they will send an 'invite to call letter' requesting the patient contact the department This approach is known as partial booking. If no response from the patient is received within seven days the patient will be removed from the diagnostic waiting list and a letter sent to the patient, copied to the clinical referrer.

The clinical referrer then makes the decision on whether the patient is to be discharged back to the GP, on discharge from the Trust's care the RTT clock will stop. If further tests are required, the clock will continue.

Once booked every patient must be sent or given a letter confirming that he or she has an appointment for a diagnostic test, including instructions for the appointment or regarding the admission and the location of the diagnostic appointment along with appropriate information relating to the procedure and any necessary preparations the patient should take.

The 'appointment/to come in' letter should be an agreed template generated from CareFlow with details of how to contact the Trust. Patient information should be made available in a variety of languages and formats such as large print, Braille and audio as required.

Patients who require diagnostics to be performed at specific times, such as HCGs (Human Chorionic Gonadotrophin) at specific days of a menstrual cycle must be given clear instructions for the procedure at both the outpatient clinic when the decision is made and at the point of diagnostic appointment booking.

Top Tip - If a patient fails to comply with written instructions a clinical decision will be required on the next steps.

There is no blanket rule for patients not having adhered to instructions.

Declined Reasonable Offers

If a patient turns down reasonable appointments, i.e. 2 separate dates and 3 weeks' notice or sooner if the patient verbally agreed to the date, then the diagnostic waiting time for that test/procedure can be set to zero from the first date offered. This is in line with DM01 guidance.

However, the Trust must be able to demonstrate that the patient's original diagnostic appointment fulfilled the reasonableness criteria for the clock start to be reset.

Resetting a diagnostic clock start has no effect on the patient's RTT clock. This continues to tick from the original clock start date where the patient is on an active pathway**.**

Only the referring consultant can make a clinical decision to stop the RTT clock, if this is deemed to be in the patient's best clinical interests, by discharging the patient or agreeing a period of active monitoring.

Diagnostic Cancellations / DNA

CANCEL - If a patient cancels an appointment for a diagnostic test/procedure that has been offered under "reasonable" criteria then the diagnostic waiting time for that test/procedure is set to zero and the Diagnostic waiting time starts again from the date of the appointment that the patient cancelled.

Where a patient has cancelled their diagnostic appointment and a clinical decision is made to return them to the referring consultant, the RTT clock **if active** should continue to tick. The patient's consultant should clinically review the patient and indicate one of the following:

- The patient will be discharged back to the GP
- The patient MUST be offered another diagnostic test/procedure appointment
- The patient will be contacted by telephone or seen back in clinic to discuss further the need for the diagnostic

DNA - If a patient does not attend their diagnostic appointment that has been offered under "reasonable" criteria then the diagnostic waiting time for that test/procedure is set to zero and the waiting time starts again from the date of the appointment that the patient missed.

If a patient does not attend their diagnostic appointment that does not fulfil "reasonableness" criteria, the clock is not reset, and the patient should be offered an alternative appointment date.

Where a patient has failed to attend their diagnostic appointment and a clinical decision is made to return them to the referring consultant, the RTT clock if active should continue to tick where applicable**.** The patient's consultant should clinically review the patient and indicate one of the following:

- The patient will be discharged back to the GP
- The patient MUST be offered another diagnostic test/procedure appointment
- The patient will be contacted by telephone or seen back in clinic to discuss further the need for the diagnostic

Active Diagnostic PTL

All patients waiting for a diagnostic test should be captured on an active diagnostic waiting list (PTL) and booked by clinical urgency and chronologically from this list in line with their RTT wait regardless of whether they have an RTT clock running or have had a previous diagnostic test.

Patients Unfit for Diagnostic Procedures

If the patient is unfit for the procedure at the time of the appointment or cannot tolerate the procedure, they should be rebooked. There is no ability to stop or reset the wait in these circumstances.

Patients listed for some diagnostics procedures should undergo an appropriate level of initial assessment to determine suitability to proceed with the diagnostic procedure. Where a patient is not fit to have the procedure performed the patient should not be added to the diagnostic waiting list and should be returned to the referring clinician. In this instance the DM01 Diagnostic clock would stop but the RTT clock (where applicable) would continue.

Where following pre-procedure fitness checks, a clinical opinion of suitability for a procedure is required from another clinical speciality such as cardiology, the patient continues to wait until a clinical decision as to the next steps is made. If the patient is not fit to proceed with the diagnostic pending further optimisation of a clinical condition the patient should be removed from the diagnostic waiting list and returned to the referring clinician. In this instance the DMO1 Diagnostic clock would stop.

Therapeutic Procedures

Some procedures are intended as diagnostic up until a point during the procedure, when the healthcare professional decides to undertake a therapeutic treatment at the same time. In this instance both the Diagnostic wait will stop, and the definitive treatment will also stop the RTT pathway.

Some procedures will include both a diagnostic test and a therapeutic treatment. If the procedure is part-diagnostic or intended to be part-diagnostic, these should be counted as diagnostic procedures.

Patients may attend a diagnostic setting for a therapeutic treatment (e.g. an x-ray guided injection in radiology). In this instance, as this is not a diagnostic this would not be applicable to the six-week diagnostic standard. If this treatment is classed as the patient's definitive treatment (e.g. the injection) the RTT clock (where applicable) will stop.

Patients Waiting for More Than One Diagnostic Test / Procedure

Where a patient is awaiting two separate diagnostic tests/procedures concurrently the patient should have two independent 6-week diagnostic waiting time clocks one for each test/procedure.

All referrals for diagnostics should include information on the patient's RTT pathway status where appropriate. Bookings for diagnostics should be undertaken on an urgency and chronological basis considering RTT breach dates.

Alternatively, if a patient needs a first test initially and once this test has been carried out, a further test is required the patient would have one waiting time clock running for the first test. And once the first test is complete the first DM01 clock will stop, and a new diagnostic clock will start for the second test.

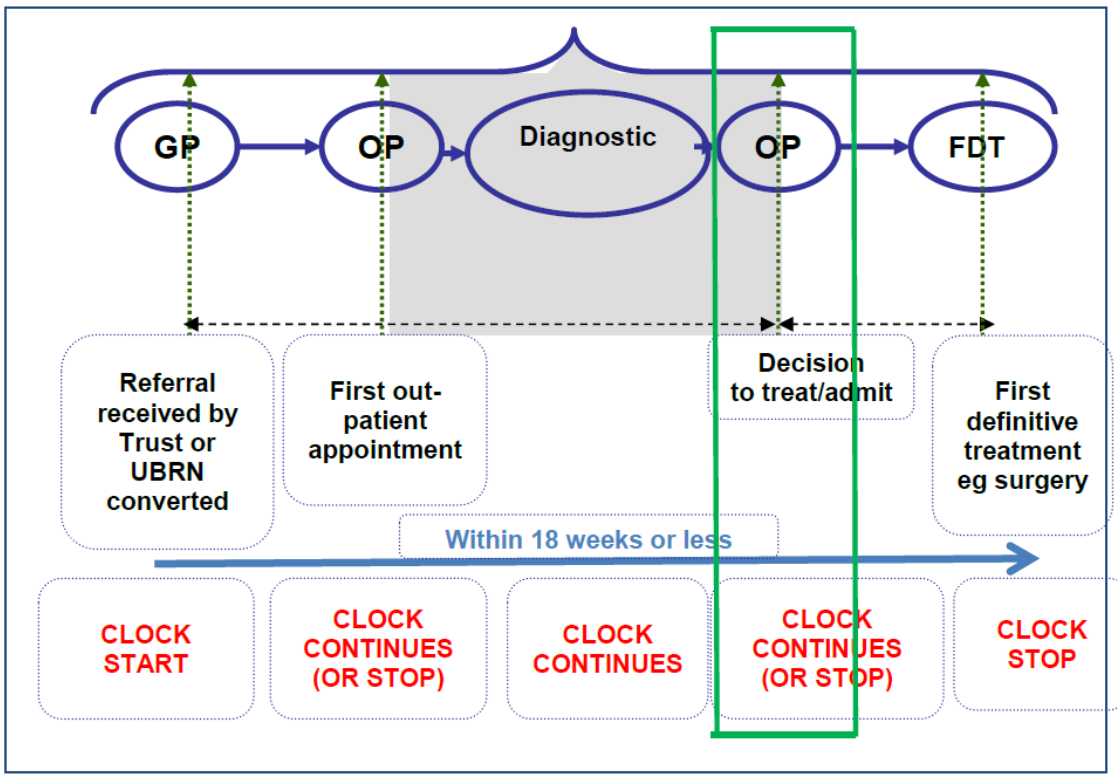
'Planned' or Sequenced Diagnostics

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

Examples may include:

- Surveillance Ultrasounds
- Surveillance Dexa
- Diagnostics to be carried out within a fixed period of time based on clinical timing such as monitoring scans, repeat endoscopies or echocardiograms

Pre-Operative Assessment (POA)



Key

OP – outpatients
FDT – first definitive treatment

All patients with a decision to admit (DTA) requiring a general anaesthetic will require a Preoperative Assessment (POA). In instances where the patient is attending the Trust at the point of the Decision to Admit (DTA) (e.g. during a face-to-face outpatient appointment), then the pre-operative assessment should take place on the same day to assess the fitness of the patient for surgery. Most patients can be assessed by the Trust's POA nurses at their first attendance to Preoperative assessment. 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.

For patients with complex health issues requiring a further POA appointment with a nurse or anaesthetist, the Trust will aim to agree this date with the patient before they leave the clinic.

Patients who DNA their first POA appointment will be contacted, and a further appointment agreed, if they DNA for a second time, they will be referred back to the responsible listing consultant. The RTT clock continues to tick throughout this process.

Top Tip - The clinician will review after any DNA and a decision will be made for one of the following outcomes:

- The patient will be discharged back to the GP
- The patient MUST be offered another appointment
- The patient should be offered another appointment – the patient will be contacted and if after 2 weeks there is no response the patient will be referred back to the GP

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

However, if the clinical issue is more serious and the patient requires optimisation/treatment for a separate condition identified during pre-operative assessment, clinicians should indicate if it is clinically appropriate for:

- The patient to be optimised / managed within secondary care – an active monitoring clock stop will be entered whilst the patient receives optimisation/treatment for the separate condition.
  When the patient becomes fit and ready to be treated for the original condition, a new RTT clock starts on the original pathway from the date the decision is made and communicated to the patient.

- The patient to be discharged back to the care of their GP - this must be clearly communicated to the patient and their GP and the RTT clock will be stopped on the date of the communication. The patient could potentially be relisted without the requirement for a further Outpatient appointment if they are confirmed as fit (i.e. lost weight/improved exercise tolerance/ BP management HBA1C reduced by the GP. In this instance the clock would restart on the re-referral.

Non-Activity Related RTT Decisions (Decisions Outside of Clinic)

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 (Letter typed date). Administration staff should update Medway PAS with the clock stop

Adding Patients to the Active Inpatient or Day Case 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 Pre-Operative assessment or whether they have declared a period of unavailability at the point of the decision to admit.

The process of selecting patients for admission is managed within the waiting list team who process elective admission requests and manage waiting lists, ensuring that patients are offered a reasonable choice of admission date. Specialities within the Divisions that undertake their own scheduling outside of the centralised team are required to follow the centralised processes as detailed in this policy.

Structure of Waiting Lists

The Waiting list PTL includes all patients who are currently waiting an elective admission either waiting list, booked, or planned. These patient's will be also recorded on the 'Admitted RTT active PTL' if they are applicable to an active RTT wait. (e.g. exceptions are planned patients, who are awaiting admission at a specific clinically defined time). The admitted RTT active patient tracking list (PTL) contains patients who are waiting for both definitive treatment and diagnostics including patients who are being investigated or treated for confirmed cancer.

All patients with a decision to admit for an elective admission must be entered onto the electronic inpatient waiting list on CareFlow. Waiting lists held off CareFlow are strictly forbidden by the Trust. The use of paper diaries for planning care is a particular risk to the organisation in terms of delivery of waiting time standards and maintaining a complete picture of patients awaiting surgical care at the Trust. Their use is contrary to

best practice and should only be authorised by the Chief Operating Officer in discussion with the Divisional Managers and be entered on the Trust's Risk Register.

Patient Information

Every patient must be sent or given a letter confirming that they have been added to the waiting list and confirmation of agreed 'To come in' (TCI) dates, including instructions for admission and details of how to contact the Trust regarding the admission. The 'admission/to come in' letter should be an agreed template generated from MEDWAY and sent out.

RTT Rules

In terms of the patient's RTT clock, 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.
- Continue a non-active clock if the patient is receiving a planned sequence of care or surveillance procedure

Patients Requiring Thinking Time

Patients may wish to spend time thinking about the recommended treatment options before confirming they would like to proceed with surgery. It may be appropriate for the patient to be entered into active monitoring (and the RTT clock stopped) where they state they do not anticipate deciding for a matter of months. This decision can only be made by a clinician and on an individual patient basis with their best clinical interests in mind. In this scenario, a follow-up appointment must be arranged around the time the patient would be able to decide. A new RTT clock should start from the date of the decision to admit if the patient decides to proceed with surgery.

Patients Requiring More Than One Procedure

- If more than one procedure will be performed at one time by the same surgeon, the patient should be added to the waiting list with extra procedures noted.

- If different surgeons will work together to perform more than one procedure, the patient will be added to the waiting list of the consultant surgeon for the priority procedure with additional procedures noted.

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

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

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

Scheduling Patients to Come in For Admission

Clinically urgent patients will be scheduled first, followed by routine patients. All patients will be identified from the Trust's PTL, and (, will be scheduled for admission in clinical priority order followed by chronological order of RTT wait.

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 as a minimum

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).

An 'invitation to call' letter will be generated from PAS, asking patients to make contact within 7 days. If the patient does not make contact; the demographic details will be confirmed with the GP Three attempts will then be made to contact the patient by telephone, with one being in the evening. Following this a second 'invitation to call' letter will be sent to the patient asking them again to make contact within 7 days.

Where a patient has failed to make contact to agree a TCI date, the responsible listing clinician will be informed; **the RTT clock if active should continue to tick where applicable.** The patient's consultant should clinically review the patient and indicate one of the following:

- The patient will be discharged back to the GP
- The patient MUST be offered a TCI date and further attempts to contact the patient will be made

Certain patient groups can be fully booked where there is agreed processes and the patient is clinically urgent or those with suspected cancer.

Patients will be offered a choice of at least two admission dates with three weeks' notice within the patients breach date. Admission dates can be offered with less than three weeks' notice and if the patient accepts, this can then be defined as 'reasonable'.

If there is insufficient capacity to offer dates within the RTT breach date this issue will be escalated to the relevant service manager. Any admission offers declined by patients will be recorded on PAS. This is important for two reasons:

- Full and accurate record-keeping is good clinical practice.
- The information can also be used later to understand the reasons for any delays in the patient's treatment, e.g. hospital or patient initiated.

If a patient's RTT status does not allow reasonable offers for admission to be made, and the patient does not wish to accept a date at shorter notice, this must be escalated to the Waiting List Manager and subsequently divisional leads.

Patients, who do not want treatment or undecided about surgery, i.e. have not actively consented to the treatment or want thinking time, **must not be** added to the waiting list. Such patients must either be reviewed

in outpatients and enter a period of active monitoring, if appropriate, or be returned to their GP's care and this must be clearly communicated to the patient and their GP.

The patient could potentially be listed without the requirement for a further Outpatient appointment if they change their mind and want to go-ahead within a short time after discharge (i.e. days or short weeks) in this instance the clock would restart on the re-referral.

All inpatient and day case waiting lists must be coded with the appropriate intended management, procedure and RTT codes.

'Sequenced' or Bilateral Procedures

Where patients may require two-part treatment or a bilateral procedure, they will be placed on the waiting list for the first procedure, treatment of which stops the clock. The decision to treat for the second procedure is likely to be made during follow up. A new RTT clock commences on the decision to admit for the second procedure.

Patients Declaring Periods of Unavailability While on the Inpatient/Day Case Waiting List / Patient Cancellations of Agreed TCI Dates

If a patient contacts the Trust to communicate periods of unavailability for social or economic reasons may mean that offering actual dates which meet the reasonableness criteria would be inappropriate (as the patient would be offered dates that the provider already knew they couldn't make). In this case, the waiting time clock cannot be paused but the provider will capture the patient being unavailable for the given period and not penalise the patient.

If the length of the period of unavailability is deemed to be unsafe and is greater than 3 months a clinical opinion will be sought. Upon clinical review, the patient's consultant will indicate one of the following:

- Clinically safe for the patient to delay continue progression of pathway. The RTT clock continues. **Patient to stay on the waiting list if a short delay is requested. If a long delay is requested (suggest > 12W) it may be more applicable to remove the patient from the active waiting list and actively monitor the patient until they are ready to be treated.**

- Clinically unsafe length of delay: clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues. 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. **Patient to stay on the waiting list Clock continues/Patient to be brought back to clinic clock stop. 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 and not be open ended, so that the patient's condition and treatment options can be re-assessed following the period of active monitoring.**

- Clinically unsafe length of delay: in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP. The patient could also be actively monitored within the Trust. **Patient to be /discharged back to the GP**

There is a requirement to sensitively obtain information around why there is a delay/cancellation to inform the clinical decision.

Patient Cancellation/ or declined offers

A rescheduled date should be offered, where possible at the time of the cancellation that is within the RTT breach date. The offers for a rescheduled date must be reasonable and be recorded on CareFlow. Should a patient accept a date with less than three weeks' notice this becomes a reasonable offer**.** If a date cannot be accommodated within the patient's RTT pathway the Divisional Management Team MUST be notified.

Should a patient contact the Trust to cancel their admission and does not wish to have a further admission date, **the patient's pathway will be reviewed by their consultant and if clinically appropriate** they will be discharged to the care of their GP informing of the reason for the discharge by letter copied to the patient. Their RTT clock will stop. Should the GP decide to re-refer the patient a new RTT clock will begin.

When a patient declines 2 reasonable offers of treatment dates and wishes to delay treatment, the consultant should review the patient and may agree a period of active monitoring with them, this 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 patients' 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.

Patients Who Fail to Attend (DNA) Their Admission

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 GP should be informed of the reason for the discharge by letter copied to the patient. Their RTT clock will stop. Should the GP decide to re-refer the patient a new RTT pathway will begin.

Patients that fall into the vulnerable groups must be contacted to arrange another admission date to take place as soon as possible and prior to their RTT breach date. If a date cannot be accommodated within the patient's RTT pathway the Divisional Management Teams should be notified.

Hospital Cancellations of a TCI Date

Patients should only have their agreed admission cancelled under exceptional circumstances. Where a patient is cancelled on the day of admission or day of surgery for non-clinical reasons, they will be rebooked on the day of cancellation. 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 source another provider for patient's treatment at the patient's hospital of choice.

Avoiding Cancellations

Pre-Operative assessment must ensure that everything that needs to be done before the patient's operation has been done (e.g. booking HDU bed, bloods taken, pre-op and post-op arrangements discussed, etc.). Any required kit will be ordered by the Theatre Resource Team. If an admission is cancelled at short notice, telephone calls and first-class mail should be used to ensure the patient is given as much notice as possible.

All cancellations at the last minute for non-clinical reasons should be escalated within the organisation, to ensure every effort is made to avoid cancellation. Escalation for last minute non-clinical cancellations must be escalated to the Divisional Business Support Unit Manager via the flow room.

The individual taking the decision to cancel the patient's admission is responsible for informing the Waiting List Team. Please follow the hospital cancellation policy and SOP for on the day theatre cancellations.

Top Tip –On the Day Theatre Cancellations SOP
https://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=57622

On Day Theatre
Cancellations SOP - D

Any patient who has had an admission cancelled by the Trust should not be cancelled a second time. The Waiting List Team should indicate on CareFlow and on admission lists that the patient has been previously cancelled and their waiting status, to identify long waiters. Prior to any repeat cancellations, Divisional Management Team must authorise the cancellation.

Where cancellations are initiated by the Trust, patients should be contacted and offered a choice of at least two different TCI dates with reasonable notice before their RTT breach date and within 28 days of their cancellation. The RTT clock will continue to tick while the patient's appointment is rescheduled.

Theatre Session Cancellations

A short-notice cancellation is defined as any cancellation or reduction of any theatre session with less than six weeks' notice. In the event of a short-notice cancellation request, this will be escalated initially to the relevant Divisional Manager.

The Divisional Manager will speak with the requesting clinician who will be expected to cancel leave or ensure that appropriate clinical cover is arranged for the theatre session to go ahead without either cancellation or reduction.

If the requesting clinician is unable to comply, the Divisional Manager will escalate directly to the Clinical Director. The Clinical Director and Divisional Manager will review the position and make a recommendation as to whether the theatre session should be cancelled or not.

The Information Team will monitor and distribute cancelled appointments with less than six weeks' notice report monthly. This will be reported as part of the Divisional Performance Review.

Planned Waiting Lists

Patients will only be added to an admitted planned waiting list where clinically they need to undergo a procedure at a specific time. The due date 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.

Patients on the 'planned' waiting list are outside the scope of RTT, as they are not actively awaiting treatment. Patients must only be included on a planned waiting list if there are clinical reasons why the patient cannot have treatment until a specified time, for example the second stage of a two-part treatment. Planned activity is also sometimes known as "surveillance".

Patients on the planned list will be reviewed administratively by the Waiting List Team on a routine basis to check patient's availability for treatment (weekly) and offered subsequently a date of admission in line with good clinical practice for their condition and specialty guidelines. 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. For some patients (e.g. surveillance endoscopies) a diagnostic clock would also start.

Validation of Waiting Lists

Appropriate validation exercises will be undertaken to ensure that data held on patients is accurate and up to date and to ensure that they still require the appointment or procedure they are waiting for.

Managers should undertake a validation exercise of the inpatient and day case waiting list on a weekly rolling basis. Divisional Managers are responsible for ensuring that the rolling validation and manual cross checks are carried out for all waiting lists, including planned waiting lists and PTLs.

Acute Therapy Services

Acute therapy services consist of physiotherapy, dietetics, orthotics, and surgical appliances. Referrals to these services can be:

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

Depending on the pathway or patient, therapy 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.

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. Equally, patients could receive dietary advice as an important step of a particular pathway (e.g. bariatric). In this example, the clock could continue to tick.

9 EVIDENCE BASE

The policy supports the delivery of the NHS Constitution, the national waiting time standards for Cancer and the national waiting time standards for Referral to Treatment (RTT).

NHS Constitution – Easy Read Format
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/963705/NHS_Constitution_EasyRead.pdf

NHS Choice Framework
https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs

The RTT Rules Suite can be located within the following web address:
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting-RTT-guidance-v24-2-PDF-703K.pdf

https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

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

Delivery plan for tackling the COVID-19 backlog of elective care:
https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/

Interim patient choice guidance:
https://future.nhs.uk/ElectiveRecovery/view?objectId=40150608

Cancer Waiting Times (CWT):
https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/cancerwaitingtimescwt

Guidance on completing the "diagnostic waiting times & activity" monthly data collection
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01-guidance-v-5.32.pdf

Diagnostics FAQs
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01-FAQs-v-3.0.pdf

10 DISTRIBUTION

This policy will be available to employees within the Trust's suite of governance policies, accessible via the Corporate Information intranet site.

11 APPENDICES

APPENDIX 1 - DEFINITIONS

Term	Definition
2WW	Two-week wait: the maximum waiting time for a patient's first outpatient appointment or 'straight to test' appointment if they are referred as a 62-day pathway patient.
31-day pathway	The starting point for 31-day standard is the date a patient agrees a plan for their treatment or the date that an earliest clinically appropriate date (ECAD) is affected for subsequent treatments.
62-day pathway	Any patient referred by a GP with a suspected cancer on a 2WW referral pro-forma, referral from a screening service, a referral from any healthcare professional if for breast symptoms or where a routine referral has been upgraded by a hospital clinician, must begin treatment within 62 days from receipt of referral.
A	
Active monitoring	**Clinician initiated** - Where a decision is made not to treat but to retain clinical responsibility for the patient in secondary care. The patient will continue to be monitored for an indefinite period through regular outpatient follow-ups or via planned surveillance. A new decision to treat may be made later. **Patient initiated** – Where treatment may be the appropriate course of action, but the patient decides that they wish to 'wait and see' how their condition progresses, or they wish to delay their treatment to consider if they wish to proceed. (Thinking time) A review appointment may be agreed at a specified time e.g. 3M/6M A new decision to treat may be made later.
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.
Admission	The act of admitting a patient for a day case or inpatient procedure.
Admitted pathway	A pathway that ends in a clock stop for admission (day case or inpatient)
B	
Bilateral (procedure)	A procedure that is performed on both sides of the body, at matching anatomical sites. For example, removal of cataracts from both eyes. A new patient pathway and clock should start once the patient is fit and ready for a subsequent bilateral procedure. In this context, fit and ready means that the clock should start from the date that it is clinically appropriate for the patient to undergo that procedure, and from when the patient says they are available.

Breach	A pathway which ends when a patient is seen/receives their first treatment outside the 14-day first seen, 62-day referral to treatment and/or 31-day decision to treat to treatment or RTT referral to treatment target times.
C	
Care Professional	A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
Chronological booking	Refers to the process of booking patients for appointments, diagnostic procedures, and admission in date order of their clock start date.
Clinical decision	A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements.
Consultant	A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. The operating standards for referral to treatment exclude non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.
Consultant-led Service	A consultant retains overall clinical responsibility for the service, team, or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.
D	
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	Where a clinical decision is taken to admit the patient for either a day case or inpatient treatment.
Decision to treat	Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatments performed in other settings e.g. as an outpatient.
DNA – Did Not Attend **(Was not brought)**	DNA (sometimes known as an FTA – Failed to attend). In the context of the operating standards, this is defined as where a patient fails to attend an appointment/admission without prior notice. WNB Applies to children and young people (who require the presence of a parent or carer to attend appointments) who did not attend a planned appointment and had not cancelled the appointment.
Direct access	Where GPs refer patients to hospital for diagnostic tests only and return to the GP for their care. These patients will not be on an open RTT pathway.
E	
e-Referrals (Choose and Book)	A national electronic referral service that gives patients a choice of place, date, and time for their first consultant outpatient appointment in a hospital or clinic.
F	
First definitive treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes First Definitive Treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.

Fit (and ready)	A new patient pathway and clock should start once the patient has been assessed by pre-op and/or an anaesthetist to confirm they are fit, ready and able to surgery.
Fixed appointments	Where an appointment or admission date is sent in the post to the patient without the opportunity to agree a date. Where an appointment is booked with the patient at a date in the future without the patient being added to an Outpatient Partial booking or Admitted waiting list.
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.
I	
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.
Interface service (non-consultant-led interface service)	All arrangements that incorporate any intermediary levels of clinical triage, assessment, and treatment between traditional primary and secondary care. e.g. MSK Service.
N	
Non-admitted pathway	A pathway that results in a clock stop for treatment or a decision not to treat that does not require an admission e.g. an outpatient diagnostic.
Non-consultant-led	Where a consultant does not take overall clinical responsibility for the patient.
Nullified	Where the RTT clock is discounted from any reporting of RTT performance e.g. following a 1st DNA after GP referral.
P	
Partial booking	Where an appointment or admission date is agreed with the patient near to the time it is due. E.g. Patients invited to contact the Trust to agree an appointment or admission date and time nearer their due date.
Pathway	Sounds so basic but many confuse Referral and Pathway An RTT Patient Pathway as generated as a referral from the GP and maps the patients' core journey. It is defined by a 20-digit unique pathway ID.
Patient-initiated delay	Where the patient cancels, declines offers or does not attend appointments or admission. This does not the stop the RTT clock. A clinical review must always take place.
Planned waiting list	Patients who are to be admitted as part of a planned sequence of care 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. E.g. planned surveillance colonoscopy.
R	

Reasonable offer	A reasonable offer is an offer of a time and date three or more weeks from the time that the offer was made.
Referral	Referral can be originated by the GP as e-referral, ICR etc. Where a referral is made to a specialist in a particular field for advice on the best way to manage a condition, this may involve a referral for tests and investigation that cannot be performed in a GP surgery and/or for a consultation in an outpatient setting. An outpatient episode starts on receipt of the referral and ends on discharge back to GP care.
Referral Management or Clinical assessment Service	Referral management or assessment services are those that do not provide treatment but accept GP (or other) referrals and provide advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient. Referral Management and Assessment Services should only be in place where they carry clinical support and abide by clear protocols that provide benefits to patients. They must not be devices either to delay treatment or to avoid having clinical discussions with GP practices about good referral practice. In the context of the operational standards, a clock only starts on referral to a referral management and assessment service where that service may onward-refer the patient to a surgical or medical consultant-led service before responsibility is transferred back to the referring health professional.
S	
Straight to test	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an RTT or cancer pathway.
Substantively new or different treatment	Upon completion of a referral to treatment period, a new pathway and clock starts upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.
T	
Therapy or Healthcare science intervention	Where a consultant-led or interface service decides that therapy (for example physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science (e.g. hearing aid fitting) is the best way to manage the patient's disease, condition or injury and avoid further interventions.
U	
UBRN (Unique Booking Reference Number)	The reference number that a patient receives on their appointment request letter when generated by the referrer through Choose and Book. The UBRN is used in conjunction with the patient password to make or change an appointment.
Convert(s) their UBRN	When an appointment has been booked via Choose and Book, the UBRN is converted. (Please see definition of UBRN).

Acronyms

Term	Definition
ASIs	Appointment slot issues (list): 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.
CATS/CAS	Clinical assessment and (treatment) service
CCGs	Clinical commissioning groups: commission local services and acute care.
DNA	Did not attend: patients who give no prior notice of their non-attendance
DTA	Decision to admit
DTT	Decision to treat (date): the date on which the clinician communicates the treatment options to the patient and the patient agrees to a treatment
E-RS	(National) E-Referral Service
GP	General practitioner: a physician whose practice consists of providing ongoing care covering a variety of medical problems in patients of all ages, often including referral to appropriate specialists
ICR	Inter consultant referral
IFR	Individual funding request
IPT	Inter-provider transfer
MDS	Minimum dataset: minimum information required to be able to process a referral either into the cancer pathway or for referral out to other Trusts.
PAS	Patient administration system records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient
PPI(D)	Patient pathway identifier
PTL	Patient tracking list. A tool used for monitoring, scheduling, and reporting on patients on elective pathways (covering both RTT and cancer).
RACPC	Rapid access chest pain clinic
RCA	Root cause analysis defines steps on a patient's pathway and identifies breach reasons. In the context of this policy, this is not the same as the level of investigation involved in an RCA for, for example, a Serious Incident (SI).
RMC	Referral management centre
RTT	Referral to treatment
TCI	To come in (date). The date of admission for an elective surgical procedure or operation.
UBRN	Unique booking reference number
WNB	Was not brought

Appendix 2 - Useful Proformas

Over 6 Weeks Clinic Cancellation Form

Over 6 weeks cancellation form 250

Under 6 Weeks Clinic Cancellation Form

Under 6 weeks cancellation form 250

Additional Outpatient Clinic Approval Form

Extra clinic template 260219.xlsx

Outpatient Clinic Booking Permanent Service Change Form

Permanent Service change proforma July

Elective Care Training Strategy

Elective Care Training Strategy.doc

DNA/WNB Process for Urgent and Routine Appointments

DNA.WNB Process Maps Final Version 20

WNB Pathway for Decision Making

Pathway for decision making DNA & WNB.d

Transfer Pathway out of SFH (Inter Provider Transfer)

Transfer Pathway Out of SFH (Inter Pro

APPENDIX 4 – MONITORING MATRIX

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (e.g. verbal, formal report etc) and by who)
Compliance with the Trust' requirements for policy formatting and processes	Director of Corporate Affairs	Review of documents on receipt from authors, prior to publication on the staff intranet/internet	As and when documents are received	Compliance with the Trust' requirements for policy formatting and processes Will be resolved directly with the Clinical / Non – Clinical Policy officer
Review of the status of Existing Non – Clinical Policies	Director of Corporate Affairs	Review New, Approved, Updated and Overdue Non – Clinical Policies	2 x yearly	Audit Committee
Review of Existing Clinical Policies	Deputy Head of Nursing Quality and Support	Review status of all existing Clinical Documents	Annually	Quality Committee
Review of Approving Committees	Director of Corporate Affairs	List of Non - Clinical Policies and associated Approving Committees to be reviewed	Annually	Executive Team Meeting
Review of Approving Committees	Deputy Head of Nursing Quality and Support	List of Clinical Policies and associated Approving Committees to be reviewed	Quarterly	Patient Safety Quality Group

APPENDIX 5 - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Elective Access Booking and Choice Policy			
Existing			
Date of Assessment: 05/2023			
Please answer the questions a – c below against each characteristic (if relevant consider breaking the document or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the document or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of the document or its implementation being assessed:			
Race and Ethnicity	Availability of this policy in languages other than English	Alternative versions can be created on request.	None
Gender	None	Not applicable	None
Age	None	Not applicable	None
Religion	None	Not applicable	None
Disability	Visual accessibility of this document	Already in font size 12. Use of technology by end user. Alternative versions can be created on request	None

Sexuality	None	Not applicable	None
Pregnancy and Maternity	None	Not applicable	None
Gender Reassignment	None	Not applicable	None
Marriage and Civil Partnership	None	Not applicable	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	Not applicable	None

What consultation with protected characteristic groups including patient groups have you carried out? None for this version, in that all previous principles remain in accordance with previous version (which was subject to consultation), and this version is primarily a reformat and codification of agreed practices.

What data or information did you use in support of this EqIA? Trust policy approach to availability of alternative versions

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints, or compliments? No

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

Name of Responsible Person undertaking this assessment: Joanna Taphouse Head of RTT

Signature: *Joanna Taphouse*

Date: 05/2023