Trust Policy	One Devon	NHS University Hospitals Plymouth NHS Trust

Elective Access Policy – Devon Community Wide

Issue Date	Review Date	Version
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Purpose
To outline the Devon Health Community's expectations and requirements in terms of managing patients referred into elective care pathways.
Who should read this document?
All staff who manage patients either clinically or administratively who are attending hospital for elective care.
Key Messages
It is imperative that all members of staff understand the 'rules' that govern the management of patients who are on our waiting lists. This is primarily to ensure that no patient is unnecessarily disadvantaged. It is every member of staff's responsibility to ensure that these rules are applied equitably.

Core accountabilities	
Owner	Head of Patient Access
Consultation	Community Access Leads, Primary Care, Internal Stakeholders, Devon ICB, NHSE
Ratification	Chief Operating Officer (on behalf of Trust Board)
Dissemination (Raising Awareness)	Head of Patient Access
Compliance	Head of Patient Access
Links to other policies and procedures	
Relevant APNs Cancer Operational Policy	

Version History		
1.0	November 2018	Initial draft
1.1	July 2021	Extended to November 2022 by Jo Beer
2	November 2022	Reviewed and updated
3	November 2024	Reviewed and updated
4	March 2026	Updated with Governance Arrangements – agreed with Jon Scott

Equality, diversity, and inclusion is at the heart of the NHS strategy and for UHP this means ensuring we create an equitable organisation for colleagues, patients, and visitors. Our inclusion agenda recognises that everyone matters, as well as understanding that there are times when people, particularly those from protected groups (defined by the Equality Act 2010 - age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation), may face unfairness and discrimination.

We have a moral responsibility to work in a way that creates fairness as well as a legal and public sector equality duty which we take very seriously. We will always aim to create policies and practices that eliminate workplace discrimination and health inequalities, as well as strengthening our relationships within the community and with our colleagues who may identify with one or more protected groups.

A diverse workforce improves the experience of our patients and creates an environment where everyone belongs and feels included. UHP recognise that we all play a part in providing exceptional care to patients as well as showing kindness and compassion to patients and colleagues.

An electronic version of this document is available in the Document Library. Larger text, Braille and Audio versions can be made available upon request.

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1 Introduction

All NHS commissioned healthcare organisations within Devon are united in their commitment as a Local Health Economy to ensure patients receive treatment in accordance with national standards and objectives. The purpose of this policy is to outline the Devon Health Community's expectations and requirements in terms of managing patients referred into elective care pathways. The policy is structured in such a way which makes it easy to navigate in both hard copy and electronically. Where a separate Administrative Procedure Note (APN) or document is referenced, a hyperlink will be shown allowing the reader to be taken directly to it if desired. The principles within the policy are applicable across all organisations comprising the Pan Devon area. APNs are generally specific to each organisation so there may be several different local versions of this policy.

2 Purpose

This policy covers the way in which the Devon Health Community will collectively manage the administration of patients who are waiting for or undergoing treatment on an elective pathway.

As set out in the Consultant-led Referral to Treatment Waiting Times Rules and Guidance (england.nhs.uk) patients have the right to start consultant led treatment within maximum waiting times. The policies and procedures comprising this policy adhere to national best practice and provide a framework to ensure that patients are treated transparently, fairly, and reasonably. This policy also ensures that:

- Trusts will give priority to clinically urgent patients and treat everyone else in turn.
- Trusts will work to meet the maximum waiting times set by NHS England for all groups of patients.
- Trusts will negotiate appointment and admission dates and times with patients.
- Trusts will work to ensure fair and equal access to services for all patients.
- Cancer patients are expected to be managed in accordance with the RTT guidance in the document but also in accordance with the cancer waiting times guidance as laid out in a separate document.
- Where a patient cannot be treated within the maximum waiting time and wishes to exercise their right under the NHS constitution to seek a suitable alternative provider, the organisation that commissions and funds the treatment (ICBs or NHS England) must investigate and offer the patient a range of suitable alternatives. Once the alternative has been identified the original hospital will generate an IPT. The local ICB or NHS England must take all reasonable steps to meet their request.

3 Definitions

See Annex One.

4 Duties

Devon Health Community:

The Local Health Economy is collectively responsible for the production, review, and revision of this policy on at least a bi-annual basis. All organisations will have a designated lead in this respect.

Integrated Commissioning Board:

- Promote the rights and pledges enshrined in The NHS Constitution (2015).
- Develop and manage the local health market to provide plurality and patient choice.
- Ensure that all patients needing planned elective care are offered clinically appropriate choices of provider.
- Ensure that patients are treated within clinically appropriate, commissioned pathways and maximum treatment times.
- Ensure that appropriate governance structures are in place to support management, delivery and escalation reporting as appropriate.

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 through the use of 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: Policies - South & West (devonformularyguidance.nhs.uk). Where available ensure adherence to Clinical Referral Guidelines: Western locality - South & West (devonformularyguidance.nhs.uk)

Provider Organisations are responsible for ensuring:

- The principles of this policy are applicable to and available for all relevant staff
- All policy statements are underpinned by relevant procedural notes
- Mechanisms are in place to ensure compliance with the principles of the policy
- Ensure that appropriate governance structures are in place to support management, delivery and escalation reporting as appropriate.

5 Main Body of Policy

Part One – General Principles

This section details the general principles which are applicable to all patients.

5.1. Chronological Booking

Patients should be selected for booking in accordance with their clinical priority and then in chronological order in terms of their RTT wait (as capacity and case mix restrictions allow) unless it is for reasons of patient safety or improved list efficiency.

5.2. National Elective Care Standards

Please see Part Three – Reference Material.

5.3. Planned Patients

Patients on a planned waiting list are outside the scope of RTT rules.

Planned procedures are part of an agreed programme of care, which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Patients should not be added to the planned waiting list for any other reason.

Please find here a link to the appropriate supporting information: Waiting List Management – Elective, Booked or Planned

5.4. Interventions Not Normally Funded, Including Low Value Procedures, Low Priority Treatments (LVP/LPP), and Evidenced Based Interventions (EBI)

LVP, LPP, and EBI policies must be adhered to. Any procedures undertaken without prior funding authorization, or which do not meet the relevant criteria, will not be authorised by the Commissioners. In these circumstances the 18-week clock will begin when the GP proceeds to make a formal referral, either with or without funding approval having been secured at the outset

The majority of treatments or conditions require funding approval to be secured prior to referral to secondary care for assessment and treatment. In these circumstances the 18-week clock will begin when the GP proceeds to make a formal referral, either with or without funding approval having been secured at the outset.

There is, however, a small number of specialist treatments where funding approval can only be sought by a secondary care consultant. In these cases, the 18-week clock will not stop whilst funding approval is sought form the Commissioner

The current list of LVP/LPP Procedures can be found here Policies (devonformularyguidance.nhs.uk) DRSS will be asked to ensure this policy is followed. However, any referral being received in secondary care that is clearly covered by the Prior Approval Policy should be rejected (and the 18-week clock nullified) and returned to the referrer with advice for them to follow the Prior Approval Policy.

Pathways are expected to be managed in line with evidence-based intervention protocols.

Please find here a link to the appropriate supporting information: Referral Management

5.5. Access to Health Services for Military Veterans

In line with the Armed Forces Covenant, the Trust will ensure that members of the Armed Forces Community (including those serving, reservists, their families, and veterans) are supported, treated equally and receive the same standard for and access to healthcare as any other UK citizen in the area they live. In such instances referrers should make it clear that the patient is a member of the Armed Forces Community.

Armed Forces Community should retain their relative position on any NHS waiting list, if moved around the UK due to the service person being posted, however, they should not be given priority over other patients with more urgent clinical needs. Inter Provider Transfer (IPT) forms should be used in these cases.

Veterans receive their healthcare from the NHS and should receive priority treatment where it relates to a condition that has been attained because of their service in the Armed Forces, subject to clinical need.

Please find here a link to the appropriate supporting information: Priority Treatment of War Pensioners (Veterans)

Prisoners and Detained Estate

All elective standards and rules are applicable to prisoners and other detained estate patients.

5.6. Private Patients

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 in line with commissioned service and clinically appropriate. The RTT clock starts at the point the GP or referrer’s letter arrives into NHS care. 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.

Patients seeking a second opinion from a Private Care provider whilst on an NHS waiting list should maintain their position on the RTT pathway.

5.7. Overseas Visitors and Patients Not Entitled to NHS Care Funding

All trusts have an obligation to identify patients who are not eligible for free NHS treatment and specifically to assess liability for charges in accordance with the Department of Health 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 “Ordinary resident status”.

Please find here a link to the appropriate supporting information: Managing Overseas Visitors

5.8. Vulnerable Patients

It is essential that patients who are vulnerable for whatever reason have their needs identified at the point of referral. This group of patients might include but is not restricted to:

- Patients with learning difficulties
- Patients with known Mental Health issues
- Patients with physical disabilities or mobility problems
- Elderly patients who require community care
- Children (defined in The Children Act (2004))

It is important that patient's attending the hospital have reasonable adjustments made to facilitate their treatment. Such status must also be considered when making decisions about their management on the waiting list.

5.9. Communication With Patients

The rules and principles must be made clear and transparent to patients at each stage of their pathway. All communications with patients whether they are verbal or written must be informative, clear and concise.

A key principle for RTT is that patients are made aware of the potential implications on their pathway should they choose to delay their treatment, either through cancellation of appointments, declining TCI offers or non-attendance.

Commissioners and providers will need to be able to demonstrate (to an auditor or the CQC or in the event of a patient complaint) that cases that take longer than 18 weeks to reach the start of first definitive treatment are legitimate exceptions.

Providers will ensure that patients receive information in formats that they can understand and receive appropriate support to help them to communicate (Accessible Information Standard 2015).

Where the patient is military or part of the detained estate, the Trust should be aware of local arrangements around direct patient communication or a requirement for communications to be directed towards the relevant Medical Officer.

5.10. Reasonable Offers

A reasonable offer for all appointment types is at least two dates and times, three or more weeks from the time that the offer was made at any of the Trust's sites. Should a patient accept an appointment less than three weeks into the future, this can be considered as a reasonable offer.

Reasonable attempts to contact a patient are defined as four attempts at different times of the day, different days of the week. If unable to contact by telephone, then you write to the patient and if they fail to respond within two weeks then the patient should be sent for clinical review. Offers should be annotated on the waiting list to maintain an audit trail.

5.11. Cancelling, Declining or Delaying Appointments/Admissions

Patients can choose to postpone or amend their appointment or treatment if they wish, regardless of the resulting waiting time. However, clinicians will be informed of patient-initiated delays to ensure that no harm is likely to result from the patient waiting longer for treatment (clinicians may indicate in advance, for each specialty or pathway, how long it is clinically safe for patients to delay their treatment before their case should be reviewed). See section 13 for further details on patients delaying a treatment. Please find here a link to the appropriate supporting information: Patient Initiated Delays (PIDs) of Patients on the Outpatient Waiting List

Patients On a Non-Treatment Waiting List

For patients who are not on a waiting list specifically for treatment the clinical reviews must determine whether:

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

The general principle of acting in the patient's best clinical interest always is paramount.

Clinicians can choose to discharge a patient after a single DNA if they feel it is clinically appropriate to do so. Two patient cancellations or DNAs on the same pathway should act as a trigger for the clinician to review the patient's case individually to determine whether a patient may be discharged.

In the event of a discharge both the patient and referrer will be notified of this in writing. The patient's RTT clock will be stopped.

Exceptions to discharging the patient are:

- When a clinical decision is taken that discharging the patient is contrary to the patient's clinical interests.
- Clinically very urgent referrals including cancer, or active surveillance for cancer, rapid access chest pain, and other critical illnesses.
- Children of 18 years and under or vulnerable adults.
- When one of the following can be confirmed.
- The appointment was sent to the incorrect patient address.
- The appointment was not offered with reasonable notice.

Where circumstances were beyond the patient's control, the Trust will endeavour to be as flexible as possible. The patient must first be contacted to ascertain the reasons for DNA and ensure compliance to attend a rescheduled appointment.

For Paediatric patients, after the reason for a DNA has been established, this should be documented in the health records. A further appointment needs to be offered to the patient and the importance of attendance needs to be reiterated to the parent / carer. If there are any safeguarding concerns about a child or young person under the age of 18 years further guidance should be sought from the relevant Trust policy or Safeguarding Lead. Please refer to the local Paediatric 'Was Not Brought' policy, via this link: Was not brought (did not attend) for children and young people.

If a patient DNAs their first appointment following the initial referral which started their RTT clock, their RTT clock should be nullified (i.e. not stopped and not reported). This includes any subsequent DNA for their first outpatient appointment on this pathway. Should the patient be offered another date, a new RTT clock will start on the date that the appointment is re-arranged.

If a patient DNAs a subsequent (follow up) appointment their RTT clock should not be nullified. Should the patient be offered another date the RTT clock will continue.

5.12. Patients Who Attend but Do Not Wait

If a patient does not wait to be seen, the Clinician will review the clinical information and arrange a further appointment as indicated. The patient should be contacted to determine whether another appointment is necessary or desired by the patient. Patients in this category must not be recorded as a DNA. If a decision is made to not rebook, the referrer and patient will be informed in writing.

5.13. Patients Who Choose to Delay Offered Treatment Dates

Patients should be offered appointment dates with reasonable notice (three weeks).

If a patient declines a reasonable appointment offer, then their waiting list entry must be annotated with the relevant C-code.

A second appointment should be offered to the patient within 6 weeks of the first offer. If this is subsequently declined by the patient and they make themselves unavailable for a period, then with the agreement of the clinician and the patient the patient should be removed from the active treatment list and placed on hospital-initiated active monitoring.

If at the end of this active monitoring the patient is available for treatment, they will return to the waiting list at the point at which they were removed and should be booked accordingly. If they remain unavailable, then consideration may be given to removing the patient from the waiting list in accordance with the patient unavailability section.

Patients should be clinically reviewed every 12 weeks of unavailability. However, if a clinician has previously indicated that a longer period of unavailability is appropriate then this review will not be required.

If a patient declines TCI dates and refuses to go on active monitoring, then consideration can be given to a waiting list removal in accordance with the patient unavailability section of this policy.

This guidance does not apply to patients on a Cancer pathway. Please find here a link to the appropriate supporting information: C Codes & RTT08 Patient Pathway

5.14. Patients Declining Treatment at an Alternative Provider

Section 13 also applies to patients who are clinically able to be treated at an alternative provider. Under these circumstances a reasonable offer may be described as with three weeks' notice and within two hours travelling of the originating Trust.

5.15. Removals Other Than Treatment

Patients who state that they do not wish to receive treatment will be subject to a clinical review. Where appropriate, there may be a local agreement e.g. for routine patients, where the waiting list entry is removed and their clock stopped, and the clinician informed. This agreement must be locally documented and able to be audited.

In all instances the GP must also be informed.

5.16. Validation of Waiting Lists

All Trusts will ensure that waiting lists are validated in accordance with the relevant national guidelines, this may be for clinical and administrative purposes. The outcomes of this validation will be available for audit purposes e.g. for health inequality purposes.

5.17. Information, Monitoring & Reporting

Monitoring and reporting will be managed through the information schedule of provider's acute contract. In addition, other statutory returns to NHS England and monitor will be provided as required. Providers will ensure robust systemic governance of data quality is in place with clear work plans, reporting and escalation.

Part Two – Pathway Specific Principles

6.1. Overview of National RTT Rules

The full national RTT rules suite can be accessed by clicking here. Detailed local application of the rules is provided in the standard operating procedures within section four at the end of this policy.

Clock Starts

The RTT clock starts when:

- A referral is received into a consultant led service, regardless of setting, with the intention that the patient will be assessed and if appropriate, treated before clinical responsibility is transferred back to the referrer.
- A referral is received into an interface or referral management assessment centre which may result in an onward referral to a consultant led service before clinical responsibility is transferred back to the referrer.
- A patient self refers into a consultant led service for pre-agreed services agreed by providers and commissioners.
- Following active monitoring.
- Following a decision to start a substantively new treatment plan
- When a patient is ready to have the second of a bilateral procedure
- A rebooking is made after a Did Not Attend (DNA) for first outpatient appointment.
- A referral is received from an emergency setting into an elective pathway

Exclusions:

- A referral to most consultant-led services starts an RTT clock but the following services and types of patients are excluded from RTT:
- Obstetrics and midwifery
- Planned patients, however where a patient requiring a planned procedure goes beyond their due date, they will be transferred to an active pathway and a new RTT clock started.
- Referrals to a non-consultant led service
- Referrals for patients from non-English commissioners
- Genitourinary medicine (GUM)/Sexual Health services
- Emergency pathway non-elective follow-up clinic activity.

Clock Stops:

The RTT clock stops upon First Definitive Treatment (FDT), or if a decision is made that treatment is not required or if the patient declines treatment.

FDT is defined as:

An intervention, for the condition for which the patient was referred, normally designed to manage the patient's condition, disease or injury to avoid further intervention.

If a patient requires a procedure or surgery as a day case or inpatient, the clock stops upon admission. If the patient's treatment is medication prescribed in outpatients or if a decision not to treat is made in outpatients, this information is captured on clinic outcomes or directly in the trusts relevant Patient Administration System (PAS). There may also be occasions where a decision not to treat is made in an 'ad hoc' setting, for example following review of diagnostic results by a clinician in the office.

Clock stops such as these must also be captured in the Provider's PAS. A full list of clock starts, and stops is documented in Annex 3.

6.2. Pathway Milestones

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

- First Outpatient Appointment
- Treatment Decision
- Treatment

Trusts will aim to identify and work to set timescales for each "stage of treatment" by speciality as best practice identifies. If urgent, timescales will be clinically appropriate.

6.3. Referral Management

Pre-Requisites Prior to Referral Primary Care

In line with national RTT rules, before patients are referred, GPs and other referrers should ensure that patients are ready, willing, and able to attend for any necessary outpatient appointments and/or treatment and that they fully understand the implications of any surgery or other treatment which may be necessary. Also, to make sure that referrals are in in keeping with the agreed local commissioning policies and clinical referral guidelines.

Secondary Care

It is the responsibility of the management teams in conjunction with clinicians to ensure that the e-Referral Service Directory of Services (DoS) is up to date in terms of the service specific criteria and that clinics are mapped to the relevant services. This

gives the best chance of the patient being booked into the correct clinic at the first visit and reduces the rejection rate.

Referral Sources

a) General Practitioners and Health and Social Care Professionals

Referrals should only be made from primary to secondary care if it is thought that the input of the secondary care specialist will contribute to the management of the patient.

In line with section SC6.6 of the National Standard Contract, Trusts must offer clinical advice and guidance via relevant local mechanisms (e.g. RAS or A&G services) to GPs and other primary care providers:

- On potential referrals, through the NHS e-referral services.
- On potential referrals and on the care of service users generally, as otherwise set out in the Service Specifications.

In accordance with section SC6.13 of the National Standard Contract Trusts should accept referrals that are made in accordance with agreed referral processes and clinical thresholds as set out across the Health Community.

b) Internal Provider Referrals (Clinician to Clinician)

When a clinician or member of their team decides that the opinion of another clinician or service should be sought, for all elective patients he/she/they can refer when:

- The referral is for the same presentation/symptom as the originating referral
- The referral is clinically urgent or a suspected cancer
- The referral prevents an urgent admission

Internal referrals for an unrelated non-urgent condition must only be made when the referrer is certain that a specialist appointment is required, and the referral complies with national and local commissioning policies and clinical referral guidelines/pathways.

If there is uncertainty as to the management of the patient, patient should be referred to the GP for their input and decision on further management without raising expectation of an onward referral.

Please find here a link to the appropriate supporting information:

Referring Internally to a Different Clinician but the same Specialty and the same Condition

Referring Internally to a Different Consultant, Different/Same Speciality and Different Condition

c) External Consultant to Consultant Referrals/Inter Provider Transfers

Referrals to other providers must be accompanied by the National Inter-Provider Transfer Administrative Minimum Dataset (IPTAMDS). All fields must be completed as fully as possible.

Patient referrals from other providers (including Primary Care Interface Services) should be accompanied by a completed IPTAMDS (Appendix 1). Where the IPTAMDS does not accompany the referral, it must follow within 48 hours. In the event of the relevant information not being received then local escalation will apply. Providers should not transfer patients with the sole intention of achieving an access target without the prior agreement of the receiving trust e.g. outsourcing arrangements. Inter Provider Transfers are not required purely for the purpose of diagnostic tests or the seeking of a second opinion where there is no transfer of care. Please find here a link to the appropriate supporting information: Inter Provider Transfers (IPTs)

d) Patient Request to Change Provider

A patient may choose to change provider at any stage in their care. They are not obliged to state a reason for requesting a change of Provider. All relevant clinical documentation must be sent directly to the new Provider, accompanied by the National Inter-Provider Transfer Administrative Minimum Dataset (IPTAMDS). Any relevant appointments or Waiting Lists still active with the previous Provider should be cancelled, and the new Provider made aware that this has been done. Any active

In the event that the new provider rejects the referral (generally only for clinical reasons) then appropriate action should be taken to ensure the patient's clinical safety is not compromised. This may include reinstating any cancelled appointments and/or Waiting Lists at the previous Provider.

Devon Referral Support Services (DRSS)

DRSS is in place in Devon Health Community to review referrals, offer choice and book and/or redirect patients to the most appropriate services. To ensure DRSS can successfully support the referral process referrers must ensure a full data set is provided when referring.

Referral Methods

The Devon Health Community jointly supports and is working towards all referrals being made directly via NHS e-Referral Service. All referrals that have a mandated proforma must be submitted using that specific proforma. For referrals without a mandated proforma, it is recommended to use the standard DRSS referral proforma.

There are currently two recognised methods of referral for non-cancer referrals as described below:

e-Referrals

a) Directly Bookable Services

Within Devon Health Community when a directly bookable appointment on NHS e-Referral Service is made, an appointment is automatically registered in the provider's PAS and the RTT clock start is triggered (i.e. this is the date the patient contacts DRSS)

Where an appointment slot issue is experienced, the patient is deferred to the Provider, it is that this point the RTT clock starts.

Referrals made to a Directly Bookable Services (DBS) from outside of the area are processed in e-RS and booked either while the patient is in the surgery, or the patient

can phone the appropriate Telephone Appointment Line (TAL) or go online using their Unique Booking Reference Number (UBRN) as a reference to book a slot at the hospital of their choice.

Trusts will ensure that sufficient capacity is available for patients to directly book their first appointment. Patients who have been directly booked will have a referral automatically created on the provider's PAS by the e- Referrals software and the RTT clock start will be automatically triggered from the referral received date on PAS i.e. when the patient first attempts to book their appointment.

Indirectly Bookable Services including Clinical/Referral Assessment Services

Referrals sent via this route will need to have a referral added to PAS, including the unique patient identifier generated (UBRN) because of the e-RS referral. The referral received date (i.e. the RTT clock start date) must be the date at which DRSS notify the provider via NHS e-Referral Service, or when the patient has contacted the hospital.

Where there is an appropriate service on eRS Primary Care will not send paper referrals if the service is available on NHS e-Referral. Where this has occurred, and

clinical urgency allows the referral will be redirected to DRSS for uploading through eRS.

Please find here a link to the appropriate supporting information: e-RS

b) Non eRS referrals

Where providers have a centralised location, all paper-based referrals should be sent to the designated centralised location within each provider. Upon receipt of paper-based referrals, the date of receipt should be clearly and permanently marked. This date is the RTT clock start date. All non-eRS referrals must be entered onto an appropriate digital system in a timely manner.

Failure of e-Referral Service

Refer to the Business Continuity Plan.

Referral Criteria/Minimum Data Sets

The referrer is responsible for ensuring that the referral letter contains the essential minimum data set see Annex 2. This includes but is not limited to the patient's NHS number, full patient demographics and including a day, evening and mobile telephone number that the patient would like to be contacted on as well as sufficient clinical data to enable the appropriate appointment to be made. The letter should also state the patient's current drug regime, clinical question to be answered and significant past medical history.

Referrals should be addressed to a speciality rather than a named consultant and the patient will be offered an appointment with the consultant with the shortest waiting time. Named referrals will be allocated to the relevant consultant but if they do not have sufficient capacity to accept the referral then a decision will be made in conjunction with the consultant and the speciality operational / service manager to allocate the referral to an appropriate alternative consultant.

Exceptions to this would be where denying access to a sub-speciality opinion would compromise clinical care or patients choose to wait to see the consultant they had requested.

Clinical Triage/Review of Referrals

All referrals should be triaged to ensure clinical suitability, unless there are clear guidelines and evidence that demonstrates patients are all typically referred correctly first time.

Rejected Referrals

If a referral has been made through eRS and the service selected does not meet the needs of the patient, the referral should be rejected via eRS to return to Primary Care.

For these rejections DRSS/GP will receive an electronic notification to inform the patient of the rejected referral. In this circumstance, DRSS/GP will redirect the referral and book an appointment to the appropriate service without delay or if non eRS then the GP will re-refer as required.

Appointment Slot Issues (ASIs)

If a direct booking via NHS e-Referral Service is not possible due to lack of capacity, the UBRN will be directed to the Trust via the 'Defer to Provider' function on the e-Referral Service for local management to resolve. This is referred to as an ASI. The RTT clock is ticking from the point at which the patient attempted to book their appointment even though they will not be visible on the Trust's patient administration system at this point. Appointment staff will then call the patient to offer an appointment.

ASIs result in a poor patient experience and time-consuming administrative workarounds. Sufficient capacity must therefore be made available via e-RS to ensure patients can book directly into services. This is the responsibility of the operational / service management team responsible for the speciality.

Please see link to APN: for e-RS.

Paper Based Referrals

Referrals received from non-GP referrers or to non-consultant led services should be sent using the e-RS system where available but can still be processed on paper. Patients that are referred via the paper referral process will have their referral added to an appropriate system in a timely fashion to be triaged and where appropriate, placed on the outpatient waiting list and will either be sent an invitation to call letter in order to book their appointment within pathway specific milestones, or appointments staff will contact the patient.

Patients should be offered a choice of reasonable dates, and an appointment made which is mutually convenient. The patient's details including daytime contact number must be checked and corrected at this time and all appointment offers must be recorded on PAS where functionality is available. A letter should be sent to confirm the appointment, which must also include details of how to cancel and reschedule appointments.

If the patient fails to respond and all reasonable attempts have been made to contact the patient to agree an appointment, the outpatient waiting list entry is removed. A

letter is sent to the patient's GP and the referral is closed. The reason for removal will be 'patient declined treatment'. **This should only happen, if in the clinical best interests of the patient, as determined by the hospital clinical lead.**

Where a patient is referred to a pooled service, they are to be offered an appointment with the consultant with the shortest waiting time.

6.4. First Appointment

Suspected Cancer Urgent and Routine GP to Consultant led first outpatient referrals

All 2ww, urgent and routine referrals from a GP to a Consultant led service must be submitted using the electronic referral service (ERS). Trusts should ensure that appropriate services are available on the e-Referral system.

Trusts will endeavour to give patients their choice of site within the Trust but as a single provider, patient appointments may be offered at a different site if appropriate treatment is available. If patients choose to wait for a particular site or consultant, the implications on their overall RTT wait for treatment should be clearly explained to them. If this subsequently causes the patient to wait more than 18 weeks for treatment, this will be accounted for within the operational tolerances.

Referrals for a same day/next day service should be referred by the most appropriate means to ensure the receiving Trust has access to relevant clinical information in a timely manner (email, telephone). Such referrals are not able to be processed using e-Referral.

Should a GP practice submit a paper 2ww referral, the receiving specialty will ring the GP and request that they submit the referral electronically within 24 hours. Should the GP fail to submit the 2ww referral within this time frame then the Acute Trust will process the paper referral and email the GP practice informing them of their actions and re-iterate the process that should be followed for all future referrals.

Any urgent or routine paper referrals received by the acute trust will be returned to DRSS to process via the e-Referral system. The paper referral will be treated as a rejection and the clock start date for RTT purposes will be the date the Trust receives the referral electronically.

A reasonable offer for attendance types is an offer of at least two dates and times three or more weeks from the time that the offer was made at any of the Trust's sites. Should a patient accept an appointment less than three weeks into the future, this becomes a reasonable offer.

If after an invite to book an appointment has been made and the patient does not make contact Three attempts will then be made to contact the patient, one of which made in the evening. If still unsuccessful, a second 'invitation to call' letter will be sent to the patient and a copy sent to their GP.

Patients should be appointed firstly by their clinical priority (i.e. urgent patients first) and then within chronological order.

6.5. Hospital Initiated Appointment Changes

In the event of a hospital-initiated cancellation, the patient's RTT clock continues to tick from the original referred received date. The patient will be contacted to arrange an alternative appointment date and time. Both an apology and a reason for cancellation will be given. The Trust will make every effort to ensure that they do not cancel patient's appointments. If the cancellation is within two weeks of the appointment date, the patient will be informed of the cancellation by telephone.

6.6. Patient Initiated Appointment Cancellations

Patients who wish to cancel their appointment and do not require a further appointment or treatment at any stage of a pathway should be removed from the waiting list, their RTT clock stopped, clinician informed, and a letter should be sent to the patient and their GP confirming their decision.

6.7. Patient Initiated Appointment Changes

Patients will have the opportunity to cancel or rearrange appointments during their pathway. The RTT clock continues to tick during the appointment reschedule but will be stopped if the patient is being discharged back to their GP. This should only happen if in the clinical best interests of the patient as determined by the hospital clinical lead.

Where there are two instances of unavailability on a single pathway then there <u>must</u> be a clinical review to determine what is in the best interests of the patient.

6.8. Clinic Attendance

a) Arrival Of Patients

- Patient demographic details should be checked at every clinic attendance and amended as necessary on the Trusts PAS system. The status of overseas visitors will be checked at this time. The relevant manager must be notified where it is suspected that there is an overseas visitor.
- All patients must have an attendance /arrival status recorded, i.e. Attended or Did Not Attend.

b) Clinic outcomes

- All patients must have an outcome (e.g. follow up, discharge or add to elective waiting list) and an updated RTT status recorded on the clinic on the relevant PAS system. Clinics will be fully outcome or 'cashed up' within one working day of the clinic taking place.

Follow Up Appointments

Consideration must be given by clinicians to placing a patient on either patient initiated, open, or remote monitoring type waiting lists. Only after this has been considered should the patient be placed on the waiting list for a routine follow-up.

Patients who are place onto a patient-initiated follow-up will have their RTT clock stopped. Any subsequent RTT clock will only start at the point of a decision to treat the patient.

Ideally those patients requiring a specifically timed follow-up will the consulted via a video or telephone contact

Patients should only be listed for a face-to-face appointment where there is a clear clinical indication to do so. Please find here a link to the appropriate supporting information: Telephone Contacts

Patients who require an appointment within six weeks should be fully booked as they leave the Department or Ward, if this cannot be accommodated then they should be added to the appropriate follow up waiting list.

Patients who require an outpatient follow up appointment in more than six weeks' time, will not be appointed and will be added to a pending list/Partial booking waiting list. With a relevant 'see by date'.

In all cases the appropriate partial or fully booked process will apply. Please find here a link to the appropriate supporting information: Outpatient Follow Up Appointments and Waiting Lists

6.9. Clinic Management

a) Clinic Cancellation, Reductions, and Scheduling

Consultants, medical staff and other health professional staff must give the agreed notice of annual leave, please refer to local policy. Where this is not given, the Consultants team or alternative health professional should provide cover for the clinic. Leave requests should be submitted as early as possible to minimise the effect on clinics.

Devon Health Community is committed to offering certainty to patients as well as choice in arranging care. As such, every effort will be made to avoid cancelling patient's appointments. Every effort will be made to backfill absent clinicians by the speciality.

Clinics should not be cancelled, reduced or re-scheduled with less than the agreed notice for any purpose unless there are exceptional circumstances.

b) Outpatient Clinic Capacity

Providers should systematically undertake a review of clinic templates and room capacity to ensure they are aligned to demand.

6.10. Diagnostic Pathways

The diagnostic stage of the pathway can be:

- The start of an RTT clock, e.g. straight to test
- Continuation on an RTT pathway

- Or not be on a RTT pathway should the GP retain responsibility for the patients care (e.g. direct access diagnostics)

6.11. Diagnostic Patients on RTT Pathways

Where a patient is referred for a diagnostic test to take place, the principles and policies within the relevant sections should be adhered to in terms of booking, cancellation and DNAs.

Some diagnostic tests will be undertaken on an admitted basis.

Patients who are referred for diagnostics as part of an RTT pathways need also to be seen within the current diagnostic waiting time.

Providers will work to establish one-stop appointments with outpatient and diagnostic elements occurring concurrently wherever clinically appropriate.

6.12. Subsequent Diagnostics

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

6.13. Straight To Test

An RTT pathway starts when a referral is triaged straight to test as the first step in a commissioned pathway. For example, where a consultant-led outpatient or pre- op appointment is the next commissioned step.

This ensures by the time the patient attends their first OP appointment, they will have already had the test, and the results can then be discussed at the OP appointment. In such instances, the RTT clock starts on the date that the provider receives the referral.

6.14. Direct Access Diagnostics

Where a GP refers a patient for a diagnostic test but retains clinical responsibility for the patient and makes a decision regarding referral on the basis of the results; this does NOT constitute an RTT pathway. An RTT clock only commences if the GP subsequently makes a referral to a consultant-led service.

6.15. Diagnostic Targets and Treatments

All diagnostic tests must be completed or carried out within 6 weeks of a decision to refer. The clock starts from the date that the request was made and ends on the date that the test was carried out. The one exception to this is direct access referrals where the clock starts on the date that the request was received.

Where there is the intention of a purely a therapeutic intervention then the 6-week diagnostic timeframe does not apply. In instances where there is both a diagnostic and a therapeutic intention then both the 6 weeks target and the RTT target apply.

Achievement against the 6-week diagnostic is measured by applying the below validation rules:

- DNA – New 6-week clock to be adjusted and start again from the point of the DNA.
- Patient cancellations – New 6-week clock to be adjusted and start again from the date of the cancelled appointment.
- Patient choice – New 6-week clock to be adjusted and start again from the point of the first declined "reasonable" appointment/TCI.

6.16. Booking Diagnostic Appointments

The appointment will be booked directly with the patient at the point that the decision to refer for a test was made wherever possible (eg the patient should be asked to contact the diagnostic department by phone or face to face to make the booking before leaving the hospital). Referrals should be booked in order of clinical priority and then waiting time.

If a patient declines an appointment the DM01 clock will restart from first appointment offered. If a patient cancels or does not attend a date for their diagnostic appointment, the diagnostic clock start 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 (two separate dates and three weeks' notice) for the clock start to be reset.
- Resetting the diagnostic clock start has no effect on the patient's RTT clock. This continues to tick from the original clock start date.

Where a patient cannot be reached by the initial phone call, three further attempts on different days at different times (ideally one out of hours) should be made to contact the patient. If the patient still cannot be reached a letter should be sent giving the patient three weeks to make contact to book their appointment. If the patient does not make contact within those three weeks they will be returned to their referrer.

6.17. Diagnostic Patient Cancellations, Declined Appointment Dates, and/or DNAs

Where a patient has cancelled, declined and/or not attended their diagnostic appointment a further booking must be made.

If in the event of two cancellation/decline or DNA the patient may be removed from the diagnostic waiting list. The investigations as describe in above section must be carried out.

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

monitoring. The referring consultant must also decide whether the patient should be re-referred to the diagnostic specialty.

6.18. Acute Therapy Services

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

- Directly from GPs where an RTT clock would NOT be applicable
- During an open RTT pathway where the intervention is intended as first definitive treatment or interim treatment. In this instance the clock would stop at the of therapy treatment.
- Therapy intervention designed to provide symptom management or optimisation prior to first definitive treatment in this case the treatment clock should continue

It is critical that staff in these services know if patients are on an open pathway and if the referral to them is intended as first definitive treatment.

Inpatient and Day Case Pathways

6.19. Waiting list "To Come In (TCI) Information

Waiting list/elective admission details must be completed at the time that the decision to admit is made by the clinician. This information must be recorded on the relevant PAS.

6.20. Decision To Admit

The decision to admit a patient for surgery (as a day case or inpatient) must be made by a consultant or another clinician who has been given delegated authority.

A patient should only be added to an active waiting list for surgery if:

- There is a sound clinical indication for surgery
- The patient is clinically fit, ready and available to undergo surgery

Patients who are added must be clinically and socially ready for admission on the day the decision to admit is made, i.e. if there was a bed available tomorrow in which to admit a patient, they are fit, ready and able to come in.

The above section for low priority/value procedures and evidence-based intervention applies. Where a decision to list for one of these procedures is made it is the

responsibility of the lead clinician to gain prior approval for the procedure. All patients must be added to the waiting list at the time a Decision to Treat is made however approval must be sought thereafter (please note that the RTT clock continues during the time approval is sought). If approval is rejected, the patient must be removed from

the waiting list and referred back to the GP with a letter documenting that approval was rejected. A copy of the letter must also be sent to the patient.

6.21. Pre-Anaesthetic & Pre-Operative Assessment

Patients should be pre-anaesthetically and pre-operatively assessed as soon as possible following the decision to admit.

This is an assessment required to ensure the patient is fit to undergo the anaesthetic and that they are listed for the appropriate type of admission (day case, or inpatient care). It is typically a conversation with the operating surgeon, pre-operative nurse and/or anaesthetist regarding the nature of the surgery. In some instances, this will happen at the point of being listed and in other scenarios at a time closer to the surgery.

Patients who are medically not fit for treatment should be managed dependent on the nature of their condition as below:

Short-Term Illnesses

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

Long Term Conditions (clinically routine)

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

- Where the patient requires optimisation in secondary care active monitoring will be applied (NB: if the patient is already on the elective waiting list, then this must be removed). Once the patient is optimised a new RTT clock will start.
- Where the patient requires referral back to the GP for optimisation, the RTT pathway clock will be stopped, and they will not be listed for their procedure. Once optimised the patient should be re-referred and start a new RTT pathway at the clinically appropriate point, i.e. pre-op assessment.

Where a patient is unfit for their treatment for a period in excess of three months then consideration may be given to the discharge of the patient back to primary care.

Consideration should be given to when the patient is optimised whether they should be prioritised and treated quickly despite having a new RTT clock.

Long Term Conditions (Urgent and Cancer).

The decision to proceed with these types of patients lies entirely with the consultant anaesthetist / consultant surgeon who following a review will make a decision whether to proceed. Patients who have previously been added to a waiting list or subsequently become unfit the above rules will apply.

6.22. Adding Patients to The Admitted Waiting List

Patients must be added to the admitted waiting list within locally agreed timescales. The date on list should be the date the patient has confirmed their wish to undergo treatment, e.g. date of clinic attendance, or after a period of the patient considering their treatment options.

When adding a patient onto the waiting list module of the relevant PAS, staff must ensure all information is gathered and recorded in line with local guidance.

All patients must have a national clinical prioritisation code applied at the point of listing.

6.23. Listing Patients/Offering TCI Dates

Where patients are not fully booked The Trust's Primary Target List (PTL) must be used as the data source for scheduling admitted patients.

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

Patients must be contacted to have the opportunity to verbally agree their TCI date. Patients should be offered two separate dates with at least three weeks' notice for routine day case or inpatient admissions.

Where available, patients can be offered dates with less than three weeks' notice and if they accept, this then becomes a 'reasonable' offer.

If the patient fails to respond and all reasonable attempts (see above section) have been made to contact the patient to agree an appointment, a clinical review must be sought to determine what is in the best interests of the patient.

Where the waiting list entry is removed as the patient has declined treatment, a letter is sent to the patient and the GP and the patient's RTT pathway will be closed.

6.24. Bilateral Procedures

Unless it is clinically appropriate to do so and in line with commissioning policy patients will only be put onto the admitted waiting list for one procedure at a time.

The RTT clock will stop when first definitive treatment for the first side begins. A second new clock starts once the patient is fit and ready to proceed with the second procedure.

6.25. Admitting Patients

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

6.26. Emergency Admissions for An Elective Procedure

Where patients are admitted as an emergency for a procedure the patient is currently waiting for as part of a RTT pathway, the patient will be removed from the waiting list and their RTT clock stopped.

Part Three – Reference Material

Annex 1

DEFINITIONS

A

Active monitoring

A waiting time clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage.

A new waiting time clock would start when a decision to treat is made following a period of active monitoring (also known as watchful waiting). Unless the patient is coming from patient choice period of unavailability.

Admission

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

Admitted pathway

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

ASI – Appointment Slot Issues

This occurs when there are no appointments available on the E-Referral System. In these instances, the ERS system informs the provider that the patient requires an appointment

B

Bilateral (procedure)

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

C

Care Professional

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

Clinical Decision

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

Consultant

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

Consultant-led

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

Convert(s) their UBRN

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

D

DNA – Did Not Attend

DNA (sometimes known as an FTA – Failed to attend). In the context of consultant-led waiting times, this is defined as where a patient fails to attend an appointment/ admission without prior notice.

Decision To Admit

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

Decision To Treat

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

DRSS – Devon Referral Support Services

DRSS works on behalf of all practices in Devon and East Cornwall as a referrals contact centre, supporting individuals in getting the right advice, care or treatment in a timely manner.

E

e-RS – e-Referrals

The NHS e-Referral Service (e-RS) combines electronic booking with a choice of place, date and time for first hospital or clinic appointments.

F

First Definitive Treatment

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

Fit And Ready (In the Context of Bilateral Procedures)

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

H

Healthcare Science Intervention

See Therapy or Healthcare science intervention.

I

Interface Service (Non Consultant-Led Interface Service)

All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care.

Consultant-led referral to treatment relates to hospital/consultant-led care. Therefore, the definition of the term 'interface service' for the purpose of consultant-led waiting times does not apply to similar 'interface' arrangements established to deliver traditionally primary care or community provided services, outside of their traditional (practice or community based) setting.

The definition of the term does not also apply to:

- Non consultant-led mental health services run by mental health trusts.
- Referrals to 'practitioners with a special interest' for triage, assessment and possible treatment, except where they are working as part of a wider interface service type arrangements as described above.

N

NHS e-Referral Service (Choose and Book)

A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic.

Non-Admitted Pathway

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

Non Consultant-Led

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

Non consultant-led interface service

See interface service.

P

Patient Pathway

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

Planned Care

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

R

Reasonable Offer

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

Referral Management or Assessment Service

Referral management or assessment services are those that do not provide treatment but accept GP (or other) referrals and provide advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient.

Referral Management and Assessment Services should only be in place where they carry clinical support and abide by clear protocols that provide benefits to patients. They must not be devices either to delay treatment or to avoid local clinical discussions about good referral practice.

A waiting time clock only starts on referral to a referral management and assessment service where that service may onward-refer the patient to a surgical or medical consultant-led service before responsibility is transferred back to the referring health professional.

Referral To Treatment Period

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

S

Straight To Test

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

Substantively New or Different Treatment

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

It is recognised that a patient's care often extends beyond the consultant-led referral to treatment period, and that there may be a number of planned treatments beyond first definitive treatment.

However, where further treatment is required that did not form part of the patient's original treatment plan, a new waiting time clock should start at the point the decision to treat is made.

Scenarios where this might apply include:

- Where less 'invasive/intensive' forms of treatment have been unsuccessful and more 'aggressive/intensive' treatment is required (for example, where Intra Uterine Insemination (IUI) has been unsuccessful, and a decision is made to refer for IVF treatment).
- Patients attending regular follow up outpatient appointments, where a decision is made to try a substantively new or different treatment. In this context, a change to the dosage of existing medication may not count as substantively new or different treatment, whereas a change to medication combined with a decision to refer the patient for therapy might.
- Ultimately, the decision about whether the treatment is substantively new or different from the patient's agreed care plan is one that must be made locally by a care professional in consultation with the patient.

T

TCI

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

Therapy or Healthcare Science Intervention

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

U

UBRN (Unique Booking Reference Number)

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

Annex 2

REFERRAL LETTER INFORMATION REQUIREMENTS MINIMUM DATA SET (MDS)

- Referring clinician
- Practice Address including postcode
- Telephone number
- Practice code
- Practice Generic Email Address
- NHS Number
- Eligibility for NHS Treatment
- Patient Surname
- Forename(s)
- Date of Birth and Age
- Sex
- Ethnicity
- Address
- Postcode
- House telephone
- Mobile telephone
- Any accessible information requirements
- Specialty/Department
- Date
- Presenting complaint
- Reason for referral
- Expected outcome
- Treatments tried and outcomes
- Significant PMH
- Relevant investigations
- Current medication
- Allergy history
- Interpreter required? If so which language?
- Does this patient have a learning disability? Yes/No
    - If yes, note to providers: *please ensure that reasonable adjustments are made to effectively meet the needs of this individual*

OPTIONAL DATA ITEMS

- BMI (to assess suitability for offering providers with BMI referral criteria)

- Smoking status

Annex 3

REFERRAL TO TREATMENT CONSULTANT-LED WAITING TIMES RULES SUITE

Clock Starts

1. A waiting time clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to:

   a) 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.

   b) 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.

2. A waiting time clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional permitted to do so.

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

   a) When a patient becomes fit and ready for the second of a consultant-led bilateral procedure.

   b) Upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.

   c) Upon a patient being re-referred into a consultant-led; interface; or referral management or assessment service as a new referral.

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

   e) When a patient rebooks their appointment following a first appointment Did Not Attend (DNA) that stopped and nullified their earlier clock.

Clock Stops

A clock stops for treatment when:

   a) First definitive treatment starts. This could be:

i) Treatment provided by an interface service.

ii) Treatment provided by a consultant-led service.

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

b) A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

Clock Stops For 'Non-Treatment'

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

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

   b) A clinical decision is made to start a period of active monitoring.

   c) A patient declines treatment having been offered it.

   d) A clinical decision is made not to treat

   e) A patient DNAs their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient

2. DNAs for a first appointment following the initial referral that started a waiting time clock nullify the patient's clock (in other words, it is removed from the numerator and denominator for Referral to Treatment time measurement purposes).

3. A patient DNAs any other appointment and is subsequently discharged back to the care of their GP, provided that:

   a) The provider can demonstrate that the appointment was clearly communicated to the patient.

   b) Discharging the patient is not contrary to their best clinical interests.

   c) Discharging the patient is carried out according to local, publicly available/published, policies on DNAs.

   d) 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.

Annex 4

NATIONAL ELECTIVE CARE STANDARDS

Referral to Treatment	
Incomplete Pathways	92% of patients on an incomplete pathway (i.e. still waiting for treatment) to be waiting no more than 18 weeks (or 126 days)
Diagnostics	
Applicable to the following diagnostic investigations	99% of patients to undergo the relevant diagnostic investigation within 6 weeks (or 41 days) from the date of decision to refer to appointment date
All the standards within the table above are set at less than 100% to allow for tolerances which apply in the following scenarios:	
Exceptions	• Applicable to RTT pathways where it is in the patient's best clinical interest to receive treatment past 18 weeks.
Choice	• Applicable where patients choose to extend their pathways via rescheduling previously agreed appointment dates or admission offers or making themselves unavailable for a period of time.
Co-operation	• Applicable where patients do not attend previously agreed appointment or admission date

Elective Access Governance Arrangements - UHP

Scope

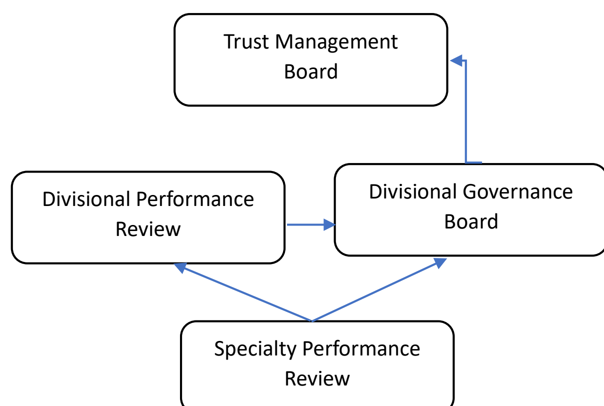
The Trust's Accountability Framework describes the Trust-wide approach to the governance, accountability and performance management including elective care waiting lists across all Divisions, Directorates and Service Lines. It covers Referral to Treatment (RTT) pathways, cancer and diagnostics waiting times, patient tracking list (PTL) processes, booking and scheduling, and escalation.

These Elective Access governance arrangements are adapted from the Accountability Framework for elective pathways. They operationalise devolved leadership through clear PTL ownership, pathway rules, and transparent consequences linked to performance and governance. They are mandatory for all teams managing elective demand, capacity and scheduling, and should be read alongside Trust Administrative Process Notes, Devon Health Community Elective Access Policy, Administrative Delivery Standards, Commissioning Policies and Referral Criteria.

Key Aims

- Provide a single, standardised operating framework for the management of elective waiting lists aligned to Trust values and devolved leadership.
- Clarify responsibilities, escalation routes across Service Lines, Directorates, and Divisional levels.
- Provide assurance on the delivery mechanisms of national access standards and Trust trajectories.

Overarching Governance Structure



Pathway Management / Clinical Admin manager / Operational Manager Roles

- Own and maintain accurate PTLs for all specialties within area of responsibility
- Day-to-day pathway management: Daily cashing up of clinical decisions, add, track, validate, book and treat within targets; manage clinics, theatres and other schedules to match demand.
- Ensure Data Quality issues are managed and fixed within Trust Standard Timescales
- Apply national RTT, cancer, and diagnostics rules consistently and without exception; ensure data quality and clock stops are recorded correctly.
- Proactive variation management e.g. DNAs, cancellations, long waiters, PIFU, virtual pathways.
- Delivery of local improvements to maximise capacity utilisation and effective housekeeping
- Engage patients with clear communications, choice, shortest appropriate wait (including mutual aid and independent sector where agreed).

Directorate Level Roles

- Coordinate PTL oversight, validation, Data Quality and performance improvement across service lines.
- Lead capacity planning and annual elective operating plan with finance and workforce alignment.
- Operate elective access governance: weekly Directorate PTL meeting; risk register oversight; incident learning; complaints themes.
- Deliver recovery plans for backlogs and long wait cohorts as per priorities.
- Ensure that roles and competencies are included in recruitment documentation, annual appraisals and individual performance reviews.

Divisional Level Roles

Monthly Divisional Performance Reviews will include a dedicated elective access section focusing on quality, performance, people, finance and strategy for elective pathways. Action logs and Risk Registers must be maintained and cross-divisional issues escalated to the Executive Team as required. All Divisions must produce a RACI summary for sharing across all stakeholder teams.

- Translate Trust strategy into elective recovery plans with clear trajectories and milestones.
- Assure data quality, governance and compliance with access standards across Directorates.
- Balance resources across specialties; assessing and decision making on competing demands for theatres, clinics, diagnostics and beds.
- Lead divisional performance reviews and escalate cross-divisional risks.

Corporate Department Enablers

Performance & Information

- Production of performance reports, PTL data standards, Performance dashboards, forecasting and modelling, productivity escalation.

Finance

- Production of financial information detailing affordability, FIP alignment, independent sector contracts etc.

People

- Production of information to support workforce plans, job planning, and effective use of non-medical colleagues to support the matching of elective demand.

6 Overall Responsibility for the Document

The Head of Patient Access has overall responsibility for the co-ordination, dissemination and implementation and review of this document.

7 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of two years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be reviewed by the Trust Management Executive and ratified by the Chief Operating Officer.

Non-significant amendments to this document may be made, under delegated authority from the Chief Operating Officer, by the nominated owner. These must be ratified by the Chief Operating Officer.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes.

8 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document owner will be responsible for agreeing the training requirements associated with the newly ratified document with the named Director and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

9 Monitoring Compliance and Effectiveness

After approval and publication, the Clinical Administration Training Team will run and coordinate mandatory training sessions, to familiarise staff with the policy. The sessions will also enable staff to ask questions about the use of the policy.

The process of tracking compliance will be monitored by monthly Data Quality and waiting list compliance reports.

10 References and Associated Documentation

South & West Devon Formulary and Referral – Referral Policies
Trust Documents – APNs
NHS Constitution
Cancer Services Operational Policy
Paediatric Safeguarding Policy
Vulnerable Adult Safeguarding Policy
Private Patients Policy
Overseas Visitor Policy

Dissemination Plan and Review Checklist — Appendix 1

Dissemination Plan			
Document Title	Elective Access Policy Devon Health Community		
Date Finalised	November 2024		
Previous Documents			
Action to retrieve old copies	Remove existing document on Staff Net and replace		
Dissemination Plan			
Recipient(s)	**When**	**How**	**Responsibility**
All Trust staff		Information Governance StaffNet Page	Information Governance Team
All relevant Trust Staff	Ongoing	Email and Training Sessions	Patient Access Team

Review Checklist		
Title	Is the title clear and unambiguous?	Yes
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Yes
	Does the style & format comply?	Yes
Rationale	Are reasons for development of the document stated?	Yes
Development Process	Is the method described in brief?	Yes
	Are people involved in the development identified?	Yes
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Yes
	Is there evidence of consultation with stakeholders and users?	Yes
Content	Is the objective of the document clear?	Yes
	Is the target population clear and unambiguous?	Yes
	Are the intended outcomes described?	Yes
	Are the statements clear and unambiguous?	Yes
Evidence Base	Is the type of evidence to support the document identified explicitly?	Yes
	Are key references cited and in full?	Yes
	Are supporting documents referenced?	Yes
Approval	Does the document identify which committee/group will review it?	Yes
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A
	Does the document identify which Executive Director will ratify it?	Yes
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Yes
	Does the plan include the necessary training/support to ensure compliance?	Yes
Document Control	Does the document identify where it will be held?	Yes
	Have archiving arrangements for superseded documents been addressed?	Yes
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes
	Is there a plan to review or audit compliance with the document?	Yes
Review Date	Is the review date identified?	Yes
	Is the frequency of review identified? If so, is it acceptable?	Yes
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes

Equalities and Human Rights Impact Assessment | Appendix 2

Core Information	
Date	November 2024
Title	Elective Access Policy – Devon Health Community
What are the aims, objectives & projected outcomes?	The purpose of this policy is to ensure that: • All of our services must be available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief. • Access to our services is based on clinical need. • The planning and delivery of our services must be focused on patient experience. • Our services must reflect the needs and preferences of patients, their families and their carers through the provision of choice wherever possible. • The NHS works across organisational boundaries and in partnership with other organisations in the interests of patients and the wider population. • PHNT is committed to providing the best possible value for money to deliver the most effective and fair use of finite resources. • All services are accountable for supplying adequate and suitable capacity to meet the needs of their patients.
Scope of the assessment	

Collecting data	
Race	Should aid inclusion but no data Collected
Religion	Should aid inclusion but no data Collected
Disability	Should aid inclusion but no data Collected
Sex	Should aid inclusion but no data Collected
Gender Identity	Should aid inclusion but no data Collected
Sexual Orientation	Should aid inclusion but no data Collected
Age	Should aid inclusion but no data Collected
Socio-Economic	Should aid inclusion but no data Collected
Human Rights	Should aid inclusion but no data Collected
What are the overall trends/patterns in the above data?	No Data Collected
Specific issues and data gaps that may need to be addressed through consultation or further research	No Data Collected

Involving and consulting stakeholders	
Internal involvement and consultation	Performance Team, Head of Business Admin and Projects, Chief Operating Officer
External involvement and consultation	Representatives from all other acute providers within the Community
Impact Assessment	
Overall assessment and analysis of the evidence	Will allow for practice that encapsulates DEI objectives

Action Plan

Action	Owner	Risks	Completion Date	Progress update

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