Trust Policy	Worcestershire Acute Hospitals NHS Trust

Elective Care Access Policy v21.1

Department / Service:	Operations / Patient Access
Originator:	Head of Elective Performance and Access RTT/ Data Systems and Training Manager
Accountable Director:	Chief Operating Officer
Approved by:	Trust Management Board
Date of approval:	31st July 2024
First Revision Due: **This is the most current document and should be used until a revised version is in place**	31st July 2027
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All Directorates
Target staff categories	Clinical and administrative staff managing elective pathways

Policy Overview:
The Trust is committed to promoting an environment that values diversity. All staff are responsible for ensuring that all patients and their carers are treated equally and fairly and not discriminated against on the grounds of race, sex, disability, religion, age, sexual orientation or any other unjustifiable reason in the application of this policy. Recognising the need to work in partnership with and seek guidance from other agencies and services to ensure that special needs are met. This policy describes how the Trust manages access to its key services and ensures fair treatment for all patients. This document is intended to be used by all staff in the local health economy dealing with waiting list management. It will ensure that patients will be treated in order of clinical priority, and that patients of the same clinical priority will be seen in turn.

Key amendments to this document

Latest Amendments/Additions to this policy:	
Updates:	**Additions/removals:**
Training and compliance	PIFU – Patient initiated follow-ups
Streamlined policy	Patient availability and Active monitoring
Updated links	Pathway Milestones
P codes	Cancer section removed

Contents

1. Access Policy Statement

This policy describes how the Trust manages access to its key services and ensures fair treatment for all patients. The successful management of waiting lists is key to achieving NHS England's objectives in reducing waiting times and improving Patient Choice. The Referral to Treatment (RTT) rules provide the framework for managing patient pathways.

The policy will state the arrangements for the management of waiting lists. It includes guidelines and procedures to ensure that waiting lists are managed effectively, a high quality of service to patients is maintained, and optimum use is made of resources at all locations within the Trust. The policy will support the training provided on the application of the RTT rules for both clinical and administrative staff to ensure that patient pathways are consistent, and patients are treated equitably.

This document is intended to be read, in full, and used by all staff in the local health economy dealing with waiting list management. It will ensure that patients will be treated in order of clinical priority, and that patients of the same clinical priority will be seen in turn. It will also help provide equity of access within specialties across sites throughout the Trust.

The policy is not intended to replace local and departmental operational policies and procedures including defined Patient Administration System (PAS) processes set out in PAS user guides, but to act as a framework to support them. It will be reviewed annually to ensure that it accurately reflects changing local, regional and national priorities.

The policy will be supported by a comprehensive suite of Standard Operating Procedures (SOPs) for use by clinical and non-clinical staff who will ensure that they follow the specific instructions and guidelines within this policy and the supporting SOPs.

1.1 Access Policy Structure

The Policy will include:

- General principles and Trust Standards
- RTT and diagnostic rules and application
- Pathway specific milestones

1.2 Equality Health Impact Assessment (EHIA)

An EHIA was completed prior to the writing of this policy and referred to throughout.

2. Referral to Treatment (RTT) pathways key standards and general principles

2.1 Introduction

This Policy has been developed and reviewed through investigation of best practice, nationally and locally. This has included partnership working with Integrated Commissioning Boards (ICBs), and

the Elective Access Team. It has been developed to align to the NHS England model access policy accessed on 11/03/2024.

Clinical staff, managers and clerical staff have an important role in managing waiting times effectively. Treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt communications with patients is a core responsibility of the Trust and the wider local health community.

The aim of this document is: -

- To establish a consistent approach to patient access across the Trust.
- To ensure that national and local standards of care are consistently complied with by all staff involved in patient access.
- To provide an operational guide for all areas to consistently work in conjunction with local operational procedures, which cover the detail of the day-to-day administrative processes. This policy does not replace local operational procedures or 18 Week RTT Pathway Training but seeks to support them.

All eligible patients referred to the Trust for elective care are within the scope of this policy.

2.2 Standards and Key Principles

2.2.1 The NHS Constitution and NHS Choice Framework

For patients whose healthcare is the responsibility of NHS England the current maximum waiting times for elective care are set out in the NHS Constitution and NHS Choice Framework.

The NHS Constitution sets out the following rights for patients:

"You have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution. "

Patients have the right to start consultant-led treatment within 18 weeks from referral, where this is not possible, for the NHS to take all reasonable steps to offer the patient a quicker appointment at a range of alternative providers.

The following links provide more information:

- NHS Constitution
- NHS Choice Framework

2.2.2 Key Principles

- The policy must be applied consistently and without exception across the Trust. This will ensure that all patients are treated equitably and according to their clinical need. Ensuring that all groups of people are treated equally avoiding unfair and systematic differences that result in health inequalities, these patients fall into four main groups, socio-economic, geographical, socially excluded and people with specific characteristics i.e. ethnicity or sexuality. Where patients fall into more than one group there is an increased risk of inequality.

- All staff employed by Worcestershire Acute Hospitals NHS Trust will adhere to the Elective Care Access Policy.
- All stakeholders including, ICBs, directorates, patient representatives, patients and others will have access to this policy.
- A summary easy read version will be made available on the Trust's patient-facing website
- The policy will be applied in line with local commissioning policy, any referrals not meeting the commissioning criteria will be returned to the referring GP
- Both Worcestershire Acute Hospitals NHS Trust and Herefordshire and Worcestershire ICB is responsible for ensuring robust communication links are in place to feedback information to GPs.
- All patients must be seen in order of clinical priority and length of wait using the patient tracking list (PTL). Clinical priority is determined in line with the Clinical Priority Framework. The Trust will negotiate at least three weeks prior to TCI, appointment, admission dates and times with patients and ensure that offers of dates are within maximum waiting times.

The Trust relies on all referrers, to ensure patients understand their responsibilities, (including providing accurate address and contact details as per minimum data set standards set out in the NHS Data Dictionary, potential pathway steps and timescales when being referred. This will help ensure that patients are:

- Referred under the appropriate clinical guidelines.
- Ready, willing and available to receive hospital care
- That pre-referral diagnostics have been completed as part of the referral process by the GP or referring practitioner in line with agreed clinical pathways
- Aware of the urgency of their referral and requirement to be available to attend hospital appointments on any of the hospital sites and that patients may be offered an appointment that is not at the site closest to their home. Patients will be made aware via the GP that they can request a specific site but will be offered the next available, which may be at any of the trust sites and will be considered a reasonable offer if at least three weeks' notice has been provided.
- That any patient potentially requiring a procedure subject to a particular commissioning policy or individual funding request procedure has been informed of the applicable criteria and initial assessment where appropriate has taken place against the criteria prior to referral. Trust clinical teams are also responsible for ensuring compliance with commissioning policies and patient expectations. The policy will be applied in line with local commissioning policy.
- Patients are aware of their responsibilities for keeping appointments and giving as much notice as possible to the Trust if unable to attend.

2.2.3 Standards

In line with the above guidance the Trust will use the following standards when agreement appointment dates with patient or their representatives:

- Inpatient/daycase notification – Two different offer dates on different days to come in (TCI) with at least three weeks' notice given to patients is best practice. All offers of dates must be recorded on PAS as a planned admission; if the patient declines, the planned admission will be cancelled using the appropriate reason i.e. patient would like to reschedule – this will have no effect on the RTT clock as the patient has given notice and would like a further date.
- All patients cancelled by the Trust on the day of admission/operation for non-clinical reasons must have a guaranteed readmission date within 28 days. This will be recorded on PAS.
- Outpatient notification – Best practice is two appointment offers on different days for routine appointments with at least three weeks' notice. This includes face to face, telephone and video

appointments. Short notice offers can still be made but cannot be recorded as reasonable, unless the patient accepts. All appointment offers will be recorded on PAS as an out-patient appointment and cancelled with the appropriate reason. Where a short notice offer has been accepted and subsequently declined a note must be added to PAS clearly stating that the offer was originally accepted, declined and therefore is reasonable.

2.3 Roles and responsibilities

Although responsibility for achieving standards lies with the Divisional Directors of Operations and ultimately the Trust board, all staff that have access to PAS and manage patient pathways have a duty to ensure that all information on PAS or any other clinical system is accurate and up to date. All staff are accountable for keeping the clinical systems updated with accurate information and correcting data as appropriate. This will include tracing missing or incomplete patient information. It is the responsibility of the staff member entering a referral onto PAS to ensure that unique identifiers are used i.e. the patient's NHS number and never to change record details if the patient has not been searched for using a unique identifier. Incomplete data or referrals missing information must be returned for completion or the referrer contacted to provide the data as set out in the minimum data set (MDS) for referrals. This includes internal and external referrals. Executives will be responsible to the board of directors, ensuring that patient experiences and care are at the forefront of all care provided.

Head of Elective Performance and Elective Access

Is the responsible author for the Trusts Access policy, including updating and ratifying as and when required. Is responsible for responding to changes in National policy guidance and making those changes to the policy. This role will establish and monitor the appropriate systems and processes to ensure that the Trusts commitments to health inequalities as it pertains to elective access is delivered.

RTT Data Systems and Training Manager

Is responsible for developing and implementing a training strategy to support the delivery of RTT training incorporating PAS processes and for the development and delivery of the Trust's Elective Access Training strategy. Providing support and liaising with directorates to ensure application of the RTT rules and the Elective Care Access policy guidance is used appropriately.

Information Manager

The information department are responsible for supplying accurate patient tracking lists (PTLs) to support divisions in complying with RTT standards and managing their waiting lists. They will provide supporting KPI (Key Performance Indicator) reports and DQ reports to support operational managers to achieve the access standards.

Divisional Directors of operations

Are responsible for the delivery of elective waiting time standards and targets including RTT and diagnostics, in line with the Elective Care Access policy. They must ensure that all operational managers have completed relevant training regarding waiting list management and RTT rules and manage patients in accordance with the policy.

Operational Managers

Ensure compliance with the Elective Care Access Policy by providing SOPs relevant to their division/ job roles and ensuring training is provided to all relevant staff so that staff understand all processes pertaining to their role and that all data entered into PAS is accurate and entered in a timely manner. They will ensure that all relevant staff attend training sessions and take appropriate action when staff are not adhering to the policy, this will be monitored via the KPI reports and data quality reports. They will view and monitor the PTL daily and ensure that pathways are updated appropriately. They will ensure that the NHS e-referral directory of services (DOS) is accurate and up to date.

Clinicians

Have a responsibility to complete an outcome form for every patient, at the time of the scheduled patient contact (including for patients who do not attend) ensuring that they accurately state the next step for the patient. This will apply to all appointments including telephone and video consultations. Where the consultation is not on site an electronic outcome form will be used and forwarded to the relevant email address.

Waiting list administrators, clinic staff, secretaries, booking clerks

Administrative staff and medical secretaries will ensure that Clinicians are aware of patients on the waiting list and ensure that patients are seen in order of clinical urgency and length of wait.

They are responsible for applying the rules, set out in the Access Policy, to all daily management of their waiting lists. They will be supported by Operational Managers and supporting reports from the information department. They are responsible for ensuring that patient's demographics are correct this includes contact details, change of GP or updates for next of kin etc. patient details should never be changed to make a referral fit the patient. i.e. a patient's date of birth must never be altered, where a date of birth, or any other demographic appears to be incorrect checks will be made and unique identifiers (NHS Number) will be used to ensure the correct patient is selected. The patient's 18 week RTT pathway will be updated when changes occur. The pathway will be checked by all medical secretaries when typing clinical correspondence or making any changes to the patient pathway that may affect the RTT 18 week clock. This could include updating the pathway, outside of a clinical setting, following the receipt of diagnostic results with the correct RTT clock action and RTT status updated on PAS i.e. where the patient has been informed of diagnostic results and can be discharged back to the GP.

Where patients are booked past the current RTT Incomplete Key Performance Target or patients on a planned waiting list or follow-up waiting list, they will be escalated following the Elective Care Escalation policy

Secretaries must check the Unoutcomed report on WREN as part of their daily work for any unknown outcomes reported and either update the outcome PAS accordingly or email the booking co-ordinator with instructions to change the outcome accordingly.

Reception staff

Reception staff will confirm demographic details are correct at every appointment and update PAS where appropriate. This will include asking the patient:

- to confirm their name
- to confirm their address
- to confirm their telephone number
- to confirm their GP practice
- to confirm their ethnicity if not already recorded on PAS
- Ask the patient if they consent to text message reminders if not already recorded on PAS

These details will be conformed with the information available on PAS, if the information has changed or is not recorded PAS will be updated, without delay.

Receptionists will ensure that all clinics are routinely outcomed on the PAS on the day and always within 24 hours. Where an outcome has not been returned by the clinician or where the outcome is unclear, they will enter an outcome of unknown.

General Practitioners (GPs)

GPs will ensure that the patient is aware of the expected waiting time for a new out-patient appointment and make the patient aware that they do have a choice of provider. Patients that choose to be seen at Worcestershire Acute Hospitals NHS Trust, should be made aware that the appointment could take place on any of the hospital sites and will be offered an appointment at the site with the shortest waiting times. Offers at all sites, including through third party providers on behalf of the Trust, will be considered reasonable offers, the GP must inform any patient that requests a specific site that the request will be noted but cannot be guaranteed. They will inform the patient that when they are contacted, they should endeavour to make themselves available. The GP will inform the patient of the clinical urgency and the importance of attending appointments i.e. suspected cancer referrals. They will encourage patients to be referred to a service rather than a clinical team, as this will ensure that no patient waits longer than necessary for treatment. They will inform the patient, that should they request a specific consultant, that there is no guarantee they will be seen by the requested consultant but will be seen by one of their team.

The GP will ensure that the patient's demographics are up to date and included with the referral. The following are mandatory:

- Registered GP
- NHS Number
- Full Name
- DOB
- Address
- At least one contact number, including mobile number if available
- Email address if available
- Ethnicity information
- Any information that will support addressing health inequalities or patient rights

Integrated Commissioning Boards (ICBs)

The ICB will ensure that lines of communication are open and robust for giving feedback to the GPs. They should also ensure that all referrals are sent via the correct route into the Trust, with the correct pro-forma attached (if required) and have the appropriate information included.

Patients

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

- Patients should be registered with a GP practice, this will be the main point of access to NHS care as commissioned by NHS bodies.
- Patients will provide accurate information regarding their health, condition, status and demographics. They will inform the Trust of any changes to demographics so that PAS can be updated, ensuring no delay in treatment.
- Patients should make every effort to attend appointments and if required to cancel give as much notice as possible.
- If an appointment is no longer required, where possible the patient should give as much notice as possible to the Trust of the cancellation, to enable the appointment to be reallocated.
- Patients must make every effort to attend appointments at any site, to prevent delay in treatment and ensure they are treated in turn.

2.4 Staff Training/ Competency and Compliance

2.4.1 RTT and Access Policy Training

The Trust is working towards creating a comprehensive training programme that will be applicable to their role. This will include all new and existing staff, clinical and non-clinical where their role involves elective care. The training programme will be supported by SOPs (Standard Operating Procedures). The Trust will also work towards making RTT Training mandatory, with a platform to report attendance and pass and failure rates.

2.4.2 PAS Training

To book PAS training contact Wah-tr.ICT-Training-Admin@nhs.net Training manuals are available on the IT Training intranet page.

2.4.3 Competency

- All new starters, managing elective (RTT) patient pathways will be required to attend RTT Training as part of their induction process.
- Existing staff will undergo mandatory RTT training that is applicable to their role, with yearly refresher training.
- Staff will complete competency tests, which will be recorded to provide evidence they have the correct skills and knowledge for their role. This will be supported by additional training where required.
- This policy will provide the framework for the training programme with the supporting SOPs.

Competency of data input, national rules/guidance and any relevant legislation will be measured using the reports available from the information department and published on WREN, these will include:

- Access Policy KPI (key performance indicator) reports. The reports will focus on the standards published in the Access policy.

- Data Quality Reports will look at where pathways/information is not logical or in line with RTT rules and/or where issues have been found previously.
- Incomplete PTLs, Shiny report and Elective Planned PTLs will be used in conjunction with other reports to ensure accuracy.
- Bi Yearly audits will examine the accuracy of the outcome selected from an out-patient setting and the outcome recorded on PAS.
- Monthly clock stop audit will take a random sample of clock stops from the previous month and audit them to check if they are correct.

2.4.4 Compliance

Where the above reports, competency checks and audits indicate that staff are not compliant with the Access Policy rules, their line manager will be contacted, and the user offered further training. If following additional training the staff member is still not compliant, then the manager will follow the appropriate HR policy to support the colleague to make the necessary improvements.

2.4.5 Governance

This table outlines the Standard Operating Procedures (S.O.P) that will enable the effective management of patient pathways as described within this policy:

SOPS	**Responsibility**	**Available/ Needs update/ Not available**
Communication contacting the patient (Uncontactable)	Booking Services	Not Available
Unavailability	RTT/ Data Systems and Training Manager	3 months
PIFU	RTT/ Data Systems and Training Manager	Available
IPT	RTT/ Data Systems and Training Manager	1 month
Elective planned	RTT/ Data Systems and Training Manager	1 month
P Code clinical prioritisation	RTT/ Data Systems and Training Manager	3 months
On the day cancellations TCI 28 day cancellations	Elective Access	3 months
DMAS	Elective Access Pathway Administrator	Available
Inpatient / theatre bookings	Surgery Division Leads	3 months
Outpatient booking guides and SOPs	Booking Services Manager	Available
Managing and booking patients for diagnostic tests	Radiology booking services	Available

This table outlines the Information Reports that will enable the effective management of patient pathways as described within this policy:

Reports	Responsibility	Available/ Needs update/ Not available
RTT Data Quality Report	Information Department	Available
LUNA	Information Department	Available
Access Policy KPIs	Information Department	3 Months
Missing outcomes/ outcome unknown	Information Department	Available
Chronological booking report	Information Department	3 Months
Clock stop new patient not seen or discharged	Information Department	Not Available
IPWL Stops	Information Department	Available
Planned past their repeat date	Information Department	Available
DNA 1st appointment	Information Department	Available
Patients transferred to therapies with completed appointment in therapies clock still ticking	Information Department	3 Months
PIFU/PCFU	Information Department	Available
Patients on 2 x treatment waiting lists	Information Department	3 Months
Hospital on the day cancellations	Information Department	Available
Unavailability monitoring IPWL	Information Department	3 Months
Virtual Clocks for clock re-starts	Information Department	3 Months
Overdue follow ups	Information Department	Available
Active monitoring overdue	Information Department	Available

This table outlines any additional requirements that will enable the effective management of patient pathways as described within this policy:

Additional requirements	Responsibility	Available/ Needs update/ Not available
RTT Training to be added as a competency for all new starters and a yearly refresher for all staff managing elective pathways	Mandatory training team to support and add the requirement	6 Months
Develop RTT training applicable to role	RTT Data Systems and Training Manager	6 Months
Develop competency tests (Role specific)	RTT Data Systems and Training Manager	6 Months

In addition to the above, elective access performance will be monitored via weekly Specialty specific meetings and fortnightly Patient Tracking List (PTL) Meetings. These will be chaired by the Head of Elective Performance and Patient Access.

2.4.6 Monitoring

Key performance indicators (KPIs) will be monitored via the access policy KPI reports and DQ reports supplied by the information department as defined in this policy. The RTT Validation Department will monitor the KPIs and feedback as necessary to the operational teams.

3. National RTT rules

Referral to Treatment
92% of patients on an incomplete pathway i.e. still waiting for treatment, to be waiting no more than 18 weeks or 126 days.

The NHS constitution sets the maximum wait for the whole of the patient pathway from GP referral to first definitive treatment is a maximum of 18 weeks for at least 92% of patients on incomplete pathways.

Those patients who choose to wait longer should have their wishes accommodated without being penalised. The tolerance of 8% set for achievement of the incomplete pathway waiting time operational standard is there to take account of the following situations that might lead to a longer waiting time:

- Patients who choose to wait longer for personal or social reasons e.g. patient who wish to delay treatment until after a holiday or special event.
- Patients for whom it is clinically appropriate to wait longer (this does not include clinically complex patients who can and should start treatment within 18 weeks) e.g. where it is necessary to complete a series of diagnostic tests prior to starting treatment.
- When external factors result in the patient waiting longer i.e. a pandemic.

As a general principle, the Trust expect that before a referral is made for treatment on an 18-week pathway the patient is both clinically fit for assessment and possible treatment of their condition and are available to start their pathway from two weeks of the initial referral.

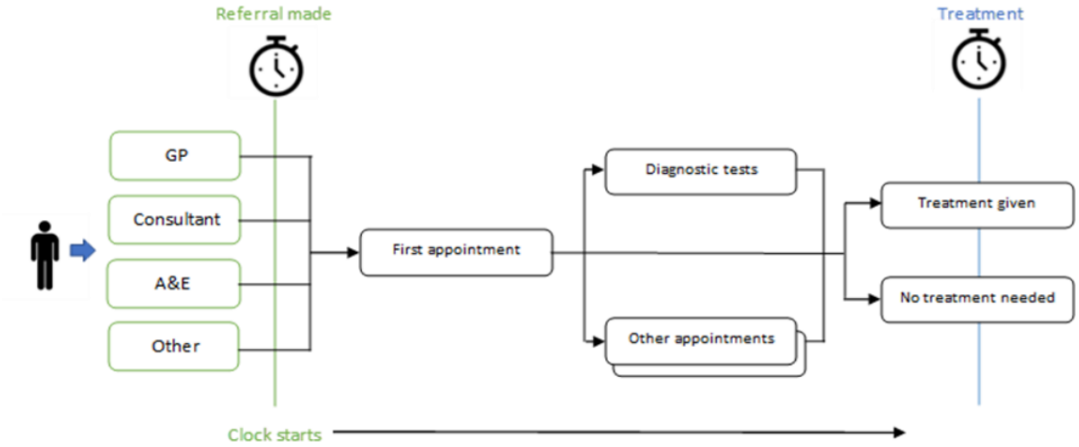
Once a referral to treatment (RTT) waiting time clock has started it continues to tick until:

- The patient starts a first definitive treatment i.e. the patient is given medication or has surgery, expected to treat the condition for which the patient was referred.
- A clinical decision is made that stops the clock for non-treatment i.e. the patient does not require any intervention at present to manage their condition, however clinically it is best for the patient to be monitored regularly for any changes in their condition. The patient will attend regular follow-up appointments.
- Patient declines treatment.

Patients should be allowed to choose their time of treatment taking account of clinical advice where undue delay may present a risk to them. The clinician will decide if it is appropriate to delay and, in some circumstances, may decide it is in the best interests of the patient to discharge them back to the GP.

3.1 Overview of national rules

The image below shows the chronological order and key stages of a typical RTT Pathway



The following professions and services accepted by the three Worcestershire ICBs may commission 18-week pathways and start an 18 week RTT clock to a consultant led service:

- General practitioners (GPs)
- General dental practitioners (GDPs)
- General practitioners (and other practitioners) with a special interest (GPSI's)
- Optometrists and Orthoptists
- Emergency Department (ED)
- Genito-urinary medicine clinics (GUM)
- National screening programmes
- Specialist nurses or allied health professionals with explicit Herefordshire and Worcestershire ICB authorisation
- Prison health services
- Consultants, or Consultant-led services, for a new condition – routine referrals excluding referrals from the Emergency Department will need to be via the GP.
- Other Hospital Trusts for treatment (Inter-provider transfer)
- Private patients

An RTT clock starts when any of the above healthcare professionals refer a patient to the Trust for any consultant led elective service for the patient to be assessed and, if appropriate, treated before responsibility is transferred back to the GP. GP referrals will only be accepted when made via eRS. For NHS e-Referral Service referrals, the clock starts on the date the unique booking reference number (URBN) is converted.

3.1.1 Clock starts for the same condition

Some patients, following initial referral, may have more than one clock stop and start along the pathway i.e. the patient may initially be offered physiotherapy, the clock will stop on the first appointment with the physiotherapy team. Once the course of physiotherapy is complete the clinician may decide that the patient needs further intervention and offers surgery. The decision to

admit will start a new RTT clock. If the patient has a previous clock stop and becomes symptomatic, the clinician may decide to proceed initially with diagnostic tests. In this instance the clock will only re-start once the diagnostics are complete and a new decision to treat has been made.

3.1.2 New clock start following a period of active monitoring

For some patients it will not be necessary to treat them immediately following referral, in this instance the patient may embark on a period of active monitoring. During this period the patient may have diagnostics procedures to monitor the patient's existing diagnosed condition and will be subject to regular follow-up appointments. If there is a new decision to treat, following a period of active monitoring, a new RTT clock will be started from the date of the decision i.e. the patient has been monitored regularly and a diagnostic test shows that the patient's condition has progressed and the patient would now benefit from surgery. The clock will be started as soon as the new decision to admit is made. If the patient has a previous clock stop and becomes symptomatic, the clinician may decide to proceed initially with diagnostic tests. In this instance the clock will only re-start once the diagnostics are complete and a new decision to treat has been made.

3.1.3 Decision to start a new treatment

To start a new clock the patient must be offered a new type of treatment, this should not be part of an existing treatment plan i.e. the patient is treated with medication and following review it is decided that the patient should now be listed for surgery.

3.1.4 Bilateral procedures

A new RTT clock will be started once the patient is fit and ready for the second bilateral procedure e.g. a patient needs cataract surgery on both eyes, the patient would attend and have surgery on the first eye and would only be listed for the second eye once they are fit, willing and available for surgery.

3.2 National Rules

Clock Stops

The RTT clock stops when the patient receives the first definitive treatment (see below) for the condition for which they have been referred. Other clock stops may occur following a consultation, receipt of results from a diagnostic test or following surgery or other specific treatment.

The following clinical decisions stop the clock, on the date the decision is communicated to the patient and GP, or the original referrer if not the GP. The decision to stop the clock can be made verbally or in writing, where the decision is communicated in writing the clock will stop on the date the letter is typed:

3.2.1 For treatment:

First definitive treatment (RTT status code 30)

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

3.2.2 Non-treatment:

Active monitoring (RTT status code 31 or 32)

Active Monitoring will commence when a decision is made (and agreed with the patient) that it is clinically appropriate to start a period of monitoring, possibly whilst the patient receives symptomatic support, but without any specific or significant clinical intervention at this stage. The patient cannot be placed on active monitoring if they are still undergoing diagnostic tests. Active monitoring can be initiated by the clinician or the patient e.g. the patient is referred with increased ocular pressures, at this point they are elevated but require no treatment. The patient can be placed on active monitoring and followed up at specified intervals.

Clinical decision not to treat (RTT status code 34)

Clinical decision not to treat will be used when it is not appropriate to treat the patient at this time. Patients should be discharged back to their GP and their referral and pathway closed on PAS

DNA – First activity (RTT Status code 33)

If the patient does not attend the first appointment following referral the RTT clock can be nullified. This will mean that the clock will stop and will only be restarted if the patient is offered a further appointment following clinical review. A new clock will need to be started manually from the date the appointment is booked. This applies to all types of appointment face to face/video/telephone. The patient will have been notified in advance and appointment date/time agreed.

Patient declined offered treatment (RTT status code 35)

Treatment has been offered and the patient has declined. Where the patient declines all treatment they should be discharged back to the referrer

Patient died before treatment (RTT status code 36)

If the patient dies before treatment the clock will be stopped on the date of death.

3.2.3 Patient is added to a matched transplant list

A decision is made to add a patient to a transplant list for a matched transplant and this has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay. Where donor material is not readily available the patient will be added to the IPWL using the **waiting list type 13P,** the RTT clock will be stopped using Clinician decision to begin

active monitoring (RTT code 32). This excludes corneal transplants that are not a matched transplant and therefore the clock will tick until treated.

3.2.4 Discharge back to the GP/external referrer

A decision is made to return the patient to primary care for non-medical/surgical Consultant-led treatment in primary care, assuming that no treatment or intervention is required in acute services (RTT code 34)

i.e. a decision is made to return the patient to Referral Management Centre (RMC) etc. for treatment if the treatment is not to be medical or surgical Consultant-led treatment e.g. the patient is referred to Ear, Nose and Throat, the clinician reviews the referral and decides that the patient doesn't require acute services and refers the patient to community audiology services (RTT code 34).

3.2.5 Non- activity related RTT decisions/ Happy letter process

Decisions can be made outside of a clinical setting regarding a patient's treatment plan that will stop the patient's RTT clock. This could be results being reviewed or a discussion at MDT. The clock is stopped when the patient is informed of the results or decisions. This is usually the date a letter is typed to the patient, however other methods of communication can be used but should be documented either in the patients notes or on PAS when adding the administrative clock event.

3.3 Exclusions

There are some exclusions to RTT. These patients may still be referred to consultant-led services however it is not appropriate for them to be recorded as RTT. The patients that fall into the categories below will be recorded as Non-RTT, assuming that the original referral was direct and not via other consultant led services that are subject to RTT.

- Obstetrics and Midwifery
- Elective planned patients
- Referrals to non-consultant led services
- Referrals for patients from non-English commissioners
- Genitourinary medicine (GUM) services
- Emergency pathways
- Follow-up patients following an emergency admission e.g. A patient that is admitted via the emergency department (ED) with acute appendicitis, the patient has surgery, and a follow-up is required 6 weeks post-surgery.
- Patients that are referred from other providers, after treatment, for follow-up.

3.3.1 Non consultant led pathways and RTT clocks

Referrals can be made in two ways to non-consultant led pathways and are managed differently:

- Patients referred internally from a consultant led service, the non-consultant led service will link all their activity to the existing open RTT pathway. The referral may result in a clock stop

for first definitive treatment or the clock may continue to tick as the therapy is not considered the definitive treatment.

- Patients referred directly to the non-consultant led service will be recorded as Non-RTT and therefore will not have a RTT clock.

Physiotherapy

Orthopaedic pathways are often referred to physiotherapy, how the pathway is managed depends on the intended management of the patient:

- If the referral is intended to manage the patients' condition, without any further intervention then the clock would stop at the point of the first appointment.
- If surgery is still required and the physiotherapy is an interim treatment, the clock will continue as the surgical procedure is the definitive treatment.

Dietetics

When a patient is referred to dietetics for advice, with no other form of treatment anticipated the clock will be stopped. If the advice forms part of a pathway where further intervention is required i.e. a surgical pathway, the clock will continue to tick until the surgical procedure takes place.

Surgical appliances

Where a patient is referred for a surgical appliance, without any other form of treatment being agreed, the clock will stop for first definitive treatment.

Speech and Language Therapy (SALT)

If the patient is referred to SALT and no further treatment is required the clock will be stopped, if the patient is referred for advice prior to a procedure or further intervention intended to manage the patient's condition the clock will continue to tick.

3.4 DNA

The process for managing non-attendance at appointments is the same for both children and adults; action taken to manage non-attendance will be based on clinical need, analysis and understanding of risk and full appraisal of existing health records.

Careful consideration must be given to assessment of any safeguarding concerns related to the non-attendance of appointments of children, young people and adults at risk in accordance with the WAHT Safeguarding Children and Safeguarding Adults policy and appropriate inter-agency procedures for safeguarding children and adults. Furthermore, collaboration with other agencies and appropriate sharing of information should be considered in order to inform safe and robust decision making.

Children and Young People

Patients who have transitioned from paediatric teams must be given further opportunities of appointments if they DNA to allow consideration for the adjustment of care and time to settle within the adult teams.

If the young person DNA their first appointment offered, then a further appointment must be offered within a timely manner and a letter sent by the adult team to the young person and family and GP. The family need to be included as the young person may have moved out of the area to university for example.

If the young person further DNAs their 2nd appointment then a further appointment should be offered however contact should be sought with the young person to try and understand the reason behind the DNA. This could be done by the Consultant, Clinical nurse specialist, the GP or by the transition nurse if referred via generic email wah-tr.transitionintoadultcare@nhs.net.

Vulnerable Adults

With vulnerable adults who do not attend, the GP will be asked to consider why they did not attend and to include safeguarding concerns within this. For adults who already have safeguarding issues, the failure to attend will be highlighted to the appropriate professionals by the clinician.

A patient can be discharged following a clinical review. This is provided the Trust can demonstrate the following:

- The TCI date was clearly communicated to the patient and can evidence the TCI date was reasonable
- Discharging the patient is not contrary to their best clinical interests
- Discharging the patient is carried out according to the local, policy on DNA's
- Discharging the patient does not affect their clinical interests. In particular this includes, vulnerable patients (e.g. children) and it has been agreed with clinicians, commissioners, patients and other relevant stakeholders that it is safe to discharge the patient back to the care of their GP.

3.5 Multiple RTT periods same pathway

An RTT pathway can have more than one clock start this could be for:

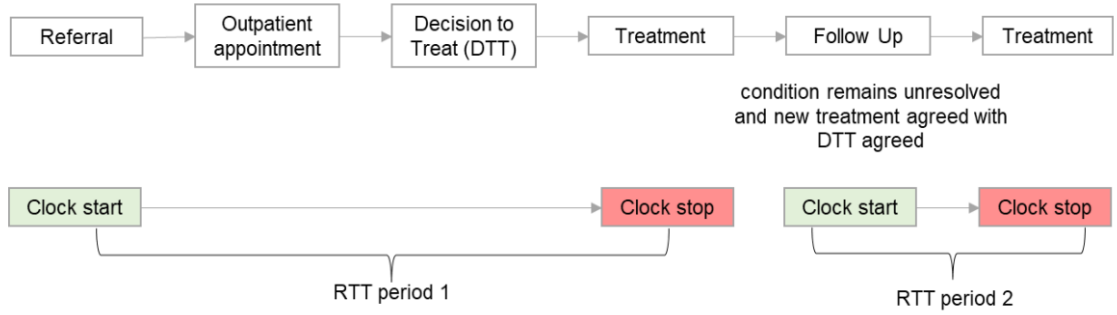
patients requiring a Bilateral procedure

The patient may require surgical intervention on both sides of the body i.e. eyes and it would not be appropriate to perform both procedures at once. The patient would have the procedure on one eye which would initiate a clock stop. Once the patient was fit enough for the second procedure a new clock would be started following the new decision to treat. The treatments may not take place immediately after each other, there may be longer periods where surgery is not currently appropriate and the patient will be reviewed until surgery is indicated.

Chronic Recurring Conditions

Some patients will be referred with conditions that are longer term and require various treatment interventions. The patient could initially be given medication to treat the condition and after a period of time this becomes less effective. The clinician may then indicate a procedure is required and the patient is added to the in-patient or day case waiting list. Following the decision to admit (DTA) a new clock will be started on the same pathway. The period between the initial stop and the clock start for treatment, could be a stop for non-treatment i.e. active monitoring.

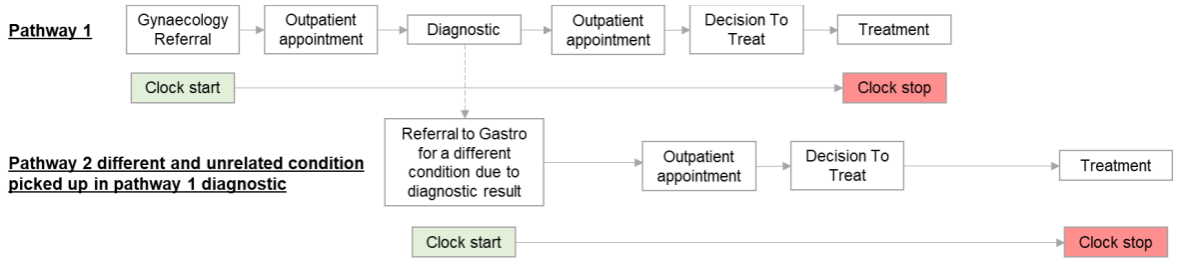
The figure below shows an example of multiple clock starts on the same pathway



Multiple RTT Pathways

Where a patient has more than one referral for unrelated clinical reasons, each referral will have its own patient pathway and separate RTT clocks. In this instance it is important to understand any impact on the management of their different conditions, for example where treatment for one condition affects the planning of another treatment, or where a period of recovery is needed before undergoing treatment for another condition. Clinical and operational teams should implement co-ordinated care pathways as appropriate for patients on multiple pathways. There may be cases where it's appropriate for a period of active monitoring to be agreed on one pathway while the patient undergoes and recovers from treatment on another pathway that's considered to be the clinical priority.

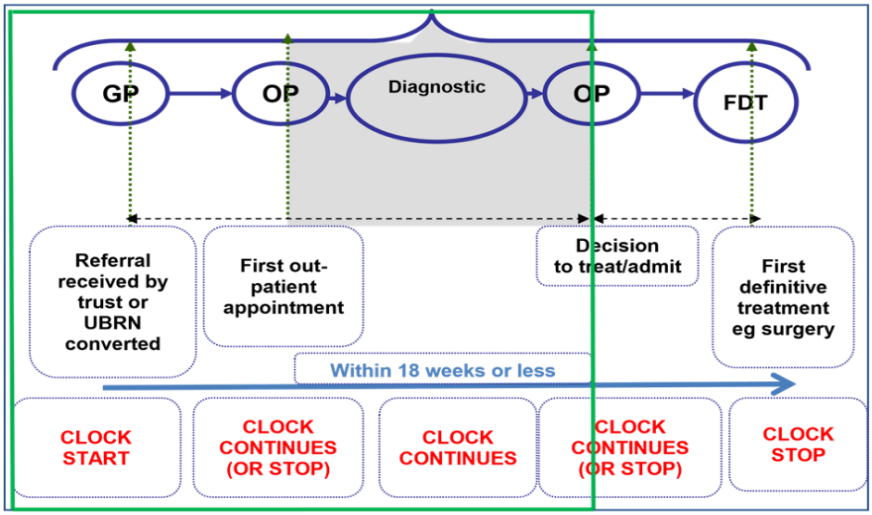
Below is an example of where an incidental find following a diagnostic starts a pathway and clock for a new unrelated condition.



4. Non-Admitted Patients

Non- admitted pathways are defined by the clock stop being initiated without the need for a surgical in-patient or day case procedure. The clock stop may not be entered on the first appointment following referral but could be stopped on subsequent follow-up appointments or following diagnostic tests.

The section indicated below shows the non-admitted stages of an RTT pathway.



4.1 Patients' rights

Access to health services for the Armed Forces Community

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 of and access to healthcare as any other UK citizen in the area they live.

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.

Veterans receive their healthcare from the NHS and should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need.

Prisoners

All elements of the Access Policy are relevant to the population of His Majesty Prison Services and patient rights under the NHS constitution apply equally to this population. Hospital appointments will need to be managed within the prison regime and the Patient Access Policy and standard operating procedures. 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.

4.2 Patient eligibility

Not all NHS-funded treatment is free for everyone. The NHS is a residency-based healthcare system and eligibility for relevant services without charge is based on the concept of 'Ordinary

Residence'. An 'overseas visitor' is any person who is not Ordinarily Resident in the UK. Patients who are not Ordinarily Resident in the United Kingdom will be required to pay for access to relevant NHS services. All providers of NHS-funded services have a legal obligation to identify patients that are not eligible to access NHS treatment without charge.

Treatment within an Accident & Emergency Department is exempt from charge for everyone, but if further treatment is required charges may apply.

Urgent or immediately necessary treatment should not be denied or withheld in relation to ability to pay (invoices will be raised retrospectively as appropriate). However, elective planned care should not be provided to a chargeable overseas visitor patient unless payment has been received in advance.

The Trust's Overseas Patient Team work to identify patients who may need to pay for their healthcare. Patient records on the National Care Records Service (NCRS) may contain a banner indicating a patient's chargeable status. Any member of staff who has reason to believe that a patient may not be 'Ordinarily Resident' in the UK should contact the Overseas Patient team to enable an assessment to be made against the National Health Service (Charges to Overseas Visitors) Regulations to determine whether a patient is required to pay.

Overseas Visitor Patients accessing NHS treatment are not private patients despite paying for their healthcare and are subject to the same access protocols and waiting times as Ordinarily Resident patients accessing NHS treatment.

Department of Health guidance on NHS cost recovery can be found here: NHS cost recovery - overseas visitors

For internal enquires please visit the Overseas Visitors intranet page.

Moving between NHS and private care.

Patients can choose to convert between NHS and private status at any point during their treatment without prejudice. All routine referrals for patients wishing to transfer from the private sector to the NHS, can be referred directly to the NHS Trust of their choice without the need to be seen and referred via their GP. Patients that are referred as a 2 week wait (suspected cancer) or the condition is life-threatening will be accepted, without delay and a referral added.

Patients who are referred via their GPs from a private service may be added direct to the IPWL, if following clinical review, the clinician agrees that this is appropriate. This will mean that the patient will not need an out-patient appointment prior to the decision to admit. This is a clinical decision and some clinicians may request the patient is seen initially in an out-patient clinic.

For patients that are seen privately but then transfer to the NHS, if they are transferring on to a RTT pathway, the RTT clock should start at the point at which the clinical responsibility for the patient's care transfers to the NHS, i.e. the date when the Trust receives the referral for the patient.

Patients whose Healthcare is commissioned by NHS Wales (Local Health Boards)

Any patient whose healthcare is commissioned by a Welsh Local Health Board that requires an elective procedure or an out-patient appointment need to obtain prior approval, initiated by the consultant. If the patient's postcode falls within Wales then the Trust will need to obtain an approval

number prior to seeing the patient, so that we can charge the Local Health Board (LHB). The individual patient funding request form (IPFR) will be completed and sent to the relevant LHB to obtain approval.

Exceptions to the above:

- Patients that have an English GP as their care is commissioned by the ICB based on the GP's address.
- A patient that fall under the Powys Local Health Board - as a contract is already in place to treat these patients without prior approval

Commissioner approved procedures and evidence-based interventions.

Patients referred for treatment outside of existing commissioning policies will follow the agreed individual funding request policy (IFR – Individual Funding Request).

Prior approval will need to be given from the relevant ICB, where a specific treatment has limited clinical evidence of effectiveness, or where the procedure could be considered cosmetic.

4.3 Methods of referral

Referral Letters- Routine and urgent referrals

All Routine and Urgent Referral letters to a consultant led service should be sent to the central outpatient booking office. The referrals can be received by the Trust in two forms; paper referrals (only acceptable from specified referral routes, see section 1.12) and the national E-Referrals System (ERS), all GP referrals will only be accepted via eRS. Any referrals that are received by medical secretaries will be date stamped and redirected within 24 hours of receipt to the Central booking team.

Both fall into two categories:

- Generic referrals to a pooled waiting list in a given speciality.
- Consultant specific referrals.

All referrals should be made to a service (an open/generic referral) rather than a named clinician. This is in the best interests of the patient as it promotes equity of waiting times and allows for more timely access to services for patients.

As a general principle, generic referrals will be sent to the consultant with the shortest waiting time in that speciality. However, it is the patient's right to request a clinical team and this needs to be documented within the body of the letter, the patient will be allocated an appointment with the named consultant's team; this may not be with the consultant themselves.

Paper referrals

Referrals from professionals other than GP are not required to be sent via the eRS but instead should be emailed to where possible to the appropriate generic email address for each speciality.

Paper referrals from other accepted sources will follow the process below:

All paper referrals must be date stamped upon receipt at point of entry to the Trust. They must then follow the agreed referral-processing route as outlined below.

All paper referral letters will be registered onto PAS within 24 hours of receipt reflecting the date received by the Trust. For patients referred by paper referrals this is the point that the Referral to Treatment (RTT) clock starts.

Referrals will be sent to triage teams for prioritisation. The only acceptable prioritisation should be recorded as 'Urgent' or 'Routine' in line with national guidelines. All triage should be completed within 5 days of receipt and sent to the central booking office. All patients should be given appointments within the agreed maximum timeframe for each specialty.

National E-Referrals System (e-RS)

All ERS referrals must be reviewed and accepted or rejected within 2 working days for an urgent referral and 5 working days for a routine referral by the clinical triage teams. In instances where there is a delay with the reviewing of these referrals, the booking team will escalate this to the Directorate manager. The RTT clock starts from the date the URBN is converted.

If a patient's appointment has been incorrectly booked or sent for assessment on the ERS system into the wrong service by the referrer, the Booking services team will re-direct the patient, after triage by the clinician, to the correct service and a confirmation letter of the appointment change will be sent.

If the ERS referral is for a service that is not provided by the Trust the referral will be rejected back to the referring GP, advising that the patient needs to be referred elsewhere, the reason for rejection must be recorded on ERS.

Where appropriate referrals for advice and guidance should be sent via ERS and responded to within 2 working days. If following the receipt of advice and guidance request, the clinician reviews the request and makes a decision that the patient has a suspected cancer; the clinician will internally upgrade the referral via email to the 2ww office, ensuring that there is no delay to the patients treatment.

Appointment slot issues

If, when the patient tries to book into a directly bookable service, there are insufficient slots the patient will appear on the ASI (appointment slot issue work list). These patients will be contacted within 2 working days by the central booking office to confirm an appointment date or add to the Outpatient waiting list.

e-RS Referral Assessment Service (RAS)

Referral Assessment Services (RAS) allow providers to:

- Assess the Clinical Referral Information from the GP/referrer without the need for an appointment being booked
- Decide on the most appropriate onward clinical pathway
- Arrange an appointment, where needed

- Reject/return the triage request to the original referrer with comment/advice, if an onward referral isn't needed)

Responsibilities:

General Practitioner
- Will identify a clinically appropriate service for their patients.
- Referrers should review the service details to ensure that the referral conforms to the service requirements (including exclusions)
- Use and attach proforma's where required
- Ensure that clinical referral information is added within the recommended timescales
    - Urgent referrals - within one working day
    - Routine referrals - within three working days
- Ensure that patients are supported in selecting their chosen provider/service. (Choice has been offered)

Service provider Clinicians
- Clinicians will review and triage referrals using eRS within the recommended timescales
    - Urgent referrals – within one working day
    - Routine – within two working days
- Ensure when selecting the triage outcome refer book later clear booking instructions are given, this will include listing the services suitable for booking. Clinicians will be provided with a list of their services.
- Ensure when selecting Return to referrer with advice a clear reason for rejecting the referral is given to the general practitioner, which should include onward referral options if appropriate.

Booking team
- Will review the appointments for booking worklist and action all triaged referrals within 5 working days.
- ID all patients by checking all demographics and updating the trust PAS.
- Ensure the RTT pathway is correct and updated to reflect the e-Referral start date.
- Will arrange suitable appointment or add to waiting list and contact the patient.
- Will upload referral information to CLIP

Booking team will escalate the referrals for review not triaged within the agreed timescales to Directorate Manager or nominated deputy.

Integrated Clinical Assessment and Triage Services (ICATS) Referrals/ referral management centres (RMC)

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

A referral from ICATS will need to accompanied by an Inter-provider transfer (IPT) form. The IPT will provide latest clock information, we may inherit a clock that is already ticking or the patient may be referred for new treatment and a clock should be started upon receipt of the referral.

Internal Referrals for the Same Condition

Internals referrals, that relate to the condition for which the patient was referred, will be made ensuring there is no delay. It will be clearly indicated in the referral that this is for an existing condition and the pathway will be included to ensure no duplication.

Consultant-to-Consultant referrals will be accepted in the following circumstances:

- to advance the management of the presenting or associated condition.
- When the referral is for investigation, management or treatment of a new condition
- Surgical assessment of an established medical condition with a view to surgical treatment
- Medical assessment of an established surgical condition with a view to medical management
- Anaesthetic risk assessment
- A&E referrals to fracture clinic
- Referrals that are part of the continuation of investigation/treatment of the condition for which the patient was referred. These will continue their existing pathway.
- Suspected cancer referral. This will be vetted and dated by the receiving consultant and upgraded if deemed necessary. Once upgraded the patient will be notified by the clinical team making the decision to upgrade and treated within 62 days of the date the referral was received by consultant.

Internal Referrals for a New Condition

Internal referrals that do not relate to the original GP referral but relate to a different unrelated condition may be referred internally within Worcestershire Acute NHS Trust in discussion with the patient and where it is in their best interests. This will be clearly indicated in the referral as a new condition with a new pathway and new 18-week RTT clock.

Guidance is available for consultant to consultant referrals in the Policy for Management of Consultant to Consultant referrals or the Consultant to Consultant Policy Summary for Clinicians need for treatment where the patient would normally be treated or managed in primary care, will be directed back to the GP.

PIFU (Patient Initiated Follow-Up) Referrals

Patients may be offered a PIFU appointment, this will give the patient the opportunity to be in control of their own care and initiate contact with the Trust if their condition changes or worsens. The PIFU SOP will provide guidance on managing PIFU pathways, however there are two PIFU options:

Discharge to PIFU – These patients are completely discharged, with the option to contact the Trust if they have any issues within the timescale indicated by the clinician. This could be quite short term or for a longer period of time. If contact is made within the time frame a new pathway is created following the PIFU process, this will be a RTT pathway but the clock will be stopped immediately. If following attendance/contact a new decision to treat is made a 18 week RTT clock will be started from the date of the decision. Discharged pathways will not be reopened.

Transfer to PIFU – These patients will remain on a waiting list or have a future appointment booked. These patients are usually on long term follow-up and will need to be reviewed at specific

times, this could be because of the medication they are prescribed or because they need a diagnostic test to ensure there are no changes. Between the appointments for review or diagnostics the patient will be offered the option to contact the Trust if they have any problems or changes to their condition. Patients that have been transferred to PIFU DO NOT require a new pathway any activity will be linked to the existing pathway. A new RTT clock will only be started if following assessment a new decision to treat is made.

PCFU – Please refer to the Cancer Access Policy

Rapid access chest pain clinic (RACPC) referrals

RACPC patients must be seen by a specialist within 14 days of the Trust receiving the referral. GPs will make the referral via RAS on ers – service name Cardiology - Rapid Access Chest pain - TRIAGE - Worcs Acute – RWP. The referrals will be screened daily and given a clinic appointment within the 14-day target.

Transient Ischaemic Attack (TIA) clinic referrals

- The TIA pathway is in place as a primary preventative measure to stop patients going on to have a Cerebrovascular Accident (CVA i.e. Stroke)
- Patients are referred internally via ED and via primary care and we work closely with our external partners (ICB) to ensure any (high risk) strokes are seen within or at least aimed to be seen within 24 hours.
- All referrals must be made on the correct profoma.

4.4 Inappropriate referrals

If a referral has been made and the special interest of the Consultant does not match the needs of the patient, the Consultant should advise the GP direct so that appropriate treatment can be sought. If the opinion of a different specialty is required, this should be made in agreement with the patient's registered GP and an onward referral made to appropriate consultant by the GP.

If the referral is for a service not provided by the Trust then the referral letter must be returned to the referring GP with a note advising that the patient must be referred elsewhere.

If the referral does not meet the Local Commissioning Policy, the Trust will not accept the referral and it will be returned to referrer, with a standard template letter from the Trust and the ICB, citing commissioning policy guidelines.

4.5 Inter-provider transfers (IPTs)

Incoming IPTs

Receiving transfers from other providers for treatment/care

The Trust will only accept inter-provider transfers for treatment where a defined clinical pathway has been agreed or where patient care has been explicitly accepted by the receiving clinician.

Where a patient is transferred to our Trust for treatment or care a referral must be made and an Inter-Provider Transfer (IPT) attached. The RTT clock will transfer with the patient and the IPT

should detail the stage of the pathway the patient is at. The IPT may be attached to the referral or could be sent separately but must be within 48 hours of the decision to transfer the patient being made.

The IPT will contain as a minimum:

Patient details

i. Patient name including title
ii. Correspondence address including postcode
iii. Date of Birth
iv. NHS Number
v. Local Patient Identifier (this is the number that identifies the patient on the referring Trusts PAS)

GP Details

i. GP Name/practice
ii. General medical practice code

Referring Organisation

i. Organisation Name
ii. Referring organisation code
iii. Name of referrer
iv. Referrer code
v. Treatment function code

Referral to Treatment: Pathway status details

i. Patient Pathway Identifier (every patient pathway is unique; the pathway identifier will be linked to the patient, until all interaction for the condition which they were referred is completed).
ii. Organisation code
iii. Referral to Treatment period status
iv. Decision to refer date
v. Referral to Treatment period start date
vi. Referral raised reason

Receiving organisation

i. Organisation name
ii. Organisation code
iii. Treatment function code

Details of transfer

i. Service requested date

Receiving requests from other providers for diagnostic test/second opinion

Where a request is made for a second opinion or a diagnostic test the clock will remain with the referring Trust. The referring trust will include a minimum dataset (MDS) and will clearly state what the referral is for.

4.6 Outgoing inter-provider transfers (IPTs)

Transferring a patient's treatment/care

Where a patient needs to be transferred to another provider for treatment an Inter-provider Transfer form (IPT), must be completed and emailed to the relevant provider within 48 hours of the decision to transfer being made. This includes details of the patient's 18 week RTT status and current waiting time. The patient's 18-week clock will transfer to the alternative provider at this stage. A copy of the IPT form must be kept in the patient's notes. PAS will be updated using outcome code **21- Transfer to another healthcare provider.** If the transfer decision is made outside of a clinical attendance i.e. at MDT the clock stop will be entered manually on PAS as an administrative clock event. If the patient is not returning to the Trust for follow-up the pathway will need to be ended e.g. the patient is going to have surgery for a cochlea implant at another Trust, follow up is not required as all follow-up appointments will take place at the Trust where the surgery takes place. The clock will stop and the pathway will be ended. The patients care will be transferred completely. If subsequently a follow-up is required at Worcester Acute Hospitals an IPT will be required.

If the patient is transferred and it is agreed that treatment will take place but all follow-up care will be delivered by Worcestershire Acute Hospitals, then the pathway will not be ended, however the clock will still be stopped using outcome code **21- Transfer to another healthcare provider.** All follow-up appointments will be attached to the original pathway; a new clock is not started unless there is a new decision to treat.

Transferring for diagnostics/second opinion

Where a patient needs to be transferred to another provider for advice or diagnostic tests a referral including minimum data set (MDS) must be completed and faxed/emailed to the relevant provider within 48 hours of the decision to transfer being made. The patient's 18-week clock will remain with the referring Trust; the RTT status should be recorded as **20 – Subsequent activity in an RTT period**. A copy of the referral\MDS form must be kept in the patient's notes.

4.7 Communication

All communication should be clear and concise; this includes any communication with anyone involved in the patient's care, along the pathway including the patient. Copies of all correspondence must be kept electronically in the patient notes for auditing purposes.

The initial referrer must be kept informed of the patient's progress in writing. When treatment is complete this will be clearly communicated to the GP/referrer in writing.

4.8 Reasonableness

Outpatient appointments – For an outpatient appointment, including telephone and video consultations, to be deemed reasonable the offer should be made with at least three weeks' notice, best practice is two offers with three weeks' notice.

4.9 Uncontactable via telephone

Where an initial attempt has been made to contact the patient, without contact being made, a further two attempts will be made. The calls will be made at different times of the day. If it has still not been possible to contact the patient a letter or text validation should be sent giving the patient two weeks to make contact with the trust. If all efforts have been made to contact the patient and there has not been a response the patient will be referred back to the referrer, if agreed by the clinical team.

4.10 Attendance and outcomes

All Outpatient Clinic attendances must have a definitive clinic outcome recorded on PAS.

- It is the responsibility of the lead Clinician to ensure all clinic outcomes are accurately documented on the Clinic Outcome Form this any procedures taking place in within an outpatient clinic setting must be recorded on the reverse side of the outcome form in the clinical coding section.
- The information must be recorded in real time, where possible and no later than 24 hours after the clinic.
- The Clinic Outcome Form must be completed in its entirety and accurately by the clinician to reflect the clinic outcome and RTT status from the outpatient consultation, any procedures that take place will be indicated on the front of the form and recorded in the coding section on the back of the form.
- The receptionist will be responsible for transferring the information from the clinic outcome form onto PAS. Where information is incomplete and the clinician is unavailable to update the form, the medical secretary will be responsible for checking the patient pathway and making amendments where appropriate when typing the clinic correspondence.
- Patients added to the follow-up waiting list will have a target date entered as indicated by the clinician. This will be the date the next appointment is due.

Where the consultation takes place outside of a face to face clinical setting i.e. a video or telephone appointment, the electronic version of the outcome form should be completed and forwarded to the appropriate generic email address to be actioned on PAS

OPA booked at WRH send the completed form to: wah-tr.OPA-Outcomewrh@nhs.net
OPA booked at KTC send the completed form to: wah-tr.OPA-Outcomektc@nhs.net
OPA booked at Alex send the completed form to: wah-tr.OPA-Outcomealex@nhs.net

4.11 DNA

The process for managing non-attendance at appointments is the same for both children and adults; action taken to manage non-attendance will be based on clinical need, analysis and understanding of risk and full appraisal of existing health records.

Careful consideration must be given to assessment of any safeguarding concerns related to the non-attendance of appointments of children, young people and adults at risk in accordance with the WAHT Safeguarding Children and Safeguarding Adults policy and appropriate inter-agency procedures for safeguarding children and adults. Furthermore, collaboration with other agencies and appropriate sharing of information should be considered in order to inform safe and robust decision making.

Children and Young People

Patients who have transitioned from paediatric teams must be given further opportunities of appointments if they DNA to allow consideration for the adjustment of care and time to settle within the adult teams.

If the young person DNA their first appointment offered, then a further appointment must be offered within a timely manner and a letter sent by the adult team to the young person and family and GP. The family need to be included as the young person may have moved out of the area to university for example.

If the young person further DNAs their 2nd appointment then a further appointment should be offered however contact should be sought with the young person to try and understand the reason behind the DNA. This could be done by the Consultant, Clinical nurse specialist, the GP or by the transition nurse if referred via generic email wah-tr.transitionintoadultcare@nhs.net.

Vulnerable Adults

With vulnerable adults who do not attend, the GP will be asked to consider why they did not attend and to include safeguarding concerns within this. For adults who already have safeguarding issues, the failure to attend will be highlighted to the appropriate professionals.

A patient can be discharged following a clinical review. This is provided the Trust can demonstrate the following:

- The TCI date was clearly communicated to the patient
- Discharging the patient is not contrary to their best clinical interests
- Discharging the patient is carried out according to the local, policy on DNA's
- Discharging the patient does not affect their clinical interests. In particular this includes, vulnerable patients (e.g. children) and it has been agreed with clinicians, commissioners, patients and other relevant stakeholders that it is safe to discharge the patient back to the care of their GP.

4.12 DNA – New appointment

Where a patient does not attend (DNA) a reasonably offered 1st (New) Out-patient appointment the RTT clock will be nullified. The clinician will review the patient's notes and decide if the patient will be offered another appointment or if the patient will be discharged back to the GP.

If after review the clinician decides that the patient should be offered a further appointment, the RTT clock will be restarted from the date when the appointment is rebooked. Patients that have failed to attend their new appointment and have not been re-booked as requested, will be monitored via a specific DNA report.

Where a patient fails to attend a first outpatient appointment on their pathway, they may be contacted and given a period of two weeks to contact the Trust to rebook their appointment. Where a patient fails to engage in their care, the clinician will be informed and decide whether to offer another appointment or if the patient will be discharged back to their GP.

If the patient is discharged, following clinical review, the referral will be discharged and the pathway ended. The referrer/patient will be informed in writing that the patient has had a clinical review and a decision has been made to discharge the patient, if the patient requires further treatment then this would require a new referral.

4.13 DNA – Follow-up appointment

If the patient DNAs a follow-up appointment of any type i.e. face to face/video/telephone the relevant clinician will review the patients notes and make a clinical decision on how to manage the patient. This can include giving the patient the opportunity to rebook their appointment (in which case the RTT clock continues) or the patient may be discharged, if the patient has a ticking clock, the clock will be stopped **35 - Patient declined treatment** the referral discharged and the pathway ended. The referrer/patient will be informed in writing of the decision and if the patient requires further treatment then a new referral will need to be made.

Where the clinician decides to give the patient a further opportunity to rebook their appointment, they will be add back to the waiting list or if appropriate the patient will be contacted and an appointment booked.

4.14 Chronological booking

All patients will be booked in chronological order; this will be based on clinical priority and length of RTT wait. Patients of the same clinical priority will be booked in RTT chronological order using the incomplete PTL (Patient Tracking List) i.e. they will be booked according to the length of wait with those patients waiting the longest being booked first.

4.2 Patient initiated cancellations and delays

New Appointments

Patients that cancel 2 x consecutive outpatient appointments for the same condition will be reviewed by the relevant clinician and a decision will be made regarding management of the patient. If the clinician decides that the patient should be offered a further appointment this will have no effect on the 18 week RTT clock. If the patient is discharged following clinical review, the referral will be discharged and the pathway ended.

The clinician will inform the patient and the GP in writing that they have been discharged and require a new referral if they want to be seen. This is provided that the Trust can demonstrate the following:

- The appointment was clearly communicated to the patient.
- Discharging the patient does not go against their best interests
- Discharging the patient is carried out according to the local, publicly available, policy on cancellations.
- Discharging the patient does not affect their clinical interests.

In particular this includes vulnerable adults and children and it has been agreed with clinicians, commissioners, patients and other relevant stakeholders that it is safe to discharge back to the care of their GP. Patients that cancel an appointment and do not wish to arrange another must have their referral discharged and the 18 week RTT pathway ended. The clock will be stopped using RTT status code 35 – Patient declined offered treatment.

Follow-up routine

Patients that cancel/reschedule 2 or more reasonably offered, routine appointments will have a clinical review, where the following options will be considered and if appropriate implemented.

- The patient will be discharged back to the GP, the clock will be stopped if ticking and the pathway ended. A clinician may decide to offer a PIFU arrangement
- A period of active monitoring will be started, the patient will indicate when they will be available and a review date will be added to PAS, this will be no more than 12 weeks. The patient will be given a date, where possible, for as soon as the period of unavailability ends. The clinician may decide it is appropriate to transfer the patient to a PIFU pathway A SOP will be available to support this process.

This is providing the Trust can evidence that:

- The appointment was clearly communicated to the patient.
- Discharging or monitoring the patient does not go against their best interests
- Discharging or monitoring the patient is carried out according to the local, publicly available, policy on cancellations.
- Discharging or monitoring the patient does not affect their clinical interests. In particular this includes vulnerable adults and children and it has been agreed with clinicians, commissioners, patients and other relevant stakeholders that it is safe to discharge back to the care of their GP.

Patients that cancel an appointment and do not wish to arrange another must have their referral discharged and the 18 week RTT pathway ended.

5. Pre-operative assessment

A preoperative assessment takes place prior to the patient being admitted for surgery.
Pre-operative assessment reasonableness – Appointment offers for pre-operative assessment are deemed reasonable if the patient is given three weeks' notice best practice is two offers with three weeks' notice.

5.1 DNA - pre-operative assessment

The POA must be deemed reasonable best practice is 3 weeks notice on two different dates.

A clinical review of the notes will take place by the treating clinician to decide on the management of the patient, these can include the following:

- If the patient is offered another appointment, the clock will continue and a further appointment will be offered, the appointment will be outcomed using RTT status **20 – Subsequent activity in a RTT period.**

If a decision is made to discharge the patient, the clock will stop using the RTT status **35 –Patient Declined Treatment**, and the pathway will be ended. The GP/patient will be informed in writing that they have been discharged and a new referral will be required if the patient still requires treatment.

5.2 Unfit short term transient condition:

A transient condition is a short-term condition that is temporary i.e. a cough, cold or UTI.

The 18 week RTT clock will continue and the patient will be added to the in-patient waiting list (IPWL), a note will be added against the IPWL confirming when the patient will be fit and the patient will be offered the first available TCI date following this date, according to clinical urgency and length of wait.

5.3 Unfit long-term condition:

Where the patient has a more serious condition that is likely to last longer than 2 weeks i.e. uncontrolled Blood pressure.

A clinical decision will be made regarding the management of the patient these include:

- Discharging the patient back to the GP for management of the condition. The GP/patient will be informed in writing of the parameters that need to be met before a new referral can be made. The clock will be stopped and the pathway ended.
- Managing the patient internally, the patient will be actively monitored (for a maximum of 12 weeks) using RTT Status **32 – Clinical Decision to Begin Active Monitoring**, the clock will stop and the patient will attend regular follow-up appointments. When the patient is fit a new 18 week RTT clock will be started and the patient will be added to the IPWL using RTT status code **11 – End of Active Monitoring**. A TCI date will be offered according to clinical urgency and length of wait.

5.4 Patients that are fit to proceed to surgery

Will be booked in turn according to clinical priority and waiting time.

6. Admitted Patients

Inpatient/Day case admissions **reasonableness**– For admission/To Come In (TCI) dates to be deemed reasonable the patient should be given at least three weeks' notice. Best practice is two offers with three weeks' notice.

6.1 Active waiting lists

The active waiting list should consist of patients awaiting a procedure/ diagnostic or treatment, who are available to attend within the waiting time standard.

Inpatient

The definition of an inpatient is any patient admitted electively or by other means with the expectation that they will remain in hospital for at least one night, including any patient admitted with this intention who leaves hospital for any reason without staying overnight.

Day case

The definition of a day case is 'A patient admitted electively during the course of a day with the intention of receiving care who does not require the use of a hospital bed overnight and who returns

home as scheduled. If this original intention is not fulfilled and the patient stays overnight, such a patient should be counted as an inpatient admission'.

6.2 Planned waiting list

Patients should only be added to a planned list where clinically they need to wait for a period of time. This includes planned diagnostic tests (e.g. check cystoscopy) or a series of procedures carried out as part of a treatment plan - which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.

Patients on planned lists should be booked in for an appointment at the clinically appropriate time and they should not have to wait a further period after this time has elapsed. For example:

A patient due to have a re-test in six months' time should be booked in and seen before this date, they must not wait more than the repeat date i.e. more than six months. This is not an acceptable use of a planned list. Patients who breach repeat dates should then have a new 18 week RTT clock started. This will be recorded on PAS.

When patients on planned lists are clinically ready for their care to commence and they reach the date for their planned appointment, they should either receive the appointment or be transferred to an active waiting list and a RTT waiting time clock should start, from the day after the repeat/target date (and be reported in the relevant waiting time return). The key principle is that where patient's treatment can be started immediately, then they should start treatment or be added to an active waiting list.

For Endoscopy, these Elective Planned (EP) patients need to have repeat endoscopies at clinically indicated intervals. The Consultant Gastroenterologist with reference to the British Society for Gastroenterology (Guidelines BSG) decides the interval. Dedicated surveillance lists are run, and each patient is allowed to choose their date of attendance on one of these lists. The booking clerk and Directorate Support Manager will review regularly any planned lists for their service to ensure that patient safety and standards of care are not compromised to the detriment of outcomes for patients. Patients should also be given written confirmation if they are placed on such lists, including the review date.

The unifying factor in all of these cases is that the required procedure cannot take place until a clinically specified time. Only these defined patients would be classed as planned admissions and as such they will not be part of the Trust's active waiting list.

6.3 Clinical prioritisation

All patients will be assigned a P Code for elective surgery at the point they are added to the IPWL. The P code will be assigned following consultation with the patient and assessment of clinical need. Once a P code has been decided, the code will be entered onto PAS with a review date. The maximum time between reviews is 6 months, reviews will take place within the timescale indicated or sooner if there has been a change in the patients' condition. Each time the patient is review this should be indicated on PAS.

P code	Booking Timescale	Review Timescale
P1a	Emergency procedures to be performed in < 24 hours – This does not apply to elective admissions	
P1b	Procedures to be performed in <72 hours – This does not apply to	

	elective admissions	
P2	Procedures to be performed in < 1 month	1 Month
P3	Procedures to be performed in < 3 months	3 Months
P4	Procedures to be performed in > 3 months	6 Months

6.4 Hospital cancellations

Every effort is made to ensure patients TCI dates are not cancelled. If a TCI date is cancelled before a patient is admitted, an alternative date should be agreed at the time of cancellation. This must be within the target wait. Theatre sessions must only be cancelled with a minimum of 6 weeks' notice.

6.5 On the day cancellations

When a patient's operation is cancelled by the Hospital for non-clinical reasons on the day of admission or day of operation, the Trust must offer another binding date within a maximum of 28 days. Breaches to this standard must be identified and reported.

All potential on-the-day cancellations must be escalated in line with the Trust cancellation policy (Cancelled Operations report) to the COO/ DCOO (in-hours) / executive on-call (out of hours) and every effort made to minimise these cancellations, which impact on the care and experience of patients. Records must be kept of last-minute cancellations; these must be reported daily on appropriate forms or entered on the information system for inclusion in weekly reporting process, 'sitrep' reports and quarterly returns as cancellations. Returns are made on the basis of elective cancelled patients only.

6.6 Patients that require more than one procedure

Two related procedures on the same pathway

If the patient needs more than one procedure, and they are to be performed in the same theatre session, then the patient will be listed on the IPWL with the primary procedure and the additional procedures noted.

If the patient requires more than one procedure that cannot be performed at the same time the patient will be listed for the primary procedure, the clock will stop when the procedure takes place. A new clock will start when the patient is fit, ready and able. The patient will be added to the IPWL when the DTA (decision to Admit) is made.

More than one procedure different pathways and conditions

A clinical decision will be made which of the procedures is most urgent. The patient will be added to the IPWL for the procedure deemed most clinically urgent. The clock will continue to tick until the patient is treated on the pathway.

Subsequent procedures, on different pathways, will have a clock stop entered. The clock will restart once a decision to treat (DTA) is made. This will be when the patient is fit, ready and able to tolerate the procedure.

6.7 Patient initiated cancellations and delays / DNA

Where a patient initiates a delay or does not attend a reasonably offered TCI the responsible clinician will make a decision, based on the patients' best clinical interests, on how to manage the patient. Each patient will be reviewed individually; the scenarios below will be used as guidance and as such will not be appropriate for all patients.

The process for managing non-attendance of appointments is the same for both children and adults; action taken to manage non-attendance will be based on clinical need, analysis and understanding of risk and full appraisal of existing health records.

Careful consideration must be given to assessment of any safeguarding concerns related to the non-attendance of appointments of children, young people and adults at risk in accordance with the WAHT Safeguarding Children and Safeguarding Adults policy and appropriate inter-agency procedures for safeguarding children and adults. Furthermore, collaboration with other agencies and appropriate sharing of information should be considered in order to inform safe and robust decision making.

Patients that DNA will be monitored via the DNA reports:

- DNA 1st Appointment
- DNA follow up appointment

Where the patient is failing to engage with the Trust a clinical review will be required to support attendance, the patient may be contacted, before offering a further appointment.

6.8 DNA - Admission

Patients that DNA a TCI date will have their notes reviewed by a clinician. If the clinician decides that the patient should be offered a further TCI date, the clock will continue and the patient will remain on the IPWL. The GP will be informed that the patient failed to attend. The patient may be contacted in writing and given two weeks in which to contact the Trust to rebook their treatment. If a patient fails to contact the Trust in this period, the clinician will be advised and decide whether to offer another appointment or if the patients will be discharged back to their GP.

If, following a review the clinician decides that it is in the patient's best clinical interests to discharge the patient, the clock will stop, the referral will be discharged and the pathway ended. The GP and the patient will be informed that they have been discharged in writing.

6.9 Thinking time following a decision to admit

Patients may wish to take some time and review all their treatment offers. It is not appropriate to stop the patient's clock if they request less than two weeks to consider their options. If the patient requests more than two weeks thinking time or does not notify the clinical team of their decision within the two-week period; then the clinician may decide to initiate a PIFU pathway where clinically appropriate for a period of up to six months, this will be discussed with the patient. Alternatively the clinician may:

- Book OPA to discuss decision with patient
- Discharge to external referrer/back to Primary Care

6.10 Patients that are unavailable

Patients may declare that they are unavailable for a period of time; this could be due to holidays, exam timetables or work commitments.

If the period of unavailability is less than 4 weeks then the patient will remain on the IPWL, a note will be added to the IPWL detailing the period of time the patient is unavailable for ensuring that offers are made outside of these times. The RTT clock will continue to tick.

Where the patient is unavailable for 4 weeks or more, a clinical review will need to take place and a decision made on further management of the patient:

- Where it is clinically safe for the patient to remain on the pathway, including the delay the clock will continue and a TCI date offered during the patient's availability.
- Where the clinician believes that a delay is unsafe the patient will be contacted, and this will be communicated to them the patient. Explaining that delaying treatment is unsafe.
- Where the patient is contacted and wishes to delay against clinical advice, it may be in the patients best clinical interests to discharge them back to the GP. The clock will stop when the patient and GP are informed of the decision and the patient will be removed from the IPWL and the pathway ended.
- Where the clinician believes that the delay may impact on the treatment offered, it may be appropriate to place the patient on a period on active monitoring i.e. following review the clinician believes that the delay is acceptable and no harm will come to the patient by the delay, the patient can be placed on active monitoring and reviewed. The patient must be informed of the decision either verbally or in writing depending on which is most appropriate. The patient's clock will stop and the following process will be followed:

    - The clock will be stopped
    - The patient will remain on the IPWL.
    - The patient will have a review date entered onto the IPWL that matches the date the period of unavailability ends with the appropriate reason. This cannot exceed 12 weeks.
    - The patient will be reviewed at the review date.
    - If the patient is now available a new clock will be started
    - The patient will be offered a TCI according to clinical priority and the RTT wait at the point of the clock being stopped and the review date entered. Where possible this will be agreed at the point the patient states, they are unavailable.

6.11 Patients that are unfit

Patients on the Inpatient Waiting List may become unfit and therefore unable to proceed with their admission. This can be found at pre-operative assessment or at any stage when a patient is awaiting an admission.

Managing patients that are awaiting an admission varies depending upon the reason for them being unfit. If a patient is unfit due to a transient condition (a short-term condition that is temporary i.e. a cough, cold or UTI) that is expected to be for 2-weeks or less, the patient will remain on the waiting list and no changes will be made to their RTT clock. A note will be added against the IPWL confirming when the patient will be fit and the patient will be offered the first available TCI date following this date, according to clinical urgency and length of wait.

Where the patient has a more serious condition that is likely to last longer than 2 weeks i.e. uncontrolled Blood pressure. It may be in the patient's best interest to start a period of active monitoring and transfer the patient to a PIFU pathway allowing them to re-engage when they are fit, ready and able to do so. Alternatively, the clinical team could consider:

- Discharging the patient back to the GP for management of the condition. The GP/patient will be informed in writing of the parameters that need to be met before a new referral can be made. The clock will be stopped and the pathway ended.
- Placing the patient on active monitoring until the patient is deemed fit to proceed with their admission. Decision to actively monitor will be communicated with the patient. The following process will be followed:
    - The clock will be stopped
    - The patient will remain on the IPWL.
    - The patient will have a review date entered onto the IPWL that predicts the date the patient will become fit for admission with the appropriate reason. This cannot exceed 12 weeks.
    - The patient will be reviewed at the review date.
    - If the patient is now fit a new clock will be started
    - The patient will be offered a TCI according to clinical priority and the RTT wait at the point of the clock being stopped and the review date entered.

6.12 Patients that decline or cancel TCI offers

All TCI offers should be reasonable (as set out in section X). All offers will be recorded on PAS as a planned admission and cancelled with the appropriate reason i.e. Patient cancelled before admission date. Short notice offers can and should be made where appropriate, however these cannot be counted as reasonable, unless the patient accepts the offer and subsequently cancels.

Where a patient declines or cancels two reasonably offered appointments, the clinician will review the notes to ensure that the patient is not clinically at risk by delaying their treatment. It may be in the patient's best interest to start a period of active monitoring and transfer the patient to a PIFU pathway allowing them to re-engage when they are fit, ready and able to do so. Alternatively, the clinical team could consider:

- Where it is clinically safe for the patient to remain on the pathway, including the delay the clock will continue and another TCI date will be offered.
- Where the clinician believes that a delay is unsafe the patient will be contacted, and this will be communicated to them the patient will remain on the pathway and the clock will continue. The patient will be offered a further TCI date.
- Where the patient is contacted and wishes to delay against clinical advice, it may be in the patients best clinical interests to discharge them back to the GP. The clock will stop when the patient and GP are informed of the decision and the patient will be removed from the IPWL and the pathway ended.
- Where the clinician believes that the delay may impact on the treatment offered, it may be appropriate to place the patient on a period on active monitoring. The patient's clock will be stopped. The following process will be followed:
    - The clock will be stopped
    - The patient will remain on the IPWL.
    - The patient will have a review date entered onto the IPWL with the appropriate reason. This cannot exceed 12 weeks.
    - The patient will be reviewed at the review date.

- If the patient is now available a new clock will be started
- The patient will be offered a TCI according to clinical priority and the RTT wait at the point of the clock being stopped and the review date entered.

The Directorate teams will monitoring cancellations and patient declines via the Consecutive patient cancellation report, this will be reviewed weekly and if the patient has breached the policy guidelines the patient should be escalated for clinical review. The clinician will either decide another offer should be made – in this instance the clock will continue. They may decide it is in the best clinical interests for the patient to be discharged back to the initial referrer. In this case the clock will stop the pathway will be ended and the referrer and patient will be informed.

6.13 Patients declining earlier treatment at an alternative provider

Some patients may be offered the option to be treated at another provider. All TCI offers must include the following and must meet the criteria for reasonableness:

- Date
- Provider
- Clinical Team

The same rules will be applied to these patients in regard to patients that are unavailable, cancel or decline TCI offers.

The above will also apply to any outsourcing agreement with a private provider.

Careful consideration should be given to social and clinical factors when offering patients alternatives. These factors could include access to transport, assistance and any limitations that would impact on the ability of the provider to treat the patient.

Further information is located at Recording and reporting referral to treatment (RTT) waiting times for consultant led elective care

6.14 Active monitoring

Active monitoring is a period when the patient does not require any intervention either diagnostic or surgical and all results have been communicated to the patient. However, there is still a requirement for the patient to be monitored and followed-up at regular intervals. Active monitoring can be initiated by the clinician or the patient but should be carefully considered before any decision is made.

If active monitoring has been initiated due to a patient being unavailable, unfit or cancelling/declining offers of activity; the patient must be reviewed within 12 weeks of the decision or less.

Where active monitoring has been initiated for other reasons, the period for review is considered on an individual basis and can exceed 12 weeks but no longer than 12 months, depending on clinical need. The process will remain the same with a target date entered onto PAS or the appointment booked according to the clinician's instructions.

Hospital initiated Active Monitoring

- Clinically it may be more appropriate to actively monitor a patient for a period of time. Active monitoring will only apply if the patient does not require any further clinical intervention at this time but clinically requires a follow-up appointment for monitoring purposes.
- It may be appropriate, if the patient is unavailable for a period of time, to apply active monitoring as stated in this policy i.e. if the patient is unavailable for more than 4 weeks and there has been a conversation between the clinician and the patient where it is agreed that active monitoring should be initiated.
- If the patient is offered two reasonable treatment dates at an alternative provider and they decline, the clinician following discussion and agreement from the patient, initiate a period of active monitoring. All TCI dates at alternative providers must include the date, provider and team.

Patient initiated Active Monitoring

Patients can initiate active monitoring, in some instances the patient may wish to decline treatment and see how they manage their condition without any intervention. There should always be clinical input and the patient should be made aware of any implications for delaying treatment. Clinically the patient will need to be reviewed every 12 weeks, however the patient can request to be actively monitored for any period. All patients will be visible on the Holistic PTL for non-RTT pathways and added to an appropriate waiting list with a review date so that they are visible on the waiting list reports.

Any patient commencing on a period of active monitoring will be given clear, written contact information and have a clear process for contacting the trust if their condition deteriorates or their circumstances change.

When a new decision to treat is made the patient will have a new RTT clock started as per RTT rules. If the patient deferred during the treatment phase of their pathway the patient will be treated in turn, according to clinical urgency and length of wait. The wait will be calculated from the wait when the patient was removed from the waiting list i.e. if the patient was removed at 10 weeks wait they would be dated as though they had a clock of 10 weeks.

6.15 Patients declaring periods of unavailability while on the in-patient/ day case waiting list

Where a patient indicates that they are unavailable for social reasons, this will be recorded on PAS, a clinical decision will be made to ensure that the next steps are appropriate for the patient, this may include active monitoring.

The clinician will assess the impact the delay could have on the patients condition and treatment plan. The following options may be considered:

- **Clinically safe for the patient to delay treatment** – if the delay requested is less than 4 weeks the treatment will be planned around the delay. If the delay is more than 4 weeks, the clinician will discuss options with the patient and if appropriate and agreed the patient can have a clock stop entered for active monitoring and regular reviews scheduled.
- **Clinically unsafe length of delay** – The clinician will contact the patient to ensure they understand the implications of the delay to their treatment. If the patient persists in requesting

the delay it may be appropriate to stop the clock and actively monitor the patient. This will be a shared decision and the patient will have a review to assess their condition and treatment options no later than 12 weeks after the decision.

- **Clinically unsafe length of delay** – the clinician may, following assessment, decide it is in the patients best interests to be discharged back to the GP. The clock will stop on the day this is communicated to the patient and the GP.

6.16 Appointment changes initiated by the hospital

Every effort is made to ensure clinics are not cancelled at short notice. Clinics must only be cancelled with a minimum of 6 weeks' notice. Clinical staff are encouraged to book, leave of any type, as soon as possible to prevent inconvenience to patients and poor practice.

Hospital cancellations may result in multiple patients being impacted to ensure that the Trust treats patients on clinical priority first and waiting time second.

Where a clinic with patients booked in to requires cancelling the patients will be contacted immediately with alternative dates. This ensures that patients on a RTT pathway are treated within timescales and patients without a clock are reviewed at the appropriate time.

Where a cancellation is initiated by the Trust there will be no amendment to the clock.

6.17 Mutual Aid

Mutual Ais Transfer Process, Digital Mutual Aid System (DMAS), Patient Initiated Digital Mutual Aid System (PIDMAS) – please refer to the SOP

Mutual Aid is part of the recovery plan to help providers reduce waiting times. It is also within patient choice requirements. It is a solution to relieve pressure from the most challenged areas within NHS Trusts, to reduce the volume of long waiting patients and improve access to care by pooling resources and moving patient care to where there is capacity with another provider. This will support the longest waiting routine patients to have equitable access to treatment, enabling them to choose to change to an alternative NHS provider regionally.

DMAS

Don't reference PIDMAS explicitly in policy as it might not happen – just allow for the use of systems to support patients to initiate mutual aid in line with national policy.

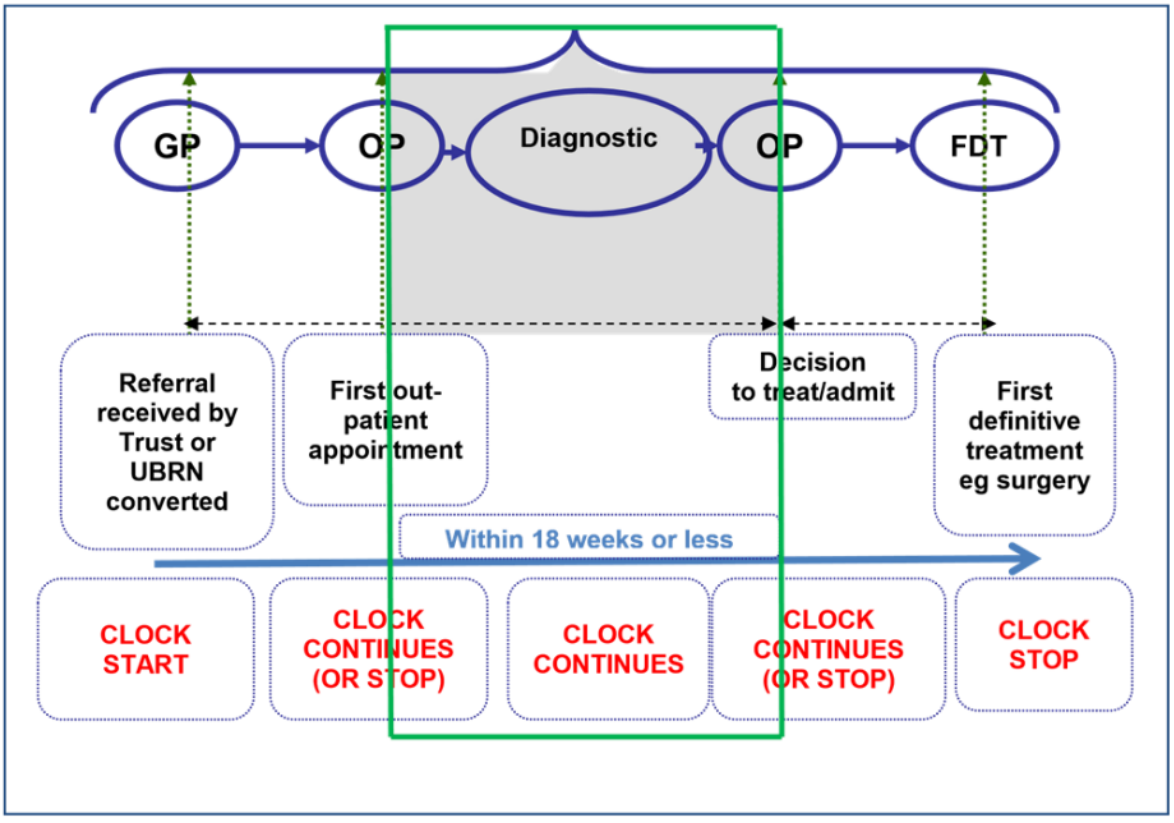
NHS Trusts were required to implement a system-wide solution called 'Digital Mutual Aid System' (DMAS) in 2023. This is a hospital-initiated process for requesting mutual aid for long, incomplete waiters, for both admitted and non-admitted activity. The Directorate Team enter individual patients (admitted) or cohorts of patients (admitted and non-admitted), following validation of the pathways, where they require support to the DMAS nationwide database. Providers with capacity in those areas can then elect to offer to accommodate those patients. Offers are then visible on DMAS which can be reviewed and considered by the Directorate Team. Throughout the process the patient remains on the waiting list at their current Trust to be dated, they will only be removed by the administrator, booking coordinator or medical secretary with confirmation from the nominated Directorate Manager/Team member when agreement is made between patient and new provider.

7. Diagnostics

7.1 Diagnostic pathways

The picture below shows the diagnostic phase of the pathway, indicated in the green border. The diagnostic stage starts when the decision to refer is made and stops when the results are reported. The diagnostic stage of the pathway forms part of the non-admitted pathway.

If the patient is referred externally for a diagnostic test the Trust will retain responsibility for the patient.



7.2 Patients with a RTT and Diagnostic Clock

Please note any adjustment to the six-week diagnostic standard as outlined above does not affect the patient's RTT clock if they are on an active RTT pathway. Their RTT clock will continue to tick. It is therefore important that Directorate Management Teams are aware of patients who are on both a diagnostic waiting list and RTT pathway and that their care is delivered in line with both national standards.

7.3 Straight to test - clinical review consultant led service

When a referral is made for a diagnostic test and the results are reviewed by a consultant led service, without the GP reviewing the results first, the clock will start from the point the referral is received for the diagnostic test. The patient in this instance will have both a diagnostic clock and a RTT clock.

7.4 Direct Access to Diagnostic Tests

Patients referred straight to test and the results go back to the referrer, remain the responsibility of the referrer and will not have a RTT clock, they will have a diagnostic clock running. These referrals are called direct access.

7.5 National diagnostic rules

The diagnostic waiting time clock starts when the request for a diagnostic test or procedure is made. This is when the request for a diagnostic procedure is entered on to Order Communications or by using the date written on the diagnostic request form by the referring clinician. This date is entered onto the relevant clinical system i.e. CRIS/ Medilogik EMS at the point of entry of the request form.

For direct access referrals, where it is the responsibility of the patient to arrange booking of the diagnostic appointment, the diagnostic waiting time should start at the point when the patient contacts the Trust to arrange the diagnostic appointment. For eRS, this will be the point when the UBRN (Unique Booking Reference Number) is converted.

All attendances must be recorded on the appropriate clinical system i.e. PAS/Medilogik EMS. This information should be recorded at the time of attendance.

Session templates must be adhered to; these will be continually monitored by Directorate manager, in conjunction with modality leads and booking managers who will ensure changes are made optimising the most effective use of session time CRIS will be the only tool for waiting list management, manual card or diaries alone are not acceptable they relate to manual backup only.

7.6 Patient initiated DNA

Where a patient does not attend a reasonably offered diagnostic appointment, the referral will be cancelled and the referring clinician informed (with the exception of referrals for children). The referring clinician will make a decision, based on the patients' best clinical interests, on how to manage the patient and if feels the diagnostic test remains to be required, will provide a further request.

If a child does not attend a diagnostic test, a further appointment will be provided, should they not attend a second appointment, the referring clinician will be informed and the referral will be request will be rejected.

Careful consideration must be given to assessment of any safeguarding concerns related to the non-attendance of appointments of children, young people and adults at risk in accordance with the WAHT Safeguarding Children and Safeguarding Adults policy and appropriate inter-agency

procedures for safeguarding children and adults. Furthermore, collaboration with other agencies and appropriate sharing of information should be considered in order to inform safe and robust decision making.

7.7 Planned waiting list

Patients should only be added to a planned list where clinically they need to wait for a period of time. This includes planned diagnostic tests (e.g. check cystoscopy) or a series of procedures carried out as part of a treatment plan - which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.

Patients on planned lists should be booked in for an appointment at the clinically appropriate time and they should not have to wait a further period after this time has elapsed. For example:

A patient due to have a re-test in six months' time should be booked in and seen before this date, they must not wait more than the repeat date i.e. more than six months. This is not an acceptable use of a planned list.

When patients on planned lists are clinically ready for their care to commence and they reach the date for their planned appointment, they should either receive the appointment or be transferred to an active waiting list with RTT clock and a DM01 waiting time clock should start, from the day after the repeat/target date (and be reported in the relevant waiting time return). The key principle is that where patient's treatment can be started immediately, then they should start treatment or be added to an active waiting list.

The booking clerks, managers and Directorate Manager will review regularly any planned lists for their service to ensure that patient safety and standards of care are not compromised to the detriment of outcomes for patients. Patients should also be given written confirmation if they are placed on such lists, including the review date.

7.8 Clinical prioritisation

All referrals will be vetted by a Radiologist of qualified Radiographer/Sonographer and will be assigned a clinical urgency of cancer, urgent or routine

Urgency	Booking Timescale
Cancer referral	<7 days
Urgent	< 4 weeks
Routine	< 6 weeks

7.9 Hospital cancellations

Every effort is made to ensure patients appointment dates are not cancelled. If an appointment is cancelled an alternative date should be agreed at the time of cancellation. This must be within the assigned target date.

7.9.1 On the day cancellations (Interventional Radiology)

When a patient's procedure is cancelled by the Hospital for non-clinical reasons on the day , the Trust must offer another binding date within a maximum of 28 days. Breaches to this standard must be identified and reported.

All potential on-the-day cancellations must be escalated in line with the Trust cancellation policy (Cancelled Operations report) to the COO/ DCOO (in-hours) / executive on-call (out of hours) and every effort made to minimise these cancellations, which impact on the care and experience of patients. Records must be kept of last-minute cancellations; these must be reported daily on appropriate forms or entered on the information system for inclusion in weekly reporting process, 'sitrep' reports and quarterly returns as cancellations. Returns are made on the basis of elective cancelled patients only.

7.9.2 Diagnostic reports

All diagnostic imaging will be completed with a radiological report back to the referring clinician.

It is the responsibility of the radiologist, reporting radiographer or sonographer to produce reports as quickly and efficiently as possible and to flag reports when they feel a clinical alert is required.

Radiological reports are available to clinicians in Worcestershire by accessing the ICE system.

Referring clinicians are responsible for viewing and filing in ICE all radiology reports requested under their name

It is the responsibility of the referrer, their team and/or other relevant clinicians to read and act upon all reports with a permanent audit trail of who has read the report and who has taken responsibility for acting upon it.

In the event that a critical finding is identified, Radiology will take immediate action to contact the referring clinician, in the event that contact cannot be made, the referring clinician`s manager will be contracted.

Glossary

Term	Definition
Active monitoring	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures.
Advice and Guidance (A&G)	By providing a digital communication channel, A&G allows a clinician (often in primary care) to seek advice from another (usually a specialist) prior to or instead of a referral.
Active waiting list	The list of elective patients who are fit, ready and able to be seen or treated at that point in time. Applicable to any stage of the RTT pathway where patients are waiting for hospital resource reasons.
Appointment Slot Issue (ASI)	A list of patients who have attempted to book their appointment through the national E-Referral Service but have been unable to due to lack of clinic slots.
Bilateral procedures	Where a procedure is required on both the right and left sides of the body.
Breach	A pathway where the period waited to be seen or receive treatment exceeds the access standard, national or local target time.
Integrated Clinical Assessment and Treatment Service (ICATS)	Clinical assessment and treatment service
Clinic Outcome Form (COF)	Used to record the RTT outcome and other clinical information after an outpatient appointment.
Consultant-led service	A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse-led clinics which come under the umbrella of consultant-led services.
Day case	Patients who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight
Decision to admit (DTA)	Where a clinical decision is made to admit the patient for either day case or inpatient treatment.
Direct access	Where GPs refer patients to hospital for diagnostic tests only. These patients will not be on an open RTT pathway.
Did Not Attend (DNA)	Patients who give no prior notice of their nonattendance.
Elective care	Any pre-scheduled care which doesn't come under the scope of emergency care.
E-RS	(National) E-Referral Service
First Definitive Treatment (FDT)	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgement in consultation with the patient
Incomplete pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage.
Inpatients	Patients who require admission to the hospital for treatment

	and are intended to remain in hospital for at least one night
Integrated Care Board (ICB)	An organisation that brings NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS
Inter-provider transfer (IPT)	Inter-provider transfer is when a patient is transferred to another provider
Minimum Data Set (MDS)	Minimum information required to be able to process a referral either into a trust or for referral out to other trusts.
Nullified	Where the RTT clock is discounted from any reporting of RTT performance
Partial booking	Where an appointment or admission date is agreed with the patient close to the time it is due.
Patient Administrative System (PAS)	A patient administration system records the patient's demographics (eg: name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient.
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.
Patient Initiated Follow Up (PIFU)	PIFU is when a patient initiates an appointment when they need one, based on their symptoms and individual circumstances
Planned waiting list	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18-week RTT pathway.
Patient pathway identifier (PPID)	A unique identifier which together with the provider code uniquely identifies a patient pathway.
Patient Tracking List (PTL)	A tool used for monitoring, scheduling and reporting on patients on elective pathways (covering both RTT and cancer).
Reasonable offers	A choice of two appointment or admission dates with three weeks' notice.
Referral management centre (RMC)	The Referral Management Centre (RMC) provides a single point of access for professionals to make referrals into providers.
Referral to treatment (RTT)	The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.
Straight To Test (STT)	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an RTT pathway.
To come In (TCI)	The date of admission for an elective surgical procedure or operation.

Further Reading and references

Title	Publication date	link
Referral to treatment consultant-led waiting times Rules Suite	10/2022	https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks
Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care	02/2024	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2024/02/Recording-and-reporting-referral-to-treatment-RTT-waiting-times-for-consultant-led-elective-care-v4-1.pdf
Recording and reporting referral to treatment (RTT) waiting times for consultant led elective care: frequently asked questions	10/2023	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2023/10/20231020-Accompanying-FAQs-v7.34-October-2023-Choice-Update-Final-2.pdf
Evidence-based interventions programme		https://www.england.nhs.uk/evidence-based-interventions/
The NHS Constitution	08/2023	https://www.gov.uk/government/publications/the-nhs-constitution-for-england
The NHS Choice framework	08/2023	https://www.gov.uk/government/publications/the-nhs-choice-framework
Diagnostics waiting times and activity		https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/
Guidance on completing the 'diagnostic waiting times & activity' monthly data collection	03/2015	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01-guidance-v-5.32.pdf
Diagnostics FAQs	02/2015	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01-FAQs-v-3.0.pdf

Supplementary Diagnostics FAQ	10/2022	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2022/11/Supplementary-FAQ-v1.0.pdf
Equality Act 2010	06/2015	https://www.gov.uk/guidance/equality-act-2010-guidance
Armed Forces Covenant	06/2016	https://www.gov.uk/government/publications/armed-forces-covenant-2015-to-2020/armed-forces-covenant
How charges for NHS healthcare apply to overseas visitors		https://www.gov.uk/government/publications/how-the-nhs-charges-overseas-visitors-for-nhs-hospital-care/how-the-nhs-charges-overseas-visitors-for-nhs-hospital-care
NHS England Did Not Attends (DNAs)		https://www.england.nhs.uk/outpatient-transformation-programme/did-not-attends-dnas/
Good communication with patients waiting for care		https://www.england.nhs.uk/long-read/good-communication-with-patients-waiting-for-care/#introduction
Management of Consultant to Consultant Referrals	31/07/24	**https://www.hwics.org.uk/download_file/2006/561**
Consultant to Consultant Policy Summary for Clinicians	31/07/24	**https://www.hwics.org.uk/download_file/2007/561**

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Visibility of the WL	Elective Planned Waiting List	Daily	Divisions	Divisions	Divisions
	Visibility of records requiring dating	Elective Planned Waiting List	Daily	Divisions	Divisions	Divisions
	Visibility of records with no repeat date	Elective Planned Waiting List	Daily	Divisions	Divisions	Divisions
	Patients moved to the live RTT PTL	RTT PTL	Daily	Divisions	Divisions	Divisions
	Monitoring of repeat date changes	Provided in reporting to Head of Elective Performance and Patient Access	Weekly	Information Team	Information Team	Information Team
	Summary of DQ issues	In development	Weekly	DQ team	DQ team	DQ team

1. Policy Review

The policy will be reviewed two yearly by the Head of Elective Access and Performance and the RTT Data Systems and Training Manager.

2. Background

2.1 Equality requirements

The EIA form details the impact both negative and positive for the patients detailed in this policy

2.2 Financial risk assessment

No Impact financially

2.3 Consultation

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Director of Performance
Directors of Operations
ICB
Trust Management Group
Elective Cancer Delivery Group

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Trust Management Group
Elective Cancer Delivery Group

2.4 Approval Process

This section should describe the internal process for the approval and ratification of this Policy.

Supporting Document 1 – Equality Impact Assessment form

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	X	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Heather Fleming**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Heather Fleming	**Head of elective performance and patient access**	**Heather.fleming@nhs.net**
	Judith Shervington	**RTT/ Data systems and training manager**	**Judith.shervington@nhs.net**
Date assessment completed	**22/03/2024**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Elective Care Access Policy
What is the aim, purpose and/or intended outcomes of this Activity?	Ensuring patients are managed inline with RTT rules and that they are treated equitably. Add in equalities

Who will be affected by the development & implementation of this activity?	X X X X	Service User Patient Carers Visitors	X X ❑ ❑	Staff Communities Other _____
Is this:	X Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	NHS England publications and guidance RTT Rules suite			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	ICB, IST, Patient representatives, Directorate managers,			
Summary of relevant findings				

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	X			All patients will be treated equitably, they will be treated in chronological order according to clinical urgency. The SOP's and guidance provided will support chronological booking ensuring that patients are tracked throughout their pathway.
Disability	X			As above
Gender Reassignment	X			As above
Marriage & Civil Partnerships	X			As above
Pregnancy & Maternity	X			As above

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Race including Traveling Communities	X			As above
Religion & Belief	X			As above
Sex	X			As above
Sexual Orientation	X			As above
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)			X	Some patients including prisoners rely on staff being available to support them for attendances. This may mean that they have appointments cancelled at short notice. This could result in patients being discharged under the unavailability rules.
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)	X			Members of our Armed Forces and veterans are given priority if their condition relates to their service. Priority is only given where patients are referred for the same clinical urgency. This is part of the Armed Forces Covenant.

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	Chronological booking	**Reports**	**Divisional teams**	**Ongoing**
	Booking rules	**Reports**	**Divisional teams/ booking teams**	**Ongoing**
How will you monitor these actions?	KPI elective and cancer deliver group and monitoring PRMs,			

When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	**In line with the Elective Care Access Policy review date.**

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	J Shervington
Date signed	
Comments:	
Signature of person the Leader Person for this activity	H B Fleming
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval

-End of Document-