TRUST POLICY

Patient Access Policy

Overview	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
Staff / stakeholders /Consultation Groups), involved in development:	Planned Care and Cancer Governance Oversight Group Divisional Directors of Operations Deputy Divisional Directors of Operations General Managers Associate Director of Planned Care RTT validation officers

Division:	Corporate
Department:	Resilience and Flow
Responsible Person	Huw Edwards, Managing Director (Planned Care and Cancer)
Authors:	Ali Robinson, Head of Performance Tracy Maclean, RTT Performance Manager Richard Umney, Associate Director of Cancer Performance and Improvement
For use by:	All staff
This document supports: *Standards and legislation*	The NHS Constitution for England Referral to Treatment Time standard Cancer Waiting Times standards
Key related documents:	
Superseded documents	UHSC046 Patient Access Policy v1
Reference Number:	UHSC046

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Huw Edwards, Managing Director of Scheduled Care	**Date approved:**	6th January 2026
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Version	**Date**	**Author**	**Status**	**Comment**
1.0	February 2022	Marianna Windham RTT Performance Manager / Ashley Standford RTT Lead	Archived	Policy for newly merged trust
2.0	December 2025	Ashley Stanford / Ali Robinson	LIVE	New version updated to reflect new published national guidance. Incorporated cancer section and amendments throughout where required.
3.0				

Contents

1. Introduction

University Hospitals Sussex NHS Foundation Trust will treat patients in line with the NHS Constitution and national standards. This policy is agreed by the Planned Care Board, aligned across all Sussex providers, and developed with the ICB and Clinical Advisory Groups.

It sets out Trust and commissioner operating standards for access to consultant-led secondary care from referral to first definitive treatment for cancer, urgent and routine care pathways. Access is according to clinical priority and is fair and non-discriminatory (including gender, race, disability, age, sexual orientation, religion or belief, gender reassignment, health inequalities, pregnancy and maternity, and marital or civil partnership status).

The policy provides a single approach to waiting lists, scheduling and booking across the organisation. Care will follow local and national policies on Vulnerable Adults, Patients with Learning Disabilities, Safeguarding Children, and War Veteran guidance. The Trust remains committed to same-sex accommodation to protect privacy and dignity through segregated facilities.

All staff involved in elective pathways must understand their roles. Processes must be clear to patients and partners and open to inspection, monitoring and audit.

This policy describes how patients are managed administratively at every contact point in the Trust and must be applied with the supporting Standard Operating Procedures (SOPs). It has been developed in accordance with national objectives, targets and guidance from the Department of Health, including the NHS Constitution, version 12.1 of the NHS England's Cancer Waiting Times Guide and Cancer Model Access Policy (V1.0).

Aims:

- Treat patients by clinical urgency; treat others in turn, with clinical reviews where patients delay, decline or cancel.
- Reduce waiting times and meet agreed targets.
- Minimise non-clinical cancellations.
- Enable patients to exercise their right to choice of care and treatment.

Use this policy alongside the Private Patients policy and the Evidence-Based Interventions criteria.

2. Responsibilities, Accountabilities and Duties

Accountability applies to both individuals and Committees/Groups. Divisions and Directorates are accountable for meeting access standards, while all staff who use or maintain referral and waiting list systems are responsible for accurate data.

This policy applies consistently across UHSussex. Access is based on clinical need and includes military and veteran patients. Cancer pathways are prioritised in line with national guidance. Non-NHS patients, including overseas visitors, are outside the 18-week right, although emergency care may still be provided. UHSussex will work with the ICB, GPs and primary care to ensure patients understand eligibility before any 18-week pathway starts, and commissioners must maintain robust feedback channels to GPs.

The ICB will work with commissioned diagnostics, consultant-led community services and Referral Management Services to ensure appropriate waits before onward referral to UHSussex. The Trust will support this and escalate ongoing concerns to the ICB.

Under the NHS Constitution, 18 weeks is a maximum wait, not a target, and most patients should be seen sooner. The Trust aims to treat 100% within 18 weeks where clinically appropriate and where the patient agrees. No minimum waiting time applies.

Role responsibilities and accountabilities by group:

The **Chief Executive Officer** is responsible for:

- The Chief Executive is accountable to the Trust Board for patient access performance. They must ensure robust processes are in place to manage care and treatment, meet NHS Constitution and national/local standards, and achieve the required targets.

The **Chief Operating Officer** is responsible for:

- Executive lead for clinical operations and patient access.
- Ensures, via Divisional Management Teams, that processes meet national/local and NHS Constitution standards.
- Implements Trust-wide monitoring to secure compliance with this policy and prevent breaches.
- Reports progress and remedial actions on access standards to the Trust Board.
- Delivers operational targets in line with the annual business plan (e.g., 18-week RTT, cancer waiting times and other access standards).
- Owns, communicates and embeds the Patient Access Policy across the Trust.

The **Director of Operations** are responsible for:

- Own divisional business plans and deliver against key objectives.
- Work with Divisional Managers to monitor access performance and act early to prevent breaches.
- Lead the management of any actual breaches with Divisional Managers.
- Assure data quality and produce accurate performance reports for internal use and external returns.
- Ensure reporting methods and definitions align with national best practice.

- Partner with ICBs to evaluate, agree and implement pathway transformation where appropriate.

The **service management teams (service triumvirates)** are responsible for:

- Run specialty-level processes that meet NHS Constitution, national and local access standards.
- Plan and deploy resources (clinics, theatres, staff, diagnostics) to hit RTT/eRS/cancellation standards and avoid non-clinical cancellations.
- Implement this policy locally, brief and train relevant staff.
- Monitor performance and data quality; validate records and deliver accurate, timely reports aligned to national definitions.
- Identify risks early and escalate potential or actual breaches to the Director of Operations; the DDO will escalate to the Chief Operating Officer as needed.
- Review clinical pathways regularly to keep them patient-centred, efficient and continuously improving.
- Hold a weekly Patient Tracking List (PTL) meeting using the Trust standard agenda; attend the weekly Divisional RTT meeting; and cancer PTL/ tracking meetings.
- Work with the ICB to design and implement pathway transformations where appropriate.

Each **consultant** is responsible for:

- Triage referrals within 3 working days: assign clinical priority in the referral system and forward to booking; return incomplete or inappropriate referrals with a brief clinical reason within 3 working days.
- Respond to Advice & Guidance requests within 3 working days (consultant or designated deputy).
- Review eRS referrals; if delegating any task, ensure the delegate is competent and informed. The consultant remains responsible and accountable for the patient's care and decisions.
- Record a clear, timely management plan (e.g., TCI/e-TCI, clinic outcomes, electronic records) so administrative teams can progress the pathway.
- Lead the patient's care to meet NHS Constitution and national/local access standards.
- Clinically review waiting lists using the Prioritisation of Waiting Lists Framework.
- Supervise junior medical staff to run clinics, treatment and theatre sessions, avoiding non-clinical cancellations and rescheduling any cancelled patients within policy timescales.
- Communicate accurate waiting time information to patients and carers and handle queries or complaints in line with Trust policy.
- Support waiting list monitoring, data quality and reporting.

- Work with managers, colleagues and the ICB to evaluate and deliver pathway improvements.
- Ensuring that before adding a patient to the waiting list for a cancer treatment, the patient is fit, ready and able to come into hospital for their procedure. Clinicians must inform their PPC's if they wish to upgrade patients to the national 62-day target.

All **outpatient booking and admin staff (including cancer pathway coordinators)** are responsible for:

- Register all outpatient referrals on the Trust's patient administration/referral system (e.g., PAS/RMS) within 1 working day and date-stamp them.
- Route referrals to the correct specialty for clinical priority assignment.
- Once prioritised, contact the patient (letter or phone) to agree an appointment with reasonable notice (≥21 days), unless the patient chooses a shorter date.
- Record any cancellations and all relevant appointment details in the system.
- Update the system for attendances/appointments within 24 hours (same day where possible), including any patient choice decisions.
- Record the correct RTT status at each step.
- Escalate problems or suspected/potential RTT or policy breaches to the management team.
- At attendance, book follow-up appointments due within 6 weeks, as documented on the clinic outcome.
- Ensuring the accuracy of information for all patients managed against national cancer waiting time targets on the Somerset Cancer Registry database.
- Inputting data received from multi-disciplinary sources and tracking patients through their pathway.

All **inpatient booking and admin staff** are responsible for:

- Maintain an accurate, up-to-date waiting list.
- Add patients within 3 working days of the decision to admit and inform them in writing that they are on the waiting list (from receipt of TCI/e-TCI or booking form).
- Record the Decision to Admit (DTA) date in the patient administration system.
- Ensure patient contact details and any required additional information are complete and correct.
- Offer reasonable notice (≥21 days) and a choice of admission dates; shorter notice is acceptable if the patient agrees directly.
- Record all admission offers and outcomes in the system.
- Record all cancellations with reasons, including patient-choice delays and periods of unavailability or medical reasons.

- Accurately record the appropriate RTT status at each step.

All **general medical, dental practitioners and other referees** must:

- Refer only when the patient is ready, willing and able to attend and undergo assessment and any required treatment within 18 weeks (clinically fit for assessment/treatment).
- Book the first new appointment via the National e-Referral Service (eRS).
- Provide accurate contact details, clearly marked urgency and the appropriate specialty on every referral.
- Ensure patients understand their responsibilities, likely pathway steps/timescales, and their choice of provider under national guidance.
- Refer in line with appropriate clinical guidelines and prepare patients to accept timely appointments throughout their pathway.

Patients also have a duty within the NHS Constitution to make themselves accessible to care. They must:

- Under the NHS Constitution, patients must make themselves accessible to care by attending booked appointments or cancelling with as much notice as possible.
- Follow clinical advice and manage your health where you can.
- Use the most appropriate service for your needs.
- Take part in decisions about your treatment and the management of your pathway.
- Keep your details up to date, including contact information and registered GP.
- Tell the Trust promptly if you have been treated elsewhere or privately and no longer need your appointment (by phone, letter, email, NHS App or text).

Competency

As a key part of their induction programme, all new trust starters will undertake mandatory contextual elective care training applicable to their role.

All existing staff will undertake mandatory contextual elective care training on at least an annual basis. All staff will carry out competency tests that are clearly documented to provide evidence that they have the required level of knowledge and ability. This policy, along with the supporting suite of SOPs, will form the basis of contextual training programmes.

A cascade programme of training has been developed and will be delivered to all staff groups responsible for the administration and management of patients on an elective pathway. The training will be delivered by key individuals such as the Trust's RTT Pathway Trainer, RTT Performance Manager and the PAS trainers for the technical use of PAS.

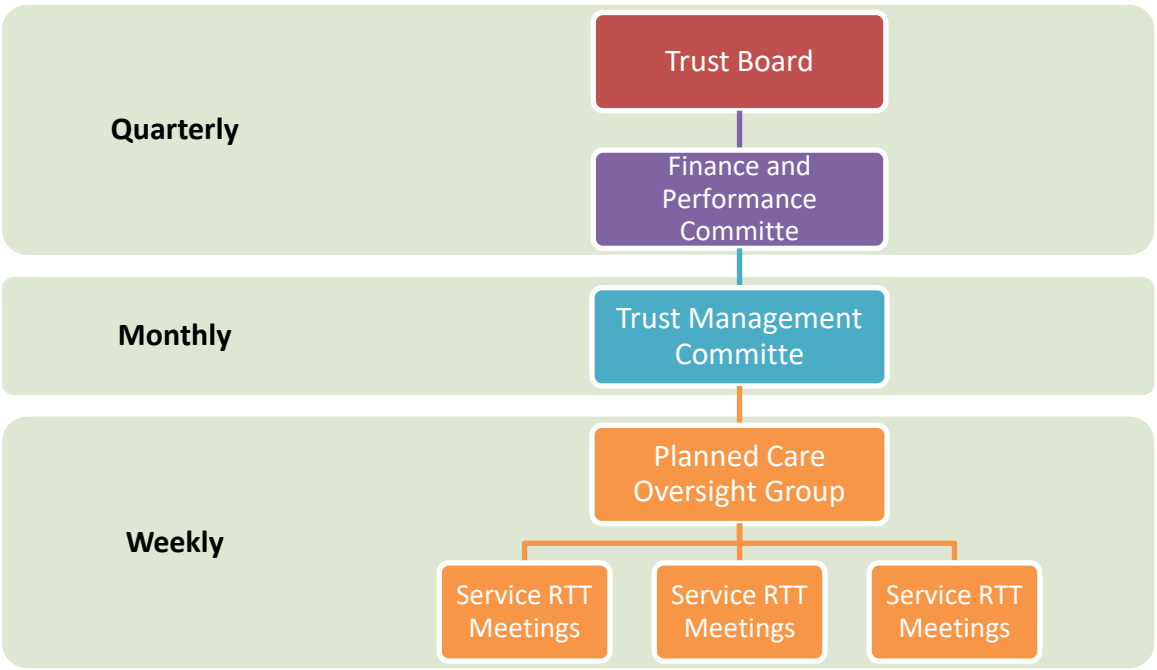
Compliance

Operational 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 SOPs. In the event of non-compliance, a resolution should initially be sought by the team, specialty or individual's line manager. If it cannot be, the matter should then be dealt with via the trust's disciplinary or capability procedure.

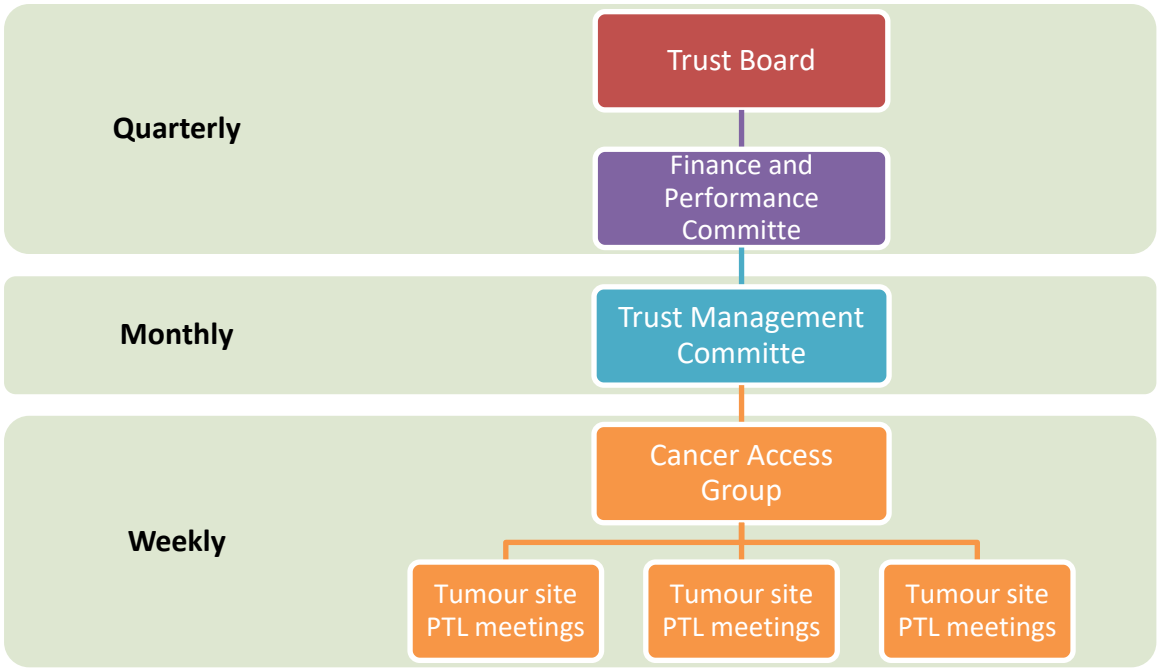
3. Governance

Compliance with the constitutional access standards is monitored through regular fora with specialty teams, divisions and through the executive board. The exact governance structure may change outside of the review timelines of the policy. Indicative structures are:

3.1. RTT (routine and urgent referrals to treatment).



3.2. Cancer



4. Patient Rights

The NHS Constitution for England sets out pledges and rights stating what patients, the public and staff can expect from the NHS.

Section 3 of the NHS Choice Framework states that a patient can choose where they go for their first appointment as an outpatient and section 4 states, they can ask to be referred to a different hospital if:

- they must wait, or have already waited, more than 18 weeks before starting treatment or assessment for a condition following non-urgent referral to a consultant led service

  or

- following urgent referral for suspected cancer or breast symptoms, the provider is satisfied that the patient will not receive a diagnosis or ruling out of cancer within 28 days of referral, and an appointment with a suitable alternative provider may expedite a diagnosis or ruling out of cancer

Patients should be made aware of the support available to them, such as the travel reimbursement scheme, so they can make an informed decision.

Patient choice is a legal right for patients, but there are exceptions to be aware of. These are detailed in the NHS Choice Framework.

4.1. Military veterans

In line with the Armed Forces Covenant (2016), all veterans and war pensioners should receive priority access to NHS care for any conditions related to their service, subject to the clinical needs of all patients.

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

4.2. Prisoners

All elective standards and rules apply to prisoners. Delays to treatment because it is difficult for prison staff to escort patients to appointments or for treatment do not affect the recorded waiting time for the patient

4.3. University Hospitals Sussex Staff

Trust staff can be prioritised by a clinician if earlier treatment will assist the staff member to return to work sooner and in turn supporting hospital services, enabling the treatment and care of more patients. Clinical urgency of all patients must still take priority.

Staff who believe they are eligible are encouraged to speak to their line manager to facilitate expedition where appropriate and possible.

4.4. Patient eligibility

People who do not normally live in the United Kingdom are not automatically entitled to use the NHS free of charge (regardless of their nationality or whether they hold a British passport or national insurance contributions).

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.

If a member of staff requires clarification or support on a patient's eligibility, they should contact the oversees patient service

4.5. Patients moving between NHS and private care

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

The 18-week clock starts at the point at which clinical responsibility for the patient's care transfers to the NHS (i.e. when the Trust accepts the referral for the patient.) Private patients transferring in this way will be treated in turn within the terms of this access policy.

For patients on a cancer pathway, if a patient transfers from a private provider onto an NHS waiting list, they will need to be upgraded (please see section on upgrades) if they have not made a DTT and the consultant wants them to be managed against the 62-day target. If a decision to treat has been made in a private setting, the 31-day clock will start on the day the referral was received by the trust

Any change of status must be accompanied by an assessment of the patient's clinical priority for treatment as an NHS patient, and in consultation with their General Practitioner. A patient's entitlement to access NHS healthcare should not be affected by a decision by a patient to fund part or all their healthcare needs privately.

A patient who has chosen to pay privately for an element of their care, such as a diagnostic test, is entitled to access other elements of care as an NHS patient, provided the patient meets NHS commissioning criteria for that treatment. However, at the point that the patient seeks to transfer back to NHS care:

- The NHS Commissioning Board is at liberty to request the patient be reassessed by an NHS clinician.
- The patient will not be given any preferential treatment by virtue of having accessed part of their care privately

And

- The patient will be subject to standard NHS waiting times.
- If first treatment has already started or been given, then a referral from private to NHS care would not start a new clock and the patient will be on a non-RTT pathway, unless the patient requires a substantially new course of treatment in which case a clock and RTT pathway would start at the point clinical responsibility for the patient is accepted.
- If a patient who is already on an NHS waiting list decides to have their treatment privately, the 18-week clock will stop on the date of disclosure by the patient, ending their pathway and thereby removing them from the NHS waiting list, transferring them to private care
- If a patient is on an 18-week pathway and is offered treatment in the private sector under the care of an NHS consultant, to reduce the time waiting for treatment, they will remain on their 18-week pathway.
- Please refer to the Trust's Private Patient Policy for further advice and guidance.

5. Commissioner/ICB - Approved Procedures under the Clinical Effective Commissioning Clinical Policies (CEC) (Formerly known as Evidence Based Interventions)

Patients referred for specific treatments where there is limited evidence of clinical effectiveness, or which might be considered cosmetic can only be accepted with the prior approval of the relevant ICS subject to approval of an Individual Funding Request (IFR).

All clinicians must review the policy for the procedures within their specialties and in consultation with the patient determine if their condition meets the criteria. The policy is to ensure that the required criteria are met before placing a patient on the waiting list.

If a patient is referred to a consultant-led service and funding approval is required before treatment, the RTT clock will continue to tick during the approval process. Where commissioners are asked to approve funding before a referral is made, then an 18-week clock would start once funding has been approved and the subsequent referral is received by the provider. The requesting clinician is required to affirm that they have discussed the proposed treatment with the patient (or has offered such a discussion) before an IFR request is submitted on their behalf.

Commissioners need to ensure that IFR requests are responded to as quickly as possible to minimise any impact on treatment within 18 weeks.

More information on specific conditions/ procedures can be found here.

6. Communication

All communications with patients and anyone else involved in the patient's care pathway, whether verbal or written, must be informative, clear and concise. Copies of all correspondence with the patient must be kept in the patient's clinical notes or stored electronically for auditing purposes.

GPs or the relevant referrer must be kept informed of the patient's progress in writing. Regular two-way communication with the patient is key to ensuring that patients are fully informed and aware of any appointments for their care.

Where patients are unable to attend or do not attend (DNA) their appointment there should be locally agreed processes to explore the causes. The clinician responsible must be advised so they can make an informed decision about the patient's RTT pathway and whether it is appropriate to offer further appointments.

Patients should be made aware of their responsibility to attend agreed appointments.

6.1. Reasonableness

For patients not on a cancer exclusion pathway, a reasonable offer for any appointment for any service is one that is made with at least 3 weeks' notice.

When made verbally or via email, the patient should be given 2 or more dates with at least 3 weeks (21 days) notice to choose from. Patients can accept offers of shorter notice appointments which will be deemed as reasonable offers, however, cannot be classified as reasonable if not accepted.

6.2. Uncontactable

Patients have a duty to make themselves available for care and the trust has a responsibility to ensure equitable access is offered. To enable this, a patient's demographics should always be checked at any appointment or when contact is made.

Where a patient cannot be reached by the initial phone call, two further attempts, ideally at different days at different times, should be made to contact the patient (three attempts total).
Where appropriate, efforts should be made to contact the original referrer (e.g. GP) to confirm the patient's demographics. If the patient still cannot be contacted, a letter should be sent giving the patient three weeks to make contact to book their appointment.

The GP will also be informed so they can ascertain any reasons as to why the patient has not responded and to resolve any safe-guarding concerns.

If patient contact is not obtained, the patient is not fulfilling their obligation to make themselves available and is not known to the service (e.g. a first outpatient appointment has not occurred) a letter will be sent stating the patient is being discharged unless contact is made. The discharge date will be matched when the letter is sent.

If the patient has already had a clinical contact (e.g. a first outpatient appointment or diagnostic), a clinical review must be conducted before the patient is discharged back to their referrer.

For patients on a cancer pathway:

- If the patient is uncontactable at any time on their 62/31-day pathway, a record of the time and date of the call to them in the 'additional information' section on PAS should be made at the time of the call.
- Two further attempts will be made to contact the patient by phone, both of which must be at different times of the day (AM/PM). Each of these calls must be recorded in real time on PAS. These attempted contacts must be made over a maximum two-day period.
- If contact cannot be made by such routes, the GP surgery must be contacted to ask for alternative contact routes. If contact still cannot be

made, an appointment/diagnostic booking should be made no sooner than 7 days (where appropriate) from the letter being sent.

6.3. Non-activity related RTT decisions

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

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

Every patient, whether they attend or not, will have an attendance status and outcome recorded on the patient administration system (PAS) at the end of the appointment.

6.5. Chronological booking

Patients will be selected for booking appointments or admission dates according to clinical priority. Patients of the same clinical priority will be offered an appointment or treatment date in RTT chronological order; that is, patients who have been waiting longest will be seen first. Patients will be selected using the trust's PTLs.

The Trust operates a policy of shared patient care; this enables patients to be listed to the most appropriate clinician with the shortest wait time to ensure the patient is seen in a timely manner and within 18 weeks. However, the patient has the right to choose a named consultant without detriment to their waiting time.

7. National referral to treatment, cancer and diagnostic standards and rules application

7.1. The elective care standards are:

- referral to treatment: 92% of patients on an incomplete pathway (that is, 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.

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

- Clinical exceptions: when it is in the patient's best clinical interest to wait more than 18 weeks for their treatment

- Choice: when patients choose to extend their pathway beyond 18 weeks by declining reasonable offers of appointments, rescheduling previously agreed appointment dates or admission offers, or specifying a future date for an appointment or admission (in some situations a clock stop for active monitoring may be appropriate for patients choosing to wait longer)
- Co-operation: when patients miss previously agreed appointment or admission dates (TCI) and this prevents the trust from treating them within 18 weeks.

In addition to these standards, separate cancer standards must be adhered to.

Maximum 28 days from:	
Receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer	Operational Standard - 75%*
Maximum one month (31 days) from:	
From Decision to Treat/Earliest Clinically Appropriate Date to Treatment of cancer	Operational Standard - 96%*
Maximum two months (62 days) from:	
From receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer	Operational Standard - 85%*

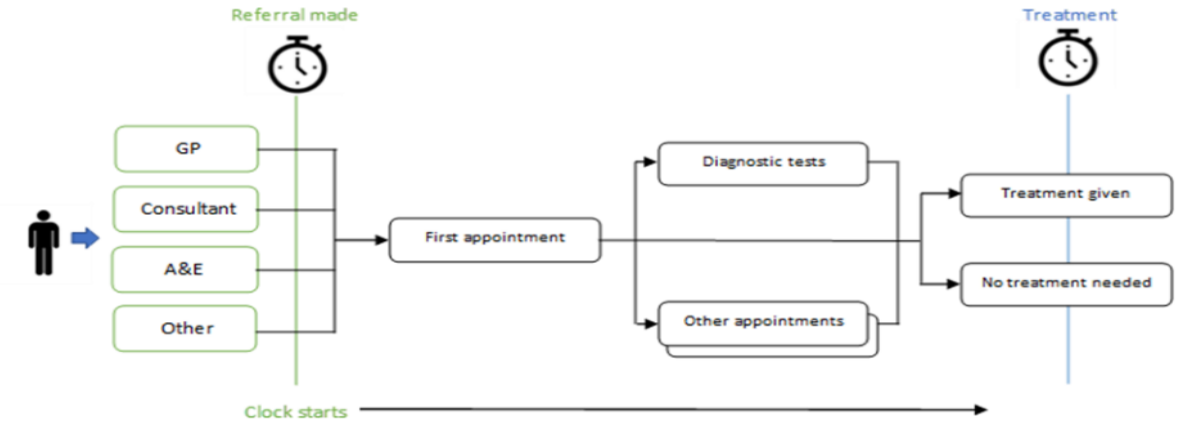
**Correct at the time of ratification but subject to national expectations.*

7.2. Overview of national referral to treatment rules

A typical RTT pathway consists of:

Step 1: A patient attends a GP appointment, A&E or another healthcare setting, or self-refers to a consultant, and is referred for a first appointment. The receipt of this request (or UBRN conversion) starts the RTT clock.

Step 2: At the first appointment the patient could be referred for diagnostic tests or other appointments, or alternatively treatment is given or a decision that no treatment is needed is made; this is when the clock stops. Patients may have multiple diagnostic tests and/or appointments before a treatment decision is made. A patient may be added to the inpatient waiting list for treatment and the clock would stop when treatment starts



7.2.1. Clock starts (Rules 1 to 3)

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

Rule 1: Referrals by healthcare professionals or services

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

Rule 2: Self-referrals

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

Rule 3: The need for a new clock

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

a. when a patient becomes fit and ready for the second of a consultant-led bilateral procedure
b. upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan
c. upon a patient being re-referred into a consultant-led, interface or referral management or assessment service as a new referral

d. when a decision to treat (DTT) is made following a period of active monitoring.
e. when a patient rebooks their appointment following a first appointment did not attend (DNA) that stopped and nullified their earlier clock

7.2.2. RTT clock stops (Rules 4 and 5)

Rule 4: clock stops for treatment

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

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

B. clinical decision is made to add the patient to a transplant list and this decision has been communicated to the patient and subsequently their GP or other referring practitioner without undue delay

7.2.3. Rule 5: Clock stops for non-treatment

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

a. it is clinically appropriate to return the patient to primary care for any non-consultant led treatment in primary care
b. a clinical decision is made to start the patient on a period of active monitoring
c. a patient declines treatment having been offered it
d. a clinical decision is made not to treat
e. a patient misses their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient (DNAs for a first appointment following the initial referral that started a waiting time clock nullify the patient's clock; that is, it is removed from the numerator and denominator for RTT time measurement purposes)
f. a patient misses any other appointment and is subsequently discharged back to the care of their GP, provided that:

    - the trust can demonstrate that the appointment was clearly communicated to the patient (according to their preferences)

- discharging the patient is not contrary to their best clinical interests
- discharging the patient is carried out according to local, publicly available or published policies on missed appointments
- these local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (for example, children), and are agreed with clinicians, commissioners, patients and other relevant stakeholders

7.3. Exclusions

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

- obstetrics and midwifery
- planned patients
- referrals to a non-consultant led service
- referrals for patients from non-English commissioners
- genitourinary medicine services
- emergency pathway non-elective follow-up clinic activity

7.4. Non-consultant led pathway and RTT clocks

Referrals to therapy or healthcare science interventions (for example, physiotherapy, dietetics, orthotics and surgical appliances) can be:

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

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

7.4.1. Physiotherapy

For patients on an orthopaedic pathway referred for physiotherapy as first definitive treatment, the RTT clock stops when the patient begins physiotherapy.

For patients on an orthopaedic pathway referred for physiotherapy as interim treatment (as surgery will be required), the RTT clock continues when the patient has physiotherapy.

7.4.2. Surgical appliances

Patients on an orthopaedic pathway can be 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.

7.4.3. Dietetics

If patients are referred to the dietitian 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 (for example, bariatric surgery). In such a pathway, the clock could continue to tick.

7.5. Cancer access standards

7.5.1. General principles

- All patients with suspected or diagnosed cancer will be managed in line with national cancer targets.
- All patients will be recorded on PAS to ensure they can be tracked through their clinical pathway.
- All relevant patients will be recorded on the Somerset Cancer Registry database (SCR) which will hold comprehensive records for each patient. The record will include a full Cancer Outcomes and Services Dataset (COSD) detailing cancer waiting time and multi-disciplinary team (MDT) discussion notes.
- Patients will be tracked against national standards with delays actioned and pathway breaches escalated as appropriate.
- Compliance and breaches of the targets will be reported in line with national reporting guidelines.
- Data quality checks will be undertaken to ensure data collection systems, and the tracking of patient pathways is compliant with cancer waiting times rules.

7.5.2. Clock starts

28-day Faster Diagnosis Standard (FDS)

A 28-day (FDS) cancer clock can start following the below actions:

a) Urgent referral for suspected cancer (including direct referrals from the Independent Sector)
b) All referrals for breast symptoms (where cancer is not suspected).
c) Urgent referral from NHS cancer screening programme.

62-day Standard

A 62-day cancer clock can start following the below actions:

a) Urgent referral for suspected cancer (including direct referrals from the Independent Sector)
b) All referrals for breast symptoms (where cancer is not suspected).
c) A consultant upgrade.
d) Urgent referral from NHS cancer screening programme.

The receipt of referral or upgrade is day 0 in the 62-day pathway.

31-day Standard

A 31-day cancer clock will start on the date the patient agrees a plan for their treatment as following:

a) A DTT for first definitive treatment.
   - This can be either at a face-to-face consultation or telephone consultation with the patient.
   - Signing of the consent form by the patient may often occur after they have agreed to their treatment plan and it therefore should be noted that this is not the decision to treat date.
b) A DTT for subsequent treatment.
c) An ECAD following a first definitive treatment for cancer.
d) If a patient's treatment plan changes, the DTT can be changed, i.e. if a patient had originally agreed to have surgery but then changed their mind and opted for radiotherapy instead.
e) If a patient has seen a consultant in the private sector and a decision to treat is made, if the patient requests NHS treatment the decision to treat date is the date that the Trust accepts the referral.

NB. All suspected cancer referrals also start an RTT clock.

7.5.3. Clock stops

28-day Faster Diagnosis Standard (FDS)

A 28-day (FDS) cancer clock will stop when:

a) A patient is told they have a cancer diagnosis including recurrent and unknown primaries.
b) A patient is told cancer is ruled out.
c) A patient is placed onto an interval scanning protocol.
d) A patient declines all diagnostic tests.
e) A patient agrees with a decision to treat prior to a diagnosis being made.

NB. patients in category BC&D above, would also be removed from the 62-day pathway. E would remain on the 62-day pathway until a treatment date was entered

62-day Standard

A 62-day cancer clock will stop when:

a) A patient undergoes a first definitive treatment or enabling treatment.

- For surgical intervention it will be the date the patient is admitted for surgery.
- For anti-cancer drug therapy, it is the date the first drug in an agreed treatment plan is given. Where the drug is self-administered, it will be the date when the drug was prescribed.
- For radiotherapy it is the date the first fraction is given.
- For patients receiving palliative care with no specific anti-cancer treatment, it is the date this plan of care was agreed with the patient.

b) A patient with a confirmed cancer diagnosis agrees to be placed onto active monitoring (or falls under CPG category 1 or 2 for prostate cancer)
c) When cancer is excluded.
d) The clock stops if the patient refuses all diagnostic tests or treatments and therefore opts out of the 62-day pathway. If the patient chooses to have tests or treatment at a later stage and cancer is diagnosed, a new 31-day clock would commence.

31-day Standard

The 31-day standard stops with a definitive treatment. A treatment is 'an intervention intended to manage the patient's disease, condition or injury and avoid further intervention. It is a matter of clinical judgement, in consultation with the patient.' For cancer waits a definitive treatment is further defined as the start of the treatment intended to remove, debulk or shrink the tumour. Therefore a 31-day cancer clock will stop following:

a. Delivery of first definitive treatment or a subsequent treatment
    - For surgical intervention it will be the date the patient is admitted for surgery.
    - For anti-cancer drug therapy, it is the date the first drug in an agreed treatment plan is given.
    - For radiotherapy it is the date the first fraction is given.
    - For patients receiving palliative care with no specific anti-cancer treatment, it is the date this plan of care was agreed with the patient.

b. Placing a patient with a confirmed cancer diagnosis onto active monitoring (only for first treatment. Active monitoring isn't counted for 31 days when it is a subsequent treatment).
c. Where no definitive anti-cancer treatment is planned almost all patients will be offered a palliative intervention (e.g. stenting) or palliative care (e.g. pain relief), which would count as a first definitive treatment.

NB. In some cases where a cancer clock stops, the 18-week RTT clock will continue. Such as, confirmation of a non-malignant diagnosis.

7.5.4. Suspected Cancer Referrals

This section will include the process, recording and timescales for suspected cancer referrals.

All suspected cancer referrals should be referred on the relevant cancer pro-forma provided and submitted via e-referral system.

All breast symptomatic referrals which are not triaged and diverted into alternative pathways (such as Breast Pain community care led service) are treated as suspected cancer referrals for the purpose of this policy.

- Day 0 is the date the referral was received.
- For referrals received electronically the clock start date is the date the electronic referral is received.
- For paper referrals the date the referral is received is the clock start date for pre-October 2018 at which point ALL referrals will be electronic in line with the National Paper Switch Off Programme.
- All referrals will be registered on PAS within 24 hours of receipt. All suspected cancer referrals will be checked for completeness by the cancer team within 24 working hours of receipt of referral.
- When registering the referral on PAS the outpatient priority type must be recorded as referral type "critical (2-week rule) referral". All referrals registered on PAS as "critical (2-week rule) referral" will automatically interface from PAS to SCR in near real-time from the Trust's data warehouse so the patient can be tracked.
- When making the first outpatient appointment the booking item on PAS must be recorded as NEW 2 WK RULE.
- The first appointment can be either an outpatient appointment with a consultant or member of their team or investigation relevant to the referral, i.e. 'straight to test.'
- A telephone or virtual consultation can count as a first-seen date, provided it is a consultant led clinic, and a patient's full symptoms are considered.

- Although the 2 weeks wait standard no longer applies, it is still necessary to record the date first seen (this can be physically or virtually, a STT diagnostic or the date that a suspected skin cancer image is reviewed through tele dermatology).
- Where patients are at the outset referred direct for a test / investigation (e.g. Endoscopy), they must be identified on PAS by adding to the inpatient or day case waiting list as referral type “critical (2-week rule) referral” and referral urgency “urgent – critical referral”.
- Where patients are undergoing surgery as treatment for primary or recurrence of cancer, they must be identified on PAS by adding to the relevant consultant inpatient or day case waiting list with a referral urgency “urgent – critical referral”.
- For suspected cancer referrals received by the trust without key information the cancer team will contact the referrer by phone within 48 hours of receipt of referral to obtain the missing information. The referral process should begin, i.e. outpatient appointments booked for patient while information is being obtained, to ensure there is no delay to the patient’s pathway.
- Any suspected cancer referral received by the trust for a service that the trust is not commissioned to deliver will be sent electronically to an appropriate local provider with a copy of information sent electronically to the referrer within 24 hours of receipt.
- Any suspected cancer referral received inadvertently by the trust which was meant for another trust will be sent electronically to the intended provider with a copy for information sent to the referrer electronically within 24 hours of receipt.

7.5.5. Re-prioritising or Rejecting Suspected Cancer Referrals

It is important to note the process for discussing the referral with the referrer and that only the person who made the referral can decide to withdraw the referral.

- If a consultant thinks the referral is inappropriate this should be discussed with the referrer, only the referrer can downgrade or withdraw a referral.
- This is also the case where it is considered that insufficient information has been provided.
- Referrals must not be rejected for this reason or the pathway paused or delayed.
- Referrals can only be downgraded by a GP. If a clinician believes a referral to be inappropriate this must be discussed with the GP who can authorise for the referral to be converted to a non-2WW referral.
- If the GP chooses not to downgrade the referral their decision is final, and the patient must remain on a cancer pathway. Confirmation of the conversation with the referring GP must be documented.

7.5.6. Two referrals on the same day

If two referrals are received on the same day, both referrals must be recorded and diagnosed in 28 days. If two primary cancers are diagnosed, treatment for both cancers should start within 62 days of receipt of referral if clinically appropriate.

7.5.7. Screening pathways

A section on the screening pathway is important to note the services involved and the instances that create a clock start.

The clock start is the receipt of the referral (day 0) which for the individual screening programmes is as follows:

- Breast: receipt of referral for further assessment (i.e. not back to routine recall).
- Bowel: receipt of referral for an appointment to discuss suitability for colonoscopy with a specialist screening practitioner (SSP).
- Cervical: receipt of referral for an appointment at colposcopy clinic.
- Lung: receipt of referral for further investigation for Suspected Cancer after an initial screening test (i.e. referral to the multidisciplinary team to review the low dose CT scan results).

Reinstated Bowel Screening pathway – if a person is medically fit for colonoscopy and decides not to book their colonoscopy date but take time to consider if they wish to progress with the procedure – they would be able to request a test for the next 2 years without presenting to their GP. This would create a new pathway clock start as a consultant upgrade with day 0 being the day the patient contacts the bowel screening service to request colonoscopy.

7.5.8. Consultant upgrades

Hospital specialists should ensure that patients who are not referred urgently as suspected cancer referrals or through the screening programmes, but who have symptoms or signs indicating a high suspicion of cancer, are managed on the 62-day pathway. This can be achieved by upgrading the patients onto a 62-day.

- The 62-day pathway starts (day 0) from the date the patient is upgraded.
- If a request is made for the patient to be reviewed at the cancer MDT, the date of the request must be counted as a consultant upgrade unless the patient is already on a 62-day pathway or a decision to treat has been made.
- Where a patient is to be referred for a Cancer MDT meeting at another

provider, even for discussion only, it is important that the consultant upgrade is completed on or before the date of the inter-provider transfer.
- Upgrades must occur before the DTT date. Patients not upgraded at this point will be measured against the 31-day DTT to first definitive treatment.

7.5.9. Who can upgrade patients onto a 62-day pathway

A consultant or authorised member of the consultant team (as defined by local policy) can upgrade a patient if cancer is suspected. This could be:

- Specialist nurse/practitioner, either by triaging the referral form/letter or at nurse led initial clinic.
- Specialist registrar either by triaging the referral form/letter or at initial clinic.
- Radiologist/histologist/other trust clinicians on reviewing patients and/or diagnostics.

7.5.10. Responsibilities

The consultant or delegated member of the team upgrading the patient is responsible for informing the Patient Pathway Co-ordinator (by completing the upgrade pro forma) that an upgrade has occurred. If a patient has been upgraded to a 62-day pathway this must be communicated with the patient so they understand why they are being upgraded, and the GP should be notified by the upgrading clinician.

7.5.11. Subsequent treatments

The section includes details on subsequent treatments and the management of the earliest clinically available date.

- If a patient requires any further treatment following their first definitive treatment for cancer, they will be monitored against a 31-day clock. The clock will start following the patient agreeing a treatment plan with their clinician. This will be the decision to treat (DTT) date.
- In some circumstances it may be appropriate for the clinician to set an ECAD (earliest clinically available date) which is when a patient needs to recover following their preceding treatment. An ECAD can be adjusted but only if the date has not passed.
- The 31-day clock start date should be the same as the ECAD date for these patients.
- An ECAD might not be the start of subsequent treatment itself, but could be the next activity that actively progresses a patient along the pathway for that treatment to take place, i.e. A patient with rectal cancer who is to

have radiotherapy then surgery, the patient would not be clinically fit for surgery so the ECAD would be set for six weeks after the radiotherapy is complete.

- Where patients are undergoing surgery as treatment for primary or recurrence of cancer, they must be identified on the PAS system by adding to the relevant consultant inpatient or daycase waiting list with a referral urgency "Urgent – critical referral".

7.5.12. Reasonableness

Unlike for RTT there is not national definition of reasonableness, the time frame below is agreed locally in line with national guidance.

- For patients on a cancer pathway, an offer will be deemed to be reasonable if 72 hours' notice of an appointment/diagnostic test/admission is given, and the appointment is booked over the phone. Where the appointment has to be booked via letter, this should be sent 1st class and appointment should be scheduled 7 days ahead of posting of the letter.

7.5.13. Waiting-time adjustments

It is possible to adjust patient clocks on a cancer pathway in specific instances. These instances are included below. The trust should make sure that these adjustments are understood by their operational teams and are defined in their processes and documentation.

First Appointment:

- It is best practice to offer patients their 1st outpatient appointment or attendance at straight to test (STT) appointment, within 7 days of the referral being received to ensure 28 Day standard is achieved.
- Patients who choose to wait longer for social reasons must not be referred to their GP or have their clocks stopped. It is expected that some patients will choose to wait longer and will be recorded as a breach - the operational standard/tolerance takes account of this (IMAS guidelines).
- Patients must not be discharged if they DNA their first appointment. If a patient DNAs their initial (first) outpatient appointment, tele-dermatology image appointment or attendance at straight to test (STT) appointment, e.g. a straight to test endoscopy, the clock start date can be reset to the date the patient rebooks their appointment (the date the patient agrees the new appointment not the new appointment date).
- Patients should not be documented as DNAs if they turn up in a condition where a procedure is not possible (e.g. if they have not taken a preparation they needed to take prior to appointment).

- The clock for 1st appointment can be reset as long as a patient has been contacted and provided with reasonable notice of their appointment.
- Any short notice cancellation by the patient (within 24 hours of the appointment) will be deemed to be a DNA.
- Patients must not be referred to their GP or adjustments made to their pathway if they cancel their appointment – patients are permitted to cancel as many times as they wish.
- Patients that DNA their 2nd appointment may be discharged back to the GP with agreement of the clinician – the GP must be informed that no further appointment will be offered without a new referral, and this confirmation needs to be provided to the GP in writing.

For 62/31-day pathways:

- If a patient declines a date for treatment, providing the offer was 'reasonable' the clock can be adjusted from the decision to treat date to when the patient is available after the offered date.
- If a patient declines a date for treatment, and requests a specific surgeon instead, providing the offer was 'reasonable' the clock can be adjusted from the decision to treat date to the date the patient declined.
- If a patient DNAs or cancels a previously agreed 'reasonable' date, then the clock can be adjusted from the decision to treat date to the date of cancelled/DNA appointment.
- If it is deemed clinically essential to treat another medical condition before treatment for cancer can be given, after a decision to treat the cancer has been made, the clock can be adjusted from the cancer pathway decision to treat to the point at which after receiving treatment for this condition the patient is deemed clinically fit to commence their cancer treatment. This adjustment cannot be applied for where a patient is advised to make lifestyle changes for example stop smoking, lose weight, or commence a period of pre-habilitation prior to their cancer treatment.
- Where a patient opts for egg harvesting prior to their cancer treatment, an adjustment can be applied from the point at which the decision is made to harvest eggs until eggs are harvested.
- If the patient during a consultation, or at any other point, while being offered a treatment date states that they are unavailable for a set period (e.g. due to holiday or work commitments), an adjustment can be applied from the decision to treat date to the date the patient is available after the unavailability.
- If the patient tests positive for COVID or influenza after a decision to treat, the clock can be adjusted from the date of positive testing to the point the patient is fit to proceed with the cancer treatment.

Any adjustment must be supported by clear documentation in the cancer management system and PAS or other relevant clinical system. The trust will ensure that TCIs offered to the patient will be recorded.

7.5.14. Root cause analysis and clinical harm review process

This section sets out the trusts process for managing “long waiting” cancer patients on 62-day pathways and describe the ‘backstop’ waiting time beyond which patients should be specifically reviewed for potential harm. The policy is as follows:

An RCA review should always be carried out by the service operational team for each confirmed cancer pathway not meeting the 62-day standards.

Any cancer patients waiting 104 days or more from referral to the first definitive treatment should have a clinical harm review undertaken.

7.5.15. Cancer monitoring and audit

Monitoring and audit are an important part of cancer management and the section below details how this process is undertaken. The text below provides an example of how a trust may outline its approach.

- It is the responsibility of the cancer information team who will run a weekly programme of audits for data completeness and data anomalies.
- Any data anomalies are highlighted to the relevant tumour site MDT co-ordinator for investigations and correction. Response to the cancer information team must occur within 1 week of the anomaly being raised in order not to delay the audit programme and to ensure accurate performance available at all times.

In addition, a regular data quality programme will be established to review the following:

- Comparative audit of data on the cancer management system and PAS.
- Comparative audit of diagnosis code on PAS, cancer management system and healthcare records.
- Comparative audit of cases removed from the 62-day pathway and re-entered as 31-day patients within four weeks of removal.

This will involve reviewing a random selection of healthcare records from each tumour site and will be led by the cancer information team.

The cancer information team will also capture numbers of patients 'upgraded' each month and will carry out a quarterly audit to ensure that patients are being 'upgraded' at the earliest opportunity.

8. Missed Appointments (patient did not attend)

A clinical review must occur for any missed appointment. A clinician can decide to discharge the patient back to the original referrer (stopping the clock) where this is not contrary to the patient's best clinical interests. Where a patient misses a subsequent appointment and another appointment is offered, the RTT clock continues to tick.

8.1. Outpatients

The clinician will review all missed appointments at the end of their clinic to make a clinical decision regarding next steps. Appointments missed by paediatric and other vulnerable patients should be managed with reference to the safeguarding policy.

8.1.1. Missed first appointment

The RTT clock is stopped and nullified in all cases (Rule 5e), if the it can be demonstrated the appointment was clearly communicated and given reasonable notice to the patient.

If the clinician indicates another first appointment should be offered, a new RTT clock will be started on the date this decision is made. If it is not possible to book an appointment due to capacity pressures or lack of available appointment slots, the clock should still start from the decision to offer another appointment, and the patient should be added to a waiting list as an alternative to booking their appointment.

8.1.2. Missed follow ups

The RTT clock is stopped if the clinician, following engagement with the patient, decides it is in their best clinical interest to be discharged back to their GP or referrer, as long as it can be demonstrated the appointment was booked in line with the criteria listed in Rule 5f.

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

If the subsequent appointment is with a support service, for example preoperative assessment or diagnostics, and is missed, the decision about rebooking should be made by the requesting clinician.

8.1.3. Admission DNA's

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. If the patient's consultant decides that it is in the patient's best clinical interest to be discharged back to their GP, the RTT clock is stopped.

8.1.4. Safeguarding and missed appointments

It is the responsibility of all staff to remain vigilant to potential safeguarding risks of vulnerable patients. If a member of staff suspects a patient may come to harm through multiple missed appointments, either due to cancellation themselves or via a carer, relative or friend, the staff member should contact their local safeguarding lead or responsible clinician for advice.

9. Cancelled appointments or admissions

9.1. Cancellations

9.1.1. Patient initiated cancellations (RTT)

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

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

Where a patient cancels at short notice (< 48 hours before appointment) or has cancelled more than 2 appointments on the same pathway, the Trust should ensure that the patient's reasons for this are understood, and a clinical review is undertaken.

National guidance states if a patient cancels on the day it should be assumed that it was their intention to attend, and they should be offered the opportunity to rebook their appointment. Their clock should not be nullified or stopped.

Local services must ensure mitigations are in place to mitigate the impact of short-notice cancellations (<48hrs) notice to ensure service capacity is utilised. This could involve informed overbooking, patients available on standby or alternative uses of lost cancelled appointments.

9.1.2. Patient initiated cancellations (Cancer)

Due to the urgency associated with cancer patients it is important that there is a detailed approach to patient cancellations, DNAs and when patients are uncontactable. This section details how the trust will approach such instances and the escalation process. This guidance is consistent with national rules and act in the best interest of the patient.

If the patient gives prior notice of ≥24 hrs of their appointment, that they cannot attend, this should be recorded as a cancellation. Any notification of cancellation by the patient with ≤24 hrs of their appointment, it will be deemed to be a DNA. The trust will make every effort to reschedule patient appointments at the convenience of the patient. If a patient cancels an appointment the following guide must be followed.

- Suspected cancer referral patients who cancel their first appointment should be offered another appointment within seven days of the referral being received. Patients who cancel an appointment/investigation date will be offered an alternative date within seven days of the cancelled appointment (no waiting time adjustment will apply).
- All patients who are referred on a 62-day GP pathway, screening pathway or breast symptomatic referral who cancel two consecutive appointments (i.e. outpatient, diagnostic investigation) will be contacted by an appropriate member of staff to identify any factors that may be stopping the patient attending. Another appointment will be offered if the patient agrees.
- Patients can be discharged after multiple (two or more) appointment cancellations if this has been agreed with the patient following a clinical decision to do so.

9.2. Appointment changes initiated by the hospital

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

Clinicians are actively encouraged to book annual leave and study leave as early as possible. Clinicians must provide 6 weeks' notice if a clinic must be cancelled or reduced. All short notice (less than 6 week) clinic cancellations must be authorised by the appropriate Managing Director. In their absence authorisation must be given by the Deputy Chief Operating Officer, or in their absence, the Chief Operating Officer.

The outpatient booking centre staff will not action any short notice cancellations without this authorisation. Reference the Short Notice Cancellation Policy for more information.

Patients will be contacted as soon as possible if the trust identifies it needs to cancel their appointment or admission, and they will be offered an alternative date(s) that will allow patients on open RTT pathways to be treated as quickly as possible.

Hospital-initiated changes to appointments do not affect the RTT waiting time.

It is expected services maintain capacity in line with their operational plans and cancelled appointments are mitigated to ensure compliance with access standards is maintained.

9.3. Patients who decline appointment or admission date offers

If patients decline TCI dates they are offered or contact the trust to cancel a previously agreed appointment or admission date, this will be recorded on the PAS and where appropriate, teams will update PAS with the relevant P6 suspension function. The RTT clock continues to tick until a clinical decision is made about the next steps.

A reasonable offer for any appointment or admission for any service is one that is made with at least 3 weeks' notice. When made verbally or via email, the patient should be given 2 or more dates with at least 3 weeks' notice to choose from. If other dates become available at short notice, these will be offered to patients but can only be considered reasonable if the patient accepts them. If they decline these short notice offers, there is no impact on the patient's pathway.

When a patient declines 2 reasonable offers of dates (which may be at different sites), the managing consultant will review the patient and consider discharging the patient back to their referrer or continue to actively the monitor patient for 'choice'. The consultant may agree a period of active monitoring with the patient, which should include an appropriate timeframe for further follow-up or review.

If at the point the patient indicates their availability or at the agreed follow-up review there is agreement to proceed to treatment, a new decision to treat will be recorded and a new RTT clock will start. Although the patient's clock will start from 0 as normal, the service will offer a new appointment or TCI date in line with clinical prioritisation and act as if the patient is on the waiting list at the point they were before active monitoring started.

For patients on a cancer pathway, they will not be routinely reviewed if they make themselves unavailable and must be reviewed by their managing clinician as soon as possible.

9.3.1. Patients who decline earlier appointments or treatment at an alternative provider

It may be necessary to offer patients the option to be seen or treated at another provider. This may be at a private provider as part of an outsourcing arrangement.

The same process and clock rules apply as for patients who cancel or decline appointment or admission offers. However, offers at alternative providers must state date, provider and team and meet reasonableness criteria.
It is important to fully understand a patient's social as well as clinical factors to best assist them in deciding whether to move to an alternative provider. Considerations may include access to transport and carer assistance.

9.4. Active monitoring

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

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

Active monitoring may be appropriate in the following situations:

9.4.1. Hospital initiated:

- When the most clinically appropriate option is for the patient to be actively monitored over a period, rather than to undergo any further tests, treatments or other clinical interventions at that time
- When a patient wishes to delay their pathway and declines 2 offers of reasonable dates, the clinician may decide to start a period of active monitoring, following a clinical conversation with and the agreement of the patient. Where a patient declares a period of unavailability (for example, a teacher wishes to wait until the school holidays for treatment), it may not be appropriate to offer specific dates within this period (as it is known that the patient will not be able to attend). In this situation, active monitoring should not be considered unless 2 reasonable dates could have been offered during the period of declared unavailability.
- When a patient declines 2 reasonable offers of dates for earlier appointment or admission at an alternative provider, the clinician may decide to start a period of active monitoring, following a clinical conversation with and the agreement of the patient. Before offering dates at an alternative provider, the trust should have 21 determined that it would be clinically and socially appropriate for the patient to be seen at the alternative provider. A reasonable alternative provider should be agreed on a case-by-case basis, recognising geographical and social factors, and offers must state details of the date, provider and team.

9.4.2. Patient initiated:

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

Where a patient declines reasonable offers of dates and indicates that they wish to delay their pathway, or where a patient communicates a period of unavailability for social reasons (for example, holidays, exams) in which 2 reasonable dates could have been offered, this should be recorded on the PAS. The clinician should arrange a discussion with their patient to ensure the patient fully understands the clinical implications of the delay and allow a clinical decision to be taken on next appropriate step, which may be a period of active monitoring. Any decision that affects the RTT status of the pathway should be discussed and agreed with the patient.

Patient scenarios will be varied and should be considered specifically in relation to each episode of care. However, as a guide, where a patient wishes to delay their pathway by more than 6 weeks, they should have a clinical review to assess the potential impact on their condition and treatment plan and support the clinical decision on next steps. The following next steps may be considered:

- **Clinically safe for the patient to delay**: continue planning for the patient's treatment if only a short delay is requested or active monitoring were agreed with the patient, including regular review.
- **Clinically unsafe length of delay**: clinician to contact the patient with a view to persuading them not to delay. In exceptional circumstances where the clinician believes the patient's decision to delay their pathway will have a consequential impact on the patient's treatment plan, it may be appropriate to place the patient on active monitoring (clock stop). If the clinician and the patient make a shared decision to start active monitoring, this decision should include a date for review within a maximum of 12 weeks, so that the patient's condition and treatment options can be reassessed following the period of active monitoring
- **Clinically unsafe length of delay**: clinical assessment that it is in the patient's best clinical interests to return them to their GP. The patient is discharged and their RTT clock stops on the day this decision is communicated to the patient and their GP.

At the point a decision to start a period of active monitoring is made, the RTT clock will stop.

The discussion with the patient about starting a period of active monitoring should include an appropriate timeframe for further follow-up or review. Patients can request delays of any length but should be regularly reviewed in case their condition deteriorates. Where patients are placed on active monitoring due to their request to delay their pathway, a clinical review must take place at least every 12 weeks. Where

active monitoring extends past 12 weeks, a clinical review should be undertaken to check the patient's condition and confirm that active monitoring remains appropriate. The pathway should be visible on a relevant PTL or waiting list report for non-RTT pathways and be booked in chronological order once their period of monitoring is over.

When a patient is placed on active monitoring they should be given written contact details and a clear process for two-way communication between them and the clinician in the event that their condition or circumstances change. In all scenarios a new waiting time clock will start when a new decision to treat is made with the patient following a period of active monitoring. For patients who have been placed on active monitoring due to their unavailability (within 12 weeks as per National Choice Policy), once the patient wishes to go ahead the provider should offer a new appointment or admission date, acting as if the patient is on the waiting list at the point they were before active monitoring started.

Patients should be signposted to relevant information or organisations, such as those in the voluntary, community and social enterprise sector, for social issues and any resources that may help them self-manage their condition.

9.4.3. Patients who require thinking time

Patients may wish to think about the recommended treatment options before confirming they would like to proceed. They should be signposted to any support they need to make an informed decision. The RTT clock should not be stopped where the patient takes only a few days to think about their decision. Where a patient states that they anticipate they will need longer to decide, such as months, it may be appropriate to agree a period of active monitoring with them. This decision can only be made by a clinician and on an individual patient basis with their best clinical interests in mind.

Where more than 14 days elapse without next steps being agreed, the patient must be contacted so options can be discussed with them.

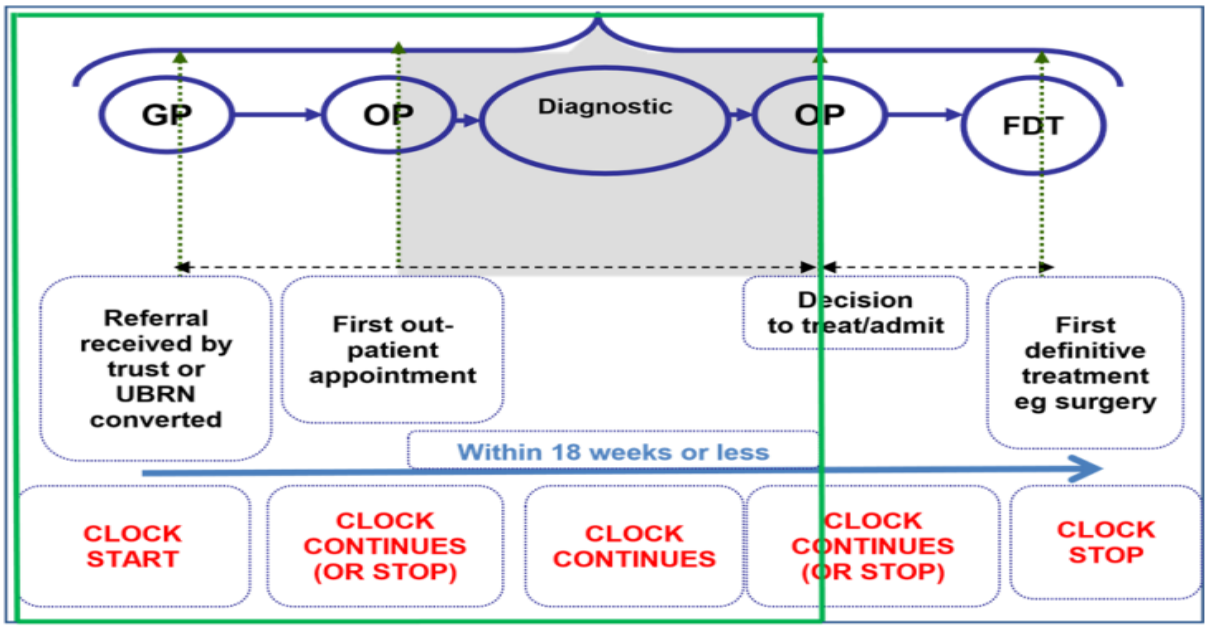
Where active monitoring has been appropriately applied and the patient decides to proceed, a new RTT clock should start from the date of the decision to admit (DTA).

10. Pathway Specific Milestones

10.1. Non-admitted pathways

The non-admitted part of the patient pathway comprises the outpatients and diagnostic stages. It starts from the clock start date (that is, the date the trust receives the referral) and ends when a clock stop happens in outpatients (this could at the first, second or a

further appointment) or when a decision to admit for treatment is made and the patient transfers to the admitted pathway.



10.2. Methods of receipt

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

10.3. Referral types

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

This is different to advice and guidance (A&G), which does not start an 18-week RTT clock unless the consultant converts the request or receives notice of the referral.

A clinician may wish to seek A&G to:

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

10.4. Inappropriate Referrals

For patients not on a cancer exclusion pathway, if a consultant deems a referral to be inappropriate, it will be returned to the referring GP within five working days with the

reason for rejection. Rejected referrals will be closed on PAS and the 18-week clock stopped.

10.4.1. Consultant to consultant Referrals

When a consultant identifies a possible non-urgent medical condition in a patient other than that identified in the original GP referral or reason for admission, the patient will be referred to their GP. This will allow the GP to decide, in consultation with the patient, whether a new hospital referral is appropriate and, if so, give the patient choice of provider. This will start a new 18-week clock and pathway under the e-Ref system.

Similarly, if the patient has been referred internally (for the same condition) by a clinician to another clinician and is still awaiting treatment, then the 18-week clock continues to tick from the original date of referral.

If the patient's condition is identified as clinically then a referral to another consultant in the same Trust (where possible) should be made immediately. In cases such as these the internal referral should be copied to the Booking Hub.

10.5. Inter-provider transfers (IPTs)

Where patients are transferred between providers, including primary care or community intermediate services, the standard minimum data set (MDS form) which may also be known as an Inter-Provider Transfer From (IPT) must accompany the referral, this is to ensure all service providers involved in a patients pathway have adequate information about clock starts and stops to enable the patients pathway to be managed within appropriate time.

Where the Trust refers a cancer patient to a tertiary centre for treatment, best practice guidance indicates that the referral should be sent on or before day 38-day of a 62-day pathway. The patient must have completed all diagnostic testing for this date to be captured for reporting for national cancer waiting times. However, there should not be any delay in referring the patient for discussion at an MDM during the diagnostic work up.

Where patients are undergoing surgery as treatment for primary or recurrence of cancer, they must be identified on the PAS system by adding to the relevant consultant inpatient or day case waiting list with a referral urgency "Urgent – critical referral".

10.5.1. Incoming IPTs

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

The trust expects to receive an MDS pro forma with the IPT, detailing the patient's current RTT status (the trust will inherit any RTT wait already incurred at the referring trust if the patient has not yet been treated) and whether the patient has been referred for a new treatment plan for the same condition (where a new RTT clock will start on receipt at the receiving trust). The patient's pathway identifier (PPID) should also be provided.

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

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

10.5.2. Outgoing IPTs

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

An accompanying MDS pro forma will be sent with the IPT, detailing the patient's current RTT status (the receiving trust will inherit any RTT wait already incurred if the patient has not yet been treated). If the patient has been referred for a new treatment plan for the same condition, a new RTT clock will start on receipt at the receiving trust. The patient's PPID will also be provided.

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

Referrals and the accompanying MDS will be emailed securely from the specialty NHS.net account to the generic central booking office NHS.net account. The central booking office will verify (and correct if necessary) the RTT status for the patient. If the patient has not yet been treated, the RTT clock will be nullified at this trust. This trust will then forward this information to the receiving trust within 1 working day of receipt into the generic email inbox.

RTT waits should be reported by the provider that has overall clinical responsibility for the patient. Where the transfer of responsibility and reporting may affect acceptance of the pathway – for example, due to the time the patient has waited – arrangements should be discussed and agreed with all relevant providers and commissioners. Referring and receiving providers should ensure clear processes are in place to support the clinical management of the patient, with timely updates to allow pathway data to be accurately reported.

10.6. Appointment slot issues (ASIs)

Appointment slot issues are problems with how clinic booking slots are created, allocated or used (e.g. wrong slot types or lengths, misaligned templates, overbooking or unused capacity) leading to avoidable delays and wasted resource.

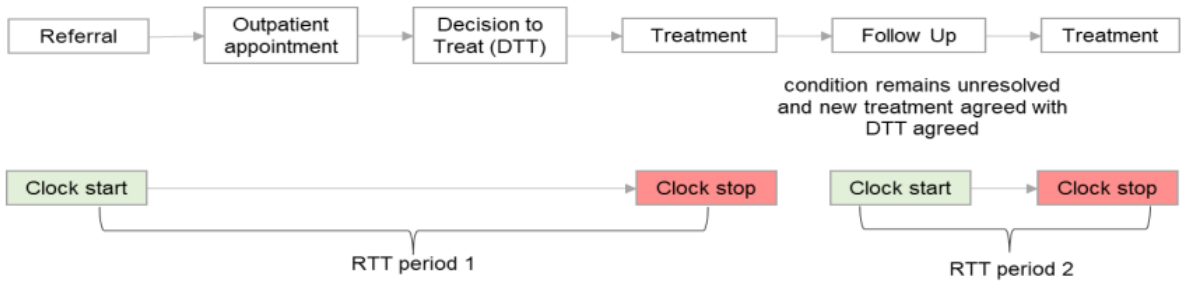
ASIs present a clinical risk as an RTT clock does not start on a trust's PAS while the patient's referral is on an ASI worklist, and patients may not be visible on the trust's PTL.

Referrals should be either resolved or added to the PAS within 48 hours with the date the unique booking reference number (UBRN) was created as the RTT clock start. It is important to resolve these ASIs promptly as they will be removed from the worklist if not actioned after 26 weeks and will then only be visible on another report within e-RS. They should be monitored closely so that action can be taken to prevent referrals being lost.

10.7. Multiple RTT periods on the same pathway

A patient can have multiple RTT periods along the patient pathway for the same original referral. This is where a patient is treated for a condition and then has further treatment for the same underlying condition (for example, chronic or recurrent). The patient pathway will continue beyond the point the first definitive treatment starts, to include further treatment for the same condition. The RTT clocks for these treatments are sequential, not concurrent, as new treatment decisions and plans are made. There may also be periods of active monitoring between these decisions.

This diagram shows 2 RTT periods on the same pathway:



RTT period 1:

1. referral (clock start)
2. outpatient appointment
3. decision to treat (DTT)
4. treatment (clock stop)

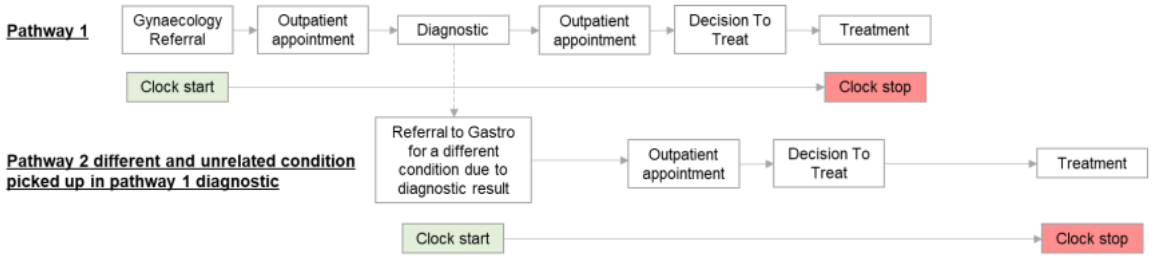
RTT period 2:

1. follow-up – condition remains unresolved and a new DTT is agreed for a new treatment (clock start)
2. treatment (clock stop)

10.8. Multiple RTT pathways

Where a patient has more than one referral for unrelated clinical reasons, each referral will have its own patient pathway and RTT clock. It is important to understand any impact the management of one condition has on that for another – for example, where treatment for one condition affects the planning of another treatment or where a patient needs a period of recovery before they can be treated for another condition.

Clinical and operational teams should co-ordinate care pathways as appropriate for patients on multiple pathways. It may be appropriate to agree a period of active monitoring for one pathway while the patient undergoes and recovers from treatment on another pathway that is considered to be the clinical priority.



This diagram shows 2 pathways for the treatment of different conditions and their coordination:

Pathway 1:

1. gynaecology referral (clock start)
2. outpatient appointment
3. diagnostic – referral to gastro for a different condition due to diagnostic result
4. outpatient appointment
5. decision to treat
6. treatment (clock stop)

Pathway 2 (for a different unrelated condition picked up in pathway 1 diagnostic):

1. referral to gastro for a different condition due to diagnostic result (clock start)

2. outpatient appointment
3. decision to treat
4. treatment – after treatment and recovery from pathway 1 treatment (clock stop)

10.9. Diagnostics

The diagnostic stage of the RTT pathway forms part of the non-admitted pathway. It starts at the point a decision is made to refer a patient for a diagnostic test and ends when the result or report from the diagnostic procedure is available to the requester. Where a patient is referred to another provider for a diagnostic test while on an active RTT pathway, the host trust will retain overall and reporting responsibility

10.9.1. Patient with a diagnostic clock and RTT clock

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

- their RTT clock – started at the point the trust received the original referral
- their diagnostic clock – starts at the point the decision is made to refer for a diagnostic test

Where the patient is solely waiting for a therapeutic procedure – for example, in the radiology department – there is no 6-week diagnostic standard. However, for many patients there is also a diagnostic element to their admission or appointment, and so they will need to have their procedure within 6 weeks.

10.9.2. Patient with a diagnostic clock and RTT clock

Patients should be managed in line with the principles above (patient cancellations, DNAs and uncontactable). Therefore:

- All tests should be booked in line with the reasonableness criteria as above.
- Patients will remain under the care of the diagnostics service to which they have been referred even if unavailable (for a period up to and including 2 weeks from referral). Patients may be referred to their clinicians if unavailability exceeds 2 weeks, where they should be reviewed and if safe and appropriate re-referred by the managing clinician.
- Referrals for diagnostics should only be made where clinical guidance/SOP protocols have been completed (where they exist) or if not, where all pre-requisite test results are available

10.10. Straight-to-test arrangements

For patients who are triaged for a diagnostic test for which one of the possible outcomes is review and, if appropriate, treatment within a consultant-led service, an RTT clock will start on receipt of the referral. These are called straight-to-test referrals. The benefits of this is that by the time the patient attends their first OP appointment, they will have already had the test, and the results can be discussed at the first OP appointment.

10.11. Direct access diagnostics

Patients who are referred directly for a diagnostic test (but not consultant-led treatment) by their GP – that is, clinical responsibility remains with the GP – will only have a diagnostic clock running. These are called direct access referrals. This is known as a No-RTT Pathway.

10.12. National diagnostic clock rules

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

Diagnostic clock start: the clock starts at the point the GP or consultant decides to refer for a diagnostic test (day 0).

Diagnostic clock stop: the clock stops at the point the patient has the test. Patients referred for planned diagnostics must be offered a date by their due date.

A diagnostic 6-week clock will start on the due date for patients who have not been dated by this date. If a patient declines a reasonable offer, cancels an appointment offered with reasonable notice or misses an appointment offered with reasonable notice, the diagnostic 6-week waiting time clock can be reset to 0 and the waiting time will start again from the date the appointment is declined, cancelled or missed. This has no effect on the RTT clock and so all patients should be offered the next available appointment.

10.13. Preoperative assessment (POA)

All patients with a decision to admit (DTA) requiring a general anaesthetic will require a POA. A patient's fitness for surgery should be assessed or as a minimum they should have initial screening, as soon as possible after the DTA. Where necessary, patients should be made aware in advance of their outpatient appointment that they may need to stay longer on the day of their appointment for POA.

Many patients can be assessed by the trust's dedicated POA nurse specialists. For patients with complex health issues requiring a POA appointment with a nurse consultant or anaesthetist, the trust will aim to agree the date for this with the patient before they

leave the clinic. The trust will aim to agree a POA appointment no later than 7 working days from the DTA.

If additional tests are required to ascertain a patient's fitness, the RTT clock continues while these are arranged

10.13.1. Patients who are unfit for surgery

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

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

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

- That the patient requires optimisation within secondary care or treatment for another condition or a period of recovery before proceeding, and if they will be placed on active monitoring. If a clinical decision is made to stop the RTT clock for active monitoring, the patient's next steps should be agreed, including timescale for further review or follow-up to assess their condition. The pathway should remain visible on the relevant PTL or waiting list report to support ongoing management
- That the patient is being optimised or otherwise managed within primary care and will be discharged back to the care of their GP (clock stop

10.14. Admitted pathways

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

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 DTA, regardless of whether they have undergone POA or declared a period of unavailability at the point the DTA is made.

The active inpatient or day case waiting lists or PTLs include all patients who are awaiting elective admission. The only exceptions are planned patients, who are awaiting admission at a specific clinically defined time.

Adding a patient to the inpatient or day case waiting list 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 that was not part of the original treatment package, providing that another definitive treatment or a period of active monitoring has already occurred
- start a new RTT clock if the patient's previous clock had been stopped for active monitoring

The RTT clock will stop on admission.

10.14.1. On the Day Cancellation

Where a patient is cancelled on the day of admission or day of surgery for non-clinical reasons, they will be rebooked within 28 days of the original admission date and must be given reasonable notice of the rearranged date.

The patient may choose not to accept a date within 28 days. If it is not possible to offer the patient a date within 28 days of the cancellation, the trust will offer to fund the patient's treatment at the time and hospital the patient chooses, where appropriate.

10.15. Bilateral Procedures (Patients requiring more than one procedure)

If more than one procedure will be performed in the same scheduled slot by the same surgeon, the patient should be added to the waiting list with all the 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 the additional procedures noted.

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

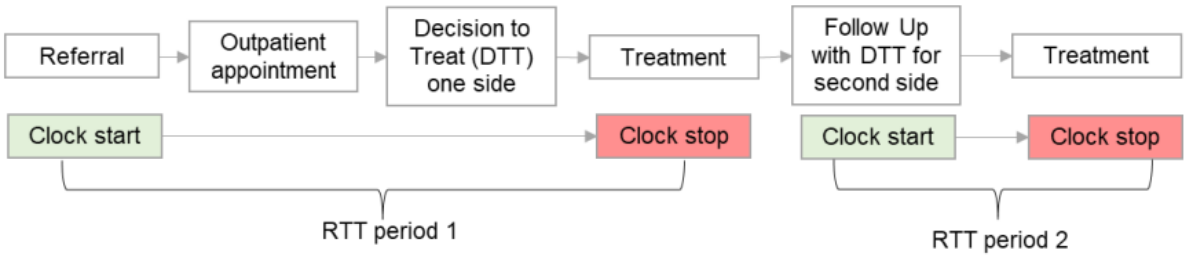
The patient:

- will be added to the active waiting list for the primary (first) procedure
- when the first procedure is complete and the patient is fit and able to proceed with the second procedure, will be added (as a new waiting list entry) to the waiting list and a new RTT clock will start

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

Bilateral pathway

This diagram shows 2 RTT periods on a bilateral pathway:



RTT period 1:

1. referral (clock start)
2. outpatient appointment
3. decision to treat (DTT) one side
4. treatment (clock stop)

RTT period 2:

1. follow-up with DTT for other side (clock start)
2. treatment (clock stop

10.16. Planned waiting lists

Patients will only be added to an admitted planned waiting list if there is a clinical reason they need to have a procedure at a specific time or repeated at a specific frequency, such as a repeat colonoscopy. Patients who are on an RTT pathway should not be placed on a planned list if they are unfit or unavailable for a procedure or operation.

A patient's 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 any longer after this time has elapsed.

When patients on planned lists awaiting admission for treatment are clinically ready for their treatment to begin and reach their due date for their planned procedure, they will either be admitted for the procedure or transferred to an active waiting list and a new RTT clock will start.

Patients who require a diagnostic test at a specific point in time for clinical reasons (such as for post-treatment surveillance) are exempt from the diagnostic clock rules and will be held on a planned waiting list with a clinically determined due date identified. However, if the patient's wait goes beyond their due date for the test, they will be transferred to an active waiting list, and a new diagnostic clock will start.

Patients on planned lists are not included in any calculation of the size of the waiting list because their procedures must take place at a clinically determined interval and cannot be performed any sooner than this. Planned patients are monitored via planned patient lists and must have their treatment at their clinically determined interval, this date must be recorded on the PAS system and compliance will be monitored.

For those patients referred to the Trust who are waiting until a certain age to be able to proceed to surgery, if the patient will not be reviewed during the intervening period, then their clock stops, and the patient is added to the planned waiting list with a review date.

Examples of procedures which should be on surveillance or planned lists are:

- Patients waiting for more than one procedure where the procedures need, for clinical reasons, to be undertaken in a certain order, e.g. injections as part of the pain management service.
- Follow up check procedures such as cystoscopies, colonoscopies etc.
- Patients proceeding to the next stage of treatment i.e. Patients undergoing chemotherapy

Please note this is not an exhaustive list. A clinician will decide whether a patient should be added to, or remain on the planned waiting list, and in conjunction with the patient decide a date by which the next stage of treatment will commence.

10.17. PIFU: Patient initiated follow-up

The term patient-initiated follow-up (PIFU) describes when a patient (or their carer) can initiate their follow-up appointments as and when required within a specified time frame decided by the clinician, e.g. when symptoms or circumstances change. This helps patients access support when they need it (e.g. during a flare-up of their symptoms) and avoids unnecessary routine ‘check in’ appointments. The patient is empowered to manage their own condition and takes responsibility for initiating the appointment. The patient is therefore not managed on an active RTT clock.

The trust now operates a PIFU programme in a wide range of specialties. PIFU is one aspect of personalised follow up which describes the broader concept of when a patient’s follow up care is tailored to their individual clinical need, circumstances and preferences.

PIFU will not be appropriate for all patients, and this will be decided by the clinician who may wish to keep the patient on a managed follow-up rather than a PIFU pathway.

Clinicians should follow principles of personalised care and engage in shared decision making with the patient to assess their individual and clinical risk.

Clinicians should ensure that patients have a good understanding of PIFU and how and when to contact services. Patients should be provided information on which symptoms to watch out for, when to contact the service and details on how to contact the service for an appointment. The information can be sent both digitally (e.g. via email and SMS messages) and as a hard copy handed/posted to the patient so they can keep track of their PIFU information.

The information should also be communicated to the patient's GP so they are kept informed.

11. Clinical Prioritisation

When a patient is added to the waiting list the clinician should assign them a clinical prioritisation code. Clinical prioritisation criteria for each elective specialty should be agreed by clinical leads following guidance from respective Royal Colleges.

These follow a standard format as detailed below:

P code	Booking timescale	Review
P1a	Emergency procedures to be performed in < 24 hours. Would not usually apply to patients awaiting elective admission	
P1b	Emergency 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 month.	3 month
P4	Procedures to be performed in > 3 month.	

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 6 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).

12. Glossary

Active monitoring	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures. Often referred to as 'watchful wait'
Advice and guidance (A&G)	By providing a digital communication channel, A&G allows a clinician (often in primary care) to seek advice from another (usually a specialist) before or instead of a referral.
Active waiting list	The list of elective patients who are fit, ready and able to be seen or treated at that point in time. Applicable to any stage of the RTT pathway where patients are waiting for hospital resource reasons.
Appointment slot issue (ASI)	A list of patients who have attempted to book their appointment through the national e-Referral Service but have not been successful due to lack of clinic slots
Bilateral procedures	Where a procedure is required on both the right and left sides of the body
Breach	A pathway where the waiting time to be seen or receive treatment exceeds the access standard, national or local target time.
Clinic outcome form (COF)	Used to record the RTT outcome and other clinical information after an outpatient appointment.
Consultant-led service	A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse-led clinics, which come under the umbrella of consultant-led services.
Day case	Patients who require admission to hospital for treatment and will need the use of a bed but are not expected to need to stay overnight.
Decision to admit (DTA)	Where a clinical decision is made to admit the patient for either day case or inpatient treatment
Direct access	Where GPs refer patients to hospital for diagnostic tests only. These patients will not be on an open RTT pathway
Elective care	Any pre-scheduled care that is not within the scope of emergency care.

First definitive treatment (FDT)	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgement in consultation with the patient.
Fixed appointments	Where an appointment or admission date is sent to the patient without the opportunity to agree a data.
Full booking	Where an appointment or admission date is agreed either with the patient at the time of the decision or within 24 hours of the decision.
Incomplete pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage.
Inpatients	Patients who require admission to the hospital for treatment and will remain in hospital for at least 1 night.
Integrated care board (ICB)	An organisation that brings NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS.
Minimum data set (MDS)	Minimum information required to process a referral either into a trust or out of another trust.
Missed appointment (DNA)	Patients who give no notice of their non-attendance. Also known as did not attends (DNAs).
Nullified	Where the RTT clock is discounted from any reporting of RTT performance.
Partial booking	Where an appointment or admission date is agreed with the patient close to the time it is due
Patient administrative system (PAS)	Records the patient's demographics (for example, name, home address, date of birth) and details all patient contacts with the hospital, both outpatient and inpatient.
Patient-initiated delay	Where the patient declines offers or cancels or does not attend an appointment or admission. This in itself does not the stop the RTT clock. A clinical review must always take place.
Patient initiated follow-up (PIFU)	PIFU is when a patient initiates an appointment when they need one, based on their symptoms and individual circumstances.
Patient pathway identifier (PPID)	A unique identifier that together with the provider code uniquely identifies a patient pathway.

Patient tracking list (PTL)	A tool used for monitoring, scheduling and reporting on patients on elective pathways (covering both RTT and cancer).
Planned waiting list	Patients who are to be admitted as part of a planned sequence of treatment or they have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment or treatment at the clinically appropriate time. They are not counted as part of the active waiting list or on an RTT pathway
Reasonable offers	An offer of an appointment or admission date with 3 weeks' notice. It is good practice to offer patients 2 reasonable dates.
Referral management centre (RMC)	Provides a single point of access for professionals to make referrals into providers.
Referral to treatment (RTT)	The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.
Straight to test (STT)	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an RTT pathway.
To come in (TCI)	The date of admission for an elective surgical procedure or operation.

13. References & Further Reading

Referral to treatment consultant-led waiting times rules suite (Oct 2022)
https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks

Referral to treatment (RTT) statistics
https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/#guidance

Evidence-based interventions programme
https://www.england.nhs.uk/evidence-based-interventions/

The NHS Constitution (Aug 2023)
https://www.gov.uk/government/publications/the-nhs-constitution-for-england

The NHS Choice framework (Aug 2023)
https://www.gov.uk/government/publications/the-nhs-choice-framework

Handbook to the NHS Constitution for England (Jan 2025)
https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england

Equality Act 2010 (June 2015)
https://www.gov.uk/guidance/equality-act-2010-guidance

Armed Forces Covenant (June 2016)
Armed Forces Covenant: guidance and support - GOV.UK

NHS cost recovery - overseas visitors (December 2024)
https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.gov.uk%2Fgovernment%2Fpublications%2Fnhs-cost-recovery-overseas-visitors&data=05%7C02%7Crebecca.wootton4%40nhs.net%7Cdfe2869e6f73448a93c308dd49f768a5%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638748049144302466%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=ecnvWBETgbDMTYAPRjtkvWp02%2FW%2FpnAS0pidwUe9bkk%3D&reserved=0

Did not attends (DNAs)
https://www.england.nhs.uk/outpatient-transformation-programme/did-not-attends-dnas/

Good communication with patients waiting for care (Oct 2023)
https://www.england.nhs.uk/long-read/good-communication-with-patients-waiting-for-care/#introduction

14. Appendices

Appendix 1 – Due Regard Assessment Tool
Appendix 2 – Dissemination, Implementation and Access Plan

Appendix 1 - Due Regard Assessment Tool

To be completed and attached to any policy when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	• Age	N	
	• Disability	N	
	• Gender (Sex)	N	
	• Gender Identity	N	
	• Marriage and civil partnership	N	
	• Pregnancy and maternity	N	
	• Race (ethnicity, nationality, colour)	N	
	• Religion or Belief	N	
	• Sexual orientation, including lesbian, gay and bisexual people	N	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	N	
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**	N	
4.	**Is the impact of the document likely to be negative?**	N	
5.	**If so, can the impact be avoided?**	-	
6.	**What alternative is there to achieving the intent of the document without the impact?**	-	
7.	**Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the policy should continue in its current form?**	-	

8.	**Has the document been assessed to ensure service users, staff and other stakeholders are treated in line with Human Rights FREDA principles (fairness, respect, equality, dignity and autonomy)?**	Y	

If you have identified a potential discriminatory impact of this policy, please refer it to Huw Edwards, together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact **uhsussex.equality@nhs.net (01273 664685).**

Appendix 2 - Dissemination, Implementation and Access Plan

To be completed and attached to any policy when submitted to Corporate Governance for consideration and TMC approval.

	Dissemination Plan	Comments
1.	**Identify:**	
	Which members of staff or staff groups will be affected by this policy?	This policy applies to all staff involved in elective access processes across outpatient, diagnostics, elective inpatient/day case pathways and related waiting list/booking functions.
	How will you confirm that they have received the policy and understood its implications?	• Policy launch and key changes communicated through the Planned Care Oversight Group, then embedded through Divisional RTT meetings and specialty/service PTL forums (standing agenda item for a defined period). • Completion of mandatory contextual elective care training at induction for new starters and annual refresher for existing staff (role-appropriate). • Competency tests (documented) to provide evidence of knowledge/ability, using the policy and SOP suite as the basis of training content. • Routine data quality checks, validation activity, and KPI monitoring aligned to policy requirements; exceptions handled through line management and formal capability/disciplinary processes where needed. • Targeted spot-check audits (e.g., clock start/stop application, DNA/cancellation handling, reasonableness, active monitoring recording) with feedback loops into divisional RTT meetings. **Stage 1 (Trust-level):** Planned Care Oversight Group endorsement and launch comms; highlight key changes and expectations. **Stage 2 (Divisional):** Divisional RTT meetings adopt as standing item for an agreed period; implement templates/guides; nominate local points of contact for queries. **Stage 3 (Specialty/service):** PTL meetings and cancer tracking meetings apply the standard agenda and decision aids; reinforce consistent clock rule application. **Stage 4 (Assurance):** Data quality audits and KPI monitoring with feedback through divisional governance; address non-compliance via line management processes.

	How have you linked the dissemination of the policy with induction training, continuous professional development and clinical supervision as appropriate?	• CPD/refresher sessions to include case-based learning using common operational scenarios (DNAs, cancellations, uncontactable, active monitoring, clock starts/stops, cancer pathway specifics) aligned to the policy and SOPs. • A cascade training programme will be delivered to staff groups responsible for elective pathway administration/management, led by key trainers (e.g., RTT Pathway Trainer, RTT Performance Manager, PAS trainers for PAS technical use).
2.	**How and where will staff access the document (at operational level)?**	• The Trust's Policy Register / document management system, with version control and review dates visible. Operational accessibility will be strengthened by: • A one-page "What's changed / key rules" summary and role-based quick guides for clinicians, booking teams, inpatient schedulers, cancer coordinators, and validation staff. • Clear signposting to policy sections on reasonableness, uncontactable processes, DNA/cancellation handling, active monitoring, cancer clocks, clinical prioritisation, and governance escalation routes.

		Yes/No	Comments
3.	**Have you made any plans to remove old versions of the policy or related documents from circulation?**	Yes	• Remove UHSC046 Patient Access Policy v1 from local/shared drives and intranet locations and replace with a redirect to the current version on the Policy Register. • Update any operational packs, induction materials, and templates to reference v2 only, and withdraw legacy quick guides. • Communicate version change via Planned Care Oversight Group and Divisional RTT meetings, with clear "effective from" date and a short "what changed" summary.
4.	**Have you ensured staff are aware the document is logged on the organisation's register?**	Yes	• Standing agenda items and communications through Planned Care Oversight Group, Divisional RTT meetings, service PTLs, including where to find the policy and supporting SOPs/guides/templates.