University Hospitals of Leicester NHS
NHS Trust

Elective Care Access Policy

Originally approved by	Executive Team
Trust reference	B3/2004
Version	11
Supersedes	V10 – 5 July 2023 – PGC Chair's urgent approvals process
Trust lead	Deborah Cundey – Head of Performance and Improvement
Lead board director	Jon Melbourne, Chief Operating Officer
Date of latest approval	17 May 2024 – Policy and Guideline Committee
Next review date	January 2028

1. Contents

V11 approved by Policy and Guideline Committee on 17 May 2024 Trust ref: B3/2004 next review: January 2028

2. Approvals, updates & version history

Approvals	Forum	Date	Approved
	Operational Management Group	May 2024	Yes
	Planned Care Partnership Board	May 2024	Yes
	Policy and Guidance Committee	May 2024	Yes
Trust reference	B3/2004		
Version	11		
Supersedes	V10 – Elective Care Access Policy		
Updates	V11 of this policy has the following updates: • Detail regarding GP / referrer responsibilities • Updated governance and compliance framework • Further detail relating to good and best practice reasonableness criteria • Further detail regarding patient-initiated delays and social active monitoring • Further details regarding outgoing inter-provider transfers • New section on expediting patient care • New section on pooled services • Further detail on thinking time • Clarification relating to Trust staff who become patients • Update to the fitness to surgery in terms of senior pre-operative assessment nurses having autonomy to enter P4 patients into clinical active monitoring • Non-RTT section updated with UHL definition and more clarity regarding management of non-RTT patients • Links to relevant supplementary policies and standard operating procedures • Revised monitoring compliance table • Glossary of terms, definitions and acronyms added.		
Trust lead	Lynn Neat, Elective Pathway Lead		
Lead board director	Jon Melbourne, Chief Operating Officer		
Date of latest approval	May 2024 PGC		
Next review date	January 2028		

3. Introduction and overarching principles

The Trust is committed to delivering high quality and timely elective care to patients. This policy:

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

The Trust's Elective Care Access Policy was developed following consultation with staff, the LLR ICB, general practitioners, clinical leads and patient representatives. It will be reviewed and ratified at least annually or earlier if there are changes to national elective access rules or locally agreed principles.

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

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

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

4. Purpose

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

This document sets out the Trust's policy for the management of patient access to elective services. In partnership with all local health care organisations, the University Hospitals of Leicester NHS Trust (UHL) is committed to ensure patients receive treatment in accordance with national standards and objectives. The policy

covers the way in which UHL will manage administration for patients who are waiting for or undergoing treatment. It includes admitted, non-admitted and diagnostic pathways for Referral To Treatment (RTT) and patients undergoing follow up treatment or investigations.

As set out in the NHS Constitution, patients have the right to start consultant-led treatment within maximum waiting times.

Under the NHS Choice Framework, should patients wait beyond 18 weeks, they can ask to be referred to a different provider.

For non-cancer patients this is 18 weeks from referral. Shorter targets for Cancer pathways apply. Guidance for cancer patients can be found in the separate Cancer Access Policy (link to be added).

This policy adheres to national best practice and provides a framework to ensure that patients are treated transparently, fairly and reasonably. The policy:

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

5. Scope

This policy sets out the principles and procedures for the management of the different groups of patients encompassing elective pathways. These are categorised as follows:

Patients on a Referral to Treatment (RTT) pathway awaiting treatment
Patients not on an RTT pathway but still under review by clinicians (referred to as non-RTT for non-admitted and planned patients for admitted pathways)
Patients who have been referred for a diagnostic investigation either by their GP or by another clinician.

Management of patients on a cancer pathway are outside the scope of this policy.

This policy should be viewed in conjunction with the Trust's outpatient clinic template management policy (link to be added).

To underpin the principles contained within this elective access policy, the Trust is working towards the development of a suite of standard operating procedures (SOPs). The planned completion date for approval of the SOPs is summer 2024.

6. Roles and responsibilities

Board of directors

The Chief Operating Officer (COO) is the Executive Director Lead for this policy. The Chief Operating Officer has responsibility for the implementation of this policy and board level accountability for the delivery of elective access standards. The COO is responsible for ensuring the delivery of targets and monitoring compliance of elective access standards.

The Chief Executive Officer (CEO) has overall responsibility for patient safety and ensuring that there are effective risk management processes within the Trust which meet all statutory requirements and adhere to guidance issued by the Department of Health.

The Director of Corporate and Legal Affairs, on behalf of the BoD, is responsible for determining the governance arrangements of the Trust including effective risk management processes. They are responsible for ensuring that the necessary clinical policies, procedures and guidelines are in place to safeguard patients and reduce risk. In addition, they will require assurance that clinical policies, procedures and guidelines are being implemented and monitored for effectiveness and compliance.

Corporate directors

The Deputy Chief Operating Officer for Planned Care has responsibility to monitor performance and report all performance to the Trust Board.

General Practitioners

Prior to referral, GPs have a responsibility to ensure that patients are fit, ready and available to attend all appointments, diagnostics and admissions along their pathway. They should also make the Trust aware of any additional care and support needs, including where an interpreter may be required.

Where patients have been discharged following non-attendance and / or non-engagement, patients should only be re-referred once GPs have discussed the reasons with the patient and they are assured as far as reasonably possible that the patient will attend.

Clinicians
Responsibility for adhering to key internal procedures in the proactive management of patients along their RTT journey. Key examples are the timely and accurate completion of the clinic outcome form, swift review of referrals, clinical validation at key stages of the pathway and harm review for patients whose waiting time breach the nationally set standards.

Heads of operations, general managers and service managers
Staff above are responsible for ensuring that all staff are fully trained, competent in, and performance managed against the principles and associated procedures relevant to their role.

Operational delivery unit, including the RTT team
Performance monitoring and reporting externally to commissioners and regulatory bodies including NHS England (NHSE). As part of the RTT reporting process, the operational delivery unit should ensure compliance with the monitoring compliance framework in Appendix Y.

The provision of training tools and opportunities. This includes updating the training provided on Helm and face to face training and support in respect of elective pathway management.

Role of UHL staff groups
All administration, service and general managers are responsible for ensuring that information is recorded accurately and in a timely manner.

All administrative staff with responsibilities for elective care administration are responsible for recording information accurately and timely in accordance with this policy.

Clinicians are responsible for confirming if definitive treated has commenced and when a new decision to treat has been made.

Individual staff members, including clinicians, are responsible for ensuring that their practices are consistent with the policy and that systems are in place to support effective waiting times management.

7. Staff competency and compliance

The following is applicable to all new and existing staff, clinical and non-clinical, whose role involves elective care.

As of April 2024, the Trust is currently working towards the following:

Competency

- As a key part of their induction programme, new starters to the Trust will undergo mandatory contextual elective care training applicable to their role.
- Existing staff will undergo mandatory, role applicable, contextual elective care training on at least an annual basis.
- 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.

Compliance

- Functional teams, specialties and staff will be performance managed against key performance indicators (KPIs) applicable to their role. Role- specific KPIs are based on the principles in this policy and specific aspects of the Trust's standard operating procedures.
- In the event of non-compliance, a resolution should initially be sought by the team, specialty or individual's line manager. The matter should then be dealt with via the Trust's disciplinary or capability procedure.
- Both the competency and compliance elements will be key parts of the Trust's elective care training strategy which is currently in progress and planned implementation date of summer 2024.

8. General elective access principles

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

- The individual patient rights (as in the NHS Constitution and NHS Choice Framework).
- The standards by which individual providers and commissioners are held accountable by NHS England.

The following links provide more information on the NHS Constitution and the NHS Choice Framework:

- NHS Constitution
- NHS Choice Framework

8.1 Pathway milestones

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

- First outpatient appointment
- Treatment decision
- Treatment

UHL will aim to identify and work to set timescales for each 'stage of treatment' by specialty as best practice identifies. If urgent, timescales will be clinically appropriate. These are referenced in the RTT SOPs which can be found here.

8.2 Patient eligibility

8.2.1 Overseas visitors

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

- Have paid the immigration health surcharge
- Have come to work or study in the UK
- Have been granted or made an application for asylum.
- Citizens of the European Union (EU) who hold a European Health Insurance Card (EHIC) are also entitled to free healthcare, although the Trust may recover the cost of treatment from the country of origin.

All staff have a responsibility to identify patients who are overseas visitors and to refer them to the overseas visitor's office for clarification of status regarding entitlement to NHS treatment before their first appointment is booked or date to come in (TCI) agreed.

8.2.2 Patients Requiring Cross Border Approval (Northern Ireland, Scotland & Wales Referrals)

NHS Wales, NHS Scotland and NHS Northern Ireland operate a prior approval policy for all non-emergency procedures and some highly specialised activity (e.g. ECMO) that takes place in England.

Any procedures undertaken without prior authorisation are not authorised by

commissioners and will not be paid for. In order to prevent this, a GP/referrer should request authorisation from the relevant local Health Board prior to referral to secondary care for all patients. In these circumstances the RTT clock will begin when approval for referral to secondary care has been received by the GP/referrer and the GP/referrer proceeds to make a formal referral.

Where the Trust receives a referral without the appropriate authorisation, the referral will be returned to the GP/referrer. This referral should include confirmation that the proposed treatment has been authorised by commissioners. Where prior approval is identified during a patient's pathway, the service will either discharge the patient back to an appropriate local care setting or seek prior approval in line with the local Health Board's policy.

8.2.3 Commissioner-approved procedures

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 Integrated Care Board (ICB).

For further information relating to specific procedures that are not routinely funded, or where there are funding thresholds in place by Leicester, Leicestershire and Rutland ICB, please follow this link.

8.2.4 Patients moving between NHS and private care

If a patient has been seen privately and wishes to be treated at UHL as an NHS patient, this will only happen when the Trust receives an NHS referral letter from a GP (via e-RS) or referring consultant. On receipt of this letter the patient is treated as a new referral in outpatients or placed on a waiting list for investigations or treatment but, will be treated according to their NHS medical priority. The RTT pathway starts at receipt of referral to the NHS.

If a patient seen at UHL wishes to be seen in the private sector (as a private patient) and makes such arrangements, their RTT period stops on the day their care is transferred (with the RTT status code of PDT).

If their care in the private sector is as an NHS patient via a subcontracting arrangement with UHL, their RTT pathway continues until treatment has occurred in the private sector.

If the patient's care is transferred to the private sector via an Inter Provider Transfer (IPT), the patient's clock is nullified from the date the outgoing IPT referral has been sent after the patient has agreed to transfer their care (with the RTT status code of CAT).

8.2.5 Low priority treatments

The Trust has a policy on low priority treatments agreed with local commissioners. Any low priority procedures undertaken without prior authorisation from the ICB will not be paid for. In order to prevent this, a GP should request authorisation from the ICB prior to referral to secondary care for conditions that are normally within this exclusion group. In these circumstances the RTT clock will begin when approval for referral to secondary care has been received by the GP and the GP proceeds to make a formal referral.

This referral should include confirmation that the proposed treatment has been authorised by the ICB. Where the Trust receives a referral without the appropriate authorisation, the referral will be returned to the GP. Where a low priority treatment is identified during a patient's pathway, the patient will be discharged to their GP for this to be sought. Once funding has been approved, they can be re-referred.

For further information relating to low priority procedures that are not routinely funded by Leicester, Leicestershire and Rutland ICB, please follow this link.

8.2.6 Military veterans

In line with the Armed Forces Covenant, published in 2015, all veterans and war pensioners should receive priority access to NHS care for any conditions related to their service, subject to the clinical needs of all patients. Military veterans should not need first to have applied and become eligible for a war pension before receiving priority treatment.

GPs will notify the Trust of the patient's condition and its relation to military service when they refer the patient, so the Trust 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. The Trust's SOP relating to the management of military veterans can be found here (link to be added).

8.2.7 Prisoners

All elective standards and rules are applicable to prisoners. Delays to treatment incurred as a result of difficulties in prison staff being able to escort patients to appointments or admission for treatment may affect the RTT clock following clinical review (see 10.2 Social Active Monitoring).

The Trust will work with staff in the prison services to minimise delays through clear and regular communication channels and by offering a choice of appointment or admission date in line with reasonableness criteria.

8.2.8 Patients with additional care and support needs

UHL will take all reasonable measures to manage patients who have additional

care and support needs for whatever reason. Specialty teams will take particular care to ensure that the needs of these patients are taken account of, and they experience no unnecessary delays related to their care. This group of patients might include but is not restricted to:

- Patients with learning difficulties, people with autism or a mental health diagnosis
- Patients with physical disabilities or mobility problems
- Patients with dementia
- People requiring continuing support by carers
- Looked after children
- Elderly patients who require community care
- Patients between ages 16 and 24, especially those with SEND, care leavers or who are transitioning from children's services, these patients need to be contacted by the relevant service and given further opportunities to engage, with communication to referrer of outcome as per NICE guidelines
- Children (under 18) deemed at risk of harm.

Safeguarding guidance for adults and children can be found at the following links: Safeguarding Adults and Safeguarding Children Policies and Procedures

8.2.9 Staff who become patients

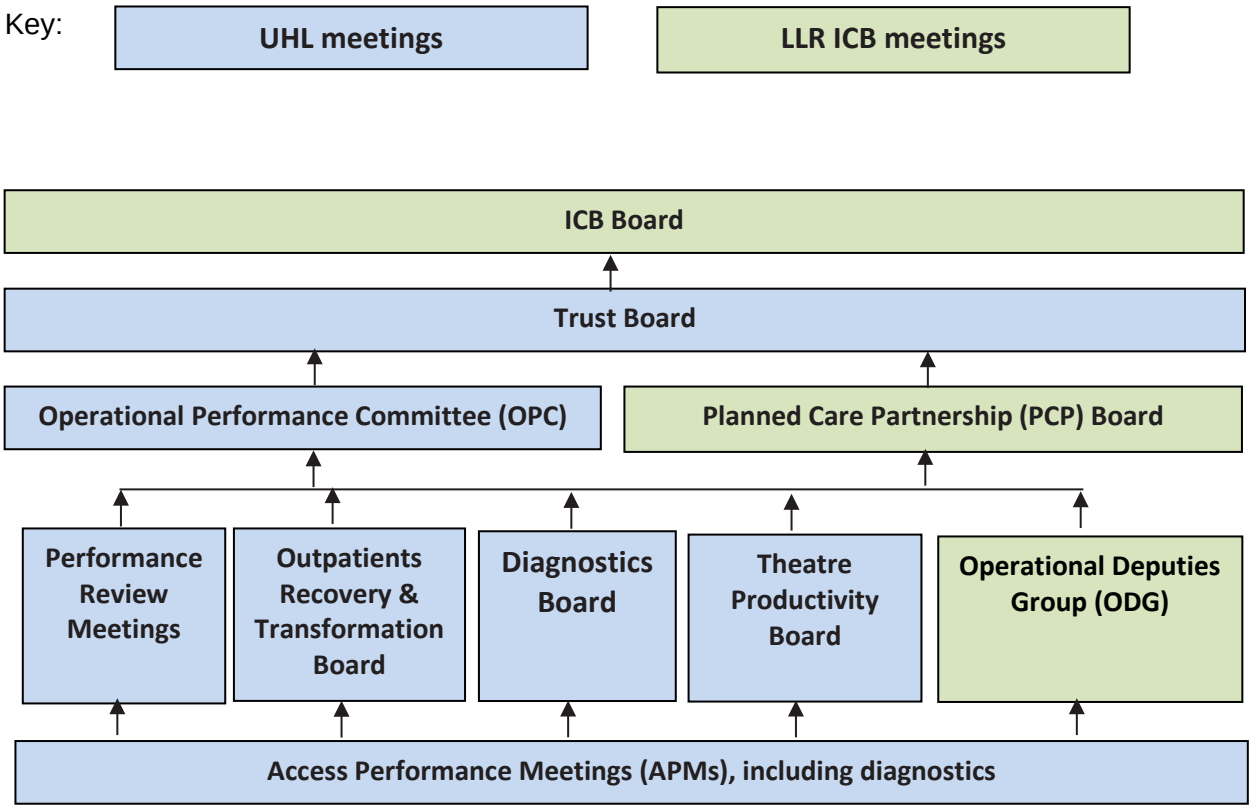
Staff working for the Trust who become patients should be referred by their GP / referrer in the same way as all other patients. They should be seen / treated within their clinical priority and then within chronological order of all other patients. Clinicians should not agree to see staff in an ad-hoc arrangement without a referral. In addition to ensuring equitable access to services, the Trust will not be paid for any first outpatient appointments resulting from a GP referral outside of the e-Referral Service.

9. Governance and monitoring compliance

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

Key indicators relating to access to elective care are managed by individual specialties and monitored via the forums within the governance structure shown below. Attendance should be in accordance with the terms of reference for each meeting.

All elective care performance indicators are reported by exception to the Trust's board at the monthly Operational Performance Committee (OPC) and the ICB's Planned Care Partnership Board. Ultimately performance is overseen by the Deputy COO for Planned Care within UHL and the ICB's Director of Planned Care.



10. National Standards

10.1 National elective care standards

The table below provides a summary of national elective care standards.

Referral to Treatment		**Frequency of reporting**
Incompletes	92% of patients on an incomplete pathway (ie, still waiting for treatment) to be waiting no more than 18 weeks (or 126 days) Interim targets to be achieved as follows: • No patients waiting more than 65 weeks by September 2024 • No patients waiting more than 52 weeks by March 2025 (except where patients choose to wait longer or in specific specialties)	• Weekly through the Waiting List Minimum Data Set (WLMDS) • Monthly on previous month's performance
Diagnostics		
Applicable to the following diagnostic investigations on p.10 of Diagnostics FAQ	99% of patients to undergo the relevant diagnostic investigation within 6 weeks (or 41 days) from the date of decision to refer to appointment date. Interim target of 95% to be achieved by March 2025	Monthly on previous month's performance (also quarterly)

All the standards within the table above are set at less than 100% to allow for tolerances which apply in the following scenarios:

- Exceptions – applicable to pathways where it is in the patient's best clinical interest to extend the treatment standard.
- Choice – applicable where patients choose to extend their pathways via rescheduling previously agreed appointment dates or admission offers.
- Co-operation – applicable where patients do not attend previously agreed appointment or admission dates.

The lasting effects of the Covid-19 pandemic continue to put an unprecedented strain on the NHS with UHL currently having one of the largest elective treatment backlogs in the country.

With delays experienced in both elective and emergency care pathways there is a need to manage the risks associated with increased waiting times to ensure that patient harm is minimised.

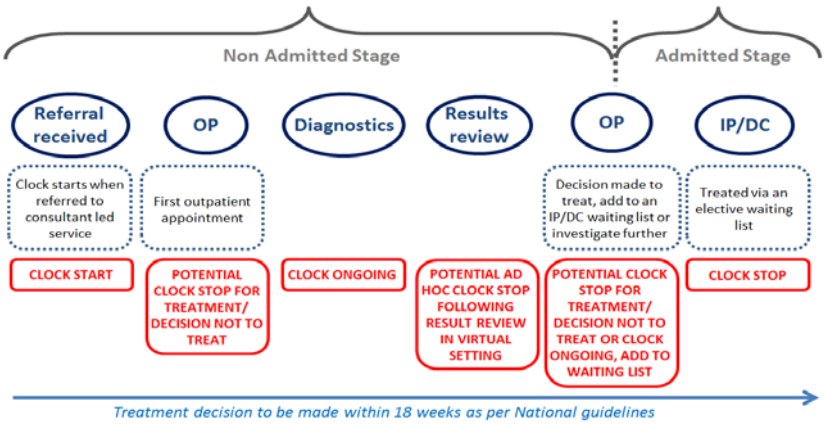
NHS England published a series of national targets as part of the national programme of elective recovery aiming to reduce the waits of the longest waiting patients for elective care. Given the significant backlog in UHL, achieving the elective recovery ambitions remains very challenging. Revised trajectories have been submitted to both the regional and national NHS England teams and it is in accordance with these deadlines we seek to restart the process of completing a formal root cause analysis (RCA) and clinical harm review.

10.2 Harm reviews

A harm review and root cause analysis will be competed for all patients who breach national recovery targets as per the RTT breach management SOP. Specialty operational teams will be advised through Access Performance Meetings specifically when RCAs and harm reviews should commence.

10.3 National Referral to Treatment (RTT) Rules

National guidance on consultant-led referral to treatment waiting times can be accessed on NHS England's consultant-led Referral to Treatment Waiting Times Rules and Guidance webpage here. Detailed local application of the rules at specialty level can be found on the Trust's RTT web page here. An overview of the rules is shown using the diagram and narrative below.



Section A: RTT General Principles

A1.0 Communication

All communications with patients whether verbal, written or digital must be informative, clear and concise. The Trust's Equality Team can support specialties with additional communication methods, for example in provision of easy reading materials, sign language interpretation or braille.

For patients who do not speak English, there is a telephone interpreting service available. Further information can be found via the Trust's Interpreting and Translations page on Insite (link to be added).

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

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

A2.0 Uncontactable patients

Where a patient cannot be reached by the initial phone call, three further attempts on different days at different times (ideally one out of hours) should be made to contact the patient. If the patient still cannot be reached, a letter or text message should be sent, giving the patient two weeks to make contact to book their appointment. An example of a best practice letter can be found here (link to be added). If the patient does not make contact within those two weeks, a clinical review must take place to establish if the patient should be discharged to the referrer.

A3.0 Reasonableness

'Reasonableness' is a term applicable to all stages of the elective pathway. Reasonableness refers to specific criteria which should be adhered to when offering routine appointments and admission dates to patients to demonstrate that they have been given sufficient notice and a choice of dates.

A good practice reasonable offer is a date at least three weeks in the future, or a date offered sooner that is verbally agreed or positively confirmed with the patient via text message. Best practice is at least two offers three weeks in the future. The table below breaks this down in further detail.

Offer method	Constitutes a reasonable offer?
Telephone call (verbal offer) made to the patient to offer a choice of 2 dates with 3 weeks' notice.	Yes – best practice
Letter sent through the post with an offer date with 3 weeks' notice.	Yes – good practice
Accurx text message sent to the patient with an offer date with 3 weeks' notice.	Yes – good practice
Telephone call or Accurx text message sent to the patient with an offer of a date with less than 3 weeks' notice and which the patient accepts or positively responds to via a return text message.	Yes – acceptable practice
An appointment letter sent through the post with less than 3 weeks' notice or an Accurx text message sent with less than 3 weeks' notice where we have no mechanism to ascertain if the patient has accepted the offer.	No

Reasonableness when making offers at alternative providers

If the patient is offered earlier treatment at an alternative provider, in addition to the above criteria, the travel time of the alternative provider must be within 2 hours of the patient's home address for it to be deemed a reasonable offer. Patients must be offered an actual date or approximation for when their treatment could be completed at the alternative provider. If these conditions are met and the alternative provider is within a travel time of 2 hours and the patient declines, this can count as declining a reasonable offer. If the alternative provider is of a travel time of longer than 2 hours, it would not qualify as declining a reasonable offer.

A4.0 Chronological booking

Patients will be selected for booking appointments or admission dates according to clinical priority. Patients of the same clinical priority will be appointed or treated in RTT chronological order from the clock start date, i.e. the patients who have been waiting longest will be seen first. Patients will be selected using the Trust's patient tracking lists (PTLs) only. They will not be selected from any paper-based systems, standalone spreadsheets or other digital methods.

A5.0 Expediting Care

In the event that routine patients feel their condition has worsened whilst awaiting appointments, diagnostic tests or admission treatment, the following should be adhered to when advising patients who to contact.

Patients on an active RTT pathway

<table>
<tr><th>Pathway stage</th><th>Patient to contact</th><th>Action required</th></tr>
<tr><td>Awaiting first outpatient appointment</td><td>GP</td><td>• GP to complete expedite request via PRISM form and email to UHL Booking Centre
• Booking Centre to forward to designated roles in each service within one working day of request received, marking email subject line as 'Patient Expedite Request'
• Consultant to determine if pathway is now more urgent.
• If so, priority updated on HISS.</td></tr>
<tr><td>Awaiting diagnostic</td><td rowspan="3">UHL Booking Centre</td><td rowspan="3">• Booking Centre to forward to designated roles in each service within one working day of request received, marking email subject line as 'Patient Expedite Request'
• Consultant to determine if pathway is now more urgent.
• If so, priority updated on HISS.</td></tr>
<tr><td>Awaiting follow up appointment post diagnostic for treatment decision</td></tr>
<tr><td>Awaiting admission for treatment</td></tr>
</table>

Patients on a non-RTT pathway

Follow up arrangement	Patient to contact	Action required
Patient Initiated Follow Up (PIFU)	Patient makes contact to request an appointment either by telephoning the department directly or via a digital link, as per the PIFU SOP	
Partial Booking of Follow Up (PBFU) Follow up already booked	UHL Booking Centre	• Booking Centre to forward to designated roles in each service within one working day of request received, marking email subject line as 'Patient Expedite Request' • Consultant to determine if pathway is now urgent. • If so, priority updated to urgent on HISS

A6.0 Pooled services

Where clinically appropriate, services should be 'pooled' across all hospital sites, including the community hospital sites. Pooling equalises waiting times across sites and provides greater choice for patients. A triaging of referrals rota should be established amongst all clinicians within the pooled service and all clinicians should see all patients, regardless of which clinician undertook the triage.

A7.0 Clock starts

The RTT clock starts when:

- Any care professional or service permitted by an English NHS commissioner to make such referrals, refers to:
- A consultant-led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner;

- An interface or referral management or assessment service, which may result in an onward referral to a consultant-led service before responsibility is transferred back to the referring health professional or general practitioner.

A waiting time clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and

providers and once the referral is ratified by a care professional permitted to do so.

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

- When a patient becomes fit and ready for the second of a consultant-led bilateral procedure;
- Upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan;
- Upon a patient being re-referred into a consultant-led; interface; or referral management or assessment service as a new referral;
- When a decision to treat is made following a period of active monitoring;
- When a patient rebooks their appointment following a first appointment Did Not Attend (DNA) that stopped and nullified their earlier clock.

A7.1 Exclusions

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

- Obstetrics and midwifery
- Planned and non-RTT patients
- Referrals to a non-consultant led service
- Referrals for patients from non-English commissioners
- Genitourinary medicine (GUM) services
- Emergency pathway non-elective follow-up clinic activity

A7.2 Planned patients

'Planned' patients are patients who need to wait for clinical reasons until they can have a procedure or test. This is different to 'active' patients who could be offered dates today if capacity was not an issue.

All patients added to the planned list will be given a due date by when their planned procedure or test should take place. Where a patient requiring a planned procedure goes beyond their due date, they will be transferred to an active pathway and a new RTT clock started. The treatment of planned patients should be closely monitored, patients should be assigned an appropriate clinical priority and any delays to treatment should be highlighted for clinical review.

A8.0 Clock Stops

A8.1 For treatment

The RTT clock stops upon first definitive treatment (FDT), which is defined as an intervention intended to manage the patient's condition, disease or injury to avoid further intervention. The code used on HISS to stop the RTT clock is TCT.

The RTT clock also stops when a clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

A8.2 For non-treatment

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

- It is clinically appropriate to return the patient to primary care for any non-consultant led treatment in primary care or a clinical decision not to treat is made. The code used on HISS to stop clock is DNT

- If the patient's condition requires a period of active monitoring (also called watchful waiting) from a clinical perspective. The code used on HISS to stop the clock is WWC.

Where the patient requires thinking time before deciding on their treatment plan, it may be appropriate for the patient, in agreement with their clinician, to be entered into active monitoring. The code used on HISS is WWP.

If the patient declines treatment. Code used on HISS to stop the clock is PDT.

A9.0 Recording clock stops

A9.1 Admitted

If a patient requires a procedure or surgery as a day case or inpatient, the clock stops upon admission.

A9.2 Non-admitted

If first definitive treatment takes place in outpatients or if a decision not to treat is made in outpatients, this information is captured on the clinic outcome form by the clinician and is transferred into HISS by the receptionist.

An example of first definitive treatment which might take place in outpatients is where medication is prescribed and this avoids or is intended to avoid the need for any other form of treatment.

A9.3 Ad-hoc

There may also be occasions where a decision not to treat is made in an 'ad hoc' setting, for example following review of diagnostic results by a clinician via a virtual clinic. Clock stops such as these must also be captured and input onto HISS.

Clinicians must write to the patient and their GP to inform them of the decision not to treat. The date of this letter should be the same as the date the clinical decision was made, and this should be recorded as the clock stop date.

A10.0 Active Monitoring (also referred to as Watchful Waiting)

Active monitoring is where a decision is made that the patient may not require treatment at this time but should be monitored in secondary care. When a decision by a clinician to begin a period of active monitoring is made and communicated with the patient, the RTT clock stops. Stopping a patient's clock for a period of active monitoring requires careful consideration on a case-by-case basis and needs to be consistent with the patient's perception of their wait. Active monitoring may be appropriate in the following situations:

A10.1 Clinical active monitoring

When a period of monitoring is appropriate before further action is needed, and the patient does not require any form of diagnostic or clinical treatment currently. The RTT clock will stop and the patient will be monitored. If their condition deteriorates and they require treatment, a new RTT clock will start at zero.

A10.2 Social active monitoring

A clinical decision could be made to enter a patient into social active monitoring if they cancel or decline two reasonable appointment, diagnostic or TCI offers, including first outpatient appointments. In this scenario, the RTT clock would stop

from the date of the second cancelled / declined date and a new clock should start at zero when the patient is available. However, the patient should be scheduled from their original clock start date, as opposed to the new one.

The following steps should be adhered to in this scenario:

1. Upon cancelling or declining the first reasonable offer of an appointment, diagnostic or TCI date, patients should be made aware that if they cancel or decline a second reasonable appointment, to ascertain how clinically safe it is for them to delay, their clinician will review their pathway and one of the following outcomes will apply:

Policy recommendations for clinical decisions	RTT clock impact	Comments
Clinically unsafe to delay: clinician to contact the patient to persuade them to be seen sooner, agree timescale and discussion of potential medical impact	Clock continues	• Patient to be engaged with to discuss reason for cancellations, identify potential safeguarding risks • Patient to be informed of risk to condition if repeated cancellations and delays
Clinically unsafe to delay: in the patient's best interest to return to GP, decision is communicated to patient and GP.	Clock stops	• Recommendations made for management or advice on re-referral
Clinically safe to delay: continuation of RTT pathway	Clock continues	• Patient to be offered subsequent appointment(s), no anticipated risk to condition
Clinically safe to delay: patient to be entered into social active monitoring	Clock stops and new clock starts from zero when patient is available	• Patients must be managed in accordance with their original clock start date, NOT the new one which has started at zero. • Patients must have a review date booked within 12 weeks of the clock stop being applied (if a new clock has not been started within this timeframe).

2. If the patient declines or cancels a second reasonable offer, a third offer must not be confirmed with the patient. The patient's pathway must be clinically reviewed in order for one of outcomes in the table above to be determined.

3. If the patient has informed the Trust that they are unavailable for a period following cancelling or declining offers, and a decision has been made to enter them into social active monitoring, a discussion should take place with the patient to agree an appropriate timeframe for further follow up or review. Patients can request delays of any length but the maximum period between monitoring appointments should be 12 weeks after which a clinical review should take place. This ensures that patients are reviewed regularly in case their condition deteriorates while they are waiting or to confirm that active monitoring remains appropriate.

4. In order to monitor patients in social active monitoring, their pathway should be visible on a relevant PTL or waiting list report for non-RTT pathways.

5. When a patient is placed on social active monitoring, they should be provided with contact details and a clear process for two-way communication

between them and the clinician in the event that their condition or circumstances change.

A detailed SOP and script relating to patient-initiated delays and the impact on the RTT clock can be found here.

A11.0 Non-attendance of appointments

If a patient does not attend (DNA) or was not brought by carers, to their appointment (new or follow up) or admission once, the Trust policy is to discharge patients back to their referrer, provided that it can be demonstrated that the appointment was clearly communicated to the patient with reasonable notice. All such patients' notes must be clinically reviewed prior to discharge to ensure it is in the best interest for the patient.

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

A11.1 First appointment DNAs

The RTT clock is stopped and nullified in all cases (as long as the Trust can demonstrate the appointment was booked in line with reasonableness criteria). If the clinician indicates another first appointment should be offered, a new RTT clock will be started on the day the new appointment is agreed with the patient. However, if there is a delay in contacting the patient due to capacity constraints the clock should start on the date that the clinician made the decision for the outpatient appointment to be rebooked.

A11.2 Subsequent (follow-up) appointment DNAs

The RTT clock continues if the clinician indicates that a further appointment should be offered. If patients wait more than 18 weeks as a result of such delays, the 8% tolerance (against the 92% standard) is in place to account for this.

The RTT clock stops if the clinician indicates that it is in the patient's best clinical interests to be discharged back to their GP/referrer. Both the patient and GP will be notified of this in writing to ensure the referring GP is aware and can action further management of the patient if necessary.

A11.3 Exceptions to DNA rules

The following patient groups should all be offered further appointments in the event of non-attendance.

- Clinically very urgent referrals including rapid access chest pain, and other critical illnesses.
- Children of 16 years and under

- Patients between ages 16 and 24, especially those with SEND, care leavers or who are transitioning from children's services, these patients need to be contacted by the relevant service and given further opportunities to engage, with communication to the referrer of outcome as per NICE guidelines
- Patients with additional care and support needs

More information about patients with additional care and support needs can be found in section 8.2.8.

A12.0 Cancelling, declining, or delaying appointment and admission offers

The Trust policy is two opportunities to reschedule or decline an outpatient appointment, diagnostic appointment, or admission before clinical review which may result in discharge or social active monitoring. At the point of first patient contact, UHL staff must advise patients that a further patient-initiated change or cancellation of the same appointment may result in discharge back to their referrer or social active monitoring.

Please also see Active Monitoring for social reasons. This section states that when a patient declines 2 reasonable offers of treatment, diagnostic, or outpatient appointment dates and wishes to delay treatment they should be reviewed by the consultant who may agree a period of social active monitoring with them. This discussion with the patient should include an appropriate timeframe for further follow up or review. Patients can request delays of any length but the maximum period between monitoring appointments should be 12 weeks after which a clinical review should take place, this ensures that patients are reviewed regularly in case their condition deteriorates while they are waiting.

Where patients have not been entered into social active monitoring following cancelling or declining a second offer and have subsequently cancelled / declined a third time, clinicians must again be informed to ensure that no harm is likely to result from the patient waiting longer for diagnosis or treatment.

Patients who declare a period of unavailability prior to offers being made

When patients are awaiting appointments or TCI offers, they may contact us to declare a period of unavailability, for example:

- Going aboard for 3 months to visit family
- Exams coming up and patient wishes to delay treatment until they are over.

The patient will not therefore be in a position to accept any reasonable offers. In the same way as cancelling or declining offers, this should trigger a clinical review to

determine if the delay incurred is clinically safe / unsafe and what the resulting RTT clock implications are. There are no blanket timeframes of unavailability in order for a clinical review but generally speaking, if the patient is unavailable for more than a few weeks (and we could have offered two reasonable appointments or TCIs within this timeframe), a clinical review should take place.

When patients make contact to declare a period of unavailability, they should be made aware that following a clinical review, they may be discharged back to their GP or be removed from the waiting list to be monitored by their clinician at the Trust until they are available again. This latter scenario would fulfil the criteria for social active monitoring. The RTT clock would stop from the date is unavailable and a new clock start would start at zero when they become available. If the delay is longer than 12 weeks, a review should be arranged to ensure the patient does not come to any harm by delaying their treatment.

A13.0 Patients who are unfit for surgery

The following sets out scenarios following assessing a patient's fitness for surgery. This typically happens at the pre-operative assessment stage of the pathway but the principles set out below in a, b and c should be applied at any stage of the pathway where the patient is being assessed. It is important to note that all decisions regarding the RTT clock should be a clinical one. To confirm that the clock should continue, this decision can be made by the POA nurse. In the event of considering a clock stop due to unfitness, this decision should always be made by an anaesthetist or any other consultant who is involved in assessing the patient's fitness for surgery.

For patients with a clinical priority code of P4, a senior POA nurse can make the decision to enter a patient into clinical active monitoring. P4 is a national clinical prioritisation code which indicates that it is clinically safe for the patient to wait more than three months for their surgery. P codes are allocated by the consultant listing the patient for surgery. The full list of P codes are:

- P1a – emergency and must be treated within 24 hours
- P1b – must be treated within 72 hours

  P1a and P1b would not normally apply to patients awaiting elective treatment

- P2 – must be treated within a month of the decision to admit
- P3 – must be treated within three months of the decision to admit
- P4 – can wait up to three months or more for treatment from the decision to admit.

The following scenarios are guidance to support with clinical decisions regarding the application of RTT rules:

- The patient is not fit due to Covid. A period of 7 weeks is usually required before offering the patient a TCI date following a covid diagnosis. However, this may be less in line with clinical guidance. For patients who are unfit due to covid the RTT clock continues.

- The patient is not fit due to a transitory and temporary illness that is not covid (e.g. a cold or chest infection) which is expected to last no more than 4 weeks the RTT clock continues

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

- If it is clinically appropriate for the patient to be removed from the waiting list (this will be a clock stop event via the application of active monitoring).

- If the patient should be optimised/treated within secondary care (active monitoring clock stop) or if they should be discharged back to the care of their GP (clock stop).

- If a clinical decision is made to stop the RTT clock for active monitoring, the patient's next steps should be agreed, including timescale for further review or follow up to assess the patient's condition. RTT clock stop is the most likely clinical decision but dependant on the nature of the condition requiring optimisation or treatment, the clock may continue.

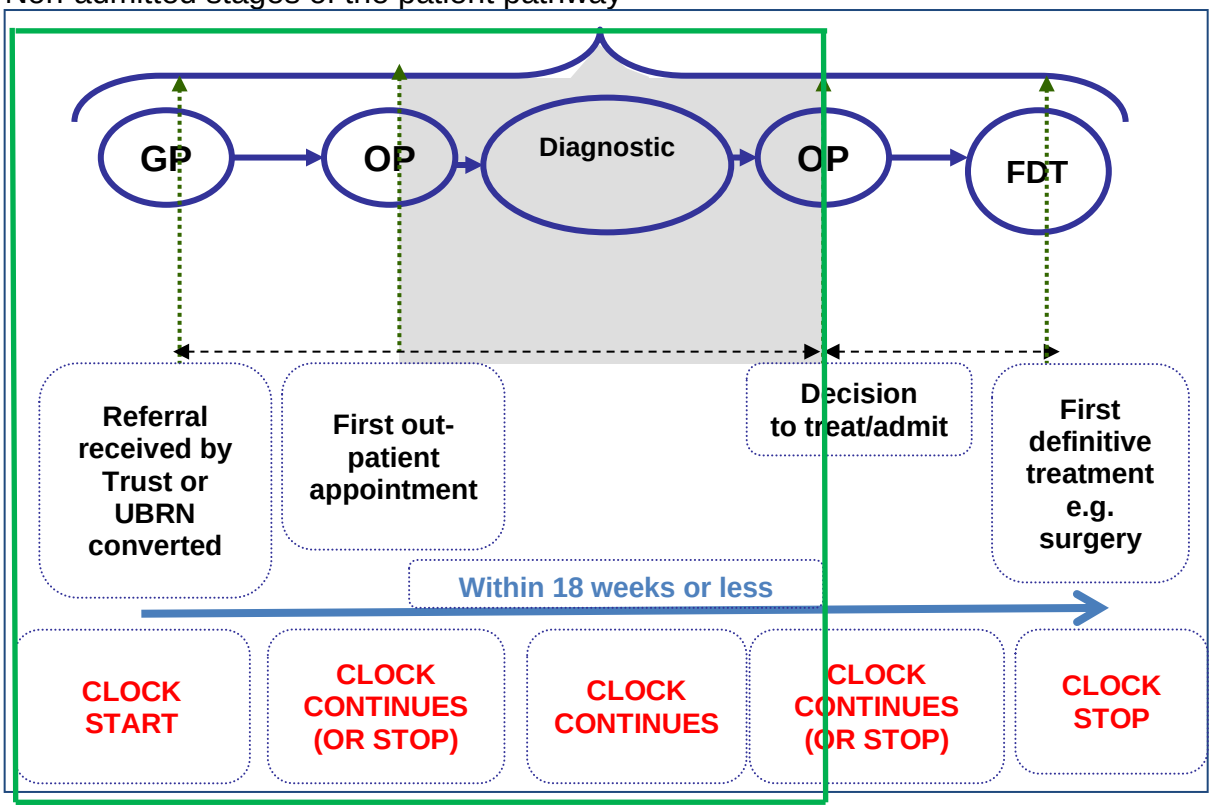
  For the Trust's SOP relating to POA, please see here (link to be added).

Section B: RTT Non-admitted Pathway-specific principles

B1.0 Non-admitted stages of the patient pathway

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

Non-admitted stages of the patient pathway



B2.0 Referral Management

B2.1 Pre-requisites prior to referral

B2.1.1 Primary Care

In line with national RTT rules, before patients are referred it is expected that GPs and other referrers ensure that patients:

- Are ready, willing and able to attend for any necessary outpatient appointments and / or treatment within national waiting times.

- Fully understand the implications of any surgery or other treatment which may be necessary.

B2.1.2 Secondary Care

It is the responsibility of the management teams within each specialty in conjunction with clinicians to ensure that the NHS e-Referral System's Directory of Service (DoS) is correct and up to date. This relates to the service specific criteria, as well as ensuring that clinics are mapped to the relevant services. This means that the patient will be booked into the correct clinic at first visit and the number of Appointment Slot Issues (i.e. NHS e-Referral System failed bookings due to unavailability of appointments on the system) will reduce.

B2.1.3 Consultant to consultant referrals

Internal within UHL

Consultant to consultant referrals are acceptable in the following circumstances:

- Routine referrals that are part of the continuation of investigation and treatment of the condition for which the patient was referred. This includes referrals to pain management where surgical intervention is not intended.

  Where an internal referral is made to another specialty and / or service in this scenario, the referral should be created and processed without delay to avoid the patient incurring any unnecessary delays to their pathway.

- Urgent referrals for a new condition.

- Suspected cancer referrals- these will be vetted and dated by the receiving consultant and upgraded if deemed necessary. Once upgraded the patient will be treated within 62 days of the date the referral was received by the consultant.

The LLR Consultant to Consultant Referral Protocol can be found here (link to be added).

External to UHL - Inter-Provider Transfers (IPTs)

Incoming IPTs

IPT referrals will be received electronically via a secure nhs.net account. The Trust expects an accompanying minimum data set (MDS) pro-forma with the IPT, detailing the patient's current RTT status (the Trust will inherit any RTT wait already incurred at the referring Trust if they have not yet been treated) and if the patient

has been referred for a new treatment plan for the same condition (where a new RTT clock will start upon receipt at this Trust). The patient's pathway identifier (PPID) should also be provided. If the IPT is for a diagnostic test only, the referring Trust retains responsibility for the RTT pathway. If any of the above information is missing, the referral should still be recorded on PAS without delay and the missing information proactively chased.

Outgoing IPTs

The Trust will ensure that outgoing IPTs are processed as quickly as possible to avoid any unnecessary delays in the patient's pathway. An accompanying MDS pro forma will be sent with the IPT, detailing the patient's current RTT status (the receiving Trust will inherit any RTT wait already incurred if the patient has not yet been treated). If the patient has been referred for a new treatment plan for the same condition, a new RTT clock will start on receipt at the receiving Trust. The patient's patient pathway identifier (PPID) will also be provided. If the outgoing IPT is for a diagnostic test only, this Trust retains responsibility for the RTT pathway.

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

Patients who move to another part of England

In the event that a patient moves to another part of the country, an outgoing IPT must be completed. If they are on an active RTT pathway still awaiting treatment, the wait incurred at UHL must transfer with the patient to avoid the need for the patient starting the wait for treatment again.

B2.2 Referral methods

There are currently two recognised methods for receiving referrals: electronic via the e-Referral Service (e-RS) and paper-based.

B2.2.1 E-Referral Service – GP referrals to consultant-led services

With effect from 1st October 2018, a national standard contract change mandated that GP referrals into consultant-led outpatient services must be made via the e-RS system. Providers need not accept, and crucially, will not be paid for any 1st appointment resulting from referrals received outside of e-RS. UHL and the local health community support this. Locally agreed exceptions are in place for certain conditions, clinics and for urgent patients seen on the day or day after referral.

B2.2.2 Directly Bookable Services

Directly Bookable Services (DBS) via the NHS e-Referral System (eRS) enables the GP to book a first outpatient appointment slot while their patient is in the surgery. If this is not the appropriate time to book, the patient will be given a Unique Booking Reference Number (UBRN) and a password so that they can book the appointment online or via The National Appointment Line.

Each service must ensure that sufficient capacity is available for patients to directly book their first appointment. For patients who have been directly booked onto HISS by the NHS e-Referral System, the RTT clock start will be auto-triggered from date the UBRN is converted (i.e. the transaction date of the booking) which is then auto-populated as the referral received date on HISS.

In the event that the patient is unable to directly book into an appointment slot due to insufficient appointment slots being available, this is referred to as an Appointment Slot Issue (ASI). The RTT clock starts at the point that the patient attempted to book.

B2.2.3 E-RS Triage Services

Where specialties have a formal triage service on e-RS, such that triage is made within secondary care prior to a definitive appointment being booked into a consultant-led clinic, the RTT clock starts at the point of the referral is received into the triage service and not at the point of any subsequent onward booking being made.

B2.2.4 Paper Based Referrals

Referrals into non-consultant-led services, or referrals other than from GPs, can continue to be accepted into the Trust outside of e-RS.

- All paper-based referrals must be received at a designated centralised location within each specialty.
- Upon receipt of paper-based referrals, the date of receipt should be clearly and permanently marked. This date is the RTT clock start date for referrals sent from outside the Trust.
- All referrals must be registered on HISS within 24 hours of receipt. This applies to referrals both internal and external to UHL.
- Non e-RS referrals from GPs will only be accepted for conditions / clinics / timescales as defined in the locally agreed exceptions. Each specialty must be familiar with their own exceptions.
- Where non e-RS referrals from GPs are received for consultant-led outpatient services, that do not fit into the locally agreed exceptions, the referral letter must be recorded on HISS but without an RTT pathway being created. Patient and GP demographic details must be checked and updated on HISS to ensure details match those on the referral letter. The referral must then be discharged on HISS, using the specific discharge code of “8 –

Paper Referral Returned" and the referral letter returned to the GP with a standardised covering letter, and without clinical triage taking place. The GP must then re-refer the patient via e-RS.

B2.3 Clinical Triage / Review of Referrals

All paper-based referrals should be clinically triaged within 2 working days of receipt to ascertain the clinical priority and to direct the referral into the most clinically appropriate service.

During the triage process, if it is found that a referral has been made to a service not provided by the Trust, it will be rejected back to the referring GP. This will stop the RTT clock.

B3.0 Booking first (new) outpatient appointments

B3.1 From E-RS

All first outpatient appointments for patients referred from GPs into consultant-led services will be made as Directly Bookable Services (DBS) via the NHS e-Referral System (e-RS). Services should ensure that sufficient capacity is available for patients to directly book their first outpatient appointments via e-RS.

B3.2 Appointment Slot Issues (ASIs)

ASIs result in a poor patient experience and time-consuming administrative workarounds. Sufficient capacity should therefore be made available via the NHS e-Referral System to ensure patients can book directly into services. This is the responsibility of the specialty management team.

ASIs also present a clinical risk as an RTT clock is not automatically triggered on HISS while the patient's referral is on an ASI worklist. As a consequence, patients will also not be visible on the Trust's PTL. ASIs should either be booked via e-RS or should be manually added to HISS within 48 hours of the patient attempting to book. The RTT clock should be recorded as the date the patient attempted to book their appointment.

B3.3 From paper-based referrals

Appointments will be booked in order of clinical priority (urgent before routine) and then in chronological order of referral received date. Patients will be selected for booking from the Trust's patient tracking list (PTL) only.

B3.4 Urgent Referrals

Urgent patients that are referred via the paper referral process should be contacted

by telephone within one working day of receipt of referral to agree an appointment date. A letter must be sent to confirm the appointment which must also include details of how to cancel and reschedule appointments.

B3.5 Routine Referrals

Routine patients referred via the paper referral process will be placed on the outpatient waiting list. Appointment offers should fulfil the reasonableness criteria (see pages 16 and 17 for details) and be booked within the agreed first appointment milestone for the specialty concerned. The patient's details including daytime contact number must be checked and corrected at this time and all appointment offers must be recorded on HISS. A letter must be sent to confirm the appointment, which must also include details of how to cancel and reschedule appointments. Where there is insufficient capacity to offer dates within the required milestone, this should be escalated to the relevant service manager.

Any appointment offers declined by patients should be recorded on HISS. This is important for two reasons: full and accurate record keeping is good practice and the information can be used at a later date to understand the reasons for any delays in the patient's treatment, e.g. hospital or patient initiated.

Where a patient cannot be reached by the initial phone call, three further attempts on different days at different times (ideally one out of hours) should be made to contact the patient. If the patient still cannot be reached, a letter or text message should be sent giving the patient two weeks to make contact to book their appointment. If the patient does not make contact within those two weeks, a clinical review should take place which **may** result in the patient being discharged and the RTT clock stopped. A letter must be sent to the patient's GP and the referral is closed. The code for the patient's RTT pathway will be 'patient declined treatment' (PDT).

If a patient has been unable to contact the service within the designated time through no fault of their own, they will be reinstated on the waiting list. and RTT pathway reopened from the original start date.

B4.0 Hospital initiated appointment changes

Hospital initiated changes to appointments should be avoided as far as possible as they are poor practice and cause inconvenience to patients. Cancellations can present a clinical risk, in particular multiple cancellations for those requiring long term follow up. Safeguards must be in place to make sure that this risk is minimised by escalation within the Clinical Management Groups and tracking on HISS.

Patients requiring a follow-up must either be booked a further appointment with the patient present or put on a follow up waiting list on HISS. Patients put on a follow up waiting list must have a guaranteed date to be seen entered on HISS. Prior to this

date the patient must be contacted to arrange their appointment. Specialties must monitor patient cancellations and identify those where multiple cancellations have occurred. These must be prioritised for appointments. Each speciality must ensure that no delays are incurred that could be detrimental to patient care.

If a significant delay is caused to the patient due to hospital initiated cancellations, this should be escalated to the patient's consultant to ensure the risk to patient safety is limited.

For patients on an RTT pathway, their clock continues to tick and is unaffected by hospital initiated cancellations.

For non-RTT patients, their due date should be recorded on HISS and appointments should rebooked in line with this due date.

The following process should be followed in the event of a hospital initiated appointment change:

- The patient should be contacted to arrange an alternative appointment date and time in line with reasonableness criteria (see pages 16 and 17).
- If the cancellation is within 5 working days of the appointment date, the patient should be informed of the cancellation by telephone or text message.
- For new appointments booked via e-RS, where capacity allows, attempts must be made to change the appointment via e-RS.

B5.0 Patient initiated appointment cancellations

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

At the point of cancelling an appointment for the first time, patients should be advised that should they cancel a second time, a clinical review will be undertaken to ascertain if they can be offered a third appointment, discharged back to their GP or monitored within secondary care.

If the patient is on an open RTT pathway, the clock continues to tick. If there are insufficient appointment slots within the agreed pathway milestones, the issue must be escalated to the relevant speciality management team. Contact with the patient must be made within two working days to agree an alternative date.

Upon clinical review, the patient's consultant should indicate one of the following:

- Clinically safe for the patient to delay: continue progression of pathway. The RTT clock continues.

- Clinically unsafe length of delay: clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues with agreed timescale to proceed or discussion with the patient about options or the impact on clinical outcome if continued delay.

- Clinically unsafe length of delay: in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP.

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

B6.0 Patient thinking time

At the point of the decision to admit / treatment offer

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

It may be appropriate for the patient to be entered into active monitoring (and the RTT clock stopped) where they state they do not anticipate making a decision for more than 4 weeks. This decision can only be made by a clinician and on an individual patient basis with their best clinical interests in mind.

In this scenario, a follow-up appointment must be arranged around the time the patient would be in a position to make a decision. A new RTT clock should start from the date of the decision to admit if the patient decides to proceed with surgery.

Whilst on the admitted waiting list

Once a treatment decision has already been agreed with the patient, they may request thinking time if they become unsure of whether they still wish to proceed with the agreed treatment. Upon patients making the Trust aware of this, a clinical review should take place to establish a plan moving forwards. This could involve a conversation with the patient to establish more clearly the reasons they are unsure about proceeding as agreed. It may be appropriate for the patient to be entered into active monitoring (and the RTT clock stopped) where they state they do not

anticipate making a decision for more than 4 weeks. This decision can only be made by a clinician and on an individual patient basis with their best clinical interests in mind.

Possible outcomes from the clinical review and conversation could be:

- Continue on waiting list – patient now sure they wish to proceed – **RTT clock continues**
- Removal from the admitted waiting list and RTT pathway completely. Patient discharged and returned to GP – **RTT clock stops**
- Removal from the admitted waiting list and returned to outpatients to consider alternative treatment options – **RTT clock continues**
- A period of active monitoring started – **RTT clock stops** and **a new clock starts** at an agreed point in the future when it is deemed sufficient thinking time.

B7.0 Clinic attendance and outcomes

B7.1 Arrival of patients

Patient demographic details must be checked at every clinic attendance and amended as necessary. Overseas visitor status must also checked at this time. The relevant service manager must be notified where it is suspected that there is an overseas visitor.

Every patient, new and follow-up, whether attended or not, will have an attendance status and outcome recorded on PAS at the end of the clinic. This should be fully actioned within one working day of the clinic taking place. This is applicable to ALL consultation types, i.e. face to face, telephone and video.

B7.2 Clinic outcomes

Clinic outcomes (e.g. discharge, further appointment) and the patient's updated RTT status will be recorded by clinicians on the agreed clinic outcome form (COF) and forwarded to reception staff immediately.

When attending clinic, patients may be on an open pathway (i.e. waiting for treatment with an RTT clock running) or they may already have had a clock stop due to receiving treatment or a decision not to treat being agreed. It is possible for patients to be assigned any one of the following RTT statuses at the end of their outpatient attendance, depending on the clinical decisions made or treatment given/started during the consultation:

Patients on an open pathway

- Clock stop for treatment
- Clock stop for non-treatment

- Clock continues if requiring diagnostics, therapies or being added to the admitted waiting list.

Patients already treated or with a decision not to treat

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

Accurate and timely recording of these RTT statuses at the end of the clinic are therefore critical to supporting the accurate reporting of RTT performance.

B8.0 Booking follow up appointments

B8.1 Follow up patients on an open pathway (RTT active)

Where possible, follow up appointments for such patients should be avoided, by discussing likely treatment plans at first outpatient appointment, and/or use of telephone/written communication where a face-to-face consultation is not clinically required. Where unavoidable, such appointments must be booked to a timeframe that permits treatment by week 18 (unless the patient choses a later date).

Follow-up appointments should be agreed with the patient prior to leaving the clinic through shared decision making. This provides the best opportunity for patient choice to be accommodated within the required timescale for achievement of the RTT standard. Where insufficient capacity is available, the clinic receptionist will escalate in line with local arrangements to obtain authorisation to overbook.

B8.2 Follow up patients not on an open pathway (non-RTT)

There are three main ways that non-RTT follow up patients should be managed.

1. Patient Initiated Follow Up (PIFU)
   This is when the patient contacts the Trust to initiate the follow-up and may be appropriate for some patients. These patients should have a clear understanding of this pathway before they leave clinic and PIFU worklists should be monitored in line with the PIFU SOP. PIFU should always be considered first as a way of managing non-RTT follow ups. However, if not deemed clinically appropriate, options 2 or 3 should be adopted.

2. Partial booking of follow-ups (PBFU)
   Patients requiring an outpatient follow up appointment in more than six weeks'

time will be added to a Trust recognised waiting list (held on HISS) and the Trust's partial booking process should be followed. Before patients leave the clinic, the process will be clearly explained to the patient:

- They will be added to the PBFU waiting list with a due date.
- Nearer to the time that their follow up appointment is due, they will be sent an 'invitation to book' letter.
- An appointment will then be agreed with the central booking office. Should the patient fail to contact the central booking office, an attempt will be made to contact the patient at three different times of days, (see Uncontactable Patients on page 18). If unable to make contact, a clinical review will take place to decide on the best course of action.

3. Direct / full booking

   Non-RTT patients who require an appointment within six weeks should be directly / fully booked as they leave the outpatient appointment, ie they should leave having with their next appointment having been given a choice of dates and the appointment booked.

   Where patients cannot be booked within the clinically determined timeframes for capacity or choice reasons as part of direct or partial booking arrangement, the process for managing patients is fully described in the Long Term Follow Up Process (link to be added).This process can be used by services to ensure no patients are lost to follow ups.

B9.0 Telephone appointments

B9.1 Appointment Notification

Patients should be notified of their telephone appointment by letter or text message. This is a direct communication to the patient's address and an opportunity to inform the patient who we currently hold as their GP. Patients will be asked to phone in and provide updated information if this is not correct.

B9.2 The timeliness of the telephone appointment

The appointment letter will provide an indicative appointment time. Given that patients may be anxious and / or need to be in a private location for the call, it is fair that they should expect the call to be timely. Every specialty should aim to phone the patient within 1 hour of their appointment time (i.e. within half-an-hour before or after).

Where specialties are still working to achieve this and this timing is not currently achievable, then realistic expectations must be provided to the patient. If a half-day

allowance is the best that can be achieved, then this must be clarified in the appointment letter or text message.

B9.3 The telephone number calling from

The incoming call to the patient may be seen as a withheld or private number. Where possible this should be altered to an identifiable telephone number via involvement of the IM&T Telecoms team.

B9.4 The patient's telephone number

HISS / Patientcentre should be kept updated with the patient's current mobile or landline number. This is the system from which text reminders are generated and is therefore reliant on current accurate numbers. Patients will be advised to inform the Trust of any revised telephone number in advance of their appointment. Clinic staff should ensure that clinicians ringing patients have the most up to date number available.

B9.5 Attendance status for a telephone appointment

The telephone appointment should be recorded on the clinic outcome form noting every time and telephone number attempted. If the first call is not picked up, alternative available numbers should be tried, and all attempts documented. The Trust's policy for the management of DNAs is detailed in section A11.0.

Attendance status to be applied	Scenario
DNA – Did Not Attend	The clinician is unable to get through to the patient and the telephone consultation does not occur. The clinician should document every date/time of call and the telephone number that was called. If other telephone numbers are available, these should also be attempted. The patient's telephone number can be validated against the Summary Care Record to see if any update has been missed. The record of attempted calls should be retained in the patient record.
CND – cancelled on the day	If the patient does pick up the call but states that the time is inconvenient, a more convenient further attempt should be agreed where possible. A CND should only be recorded when a further attempt cannot be agreed, or the patient does not pick up a subsequent call.

B10.0 Clinic Management

B10.1 Ad Hoc Clinic Cancellation & Reductions

All clinical staff must give at least six weeks' notice of annual leave. Notice of planned leave should be given as early as possible to minimise the effect on clinics.

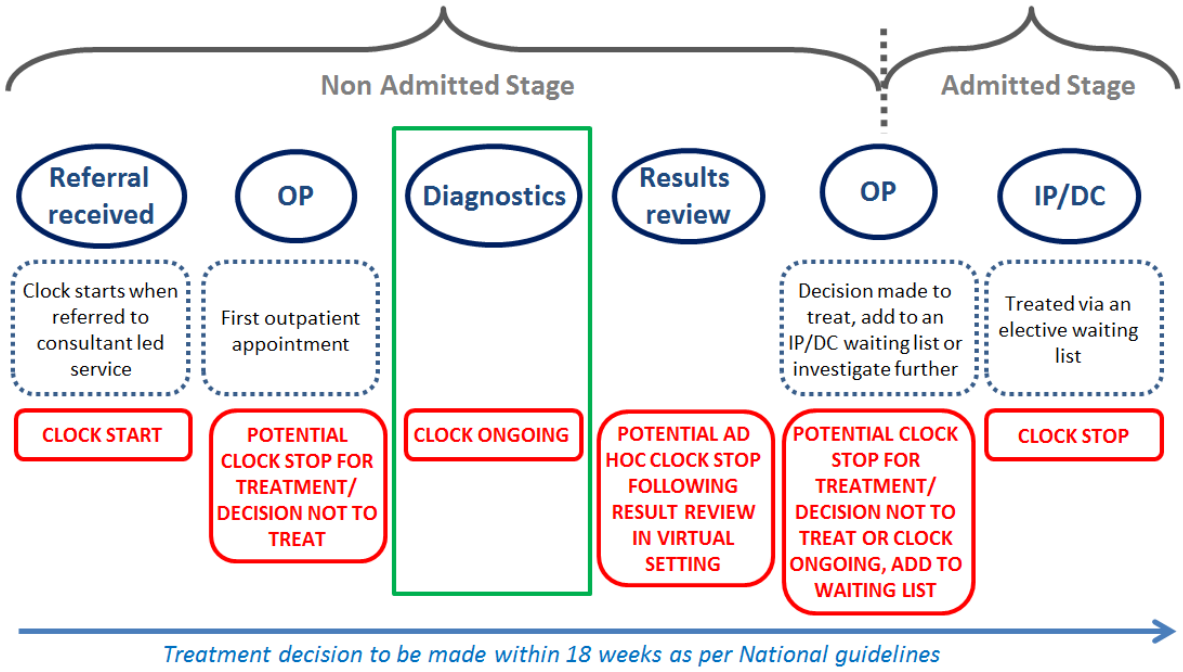
The Trust is committed to offering certainty to patients as well as choice in arranging care. As such, every effort will be made to avoid cancelling patients' appointments. Every effort will be made to backfill absent clinicians by the specialty. Cancellation will be a last resort.

B10.2 Outpatient Clinic Capacity

Specialties must systematically undertake a review of clinic templates and physical room capacity to ensure they are aligned to demand (contracted activity) on an annual basis. The Outpatient Clinic Template Management Policy (link to b added) provides guidance on template management.

Section C: Diagnostic and Acute Therapy Pathway Specific Principles

The section within the border on the diagram below represents the diagnostic stage of the RTT pathway which forms part of a non-admitted pathway. It starts at the point of a decision to refer and ends upon the diagnostic procedure being reported on.



C1.0 National Standard for Diagnostic Waiting Times

The national standard for diagnostic waiting times is 6 weeks from point of decision to referral to the diagnostic being carried out. For this standard, which is called a 'stage of treatment', the following rules apply:

- Diagnostic clock start: the clock starts at the point of the decision to refer for a diagnostic test by either the GP or the consultant.
- Diagnostic clock stop: the clock stops at the point at which the patient undergoes the test.
- If a patient declines, cancels or does not attend a diagnostic appointment, the diagnostic clock start can be reset to the date the patient provides notification of this.
- Resetting the diagnostic clock start has no effect on the patient's RTT clock. This continues to tick from the original clock start date.

National guidance on frequently asked questions for diagnostic pathways and rules can be found here here.

C2.0 Diagnostic Patients on RTT Pathways

Where a patient is referred for a diagnostic test, the principles and policies within the non-admitted section must be adhered to in terms of booking and reasonableness criteria.

Some diagnostic tests will be undertaken on an admitted basis. However, these patients still remain on non-admitted RTT pathways.

C3.0 Subsequent diagnostics

Where the patient has received first definitive treatment for a condition they were referred for and subsequent new treatment plan is agreed following the result of a 'check' diagnostic, a new RTT clock should commence.

C4.0 Direct access

Where a GP refers a patient for a diagnostic test but retains clinical responsibility for the patient this does NOT constitute an RTT pathway. An RTT pathway only commences if the GP subsequently makes a referral to a consultant-led service.

C5.0 Active diagnostic waiting list

All patients waiting for a diagnostic test should be captured on an active diagnostic waiting list, regardless of whether they have an RTT clock running, or have had a previous diagnostic test. The only exceptions are planned patients (see below).

C6.0 Planned diagnostic appointments

Patients who require a diagnostic test to be carried out at a specific point in time for clinical reasons are exempt from the diagnostic clock rules and will be held on a planned waiting list with a clinically determined due date identified. However, if the patient's wait goes beyond the Guaranteed Admission Date (GAD) for the test, they will be transferred to an active waiting list and a new diagnostic clock will be started.

C7.0 Therapeutic procedures

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

C8.0 Acute therapy services

Acute therapy services consist of physiotherapy, dietetics, orthotics and surgical appliances. Referrals to these services can be directly from GPs where an RTT clock would NOT be applicable or during an open RTT pathway where the intervention is intended as first definitive treatment or interim treatment.

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

Physiotherapy

For patients on an orthopaedic pathway referred for physiotherapy as first definitive treatment the RTT clock stops when the patient begins physiotherapy. For patients on an orthopaedic pathway referred for physiotherapy as interim treatment (as surgery will definitely be required), the RTT clock continues when the patient undergoes physiotherapy.

Surgical appliances

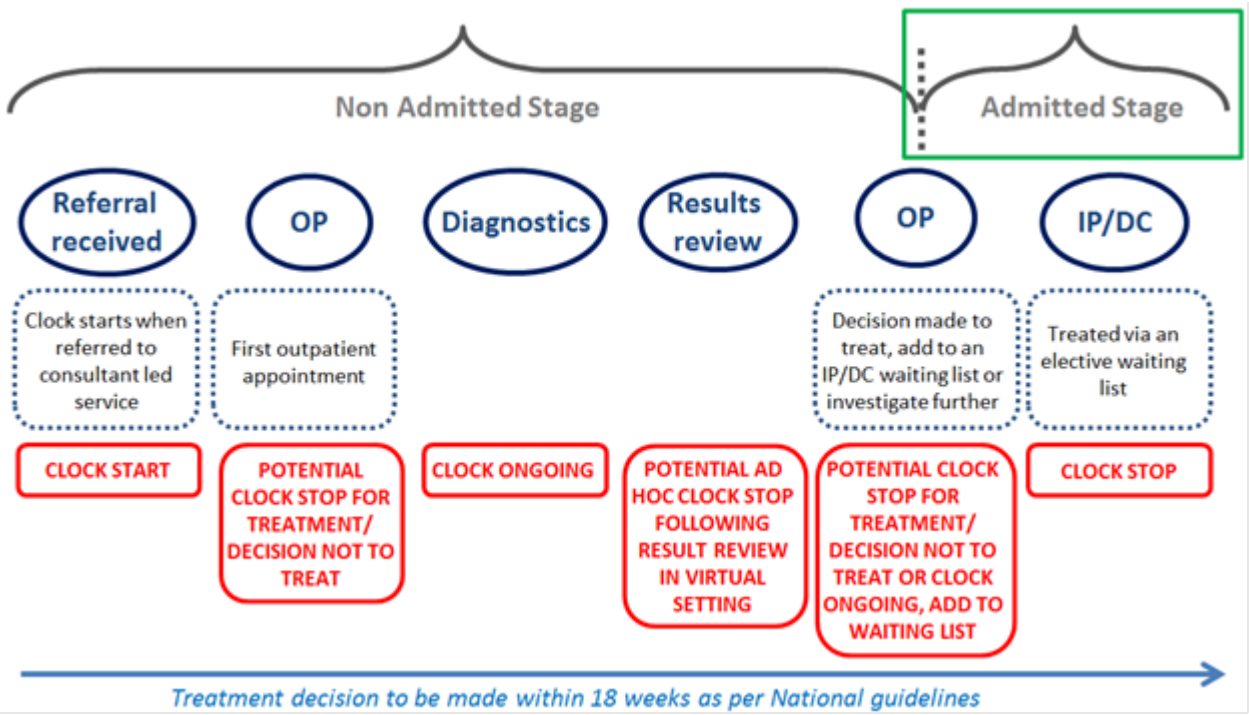
Patients on an orthopaedic pathway referred for a surgical appliance with no other form of treatment agreed. In this scenario, the fitting of the appliance constitutes first definitive treatment and therefore the RTT clock stops when this occurs.

Dietetics

If patients are referred to the dietician and receive dietary advice with no other form of treatment, this would constitute an RTT clock stop. Equally, patients could receive dietary advice as an important step of a particular pathway (e.g. bariatric). In this pathway, the clock could continue to tick.

Section D: RTT Admitted Pathway Specific Principles

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



D1.0 Decision to admit

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

- There is a sound clinical indication for surgery.
- Patients are clinically and socially able for admission on the day the decision to treat is made, i.e. if there was a treatment opportunity tomorrow in which to admit a patient, they are fit, ready and able to come in.

All patients with a decision to admit for surgery should undergo a pre-operative assessment (POA) to assess their fitness for surgery. Please refer to Patients who are unfit for surgery on page 18 for further information and guidance on RTT clock rules.

D2.0 Completion of waiting list forms

At the time of the decision to admit, a waiting list form will be completed in full by the clinician making the decision. This will happen for all patients added to the waiting list. The addition to the waiting list must be input onto HISS within 24 hours of the decision being made (link to SOP here).

From the point of adding the patient to the admitted waiting list for treatment, the patient transfers from a non-admitted pathway to an admitted pathway.

D3.0 Offering admission / TCI (To Come In) dates

Where patients are not fully booked (i.e. given a TCI date on the day of decision to admit), the Trust's RTT patient tracking list (PTL) must be used as the data source for scheduling admitted patients. This is generated from HISS data and is presented in a SharePoint report.

Listing must be undertaken by selecting patients firstly by their clinical priority and then within chronological order of RTT wait time.

Patients must be contacted by telephone to have the opportunity to agree their TCI date. In line with best practice reasonableness criteria, patients should be offered two separate dates with at least three weeks' notice for day case or inpatient admissions.

Where a patient cannot be reached by the initial phone call, three further attempts on different days at different times (ideally one out of hours) should be made to contact the patient. If the patient still cannot be reached, a letter/text message should be sent giving the patient two weeks to make contact to book their TCI. If the patient does not make contact within those two weeks, a clinical review should take place to confirm there will be no clinical risk in discharging the patient.

A confirmation letter must be sent immediately following the agreement of a TCI date. The TCI letter must contain all the relevant information associated to the admission.

D4.0 Planned patients

A planned admission is defined as a procedure which is required for clinical reasons to be carried out at a specific time. Patients added to the planned list will be given a due date by when their planned procedure or test should take place. Where a patient requiring a planned procedure goes beyond their due date, they

will be transferred to an active pathway and a new RTT clock started.

Specialty managers are responsible for reviewing the planned list on a weekly basis to ensure compliance. This review will include checking that patients are being brought in, in accordance with their planned due dates and have been listed appropriately to the planned list definition.

Patients who are added to a planned waiting list must have a guaranteed admission date (GAD) entered on HISS. This is also known as the 'due date' and it is the specific clinical date when the procedure should be carried out. This date should be added to the waiting list form and is determined by the consultant based on the patient's condition.

Patients who wait beyond their guaranteed admission date (GAD) for elective treatment must be transferred to the active waiting list with an RTT clock started on the date the patient becomes overdue for their planned procedure. If a patient has exceeded their wait for a diagnostic procedure, they become an active diagnostic but do not need to be entered onto an RTT pathway. Specialty managers should work closely with clinicians responsible for patient care to ensure that patients on planned pathways who have exceeded their GAD are allocated appropriate priority codes in line with their clinical needs and managed closely to avoid further delays to treatment.

D5.0 Bilateral Procedures

Whilst patients may have two concurrent RTT pathways open for different specialities, patients will only be put onto the admitted waiting list for one procedure at a time within the same speciality. The RTT period will stop when first definitive treatment for the first side begins. A second new RTT clock starts once the patient is fit and ready to proceed with the second procedure unless the second is planned.

D6.0 Admitting patients

Where a patient's admission is a procedure or operation constituting first definitive treatment as part of an RTT pathway, the admission will stop the patient's RTT pathway.

D7.0 Emergency admissions for an elective procedure

Where patients are admitted as an emergency for an elective procedure the patient will be removed from the waiting list and their RTT pathway stopped on the day treatment commenced.

D8.0 Cancelling, declining, or delaying appointment and admission offers

The Trust policy is two opportunities to reschedule or decline an appointment or admission before clinical review which may result in discharge or social active monitoring. At the point of first patient contact, UHL staff must advise patients that a further patient-initiated change or cancellation of the same appointment may result in discharge back to their referrer or social active monitoring.

Please also see Active Monitoring for social reasons. This section states that when a patient declines 2 reasonable offers of treatment or outpatient appointment dates and wishes to delay treatment they should be reviewed by the consultant who may agree a period of social active monitoring with them. This discussion with the patient should include an appropriate timeframe for further follow up or review. Patients can request delays of any length but the maximum period between monitoring appointments should be 12 weeks after which a clinical review should take place, this ensures that patients are reviewed regularly in case their condition deteriorates while they are waiting.

Where patients have not been entered into social active monitoring following cancelling or declining a second offer and have subsequently cancelled / declined a third or fourth time, clinicians must again be informed to ensure that no harm is likely to result from the patient waiting longer for diagnosis or treatment.

D9.0 Non-attendance of admission

If patients DNA their appointment (new or follow up) or admission once, the Trust policy is to discharge patients back to their referrer, provided that it can be demonstrated that the appointment or admission was clearly communicated to the patient with reasonable notice. All such patients' notes must be clinically reviewed prior to discharge ensure it is in the best interest for the patients.

D10.0 Hospital initiated admission cancellations

The Trust will only cancel a patient's admission when it is not possible to carry out the procedure (e.g. bed capacity, unplanned leave, emergency cases). Everything must be done to try and avoid a hospital cancellation as it causes distress to the patient and an operational challenge for the hospital. Should it be necessary to cancel elective admissions, priority will be given to clinically urgent cases and long waiters.

It is vital that any risk to elective operations is highlighted according to the Escalation for On the Day Cancellations UHL policy, Elective operations / Procedures policy (link to be added).If it is absolutely necessary for the hospital to cancel a patient's surgery, the patient should be given a new admission date at the time of cancellation where possible. This should fulfil the reasonable criteria already discussed. If this is not possible, it is the responsibility of the specialty manager to ensure that the patient has a new date of admission within 28 days (if the patient is cancelled on or after the day of admission), or as soon as possible if cancelled prior to this.

All cancelled operations need to be recorded in HISS as soon as possible. It is the responsibility of the General Manager to make sure a clear process is in place to ensure cancellations are recorded accurately in HISS.

D11.0 Removals other than treatment

Patients who state that they do not wish to receive treatment will have their pathway clinically reviewed to ascertain there is no clinical risk in removing the patient from the waiting list.

Section E: Additional Information and Appendices

E1.0 Validation of patient waiting lists

Some patients on the elective waiting list may no longer need their appointment or treatment (if they have been treated elsewhere, or symptoms resolved) or need their operation to be performed by a different Trust.

To ensure that only those patients still needing their treatment are on the waiting list and to comply with the Data Protection Act, the Trust will validate the waiting list on a rolling basis.

In partnership with the RTT team, specialties should aim to have validated all patients over 12 weeks on admitted and non-admitted pathways. This will ensure the waiting list is consistently accurate and managed.

Validation may consist of contacting patients and asking them if they still require their treatment, this includes digital validation, defined as contact through text messaging tools and other digitally enabled solutions (for example: AccuRX, Dora).

Latest national guidance indicates that patients should then be revalidated when they reach these stages of the RTT pathway: 12 weeks, 26 weeks, 52 weeks. All patients on a follow-up non-RTT pathway should be validated on a regular basis. The Trust's SOP relating to this can be found here (link to be added).

E2.0 References and further reading

No	Title	Published by	Publication date	Link
	Referral to treatment consultant-led waiting times Rules Suite	Department of Health	October 2015	https://www.england.nhs.uk/rtt/
	Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care	NHS England	October 2015	https://www.england.nhs.uk/rtt/
	Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care: frequently asked questions	NHS England	October 2015	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2023/10/20231020-Accompanying-FAQs-v7.34-October-2023-Choice-Update-Final-2.pdf
	The NHS Constitution	Department of Health	July 2015	https://www.gov.uk/government/publications/the-nhs-constitution-for-england
	Diagnostics waiting times and activity Guidance on completing the 'diagnostic waiting times & activity' monthly data collection	NHS England	March 2015	https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/
	Diagnostics FAQs Frequently Asked Questions on completing the 'Diagnostic Waiting Times and Activity' monthly data collection	NHS England	February 2015	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01-FAQs-v-3.0.pdf

	Equality Act 2010	Department of Health	June 2015	www.gov.uk/guidance/equality-act-2010-guidance
	Overseas Visitor Guidance	Department of Health	February 2024	https://www.gov.uk/government/publications/nhs-cost-recovery-overseas-visitors
	Cancer waiting times guidance	Department of Health	August 2023	https://www.england.nhs.uk/wp-content/uploads/2023/08/PRN00654-national-cancer-waiting-times-monitoring-dataset-guidance-v12.pdf
	Armed Forces Covenant	Ministry of Defence	July 2015	https://www.armedforcescovenant.gov.uk/

Appendix Y: Monitoring compliance

As highlighted in section 9 – Governance & Monitoring Compliance, key indicators relating to elective care performance from a quantitative perspective are managed by individual specialties and monitored by via the forums within the governance structure shown on page 12. They require monitoring at regular intervals to ensure appropriate escalations and interventions are implemented to sustain activity and performance levels. In addition to this, qualitative measures are also monitored and managed corporately by the RTT Improvement Team, such as data quality, adherence to national rules and compliance with standard operating procedures. Key quantitative and qualitative indicators have been grouped together in the table below to indicate which forums and / or routes performance, risks and issues are reported and / or mitigated.

To ensure this monitoring compliance framework is adhered to, a review will be undertaken by the senior planned care team every six months.

Indicator group	Monitored via	Frequency
Overall RTT performance of incomplete pathways • Against national standards (104, 78, 65, 52 plus waiters) • E-Referral performance (ASIs, Triage services, A&G) • Diagnostic issues impacting RTT performance • Planned admitted waiting lists (number on list, number past due dates) • Non-RTT pathways (indicators under development)	Access Performance Meetings	Weekly or fortnightly (depending on level of challenges within specialties)
Non-admitted performance • National validation • PIFU • Clinic Utilisation • DNA Rates • Non-RTT	Outpatients Recovery & Transformation Board	Monthly
Diagnostic performance • Against national standards (95% within 6 weeks by March 2025, progressing to 99%) • Waiting list size • Planned patients (number on list, number past due date)	Diagnostics Board	Monthly
Admitted pathways • Theatre utilisation • 6-4-2 process adherence	Theatre Productivity Board	Monthly

• Hospital cancellations		
Qualitative Measures • Data Quality • Adherence to national rules • Compliance with standard operating procedures	RTT Improvement Team	Ongoing

Appendix Z: Glossary of terms, definitions and acronyms

Active monitoring
A waiting time clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage. A new waiting time clock would start when a decision to treat is made following a period of active monitoring (also known as watchful waiting). Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to refer the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such and also stops a waiting time clock If a patient is subsequently referred back to a consultant-led service, then this referral starts a new waiting time clock.

Active monitoring can also be applied, following clinical review and agreement, when a patient has declined or cancels two previously agreed appointments or admission offers. This is known as social active monitoring.

Active RTT Pathway
An RTT pathway where the patient is still awaiting treatment. Also referred to as an 'open' pathway.

Active waiting list
A waiting list which is resource driven, ie if capacity was not an issue, the patient could be seen or treated today. This is different to a Planned waiting list where a patient needs to wait until a clinically determined timeframe (known as a 'due date') before they can be seen or treated.

Admission
The act of admitting a patient for a day case or inpatient procedure.

Admitted pathway

A pathway that ends in a clock stop for admission (day case or inpatient).

Advice and Guidance
Within the context of the national e-Referral Service (e-RS), this is where a referring clinician can request advice and guidance via e-RS. The resulting advice can then be converted into a referral or it avoids the need for a referral. There is no RTT clock ticking during the advice and guidance process.

Appointment Slot Issue (ASI)
Relating to the national e-Referral System. When a patient attempts to book into a Directly Bookable Service but there is insufficient capacity, patients are deferred onto the ASI worklist. The RTT clock start should be recorded as the date the patient attempted to book their appointment.

Bilateral (procedure)
A procedure that is performed on both sides of the body, at matching anatomical sites. For example, removal of cataracts from both eyes.

Care Professional
A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

Clinical decision
A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements.

Consultant
A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. Consultant-led waiting times exclude non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.

Consultant-led

A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.

Convert(s) their UBRN
When an appointment has been booked via the NHS e-Referral Service, the UBRN is converted. (Please see definition of UBRN).

DNA – Did Not Attend
DNA (sometimes known as an FTA – Failed to attend). In the context of consultant led waiting times, this is defined as where a patient fails to attend an appointment / admission without prior notice.

Decision to admit
Where a clinical decision is taken to admit the patient for either day case or inpatient treatment.

Decision to treat
Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatments performed in other settings, for example, as an outpatient.

Direct Access referrals
Where GPs refer patients directly for a diagnostic test in secondary care with the intention that they will not be treated in secondary care prior to GP receiving the result.

Directly Bookable Services (DBS)
Within the context of the national e-Referral Service (e-RS), this relates to a type of service where patients (or their GP surgery on their behalf) can directly book an appointment in the hospital's HISS system. An appointment needs to be directly booked before the referral can be processed further. Appointments are made available from HISS to e-RS. In directly booking an appointment, the RTT clock is automatically triggered from the date the appointment is made and subsequently the patient automatically appears on the Trust's PTL.

First definitive treatment
An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.

Fit and ready (in the context of bilateral procedures)

A new RTT clock should start once the patient is fit and ready for a subsequent bilateral procedure. In this context, fit and ready means that the clock should start from the date that it is clinically appropriate for the patient to undergo that procedure and from when the patient says they are available.

Healthcare science intervention
See Therapy or Healthcare science intervention.

HISS
UHL's patient administration system.

Integrated Care Board (ICB)
An integrated care board (or ICB) is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area. Information about Leicestershire's ICB can be found here: https://leicesterleicestershireandrutland.icb.nhs.uk/

Interface service (non consultant-led interface service)
All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care. Consultant-led referral to treatment relates to hospital/consultant-led care. Therefore the definition of the term 'interface service' for the purpose of consultant-led waiting times does not apply to similar 'interface' arrangements established to deliver traditionally primary care or community provided services, outside of their traditional (practice or community based) setting.

The definition of the term does not also apply to:
- non consultant-led mental health services run by mental health trusts.
- referrals to 'practitioners with a special interest' for triage, assessment and possible treatment, except where they are working as part of a wider interface service type arrangements as described above.

Inter-Provider Transfer (IPT)
Where the patient's NHS care transfers from a consultant-led service in one service to another. If they are on an active RTT pathway at the point of transfer, the wait incurred by the patient transfers with them. The RTT clock should then be nullified from the original provider's PTL.

NHS e-Referral Service (formerly Choose and Book)
A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic.

Non-admitted pathway
A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment'.

Non consultant-led
Where a consultant does not take overall clinical responsibility for the patient.

Non consultant-led interface service
See interface service.

Non-RTT
There is no national definition of non-RTT. However, UHL's definition is as follows: Patients who were on an RTT pathway, have been clock stopped due to treatment or decision not to treat and have not been discharged.

Patient Initiated Follow Up (PIFU)
A Patient Initiated Follow-Up Pathway allows the patient to initiate their own follow-up appointments and is intended to support the patient to manage their own condition and book appointments when they are needed, rather than at routine intervals.

Partial Booking of Follow Ups (PBFU)
A booking process whereby the patient is given timeframe when they to be seen by their clinician and is the then added to the PBFU waiting list. The patient is then contacted nearer to the time their appointment is due to book their appointment.

Patient pathway
A patient pathway is usually considered to be their journey from first contact with the NHS for an individual condition, through referral, diagnosis and treatment for that condition. For chronic or recurrent conditions, a patient pathway will continue beyond the point at which first definitive treatment starts, as it will include further treatment for the same condition. A person may therefore have multiple RTT periods (see Referral to treatment period) along one patient pathway. NHS England and NHS Improvement

often uses the term ‘RTT pathway’ in published reports and in this document and this is the same as an ‘RTT period’.

Patient Initiated Delay
An umbrella term which covers all scenarios where patients delay their pathway due to non-attendance, cancelling / declining appointments or admission offers, declaring periods of unavailability and requesting thinking time.

Planned waiting list
An appointment /procedure or series of appointments/ procedures as part of an agreed programme of care which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.

Reasonable offer
An offer is reasonable where the offer for an outpatient appointment or an offer of admission is for a time and date three or more weeks from the time that the offer was made.

Referral management or assessment service
Referral management or assessment services are those that do not provide treatment, but accept GP (or other) referrals and provide advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient. Referral Management and Assessment Services should only be in place where they carry clinical support and abide by clear protocols that provide benefits to patients. They must not be devices either to delay treatment or to avoid local clinical discussions about good referral practice. A waiting time clock only starts on referral to a referral management and assessment service where that service may onward-refer the patient to a surgical or medical consultant-led service before responsibility is transferred back to the referring health professional.

Referral to treatment period
An RTT period is the time between a person’s referral to a consultant-led service, which initiates a clock start, and the point at which the clock stops for any of the reasons set out in the RTT national clock rules, for example the start of first definitive treatment or a decision that treatment is not appropriate.

Straight to test
A specific type of direct access diagnostic service whereby a patient will be assessed and might, if appropriate, be treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional.

Substantively new or different treatment
Upon completion of a consultant-led referral to treatment period, a new waiting time clock starts upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.

It is recognised that a patient's care often extends beyond the consultant-led referral to treatment period, and that there may be a number of planned treatments beyond first definitive treatment. However, where further treatment is required that did not form part of the patient's original treatment plan, a new waiting time clock should start at the point the decision to treat is made.

Scenarios where this might apply include:

- Where less 'invasive/intensive' forms of treatment have been unsuccessful and more 'aggressive/intensive' treatment is required (for example, where Intra Uterine Insemination (IUI) has been unsuccessful and a decision is made to refer for IVF treatment)
- Patients attending regular follow up outpatient appointments, where a decision is made to try a substantively new or different treatment. In this context, a change to the dosage of existing medication may not count as substantively new or different treatment, whereas a change to medication combined with a decision to refer the patient for therapy might.

Ultimately, the decision about whether the treatment is substantively new or different from the patient's agreed care plan is one that must be made locally by a care professional in consultation with the patient.

TCI
To come in date or the date offered for admission to hospital.

Therapy or Healthcare science intervention
Where a consultant-led or interface service decides that therapy (for example physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science (for example, hearing aid fitting) is the best way to manage the patient's disease, condition or injury and avoid further interventions.

Triage services
Within the context of e-Referral Service (e-RAS), these are services where the referral information is assessed without an appointment being pre-booked. If accepted, the RTT clock is back dated to the date the referral was made.

UBRN (Unique Booking Reference Number)

The reference number that a patient receives on their appointment request letter when generated by the referrer through the NHS e-Referral Service. The UBRN is used in conjunction with the patient password to make or change an appointment.

Waiting List Minimum Data Set (WLMDS)
The national electronic database of NHS waiting times. Trusts are required to submit data for all patients awaiting treatment on a weekly basis.