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AMENDMENT HISTORY

Version No.	Date of Issue	Page/Selection Changed	Description of Change	Review Date
5.1	August 2023	Page 25 – Patient Choice	Time of delay amended from 8 weeks to 6 weeks	30/06/2026
5.2	December 2024	Page 9	Linked policy updated to Version 4.3	30/06/2026
5.2	December 2024	Page 39	Planned diagnostic guidance updated	30/06/2026
5.2	December 2024	Section 4.68	This has been removed and replaced with Section 4.9	30/06/2026
5.2	December 2024	Various	Amendments to cancer waiting times and standards in line with new guidance	30/06/2026

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? Yes
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CONTENTS

1. SUMMARY

In England, under the NHS Constitution, patients have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible

Key Points:

- Patients should only be added to the waiting list if there is a real expectation they are immediately fit for and available for treatment.
- Patients will be treated in order of their clinical need.
- Patients with the same clinical need will be treated in chronological order, according to case mix, whilst acknowledging the right of the individual to agree a date to suit their personal circumstances within defined parameters.
- Patients will be offered an appointment/admission at the site with the shortest waiting time for that specialty.
- Veterans, reservists, and active military personnel will be considered for priority treatment for conditions related to their military service, subject to clinical need.

This document sets out the overall expectations of Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR) and local commissioners on the management of referrals and waiting times. It sets out the responsibilities for staff and should be read in conjunction with any relevant Standard Operating Procedures.

This version of the Access Policy reflects the changes in the NHS England revised guidance on patient choice.

2. PURPOSE

This policy sets out the Trust's local patient access policy. The aim of this policy is to ensure that patients are treated promptly, efficiently, and consistently in line with national guidance and good practice.

The policy aims include:

- Define roles and responsibilities for key stakeholders both internally and externally to the organisation in the management of patients waiting for treatment on admitted, non-admitted or diagnostic pathways.

- Ensure processes in the management of patient who are waiting for treatment are clear and transparent to patients and all partner organisations

- Establish a consistent approach to managing patient access across the Trust supported by training and standard operating procedures

- Ensure accuracy of all related data to support monitoring of adherence to the Policy.

This Policy reflects the requirement to comply with:

- The NHS Constitution
- The Referral to Treatment Standards
- The National Cancer Waiting Time Standards (Version 12.0, August 2023)

The fundamental principles outlined in this policy have one over-reaching target, and that is that all decisions about a patient's waiting time should be made with the patients best clinical interests in mind, and in accordance with the national legally binding RTT Rules.

3. SCOPE

This policy sets out the overall expectations of LTH and its local commissioners on the management of referrals and admissions into and within the organisation, in line with current national policy regarding patient access and waiting times and defines the principles on which the policy is based.

This is underpinned by a comprehensive range of Standard Operating Procedures (SOP's).

This policy and the related SOPs are intended to be used by all staff within LTHTR who are responsible for referring patients, managing referrals, adding to and maintaining waiting lists for the purpose of organising patient access to hospital treatment.

The Policy covers the patient pathway from the point of referral to the end of the pathway (or clock stop) and the associated procedures and management principles.

4. POLICY

4.1 ROLES AND RESPONSIBILITIES

4.1.1 LTHTR Responsibilities

LTHTR is committed to delivering the highest possible quality of patient care and ensuring patient access to treatment is transparent, fair, and managed according to clinical priority. The overall aim of the Patient Access Policy is to improve access to service for patients and ensure all patients are treated consistently and in line with appropriate National Guidance. It is therefore essential that performance against the standards identified within the policy are monitored and improved upon to protect patient's access to LTH services.

The policy has been developed to ensure LTHTR provides a consistent, equitable and fair approach to the management of patient referrals and admissions that meet the requirements of the NHS Operating Framework, and the commitments made to patients in the NHS Constitution.

- **Chief Executives / Chief Operating Officers**
  Chief Executive Officers (CEOs) and Chief Operating Officers (Coo's/Director of Operations) have overall responsibility for the implementation of this policy and board level accountability for the delivery of elective access standards.

- **Clinicians**
  Clinicians have a 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 and swift review of referrals/diagnostic results.

- **Clinical Business Managers / Specialty Business Managers**
  Clinical Business Managers (CBM'S) and Specialty Business Managers (SBM' s) are responsible for ensuring that staff are fully trained / competent in, and performance managed against the principles and associated SOPs relevant to their role.

- **Administration Staff**
  All administration staff must abide by the principles in this policy and the supporting standard operating procedures.

4.1.2 Primary Care Referrers Responsibilities

- Ensure that the patient is clinically suitable for their referral and intended pathway of care.
- Ensure that the patient is prepared to be treated within the maximum Referral to Treatment times.

- Initiate the referral using the NHS e-Referral Service, where service is available.
- Identify clinically appropriate speciality services for the patients, to include priority and clinic type. Provide the minimum core data set when making a referral.
- Ensure that where appropriate, funding for interventions not normally funded has been obtained prior to referral commissioning policies.
- Where available ensure adherence to Clinical Referral Guidelines

4.1.3 Patient Responsibilities

- Attend agreed appointments and give sufficient notice in the event of the need to change agreed date and time
- Make every effort to accept an available appointment
- Respond to hospital communications in a timely manner
- Communicate immediately to the hospital or general practitioner if treatment and/or appointments are no longer required
- Consider the choice options that are available to them
- Immediately communicate to the hospital and general practitioner any changes in personal contact details

Patients who choose to delay their treatment should be aware that this may mean that they are treated outside of the 18-week referral to treatment times.

The Patient Access Policy is made available to the public via the Trusts web site https://www.lancsteachinghospitals.nhs.uk/

4.2 NATIONAL STANDARDS & KEY PRINCIPLES OF REFERRAL TO TREATMENT (RTT) CLOCK RULES

4.2.1 Patient Rights

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

A patient has the right to the following:

- The choice of hospital and consultant.
- From a GP referral for treatment into a consultant-led service have a maximum waiting time of 18 weeks from referral for elective conditions to start of treatment.
- To be seen by a cancer specialist within a maximum of two weeks from a GP referral for urgent referrals where cancer is suspected.
- If this is not possible, the Trust must take all reasonable steps to offer a range of alternatives.

The exception to the right to be treated within the maximum waiting times does not apply:

- If the patient chooses to wait longer.
- If delaying the start of the treatment is in the best clinical interests of the patient, for example when stopping smoking or losing weight is likely to improve the outcome of the treatment.
- If it is clinically appropriate for the patient's condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage.
- If the patient fails to attend appointments that they had chosen from a set of reasonable options (where late cancellations or late notifications lead to patient failing to attend appointments, this must be considered, and not adversely affect the patients right to treatment within the maximum waiting times).
- If the treatment is no longer necessary.

4.2.2 Patient eligibility

The Trust has an obligation to identify patients who are not eligible for free NHS treatment and specifically to assess liability for charges in accordance with Department of Health guidance /rules.

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.

Patients who are identified as chargeable patients under the Overseas Visitors Guidance are not included in the RTT reporting and are not reportable breaches of any of the national targets.

Please refer to the Trust Policy for the identification and management of overseas visitors; Version 4.3 for more information. Policy Link and on the Department of Health website: https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations/summary-of-changes-made-to-the-way-the-nhs-charges-overseas-visitors-for-nhs-hospital-care

4.2.3 Patients moving between NHS and private care

Patients can choose to move between NHS and private status at any point during their treatment without prejudice. Where it has been agreed, for example, that a surgical procedure is necessary the patient can be added directly to the elective waiting list if clinically appropriate.

The RTT clock starts at the point the GP or original referrer's letter arrives in the hospital.

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

4.2.4 Commissioner -approved procedures

There are several procedures which require specific approval from commissioners before the Trust can proceed with treatment. Procedures not commissioned should not be carried out by providers and will not be paid for unless prior approval or an Individual Funding Request (IFR) has been agreed.

If a GP wishes to refer a patient to secondary care for a procedure or treatment which is specifically excluded, the GP can obtain prior approval for funding before making the referral. The Prior Approval letter should be sent / attached with the referral letter.

If a GP refers a patient for an opinion and following the outpatient appointment the consultant decides that a restricted procedure is required, then it is the responsibility of the consultant to seek approval via the commissioning team.

More information linked to the Evidence Based Interventions programme which has identified procedures that require approval can be located on the NHS England website at the following link. https://www.england.nhs.uk/evidence-based-interventions/

4.2.5 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

The Trust should be notified of the patient's condition and its relation to military service at the point the referral is made. For these patients they should be seen in an outpatient setting within 4 weeks where their condition is classified as routine; and should be treated in accordance with their clinical priority for treatment so as not to disadvantage clinically urgent patients who are not military veterans.

4.2.6 Prisoner patients

All prisoners will be treated within the same waiting times as all other NHS patients. All elements of this Access Policy are relevant to the population of Her Majesty Prison Services; however, all hospital appointments will need to be managed alongside the prison regimes.
No adjustments or clock stops can be made to the pathways of patients who are prisoners due to the unavailability of prisoner escort services when this affects the ability of the patient attending their appointment or admission.
Where circumstances arise where appointments and/or treatment take longer than the RTT targets, legitimate exceptions will be clearly documented.

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.

4.2.7 Bilateral procedures

A bilateral procedure is defined as 'a procedure that is carried out on both sides of the body, at matching anatomical sites', for example cataract removals. Each of the

procedures will have its own RTT clock. The first clock will stop on the date the first procedure is carried out. The 2nd clock will start when the patient is deemed to be fit and ready for the second procedure.

4.2.8 Active Monitoring (watchful wait)

Active monitoring is defined in national guidelines as-

> "A period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage."

Applying a period of active monitoring will stop an 18-week clock at the point this decision is communicated to the patient. At the end of an agreed period of active monitoring a new RTT clock would start.
Active monitoring is usually initiated by the clinician; however, this can be initiated by the patient should the patient wish to continue to be reviewed as an outpatient and not to proceed with more invasive treatment.

The RTT Rules Suite indicates that whilst active monitoring can be applied at any point on a patient's pathway it is only -

> "Exceptionally after a decision to treat has been made. If such a decision has been made but subsequently it becomes apparent that there is a clinical reason to delay treatment/ admission, then a waiting time clock would usually continue".

Recent changes in national guidance around patient choice, and patients choosing to delay treatment when this has been offered, means that a period of watchful waiting can now be started for patients who choose to delay their treatment following a reasonable offer of treatment.

Please refer to Section 4.7.4 where additional and updated guidance is documented.

4.2.9 Acute Therapy Services

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

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

Depending on the pathway or patient, therapy interventions could constitute an RTT clock stop, e.g., fitting of an appliance or beginning a programme of physiotherapy exercises.

4.2.10 DNA (Did not attend)

A DNA is defined in the RTT Rules Suite as

> "A DNA is defined strictly as a patient failing to give notice that they will not be attending their appointment."

Patients', who give prior notice, however close to the appointment time, are not classed as DNAs and their clocks should not be stopped or nullified.

The RTT Rules Suite goes on to advise that -

> "Discharging the patient is carried out according to local, published, policies on DNAs; [and] these local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g., children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders."

This Access Policy outlines a local framework for supporting the management of patients who DNA an appointment. These are summarised in **Appendix 01.**

The NHS Standard Contract 2016/17 Technical Guidance (April 2016) advises that hospitals are no longer permitted to adopt a blanket DNA policy under which all patients who DNA are automatically discharged back to their GP.

The DNA principles outlined in this Access Policy take the above point into account and ensure that prior to any discharge back to a GP a review of the patient, their clinical needs and previous attendance at appointments is considered by the clinician before a decision to discharge back to a GP is made.

Where such a decision is made, the GP and patient will be informed as to why the decision to discharge has been made.

This framework has been reviewed and agreed by the local Clinical Commissioning Groups (CCG'S).

There are different protocols to consider if the patient is a child or vulnerable adult.

Paediatric and Vulnerable Adults Protocols

Whilst most of the principles of the Patient Access Policy apply to all patients within the Trust, there are some exceptions for paediatric patients and vulnerable adult patients.

Where these protocols are different and require specific actions/attention these are detailed below.

- **DNA of paediatric patients**
  All children's DNAs should be reviewed by the Consultant at the end of clinic. The clinician will decide whether further clinical follow-up is necessary and give due consideration to any safeguarding or child protection concerns.

Central to the clinician's decision making is the use of what is the reasonably available information about a case. For new referrals this will usually only be the referral letter, for follow-ups the hospital records will help. Where doubt exists, consider discussion with the referrer who may have more knowledge of the child and family.

A Trust wide policy has been developed which must be referred to when deciding and deciding next actions for paediatric patients who do not attend an outpatient clinic appointment. Policy for the Management of Children and Young People not brought to Appointments - Was Not Brought (WNB) / Did Not Attend (DNA). Version 2.

- **DNA of vulnerable adults**
  As a rule, it is at the clinicians discretion whether to request further appointments following a DNA for patients who are vulnerable adults. In most instances' patients will be sent a further appointment after the 1st DNA and in special circumstances the consultant may choose to offer a 3rd appointment for clinical reasons however the Trust must make every reasonable effort to ensure that the patient attends for their appointment.

4.3 National Waiting Time Operational Standards

The current maximum waiting times must be adhered to.

National standards require a maximum wait of 18-weeks from referral to first definitive treatment for a consultant led service.

There are three Referral to Treatment (RTT) Standards, which the Trust must deliver at speciality level:

- 92% of patients on an incomplete (active) pathway waiting less than 18 weeks from referral.
- 99% of patients to undergo the relevant diagnostic investigation within 6 weeks from the date of decision to refer to appointment date

4.3.1 Cancer Waiting Times

The national cancer waiting time targets were introduced to help improve the quality of patient care, and help to ensure that cancer services are delivered to patients in a timely manner

The standards all hospitals are required to perform against are as follows:

- 28-day faster diagnosis standard
  All patients referred for the investigation of suspected cancer will find out if they do or do not have a diagnosis of cancer within 28 days of referral.

- 31-day standard
  All patients with a confirmed diagnosis of cancer should expect to receive treatment within 31 days of agreeing their treatment plan with their clinician or the earliest clinically appropriate date. This is the case for all patients diagnosed with a "new" cancer, as well as those who are receiving subsequent treatments.

- 62-day standard
  All patients with a confirmed diagnosis of cancer will need to start their treatment within 62 days of the referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade.

There are national targets that the Trust must attain linked to each of these standards and these are detailed in **Appendix 02**

4.3.2 Diagnostic Waiting Times

A diagnostic test is defined as “a circumscribed procedure, which provides objective information to assist the diagnosis and treatment plan for a clinical condition. It does not imply effective intervention or amelioration”

The statutory target for diagnostic patients is that no patient to wait more than 6 weeks for diagnostics after the test has been requested. The national standard is that less than 1% of patients must wait longer than 6 weeks, for patient choice or clinical complexity reasons.

- 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

For the 6-week diagnostics standard, if a patient decline, cancels or does not attend a diagnostic appointment, the diagnostic clock can be reset to the date the patient provides notification of this. However:

- The Trust must be able to demonstrate that the patient’s original diagnostic appointment fulfilled the reasonableness criteria for the clock start to be reset.
- Resetting the diagnostic clock has no effect on the patient’s RTT clock. This continues to tick from the original clock start date.

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

Additional information relating to diagnostics waiting times is included in Section 4.9

4.4 National Clock Rules

4.4.1 Clock starts

An 18-week 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.

- 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.

Exclusions
There are a range of services that are not subject to the referral to treatment 18-week target. Referrals for these services do not start an RTT clock:

- Obstetrics & Midwifery
- Genitourinary medicine (GUM) services
- Planned patients/activity
- Referrals to a non-consultant led service
- Patients referred through the Emergency Department, e.g., Fracture Clinic, Trauma Clinic.
- Referrals for patients from non-English commissioners

New clock starts for the same condition
Upon completion of an 18-week referral to treatment period, a new 18-week 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.

- When a decision to treat is made following a period of active monitoring.

- When a patient rebooks their appointment following a first appointment DNA that stopped and nullified their earlier clock.

4.4.2 Clock stops

An RTT clock can be stopped for first definitive treatment; adding a patient to a transplant list or non-treatment.

First definitive treatment
This includes:

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

Adding the patient to a transplant list

- If a clinical decision is made to add the patient to a transplant list with no further delay and this has been communicated to the patient and their GP (or other referring practitioner)

Clock stops for non-treatment,
A clock stops when it is communicated to the patient and their GP (or another referring practitioner). Scenarios where this will apply are

- It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care.
- A clinical decision is made to start a period of active monitoring (watchful wait).
- A patient declines treatment having been offered it (or fails to respond to attempts to contact the patient to arrange treatment).
- A clinical decision is made not to treat.
- A patient does not attend their first appointment following the initial referral that started their 18-week clock.

4.4.3 Capturing and Measuring Patient Pathway Outcomes

To measure our waiting times for patient's access to our services and ensure that the patient is moved onto the correct next stage of their pathway, clinical outcomes must be captured, in an accurate and timely manner.

At every clinical outpatient encounter, the clinician completes both the appointment outcome and the RTT outcome for the patient.

Whilst the Trust transitions from a paper to a digital outpatient solution, the clinic outcome may be recorded on the Trust paper RTT Outcome Form, or digitally in Quadramed (QMED) using the e-outcome functions.

In this way, clinical decisions on both what has happened to the patient at that encounter and what needs to happen in the patient pathway next has been captured. 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.

4.4.4 COVID impact on referral to treatment and diagnostic pathways

RTT rules continue to apply to pathways. If when contacting a patient to agree an appointment, diagnostic or date of admission, the patient states that due to COVID-19 they are not willing to agree a date at this time, no pause or blanket discharge policy can be applied to the patient's pathway. Instead, these patients must be reviewed on a case-by-case basis by the relevant clinician and decisions made based on the best interest of the patient.

Prioritisation
Patients have the right to have their care prioritised, either for diagnostic or treatment purposes, against the nationally endorsed coding system for ("P" codes and "D" codes; **Appendix 03**). Patients have a right to expect that their case will be reprioritised in instances where the nature of their condition or illness deteriorates during the period of waiting, the extent of which means that their case should be treated more urgently than first envisaged.

Provision of information and shared decision-making
Patients have the right to expect that the decision around how their care is prioritised is clinically led and that they will have access to regular information and an agreed point of contact with respect to their position and progress on an elective or diagnostic care list.

Chronological approach
Patients have the right to expect that beyond clinical classification of cases (as described above), the provision of care within individual clinical classifications will reflect a chronological booking approach.
It is however acknowledged that sometimes the Trust may need to vary chronological booking approaches to make best use of finite capacity for theatre, beds, workforce, and other resource availability.

Appreciation of the impact of health inequalities and how these have changed due to Covid-19
Patients and the Trust both understand that within clinical classification categories, individual determinants of health status, co-morbidity, and the risk of

disease/condition progression and other adverse clinical sequalae may also influence the order in which patients are offered dates/slots for treatment and diagnostic procedures

Re-review of admitted patients over 104 weeks
In line with NHSE/NHSI guidance of December 2021 there is an increased focus on supporting patients who have been waiting the longest for treatment. Therefore, all patients who have been waiting 104 weeks or more will now be re-reviewed every 3 months, as a minimum, until they receive treatment or get discharged. This will be subject to ongoing review as the number of patients waiting over 104 weeks reduce.

4.5. REFERRAL PROCESSES

As a general principal the Trust expects that before a referral is made for treatment, the patient is clinically fit for assessment and treatment. The patient must be available for treatment within 18 weeks of the referral being made.

General Practitioners and other medical/clinical staff must have an awareness of the communication needs of their patients and this must be shared when the referral is made.

These needs should have been discussed with the patient at the initial consultation when the 'decision to refer' is made. Referrals from any source should indicate whether the patient has communication needs, i.e., requires an interpreter of any kind, requires letters in an alternative language or format, i.e., large print, braille etc.

Referral letters/requests content must be clear and concise stating the clinical priority, reason for referral or request.

The Trust aims to triage all non-cancer referrals within 5 days of receipt.

Prior to making a formal referral, GP's may choose to use the Advice and Guidance service, for example, asking another clinician/specialist for their advice on a treatment plan and/or the ongoing management of a patient or seek advice on the appropriateness of a referral for their patient

A request for advice and guidance will not start an RTT pathway/clock.

4.5.1 E Referral Processes

The NHS e-Referral Service (e-RS) is an electronic referral-support tool, designed to make it easy for GPs to manage patients who may need referral for onward care. It is being used by GP practices in England, with referrals into both consultant-led out-patient clinics and non-consultant-led services, such as community, diagnostic or assessment services.

The NHS e-RS has two elements: Directly Bookable Services (DBS) and Indirectly Bookable Services (IBS).

- **Directly Bookable**

Under a directly bookable service the GP or their patient can book a first outpatient appointment with the clinician/hospital of their choice.

- **Indirect Bookable Services**

The patient is first booked into a Referral Assessment Service (RAS) by the GP. This RAS will assess the patient's referral before an appointment is made. RAS's are designed to ensure the patient is directed efficiently and effectively into the most appropriate care pathway.

There are several outcomes to an e-RS referral

- **Accept**
  This is the usual outcome if a referral is clinically appropriate for the service to which it has been booked.

- **Re-direct**
  If, having read the clinical referral information, a provider clinician feels that an alternative service would be clinically more appropriate for a patient, then, rather than rejecting the referral (see below), the preferred course of action would be to re-direct it to a clinically more suitable service. This will be managed by the provider within e-RS.

- **Cancel**
  If a provider (such as a hospital or community trust) is unable to book an appointment for a patient within e-RS, or the booked clinic/appointment subsequently becomes unavailable, then the appointment and/or referral may be cancelled within e-RS. If this happens then the provider organisation will have added a reason in e-RS, which the referring practice will be able to view from their worklists. Responsibility for dealing with a provider cancellation rests with the provide

- **Advise referrer**
  This is one of the options that may result if a triage/assessment request has been made and the provider clinician has sent advice back to the referring practice to support the onward management of the patient. These referrals will appear on the Referrer Action Required worklist, from where the referring practice can see the advice supplied and act accordingly.

- **Reject**
  This option should only be used occasionally when, for clinical reasons, and after the receiving clinician has assessed the referral information provided by the GP, it is felt that the patient could be managed more effectively by alternative methods and without a prior ‘face to face’ appointment.

  Comments will always be added by the provider clinician to help advise on managing the patient, as well as, potentially, providing useful information to assist future referrals into that service. Responsibility for acting on the rejection advice rests with the referrer, in the same way that they have always been responsible for acting on any advice sent to them as a consequence of a written referral.

The RTT clock will start at the point the referral is received into the E Referral System.

4.5.2 Suspected Cancer Referrals

The NHS requires that “suspected cancer patients” or “breast symptomatic” patients will be seen by a nominated Consultant or relevant member of the clinical team and be informed of their diagnosis within 28 days. The GP must ensure the referral is received by the Trust within 24 hours of the patient seeing their GP.

There are local agreed procedures for ensuring a suspected cancer referral is made within agreed timescales and using agreed proforma’s and that these referrals are actioned in a timely manner.

GP’s should ensure their patients are able to attend an appointment within the following 2 weeks. If a patient is unavailable, GP’s and GDP’s should consider whether it is appropriate to defer the referral until such time that their patient can attend an out-patient appointment within 2 weeks of being referred.

Patients referred with suspected cancer should be made aware of the reason for their referral, the importance of attending an urgent appointment and be given a copy of the patient leaflet “Your Fast Track Appointment”, to help prepare patients for what to expect after their suspected cancer referral.

If difficulty in meeting the booking guidelines is encountered, this must be escalated through the relevant Speciality Business Manager and Clinical Business Manager for action and resolution. The Cancer Performance Manager must also be kept informed.

Only GPs can downgrade referrals from a suspected cancer pathway. Where a consultant believes that a referral does not meet the criteria for a suspected cancer referral prior to first appointment, the consultant must discuss the referral with the referring GP and the GP must agree to down grade the referral.

4.5.3 Tertiary/Inter Provider Referrals

Patients may be transferred from the Trust to another provider or may be transferred into the Trust from another provider. For all such transfers an inter-provider Minimum Data Set (MDS) must accompany the transfer. This pro forma will include all RTT clock information. The purpose of the MDS is to ensure that the administrative RTT data required to enable the receiving provider to report on the patient pathway is transferred from the referring provider to the receiving provider when responsibility for a patient’s care has transferred.

All referrals into the Trust from another provider should be received with an MDS form as described above. The referral date on this form will be the referral received date recorded on the QMED patient record. If the MDS form is not received the recorded referral received date will be the date the referral is received by The Trust.

Referrals from another Trust can only by rejected on clinical grounds, and the decision to reject a tertiary referral must not be made on the basis of RTT timeframes and targets.

4.5.4 Consultant to Consultant Referrals (within LTHTR)

The Trust has strict criteria for consultant-to-consultant referrals (CI referrals) and these are outlined below:

Approved consultant-initiated referrals

- Urgent referrals (life threatening, or suspected cancer).
- Routine LTH same condition only (Internal referrals within the same specialty relating directly to the original reason for referral, i.e., patient has associated symptoms).
- Routine Other NHS providers when referred on as a tertiary referral for complexity on an agreed pathway.
- A&E referrals - Trauma only for a symptomatic condition directly related to presentation at A&E (Patient reviewed via emergency department and referred on to a specialty as a direct result of their presentation at A&E when further intervention or significant specialist dressings are expected).
- GP referrals from Defence Medical Services.
- Midwife referrals (Antenatal referrals only related to the pregnancy).

Should a patient be referred to another consultant within LTHTR for the same condition where the patient has not received first definitive treatment the relevant clock will continue (Cancer Pathway/RTT).

The onward referral must contain relevant information about the original clock start date and its current cancer 62 days/18-week status.

Not approved consultant-initiated referrals

- Routine LTH consultants where referrals for secondary condition or where referral is only loosely associated with original problem or referrals to the wrong clinical team.
- Routine other NHS provider (unless referred on as a tertiary referral for complexity on an agreed pathway).
- Private patients should go back to GP for further discussion regarding onward treatment (This is in line with the Trust agreement with the CCG which requires referrals from private providers to go back to their GP prior to being referred to the Trust).
- Any referred source where it is a different condition.
- Bilateral procedures should be sent back to the GP for re referral for second procedure (unless there is an agreed, specified pathway for this, for example, bilateral cataract procedures).

4.5.5 Referrals from a direct to test diagnostic

Where a patient has had a direct to test diagnostic the clinician undertaking the test will determine the nature of the condition and where urgent, will make the appropriate onward referral and notify the GP accordingly.

Non-urgent conditions will be reported to the GP for further management/referral.

4.6 OUTPATIENT APPOINTMENTS (NON-ADMITTED PATHWAY)

4.6.1 General Appointment Principles

Reasonable notice
A reasonable offer for an outpatient appointment is an offer of a time and date three or more weeks from the time the offer was made. All patients must have an opportunity to negotiate their appointment time and date. If a patient declines the initial reasonable offer, a second appointment will be offered.

Should a patient refuse a second reasonable offer of an appointment, the patient may be discharged back to their GP, and any patient declining a second or subsequent appointment must be advised of this. This decision is a clinical one, and the clinician must indicate whether a decision to discharge has been made.

All patients with suspected cancer, TIA's, breast symptoms or new exertional chest pain must be seen in outpatients within 2 weeks of referral by their GP or GDP (General Dental Practitioner). Due to the urgency of these cases, patients who have a new appointment scheduled under these referral pathways will be required to accept any appointment date.

Patients Choice
All patients are entitled to negotiate a first appointment, however there is an acceptance that patient's choosing to delay their treatment for a prolonged period (more than 6 weeks) may be discharged back to their GP or removed from an outpatient waiting list until they are available to attend an appointment.

At the time the decision is made to discharge back to GP or to remove a patient from an Outpatient Waiting List, this must be communicated to the patient and to the GP. If a patient is removed from the Outpatient Waiting List but is not discharged back to the GP, it is the responsibility of the relevant service to ensure that the patient is contacted when they do become available to arrange a further appointment.

LTHTR offers a variety of outpatient clinics at both the RPH and CDH sites, as well as across the region at other hospitals and clinics.

Whilst every effort will be made to accommodate a patient at their location of choice, should the patient not accept an appointment at one of the offered locations this will be deemed to be a refusal of a reasonable appointment.

Outpatient appointments are not always a face-to-face appointment and an appointment via telephone or video may be more clinically appropriate than a face to face one.

Patients do not have the right to choose an "in person" or "face-to-face" appointment as part of the care pathway over a telephone or non-contact approach where this is

clinically appropriate, however this should be explained to the patient to avoid misunderstanding.

4.6.2 DNA protocols for outpatient appointments

All patients that DNA their appointment will be recorded as DNA on Qmed and on the clinic outcome form. The clinician must indicate if they require a further appointment booking for the patient. This will be determined by a clinical review of the patient (patient history/record/referral). Patients must not be automatically discharged back to the care of their referrer/GP without the care professional's authorisation being documented in the patient record.

4.6.3 Cancelling, declining, or delaying appointment offers (patients)

A patient who cancels their appointment before the time and date of the appointment should not be penalised. Wherever possible another appointment should be arranged with the patient at the point the original appointment is cancelled. If a patient cancels, rearranges or postpones their appointment, this has no effect on the RTT clock, which should continue to tick.

RTT Guidelines indicate that-

> "Patients should not be discharged back to their GP simply because they have cancelled or rearranged appointments; referral back to the GP should always be a clinical decision, based on the individual patient's best clinical interest."

Patients who cancel or refuse two consecutive new and/or follow-up outpatient appointments (including pre-operative assessment appointments) will not be routinely offered a further appointment.

The patient's case should be referred to the owning consultant for review and a decision made as to whether the patient should be discharged back to the care of their GP within 5 working days.

If a decision is made to discharge the patient back to the care of their GP, the consultant must write to the patient and the GP notifying them of this decision for safety and RTT audit purposes.

Suspected Cancer Appointments

Where a patient has been referred on a suspected cancer pathway they should not be re-referred to their GP (GMP, GDP or Optometrist) because they are unable to accept an appointment within 2 weeks. If a patient declines an offer within a 2-week period, a further appointment will be offered within the next 2 weeks.

If a patient cancels a pre-agreed appointment or DNA's an appointment, they should not be referred back to the GP. Patients should only be referred to their GP after multiple (two or more) DNAs but not after multiple appointment cancellations unless this has been agreed with the patient – by cancelling an appointment a patient has shown a willingness to engage with the NHS.

Cancelling, declining, or delaying appointment and admission offers due to COVID

Patients have previously been recorded as P5 or P6 priority patients if they have cancelled or declined appointments or admissions due to COVID however, these P codes no longer valid and have been removed from PTL categorisation.

4.6.4 Hospital initiated cancellations

The Trust should always mitigate against cancelling any outpatient appointment, and no patient should have their outpatient appointment cancelled on more than one occasion.

A minimum of six weeks' notice of annual or study leave is required for clinic cancellation or reduction/appointment time changes

Repeated and consistent hospital-initiated cancellations may indicate a need for clinic template review, e.g., weekly cancellation of patients to accommodate post-MDT cancer patients or post-operative ward discharges. In these instances, the situation should be escalated to the appropriate Clinical Business Manager for the service so they can set aside specific capacity for this purpose to minimise the impact on patient care and poor patient experience.

4.6.5 Patients who do not wish to attend

Patients who decide that they no longer wish to attend any appointment will be discharged back to their GP and the referral closed. If the patient was referred on a 2ww the GP should be made aware of the patient's decision not to attend any subsequent appointments. The patient is then discharged, and the referral closed.

4.6.6 Late arrival at an outpatient clinic

If a patient is less than 15 minutes late for a clinic appointment, the patient will usually still be seen in clinic, however if the patient appointment is in the last 30 minutes of the clinic, the clinician should be informed of their arrival as soon as possible to decide as to whether the patient can be seen or not.

If a patient's late arrival in clinic will delay their appointment, they should be informed of the likely wait time to be seen.

4.6.7 Follow up Appointments

Should a further out-patient review be considered necessary, the reasons must be clearly documented in the patient record. All Inpatient and Outpatient letters must clearly state the reason for the follow-up. Where no follow up is clinically required patients should be told why no follow up will occur, and that the reason is that this is clinically appropriate practice for the condition.

In some circumstances it may be appropriate to discuss outcomes and care management with the patient or their relative/carer but a face-to-face consultation may not be warranted. In these instances, alternatives to an outpatient appointment should be considered, for example a telephone follow up may be appropriate.

In relation to DNA or cancelled follow up appointments, the same principles as described for new appointments should be followed, considering, patient choice and clinical decision making.

Reporting Diagnostic Results
Results must be reported in sufficient time to allow progress through all stages of the RTT pathway and in line with internal targets.

4.6.8 Patient Initiated Follow-up

Where a patient has a condition that still requires infrequent monitoring by acute services, it is sometimes clinically appropriate for the patient to be placed on a Patient Initiated Follow-up list (PIFU). Through this process, patients can self-request a follow-up appointment when they have an exacerbation of their condition. These patients will not be formally discharged from the service and will be placed on an appropriate access plan that identifies them as for PIFU.

There is a Trust wide Standard Operating Procedure that has more information regarding PIFU pathways and processes Implementing Patient Initiated Follow Up (PIFU) appointments. Version 1.

4.6.9 RTT Outcomes

A clinic outcome form must be provided for all outpatient appointments. These may be paper or digital outcome forms.
It is the clinician's responsibility to complete the form with the correct outcome and the appropriate 18-week pathway status for all patients.

There may be instances where RTT decisions are made outside of a clinic or admission setting, e.g. a clinician reviews test results outside the Outpatient setting with the intention of informing the patient and their General Practitioner of the outcome e.g. results normal and discharged; requires follow up to discuss results. Where this happens, it is essential that this outcome is documented in a letter to the patient and/or GP. The RRT Validation & Assurance Team will then use this information to update the RTT pathways outside of the usual clinic appointment process.

4.6.10 Results Review

Where a patient has been seen in clinic and sent for diagnostic tests, the patient should only be brought back to clinic if necessary. If the patient does not require a further appointment, a letter must be dictated to the patient and their GP informing them of the results of the diagnostic tests and the next steps. If at this point the patient is discharged, the GP is requested to give medication or the patient is to be actively monitored, then the RTT Clock can stop on the date the letter was sent to the patient informing them of the decision

4.6.11 Patient Correspondence

According to the NHS Plan 2000 consultants/clinicians are required to ask patients if they would like to receive copies of correspondence written about them to another professional relating to their medical problem. Frequently this correspondence is from a consultant/clinician back to the referring GP.

Guidelines pertaining to the content and set out of letters is available on the DoH website:
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4086054.pdf

4.7. ELECTIVE ADMISSIONS

It is the responsibility of clinicians and management teams to undertake regular review of all waiting lists to ensure that patient safety standards of care are not compromised, patients are managed in line with national waiting time standards, Trust data quality is of the required standard and that patients meet the criteria for being on to the waiting list.

It is the responsibility of the Trust and of all staff to ensure that this policy is implemented in a fair and consistent manner to ensure that no equality target groups are discriminated against or disadvantaged by the implementation of these Waiting List procedures.

4.7.1 Pre-Op Procedures

Pre-operative assessment is used to determine a patient's fitness for surgery and anaesthesia. Pre-operative assessments should be carried out as soon as possible after the decision to admit preferably on the day of the decision to admit. If a pre-op assessment on the decision to admit day is not possible, patients must still be added to the waiting list without delay following the decision to admit.

Where this is not possible, and the patients are listed for surgery prior to any of the above assessments or tests a delay in any of these will not affect the patient RTT clock and the patient will remain on the RTT pathway.

Pre-Op DNA's
Patients who DNA a pre-op appointment will not routinely be discharged back to their GP. Any failure to attend a pre-op appointment must be reported back to the Booking Team and the clinician responsible for the patient care.

A clinical decision is required to determine if another date should be offered or if the patient should be removed from the waiting list. This decision must be recorded in the patient record.

4.7.2 Patients deemed unfit

If a patient is identified as unfit for a listed procedure, the nature and duration of the clinical issue should be documented in the patient record and the waiting list team, and lead consultant informed of this.

If the clinical issue is short term, i.e., cough, cold, UTI, the RTT clock will continue.

In terms of identifying what constitutes "short term", 3 weeks is deemed to be the maximum period for a short-term delay

However, if the clinical issue is more serious and the patient requires treatment or intervention, clinicians should inform the booking team to remove the patient from the waiting list.

If the decision to remove a patient from the waiting list is made, this will stop the RTT clock, either as a period of active monitoring, or a discharge back to the GP.

When the patient becomes fit and ready to be treated for the original condition, a new RTT clock will start on the day this decision is made and communicated back to the patient.

4.7.3 Adding patients to a waiting list/decision to admit

A patient should only be added to the waiting list if they are ready, willing, and available for admission within 12 weeks of the day the decision to admit is made. Patients who do not want treatment, i.e., have not actively consented to the treatment, and/or are unfit for surgery, or will not be available for surgery within 12 weeks, must not be added to the waiting list.

Patients are entitled to a period of “thinking time” following a clinical recommendation to list for surgery and have the right to delay treatment whilst they do this. The Trust has a responsibility to these patients to ensure that they are aware of any clinical implications to prolonged delay of treatment.

If the patient thinking time is only likely to be for a period of days or weeks, it is not appropriate to stop their RTT clock. It may be appropriate for the patient to be actively monitored (and the RTT clock stopped) if the patient declares that it may be a matter of months before a decision is made. The decision to stop the clock for active monitoring needs to be a clinical one and with the best interests of the patient considered.

Where a period of active monitoring is applied to allow patients thinking time, a follow up appointment must be arranged with the patient around the time the patient feels they will be able to decide.

A new RTT clock would then start from the date of the decision to proceed with surgery.

Patients who are not available/unfit for surgery as identified above may continue to be monitored in an outpatient setting, and a period of active monitoring commenced, or alternatively, and if more appropriate, should be referred back to the GP with advice on re-referral once available/fit for surgery.

Both a discharge back to the GP or the start of a period of active monitoring would stop the RTT clock.

If a patient becomes fit for surgery within 3 months of being returned to their GP, they can be reinstated onto the waiting list on receipt of the GP's written request to the consultant. The consultant can then decide whether to reinstate them to the waiting list or complete a review in outpatients before placing them on the waiting list.

A new RTT clock will start on the date the GPs request letter was received within the Trust.

Patients who are referred for surgery more than 3 months after they were referred back to their GP will need to be reviewed in an outpatient clinic first unless the consultant makes a clinical judgement to directly list. This direct listing will commence a new clock start.

Patients with a procedure which requires prior approval from the CCG should not be listed until this prior approval has been obtained. Whilst this decision is being made, the RTT clock will continue.

4.7.4 Booking a TCI date

Whilst all patient cases are reviewed on an individual basis, there is an agreed criterion for booking patients to come in for a procedure. Clinically urgent patients will be prioritised according to need and all routine elective patients must be managed chronologically in order of RTT waiting time. War pensioners and service personnel injured in conflict must receive priority treatment if the condition is directly attributable to injuries sustained in conflict.

A patient should always be given the opportunity to negotiate their admission date and agree this prior to the booking being made. A reasonable offer for a TCI date is one with at least 3 weeks' notice. There are no blanket rules that are applied to patients who initiate a delay in their treatment.

Whilst all patient pathways are different and blanket rules cannot be applied, NHSE guidance allows for a watchful wait to be applied to a patient who has chosen to reject and delay two reasonable offers of a TCI date. These patients should be recorded with a C code which indicates a patient choice to delay treatment and a watchful wait has been applied. In line with this guidance this watchful wait should be for a period of no more than 12 weeks. At the end of this agreed period, the patient should be contacted to ascertain if they are now available for a TCI and the RTT pathway will restart.

Following a period of watchful wait, the RTT pathway will re-start, however the Trust must have the ability to identify these patients and book in order of original decision to admit date/priority.

Where a patient chooses to delay their treatment, clinical advice must be sought as to whether the requested delay is acceptable or if the patient should be discharged back to the GP for re-referral once they are available.

Should a patient refuse more than 2 offers of a reasonable date (with a minimum of 3 weeks' notice), the patient must be advised that repeated refusals of a reasonable TCI date may result in them being removed from the elective waiting list and referred to their GP.

The clinician should talk through the clinical implications of delay with the patient to enable the patient to decide to either agree to come in sooner or to continue to wait – the consultant can discuss with the patient referring back to GP if they choose to continue with the delay. If the clinician is satisfied that the proposed delay is appropriate then the delay is allowed, regardless of the length of wait reported.

If the clinician is not satisfied that the proposed delay is appropriate, then the clinical risks should be clearly communicated to the patient and a clinically appropriate TCI date agreed.

If the patient refuses to accept the advice of the clinician, then the responsible clinician must act in the best interest of the patient. If the clinician feels that it is in the best clinical interest of the patient to discharge the patient back to the care of their GP and inform them that treatment is not progressing, then this must be made clear to the patient. This must be a clinical decision, taking the healthcare needs of each individual patient into account.

It is not acceptable to refer patients back to their GP simply because they wish to delay their appointment or treatment. However, it would be acceptable where referring patients back to their GP is in their best clinical interests. Such decisions should be made by the treating clinician on a case-by-case basis.

If a patient cannot be contacted to arrange and agree a TCI date (patients will be contacted by telephone on two separate days to arrange an admission) a Ring In Letter (RIL) will be sent to the patient asking them to contact the Waiting List Booking Team to arrange an admission date or offering them an admission date. The letter will advise the patient that they must make contact within 14 days of the letter being sent. If no contact is made the patient may be discharged back to their GP following a clinical review of the patient

4.7.5 Offering the patient a private provider TCI

Depending upon the procedure listed for and Trust waiting times, patients may be contacted by the Trust to be offered the option of being treated at a subcontracted private provider. The patient will be informed of the hospital choices and the surgeons carrying out the operation at the time of contact to ensure they are able to make a fully informed decision as to whether to accept this transfer.

If agreeable, the patient will be transferred to the private provider who will assume responsibility for arranging the treatment date. The Trust will maintain responsibility for ensuring compliance against the Referral to Treatment thresholds and will retain responsibility for all waiting list declarations. Patients will not be removed from the Trust waiting list until treatment has been completed and confirmed via the tracker.

If the patient chooses not to accept the offer of a transfer to a private provider, they must remain on the Trust RTT pathway. Refusal of an offer to a private provider does not constitute a refusal of a reasonable offer and the patient must not be penalised for refusing the offer to transfer.

4.7.6 Removing patients from an elective list

Patients unfit for surgery
If a patient on an elective waiting list becomes unfit for surgery (either through the pre-op processes or by the patient informing us of this), they must be removed from the elective waiting list. A clinical review of the patient must be undertaken (if the decision is not made during a pre-operative assessment) before the patient is removed from the waiting list. An alternative to the elective surgery must be agreed and documented in the patient record. This alternative option will determine the RTT clock.

Patients declining surgery
Patients may ask to be removed from an elective waiting list for several reasons. If a patient asks to be removed from a waiting list, this decision must be reviewed by an appropriate clinician to ensure that a decision made by the patient not to proceed with surgery is not an unsafe one.

This clinical review will then determine whether the patient is to be removed from the waiting list.

4.7.7 Cancellation of elective admission

Cancelled by patient
Patients should not be penalised for cancelling an elective admission with notice to the hospital.

There may be however, clinical risks to repeated cancellations of a TCI. To ensure that appropriate clinical review takes place for patients who cancel an agreed TCI date, any patient that cancels two subsequent agreed TCI dates should be escalated to the clinical team for review. This will allow the clinician the opportunity to assess the impact of the patient delaying their procedure. Patients who cancel two or more TCIs should be advised that repeated cancellations may result in the patient being discharged back to the care of their GP.

Repeated cancellations of procedures for vulnerable adults or children, should be managed as above, with additional reference made to the points previously described in **Section 4.2.10**

Cancelled by provider
Patients should only have their agreed admission cancelled under exceptional circumstances. Pre-Operative assessment must ensure that everything that needs to be done before the patient's operation has been done (kit ordered, bloods taken, post-op arrangements discussed, etc.). If an admission is cancelled at short notice, telephone calls and first-class mail should be used to ensure the patient is given as much notice as possible.

Cancelled on day (by provider)
National RTT guidelines require that a patient who has an elective admission cancelled on the day of procedure must be offered a new admission appointment within 28 days of the original cancelled TCI date. Wherever possible this new date should be offered to the patient at the point of cancellation.

Where LTHTR cannot offer another date within 28 days of the cancellation the patient should be offered the choice to have the procedure carried out in the private sector.

4.7.8 Date of admission

On the date of admission for treatment the clock stops on the 18-week RTT pathway (assuming treatment is received).

4.7.9 Failure to attend (DNA)

Like the DNA process for an outpatient appointment, there is no blanket DNA policy for patients who fail to attend their date for an elective admission. All DNA appointments will be reviewed on a patient-by-patient basis, and an appropriate clinical decision made as to whether a further date should be offered, or whether the patient should be discharged back to their GP.

Should a cancer patient DNA an elective admission, the patient should be contacted as soon as possible (with support from the Cancer Nurse Specialist (CNS) if needed) and another appointment made if clinically appropriate.

4.8. PLANNED ADMISSIONS

Patients on planned waiting lists are outside the scope of 18 weeks.

Planned procedures are part of an agreed programme of care that for clinical reasons needs to be carried out at a specific time or repeated at a specific frequency, for example; as part of planned sequence of treatments or investigations, e.g. check cystoscopy, OR where the procedure has to be performed at a set point linked to a clinical criteria, e.g. where a child needs to be 4 years old before a procedure can be performed OR where the date of admission is determined by the needs of the treatment, e.g. a child needs to be 4 years old/certain size before a procedure can be performed.

Planned lists may include:

- Patients who require periodic review as an inpatient/day-case for an ongoing condition to be monitored (e.g., surveillance gastroscopy, colonoscopy, cystoscopy etc.).
- Patients for whom the clinical team may request that a period elapse following initial treatment before any subsequent treatment is undertaken (e.g., a Trauma & Orthopaedic surgeon may request that metalwork inserted to support healing of a fracture is only to be removed after a certain period of time).
- Patients undergoing a series of treatments (e.g., a patient may attend for a course of pain-relieving injections on a 3-monthly basis).

All patients on the planned list must have an ‘expected date of admission’ which should not be exceeded.

When patients on planned lists are clinically ready for their care to commence and reach the date for their planned appointment, they should either receive that appointment or be transferred to an active waiting list and a waiting time clock should start

The key principle is that where patients’ treatment can be started immediately then they should start treatment or be added to an active waiting list.

National guidelines indicate that where a patient planned date has passed, they should be transferred to an elective waiting list and an RTT clock will start.

The agreed process within the Trust for patients on an RTT admitted pathway, is once a patient on a planned waiting list has waited more than 6 weeks past their clinical review date, they will be reviewed, and a decision made regarding remaining on the planned list or moved to an elective waiting list. Should a patient transfer to an elective waiting list, an RTT clock will commence.

In December 2023 the national Diagnostics Board meeting (NHS England) outlined the expectation of all Trusts to include diagnostic surveillance patients on the active DM01 waiting list, once their surveillance test or procedure is overdue.

When patients on planned or surveillance lists are clinically ready for their test to comments and reach the date for a planned appointment, they should either receive that appointment or be transferred to an active waiting list and a waiting time clock will start and be reported in the DM01 return.

The planned waiting list must not be used to hold patients who wish to defer surgery, are unable to have surgery due to underlying medical conditions and/or due to service capacity issues.

4.9 Diagnostic Tests

4.9.1 Diagnostic waiting time clock starts and stops

The diagnostic clock starts at the point of the decision to refer for a diagnostic test by either the GP or consultant (day 0).
The diagnostic clock stops at the point the patient has their diagnostic test performed.

All patients waiting for a diagnostic test should be captured on an active diagnostic waiting list (known as DM01), regardless of whether the patient has an RTT clock running or have commenced treatment. The only exception to this is planned patients.

DM01 applicable diagnostic tests:

i. Imaging – Magnetic Resonance Imaging
ii. Imaging – Computed Tomography
iii. Imaging – Non-obstetric Ultrasound
iv. Imaging – DEXA Scan
v. Imaging – Barium Enema and Barium Swallow
vi. Endoscopy – Colonoscopy
vii. Endoscopy – Flexi-Sigmoidoscopy
viii. Endoscopy – Cystoscopy
ix. Endoscopy – Gastroscopy
x. Physiological Sciences – Audiology Assessments
xi. Physiological Sciences – Echocardiography
xii. Physiological Sciences – Electrophysiology
xiii. Physiological Sciences – Peripheral Neurophysiology
xiv. Physiological Sciences – Urodynamics – Pressures and Flows
xv. Physiological Sciences – Sleep Studies

Where a patient is referred to another provider for a diagnostic test, the referring Trust will continue to report the waiting time performance for the patient into the DM01 and WLMDS, if the Trust is retaining overall responsibility for the patient care.

The importance of timely access to diagnostics and their reporting is a key element to ensuring that patients are not made to wait unnecessarily for treatment within 18 weeks.

4.9.2 Management of patients waiting for a diagnostic test

Diagnostic requests will be registered and allocated to the designated area within 24 hours of receipt. It is essential that the date of receipt of request is registered to ensure that correct access times can be calculated and audited

Any inappropriate (service not provided by the hospital) or unjustified diagnostic requests (radiation standards) will be returned to the referral source with an explanation of the criteria for rejection

4.9.3 Booking a diagnostic appointment

Patients will be offered their diagnostic appointment. It is best practice to offer an appointment by telephone and communicate confirmation of the appointment via letter to the patient.

If a patient cancels or DNA's an appointment for their diagnostic test which fulfils the reasonableness criteria (this will primarily be determined by the type of appointment), then the diagnostic waiting time is set to zero and the waiting time starts again from the date of the appointment that the patient either cancelled or missed.

If a patient turns down a reasonable appointment, then the diagnostic waiting time can be set to zero from the first date offered.

Patients will still be dated in chronological decision to admit date.

Resetting the diagnostic clock start has no effect on the patients' RTT clock. The RTT clock continues to tick from the original clock start date and patients should be offered the next available appointment.

4.9.4 Patient DNA Diagnostic Appointments Process

1. Patient fails to attend an agreed diagnostic appointment.
2. The Scheduling Team will send a 14-day letter to the patient advising them to contact the Scheduling Team to re-book an appointment.
3. Should the patient contact the Trust within 14 days of the DNA requesting to be rebooked, the patient will be rebooked retaining their revised clock start date.
4. If the patient does not respond to the 14-day letter, an email will be sent to the responsible clinician for authorisation. Should the clinician authorise the discharge, the referring clinician will send a letter to both the patient and GP. The diagnostic clock will stop.
5. Following clinical review, if the clinician does not agree to discharge the patient a further diagnostic test will be rebooked retaining their revised RTT clock start date. The referring clinician must inform the scheduling team of the need to re-date the patient.

Suspected cancer patients and paediatric patients who fail to attend a diagnostic appointment will be offered one further appointment. For these patients, the diagnostic 6-week pathway will be re-started (from the date of the missed appointment).

If these patients subsequently fail to attend two appointments the process outlined above should be followed.

4.9.5 Patient cancellation/no longer require diagnostic appointment

All patients must be informed at the time of the first cancellation that should they cancel the rescheduled diagnostic test again, it is likely they will be discharged. If the patient chooses to cancel their appointment, for example as they are on holiday, but still wishes to be seen, this will be documented on the booking system by the scheduling team.

1. Patient calls to cancel an agreed diagnostic appointment.
2. Patient must be informed at the time of the first cancellation that should they cancel the rescheduled diagnostic test again, it is likely they will be discharged.
3. Should a patient contact the Trust on a second consecutive occasion to cancel their diagnostic test, an email will be sent to the responsible clinician for review.
4. Should the clinician authorise the discharge letter, clinician will inform both the patient and the GP and the diagnostic clock stopped.
5. Following clinical review, if the clinician does not agree to discharge the patient a further diagnostic test will be rebooked retaining their revised RTT clock start date. The clinician must make the scheduling team aware of this decision and instruction to rebook.

4.9.6 Hospital Cancelled Diagnostic Appointments

Only in exceptional circumstances should the Trust cancel a patient appointment. Whilst every effort is made to agree an appointment with the patient prior to this being booked, there will be occasions when the patient will cancel a previously agreed date. Every effort will be made to accommodate a cancellation request; however multiple cancellations may result in the patient being discharged to the clinical referrer. If this happens the patient and referring clinician must be advised.

For patients where their appointment has been cancelled by the hospital, the diagnostic clock will continue.

4.10. CANCER PATHWAY INFORMATION

Cancer waiting times (CWT) measure the NHS' performance against these national NHS Constitution Standards, as well as several other metrics. These measures are used by local and national organisations to monitor the timely delivery of services to patients.

Appendix 02 outlines these targets in detail.

4.10.1 Faster diagnosis guide

Faster diagnosis clock start
The start point is the receipt of the referral by the provider who will first see the patient.
Referrals received after a working day has finished should have the start date set as the date that the referral was received and not the next working day.

Commissioners, referrers, and providers will work together to ensure processes are in place to ensure all necessary information is sent with a referral, but it is inappropriate to pause the clock pending further information given the patients expectation will be that a referral has been made.

Patients who Do Not Attend (DNA) a first outpatient appointment
All patients referred as suspected cancer including screening, upgrade, and breast symptomatic who DNA their first outpatient appointment should be offered an alternative date within 14 days of the DNA.

Patients should not be referred to their GP after a single DNA. Patients should only be referred to their GP after multiple DNAs following a clinical decision to do so.

A patient may be deemed to DNA a first appointment if a patient does not attend for the allocated appointment time and gives no notice. If the patient turns up in a condition where it is not possible to carry out the required procedure (e.g. if they have not taken a preparation they needed to take prior to the appointment), this should also be recorded as DNA.

If the patient arrives after the scheduled appointment time and it is not possible to fit them in (e.g., fully booked) or there is not enough time left to carry out the planned procedure/tests in the remainder of the session, then this is classed as a DNA.

If a patient does DNA a first appointment, the clock can be reset from the receipt of the referral to the date upon which either the patient makes contact to re-book their appointment or the date the appointment is re-booked should the patient not directly contact the relevant department to do so.

Patients who Do Not Attend (DNA) a first diagnostic appointment
An adjustment to the RTT clock start is only possible if a patient does not attend their first attendance. So, where the diagnostic appointment is also the first attendance an adjustment should be applied as described above.

A DNA for a diagnostic appointment cannot be used as an adjustment if it occurs after the first attendance.

Patients who cancel a first outpatient or diagnostic appointment
Patients should never be referred to their GP after an appointment cancellation unless this has been agreed with the patient – by cancelling an appointment a patient has shown a willingness to engage with the NHS

Patient thinking time/availability and reasonable offers
A patient will not be discharged because they are unavailable within a specified timeframe, and processes are in place to ensure patients have the choice to book outside of the two weeks wait timeframe.

The patient will always be encouraged to accept the earliest appointment. It is beneficial for the referrer to reiterate the importance of keeping an appointment once it has been made.

Patients that choose an appointment outside of two weeks do not exempt themselves from the standards.

Faster diagnosis clock stop
The 28-day faster diagnostic pathway ends only at the point of communication with the patient, whether that is to inform them of a diagnosis of cancer, a ruling out, or if they are going to have treatment before a clinical diagnosis of cancer can be made.

Where all reasonable diagnostics to exclude cancer have been completed and the patient is discharged back to their GP, the point at which this is communicated to the patient will be recorded as the end of the 28-day pathway. In such scenarios this should be recorded as a ruling out of cancer.

If a patient on the 28-day pathway cannot be given a formal non-malignant diagnosis and is followed up due to diagnostic uncertainty the patient remains on the 28-day tracking until either a cancer diagnosis is made, or a non-malignant diagnosis is confirmed, and this is communicated to the patient.

Faster diagnosis exclusions
There are some scenarios where a patient may be excluded from a 28-day faster diagnosis pathway.

These are

- Patient died before a communication of diagnosis

- Patient declined all diagnostic appointments - This can only be used where a patient declines all diagnostics appointments and is therefore discharged back to the GPs care or exceptionally when agreed with the patient followed up routinely in secondary care.
  This cannot be used in the scenario where a patient declines or delays one or more diagnostics and the patient, is still followed up urgently in hospital, for example with alternative diagnostics, or the patient asks for time to consider if they would like a diagnostic.
- Patient opted for private diagnostics
- Repeated Did Not Attends (DNAs)/Patient triggered cancellations - This can only be applied following multiple DNAs and patient cancellations where a clinical decision is made to discharge the patient back to the GPs care.
- Patient ineligible for NHS funded care

A treatment status of 'Active Monitoring' or 'Watch and Wait must not be used incorrectly to stop a patient pathway.

A suspected cancer referral will not be downgraded by a consultant without the active consent of the referring practitioner. (If a diagnosis of non-malignancy has been made and the 62-day clock has been stopped, consent from the referring GP is not required).

4.10.2 Upgrades to a cancer pathway

Should a consultant choose to "upgrade" a patient referred as non-urgent onto the 62-day cancer pathway, this must be communicated to the relevant GP/GDP at the earliest opportunity.

4.10.3 Internal suspected cancer referrals

The Trust has a dedicated intranet page that provides details for clinician and administrative teams in the management of internal suspected cancer referrals. This information can be accessed via the link below
https://intranet.lthtr.nhs.uk/internal-2ww-referrals-

4.10.4 Patient Communication

Appointment Booking

At least 2 attempts by telephone should be made to contact a patient to arrange a first appointment. At least one of these calls should be made after 5.00pm. All attempts to contact the patient must be recorded on Flex.

If the patient cannot be contacted, the patients GP should be contacted to see if there are any alternative contact details known for the patient.

Should a patient not be contactable by telephone to arrange a new appointment, a letter should be sent to the patient offering them an appointment within the 2 WW time frames.

Communicating a diagnosis to a patient
All diagnoses of cancers should be made through direct face-to-face communication with the patient, unless otherwise explicitly agreed with the patient.
Reasonable forms of communication with patients to confirm cancer has been ruled out include:

- direct communication with the patient, over phone, Attend Anywhere or similar.
- written communication by letter, or by email
- face to face communication at an outpatient appointment.

Where direct communication is not possible due to the patient not having the mental capacity to understand a diagnosis either temporarily or permanently, communication to the patient's recognised carer or a parent/guardian should be recorded in the same way as if the patient was told directly.
Example where this could apply are: -

- Patients with advanced dementia
- Patient who is unconscious
- A child where they are too young to understand the diagnosis.

This would not be appropriate where it is not possible to contact a patient.

The Trust will ensure that communication is easy to understand, and that support is available to patients who would like further information. An accurate record of all communication as confirmed by the patient will be maintained in the patient record. In the case of direct communication of the diagnosis with the patient either face to face or via phone, Attend Anywhere or similar the date of the conversation will be recorded

4.10.5 Cancer Treatment

Definitive treatment is defined as an intervention intended to manage the patient's disease, condition, or injury and to avoid further intervention. It is a matter of clinical judgement, in consultation with the patient.

For cancer waits a first definitive treatment (FDT) is defined as the start of the treatment aimed at removing or eradicating the cancer completely or at reducing tumour bulk.

The Decision to treat (DTT) date is the date the patient agrees a treatment plan, i.e., the date that a consultation between the patient and the clinician took place and a planned cancer treatment was agreed.

4.10.6 Thinking Time

Where a patient has requested thinking time prior to proceed with a treatment option, the clock will continue to tick. A local period of one week has been agreed as a local monitoring and escalation trigger point to ensure the patient is not 'lost in the system' and is being given the support needed to decide about their treatment.

The patient's clock will continue to tick during this period and must not be paused/adjusted, even if the patient requires longer deciding.

4.10.7 Active Monitoring/Surveillance

This is where a cancer diagnosis has been reached, but it is not appropriate to give any active anti-cancer treatment at that point in time, but an active treatment is still intended/may be required at a future date. The FDS clock will stop on the date the diagnosis is communicated to the patient.
The decision to whether it is appropriate to give a treatment should only consider the diagnosed cancer and not patient thinking time or other medical conditions that the patient has.

A patient would have to agree that they are choosing to be actively monitored for a period rather than receiving active cancer treatment.

If a patient has active anti-cancer treatment planned, but has other comorbidities, because of the cancer, which need to be addressed before the active cancer treatment can commence then active monitoring can be used.

4.10.8 Patient Choice

An adjustment for treatment can be applied if a patient declines a 'reasonable' offer of admission for treatment (for both admitted and non-admitted pathways).

For cancer patients under the 31-day or 62-day standard, the adjustment would be the time between the date of the declined appointment (the offered To Come In date) to the point when the patient could make themselves available for an alternative appointment.

Patients who DNA or cancel a TCI date
If a patient has agreed to a reasonable offer which they subsequently cancel/DNA, no pause is allowed, and the clock continues.

As part of the re-booking process the patient will be offered alternative dates for treatment. If at the re-booking stage the patient declines a reasonable offer of treatment, then an adjustment can be made. The clock is paused from the date of

the earliest reasonable offer given. The end of the pause will be the new date that the patient states they are available from.

Patients who choose to delay treatment

Where a patient makes themselves unavailable for treatment for a set period, then this may mean that offering actual dates which meet the reasonableness criteria would be inappropriate (as the provider would be offering dates that they know the patient cannot attend). In these circumstances the clock can be paused from the date of the earliest reasonable appointment that the provider would have been able to offer that patient.

4.11 MANAGEMENT INFORMATION

The Trust will always be able to demonstrate that the principles outlined in the Access Policy are adhered to and implemented.

4.11.1 Internal assurances

To ensure consistency and the standardisation of reporting with Commissioners and the Department of Health, all waiting lists are to be maintained in the Trusts electronic patient access (Flex) system in compliance with this policy.

Summary information relating to the numbers of patients waiting on an RTT pathway will be reported to the relevant directorates. This information is accessible by a suite of operational management reports available in the Trust Qlikview application.

A separate cancer PTL is available in Qlikview which details all patients on a cancer or suspected cancer pathway.

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.

The Trust will develop an RTT focused e-learning package supported by classroom training sessions when needed. The e-learning will be a requirement for any member of Trust staff who interacts with a patient pathway and includes (but is not exclusive to) clinicians, medical secretaries, booking teams and appointment teams, performance managers and CBM and SBM colleagues.

4.11.2 External Assurances

To ensure consistency and the standardisation of reporting with Commissioners and the Department of Health, all waiting lists are to be maintained in the Trusts electronic patient access (Flex) system in compliance with this policy.

The Trust will ensure that reporting of statutory weekly, monthly and quarterly access information in relation to 18 weeks RTT and diagnostic standards is completed to national deadlines and reported in the appropriate format on Unify.
Each return will be formally signed off by the Head of Performance/Operations Director and the Chief Executive to ensure it is validated and appropriate for use by all statutory bodies.

5. AUDIT AND MONITORING

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report and act on findings.	Group / committee / individual responsible for ensuring that the actions are completed
RTT Compliance	Monthly RTT submission	Business Intelligence	Monthly	RTT Meeting	Various

6. TRAINING

TRAINING Is training required to be given due to the introduction of this policy? No		
Action by	**Action required**	**Implementation Date**

7. DOCUMENT INFORMATION

ATTACHMENTS	
Appendix 1	DNA Protocol for adult patients on an RTT pathway
Appendix 2	National Standards for Cancer Waiting Times
Appendix 3	P codes
Appendix 4	Equality, Diversity & Inclusion Impact Assessment Form

OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	Title and web links from the document library
EBG00757	Management of Theatre Cases during COVID–19 Second Surge and onwards Policy Link
TP 105	LTHTR (2024) Policy for the identification and management of overseas visitors; Version 5. Policy Link
TP 166	LTHTR (2021) Policy for the Management of Children and Young People not brought to Appointments - Was Not Brought (WNB) / Did Not Attend (DNA). Version 2.1. Policy Link

SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS **References in full** checked by library 17/12/2024 ZM	
Number	References
1	National Cancer Waiting Times Monitoring Dataset Guidance (2023) Version 12.0. https://www.england.nhs.uk/wp-content/uploads/2023/08/PRN00654-national-cancer-waiting-times-monitoring-dataset-guidance-v12.pdf
2	*The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012* (No. 2996) http://www.legislation.gov.uk/uksi/2012/2996/pdfs/uksi_20122996_en.pdf
3	Department of Health and Social Care (2023) *NHS visitor and migrant cost recovery programme* https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations/summary-of-changes-made-to-the-way-the-nhs-charges-overseas-visitors-for-nhs-hospital-care
4	NHS England (2021) Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care. https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/05/Recording-and-Reporting-guidance-April_2021.pdf
5	NHS England (2024) *Evidence-based interventions programme* https://www.england.nhs.uk/evidence-based-interventions/
6	Department of Health and Social Care (2023) *NHS Constitution for England*. https://www.gov.uk/government/publications/the-nhs-constitution-for-england
7	Equality Act 2010. (c.15) http://www.legislation.gov.uk/ukpga/2010/15/contents
8	NHS England (2020) Second phase of NHS response to COVID-19 for cancer services https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/06/C0511-second-phase-of-nhs-response-to-covid-19-for-cancer-services-letter.pdf
9	NHS England (2020) Referral to treatment measurement and COVID19. Version 1. https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/03/C0009-RTT-measurement-and-COVID-19.pdf
10	NHS (2020) Specialty guides for patient management during the coronavirus pandemic. Version 2. clinical-guide-to-surgical-prioritisation-during-the-coronavirus-pandemic-version-2-8-june-2020.pdf (rcsed.ac.uk)
11	NHS England (2021) Waiting List Management.

	https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/12/C1449-waiting-list-management-and-prioritisation-letter-december-2021.pdf
12	NHS England (2021) Clinical prioritisation of waiting lists for endoscopy and diagnostic procedures – framework and operational guidance. Version 2. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/05/C1328-clinical-prioritisation-of-waiting-lists-for-endoscopy-and-diagnostic-procedures-guidance_June2021_v2.pdf
13	NHS England (2015) Frequently Asked Questions on completing the "Diagnostic Waiting Times & Activity" monthly data collection.
Bibliography	

DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	Definition
2WW	Two-week wait: the maximum waiting time for a patient's first outpatient appointment or 'straight to test' appointment if they are referred as a 62-day pathway patient
31-day pathway	The starting point for 31-day standard is the date a patient agrees a plan for their treatment or the date that an earliest clinically appropriate date is affected for subsequent treatments
62-day pathway	Any patient referred by a GP with a suspected cancer on a 2WW referral pro-forma, referral from a screening service, a referral from any healthcare professional if for breast symptoms or where a routine referral has been upgraded by a hospital clinician, must begin treatment within 62 days from receipt of referral
Active Monitoring	(Also known as 'watchful waiting') An 18-week clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures. A new 18-week clock would start when a decision to treat is made following a period of active monitoring
Active Waiting List	Patients awaiting elective admission for treatment and are currently available to be called for admission.
Admission	The act of admitting a patient for a day case or inpatient procedure
Admitted Pathways	Patients whose 18-week pathway ends with an elective inpatient admission

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.
CBM	Clinical Business Manager
CCG	Clinical Commissioning Group
Can Not Attend (CNA)	Patients who, on receipt of reasonable offer(s) of admission, notify the hospital that they are unable to attend.
Choose & Book/ERS	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
Consultant-led service	A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse-led clinics which come under the umbrella of consultant-led services
Date Referral Received (DRR)	The date on which a hospital receives a referral letter from a GP. The waiting time for outpatients should be calculated from this date.
Day Cases	Patients who require admission to hospital for treatment and well need the use of a bed but who are not intended to stay in hospital overnight.
Decision to Admit Date (DTA)	The date on which a clinician decides a patient needs to be admitted for an operation/procedure.
Decision to Treat (DTT)	Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatments performed in other settings e.g. as an outpatient
Defence Medical Services	https://www.gov.uk/government/groups/defence-medical-services
Did Not Attend (DNA)	Patients who have been informed of their date of admission or pre-assessment (inpatient/day cases) or appointment date (outpatients) and who without notifying the hospital did not attend for admission/pre-assessment or OP appointment
Elective care	Any pre-scheduled care which doesn't come under the scope of emergency care.
First Definitive Treatment	An intervention intended to manage a patient's condition or injury and avoid further intervention. What constitutes First Definitive Treatment is a matter of clinical judgement, in consultation with others as appropriate, including the patient. A patient's first definitive treatment may not require admission to hospital, e.g. their treatment is advice, prescribed or given in an outpatient setting
GP's	General Practitioners
Hospital Cancellation	Admissions/appointments cancelled by the hospital for either clinical or non-clinical reasons.
Incomplete Pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage

Inpatients	Patients who require admission to hospital for treatment and are intended to remain in hospital for at least one night.
Non-admitted pathway	A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment
Nullified	Where the RTT clock is discounted from any reporting of RTT performance.
Outpatients	Patients referred by a General Practitioner or another health care professional for clinical advice or treatment.
Patient Cancellation	Patients who on receipt of offer(s) of admission/appointment notify the hospital that they are unable to come in on the date offered. Patient cancellations can only be recorded providing that reasonable notice was adhered to or where the patient had previously accepted the offer.
Patient-initiated delay	Where the patient cancels, declines offers or does not attend appointments or admission. This in itself does not the stop the RTT clock. A clinical review must always take place
Planned Admissions/Planned Waiting List	Patients who are to be admitted as a day case or inpatients as part of a planned sequence of treatment or investigations. They may, or may not, have been given a firm date for admission. These patients do not form part of the active waiting list.
Reasonable Notice	For a written appointment or admission offer to a patient to be deemed reasonable, the date offered must be a minimum of three weeks' notice. In addition to the three weeks for a verbal appointment or admission offer to a patient to be deemed reasonable, the patient is to be offered:- -For an inpatient admission – a minimum of two admission dates -For an outpatient appointment – an appointment on a minimum of two different dates When a patient accepts an admission/appointment date with less than 3 weeks' notice via the booking centres the reasonable notice rule is no longer applicable.
Referral to Treatment (RTT)	Instead of focusing upon a single point of treatment (such as outpatients, diagnostic or inpatients) the 18-week pathway addresses the whole patient pathway from referral to the start of treatment.
Ring in Letter (RIL)	This is a letter sent to the patient by the Trust requesting the patient to ring the Trust to discuss or confirm their appointment/admission date
SBM	Speciality Business Manager
Tertiary referrals	Tertiary referrals received from a primary or secondary health professional, usually from outside of the local catchment area
TCI (To Come In) date	The offer of admission, or TCI date, is a formal offer in writing of a date of admission. A telephone offer of admission should not normally be recorded as a formal

	offer. Usually telephoned offers are confirmed by a formal written offer.
The Trust (LTHTR)	Lancashire Teaching Hospital NHS Trust

CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	Job Title	Date Consulted
LTHTR Clinical Business Managers	Clinical Business Managers	
LTHTR Speciality Business Managers	Speciality Business Managers	

DISTRIBUTION PLAN	
Dissemination lead:	Angela Lewthwaite
Previous document already being used?	Yes
If yes, in what format and where?	Electronic, heritage library system, hard copy
Proposed action to retrieve out-of-date copies of the document:	Knowledge and library to replace with updated version. Any paper copies to be removed and placed in confidential waste.
To be disseminated to:	Trust wide
Document Library	
Proposed actions to communicate the document contents to staff:	Include in the LTHTR weekly Procedural documents communication– New documents uploaded to the Document Library

Appendix 01
DNA Protocol for adult patients on an RTT pathway

Type of appointment/episode	Actions	RTT and Clock Status
First new outpatient appointment 1st DNA	Patient should be offered a further appointment	RTT pathway is nullified RTT clock is nullified and new clock starts at the date the new appointment is requested (if no patient contact) or agreed with patient
First new outpatient appointment Subsequent DNA	Clinical decision to be made. 2 options available to clinician. 1. Patient can be discharged back to their GP if deemed safe to do so 2. A further appointment can be offered.	 As above As above
Follow up outpatient appointment 1st DNA	Patient should be offered a further appointment	If clock is still ticking on pathway, this will continue.
Follow up outpatient appointment Subsequent DNA	Clinical decision to be made. 2 options available to clinician. 1. Patient can be discharged back to their GP if deemed safe to do so 2. A further appointment can be offered.	 If clock is still ticking on pathway, this will stop as patient is discharged If clock is still ticking on pathway, this will continue
Pre-op Assessment 1st DNA	Patient should be offered a further appointment. If date for surgery has already been confirmed, this delay must not impact on the surgery date. If so, clinical guidance must be sought.	RTT clock is not affected, will continue
Pre-op Assessment Subsequent DNA	Patient should be discharged if no clinical risk. Clinical team to be advised so they can make this decision.	RTT clock is stopped if patient is discharged. If further appointment is offered RTT clock will continue to tick.
Diagnostic DNA 1st DNA	Suspected cancer patients and paediatric patients should be	If a new diagnostic test request is made the RTT clock will continue

	offered a further appointment. Any re-booked diagnostic should take place within the 6-week diagnostic pathway All other patients should be discharged if no clinical risk. Referring clinician to be advised so they can decide if a further diagnostic test request should be made or if the patient should be discharged	If the patient is discharged this will stop the RTT clock
Diagnostic DNA 2nd and/or subsequent DNA's	Patients should be discharged if no clinical risk. Referring clinician to be advised so they can decide if a further diagnostic test request should be made or if the patient should be discharged	If a new diagnostic test request is made the RTT clock will continue. If the patient is discharged this will stop the RTT clock
TCI (Admission) 1st DNA	A clinical decision should be made. The clinician can 1. Discharge patient back to the GP 2. Offer a further TCI date	 The RTT clock would stop The RTT clock will continue
TCI (Admission) Subsequent DNA	Patient should be discharged if no clinical risk. Clinical team to be advised so they can make this decision.	RTT clock is stopped if patient is discharged. If further appointment is offered RTT clock will continue to tick.

Appendix 02 National Standards for Cancer Waiting Times

Maximum two weeks from receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer to first outpatient attendance
Operational Standard of 93%

Maximum two weeks from receipt of referral of any patient with breast symptoms (where cancer is not suspected) to first hospital assessment
Operational Standard of 93%

Maximum four weeks (28 days) from receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer, breast symptomatic referral or urgent screening referral, to point at which patient is told they have cancer, or cancer is definitively excluded.
Operational Standard of 75%

Maximum 31 days from Decision To Treat to First Definitive Treatment of cancer
Operational Standard of 96%

Maximum 31 days from Decision To Treat/Earliest Clinically Appropriate Date to subsequent surgical treatment of cancer
Operational Standard of 94%

Maximum 31 days from Decision To Treat/Earliest Clinically Appropriate Date to subsequent drug treatment of cancer
Operational Standard of 98%

Maximum 31 days from Decision To Treat/Earliest Clinically Appropriate Date to subsequent radiotherapy treatment of cancer
Operational Standard of 94%

Maximum 62 days from receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer to First Definite Treatment of cancer
Operational Standard of 85%

Maximum 62 days from urgent screening referral to First Definite Treatment of cancer
Operational Standard of 90%

Maximum 62 days from consultant upgrade to First Definite Treatment of cancer
Operational Standard to be set locally
There is no national standard from a consultant's decision to upgrade the urgency of a patient (e.g. following a non-urgent referral) due to a suspicion of cancer to first treatment; however, the Trusts aim is to treat these in line with the other 62-day standards.
Maximum 31 days from receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer to First Definite Treatment of acute leukaemia, testicular or children's cancers

No separate Operational Standard – Monitoring within 62-day classic
There is no national standard from a consultant's decision to upgrade the urgency of a patient (e.g. following a non-urgent referral) due to a suspicion of cancer to first treatment; however, the Trusts aim is to treat these in line with the other 62-day standards.

Appendix 03 P codes & D code descriptors

- P1a Emergency - operation needed within 24 hours
- P1b Urgent - operation needed with 72 hours
- P2 Surgery that can be deferred for up to 4 weeks
- P3 Surgery that can be delayed for up to 3 months
- P4 Surgery that can be delayed for more than 3 months
- P5 will identify that a patient is requesting to delay treatment due to their concerns with COVID-19 and for the hospital to avoid dating these patients until the patient is ready for treatment. When the patient feels that they are ready to come into hospital, the relevant admissions team should be contacted. The patient remains on the waiting list. (defunct January 2022)
- P6 will identify that a patient is requesting to delay treatment due to reasons other than COVID-19 and for the hospital to avoid dating these patients until the patient is ready for treatment. When the patient feels that they are ready to come into hospital, the relevant admissions team should be contacted. The patient remains on the waiting list. (defunct January 2022)

- D1 For emergency, ED and inpatients
- D2a For suspected cancer patients (2 week rule patients)
- D2b For non-cancer cases and agreed pathways in which investigations need to be carried out within 2 weeks
- D2c For urgent cases (Investigations would need to be carried out within 4 weeks)
- D3 Patient where investigation would need to be carried out within 4-6 weeks
- D4a Patient where investigation would need to be carried out in 6-12 weeks
- D4b For cancer surveillance investigation with the appropriate description (date to be recorded)
- D4c Patient where investigation would need to be deferred at a particular date (date to be recorded).

D5 and D6 codes have been removed in line with the P code criteria above

Appendix 04

Lancashire Teaching Hospitals
NHS Foundation Trust

Equality, Diversity & Inclusion Impact Assessment Form

Department/Function	Patient Access			
Lead Assessor	Angela Lewthwaite			
What is being assessed?	Patient Access Policy			
Date of assessment	03/12/2021			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☐
	Service Users	☐	Staff Inclusion Network/s	☒
	Personal Fair Diverse Champions	☒	Other (Inc. external orgs)	☒
	LTHTR SBM' s LTHTR CBM's CCG Cancer Alliance Patient Experience Group			

1) What is the impact on the following equality groups?			
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups		**Negative:** ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	**Neutral:** ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Groups	**Impact (Positive / Negative / Neutral)**	**Comments:** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?	
Race (All ethnic groups)	Neutral		
Disability (Including physical and	Neutral		

mental impairments)		
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief (includes non-belief)	Neutral	
Sexual orientation	Neutral	
Age	Neutral	
Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights, social)	Positive	Military Veterans – As per NHS England and MOD (Ministry of Defence) guidance, War Pensioners & Military Personnel should receive priority treatment if their condition is directly attributable to injuries sustained during military service.

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

ACTION PLAN SUMMARY

Action	Lead	Timescale

HOW THE NHS CONSTITUTION APPLIES TO THIS DOCUMENT

WHICH PRINCIPLES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Principles	Tick those which apply	WHICH STAFF PLEDGES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Pledges	Tick those which apply
1. The NHS provides a comprehensive service, available to all.	√	1. Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.	☐
2. Access to NHS services is based on clinical need, not an individual's ability to pay.	√	2. Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.	√
3. The NHS aspires to the highest standards of excellence and professionalism.	√	3. Provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.	☐
4. The patient will be at the heart of everything the NHS does.	√	4. Provide support and opportunities for staff to maintain their health, wellbeing and safety.	☐
5. The NHS works across organisational boundaries.	√	5. Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.	☐
6. The NHS is committed to providing best value for taxpayers' money.	√	6. To have a process for staff to raise an internal grievance.	☐
7. The NHS is accountable to the public, communities and patients that it serves.	√	7. Encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996.	☐

WHICH AIMS OF THE TRUST APPLY? Click here for Aims	Tick those which apply	WHICH AMBITIONS OF THE TRUST APPLY? Click here for Ambitions	Tick those which apply
1. To offer excellent health care and treatment to our local communities.	√	1. Consistently deliver excellent care.	√
2. To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria.	√	2. Great place to work.	☐
3. To drive innovation through world-class education, teaching and research.	☐	3. Deliver value for money.	√
		4. Fit for the future.	√