WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

Elective Care Access Policy

Version 1.4

VERSION CONTROL

Version No.	Date	Brief Description of Changes
0.1	01/11/22	TK: Following input from NHSEI Improvement Support Team, version 0.1 created from Calderdale and Huddersfield Foundation Trust's Elective Care Access Policy – incorporating COVID Recovery, Version 8 (Sept 2021)
0.2	12/01/23	TK: Updated to remove Trust-specific references to act as a high-level WYAAT Policy
0.3	20/01/23	TK: Incorporated the input from WYAAT Elective Coordination Group
0.4	15/02/23	TK: • Incorporated comments from NHSE Elective Care Improvement Support Team (IST) • Incorporated comments received from WYAAT member Trusts and COOs
1.0	23/02/23	TK: V0.4 approved by WYAAT COOs Group (pending minor amendments) – renamed v1.0
1.1	24/02/23	TK: incorporated updated responses from Trusts and IST
1.2	05/04/23	TK: incorporated updated responses from Trusts Finalised for circulation to Member Trusts
1.3 1.3.1	10/07/23	Minor amendments in places to bring wording in line with model access policy Amended links in references / further reading Detail added relating to application of interim guidance Clarified detail relating to clock stops for first appointment DNAs
1.4	09/11/23	TK: Prioritisation of patients with learning disabilities included (sections 1.1, 2.4.2, 4.1.3, 4.7.5) Reasonable adjustments to be made for patients where appropriate (2.4) Full list of protected characteristics included (2.4)

APPROVAL / CONTRIBUTIONS

Organisation / Committee	Date	Name
WYAAT Chief Operating Officers Group (v1.0)	February 2023	Russell Nightingale
WYAAT Chief Operating Officers' Group (v1.3.1)	September 2023	Russell Nightingale
WYAAT Chief Operating Officers' Group (v1.4)	November 2023	Russell Nightingale

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1. INTRODUCTION

1.1 Summary

The six WYAAT Trusts come together to unite in commitment to ensure patients receive treatment in accordance with national standards and objectives, and in removing unwarranted variation across the places and providers of health care in the area.

This Access Policy outlines the expectations and requirements in terms of managing patients treated in the six WYAAT Acute Trusts (hereafter referred to as 'The Trusts' or 'Member Trusts'), along all non-emergency pathways, referred to as 'elective care pathways'. It describes the high level generic elective care Access requirements, standards and rules that all of the major providers are required to adhere and work to but should be read in conjunction with the individual relevant provider organisations Standard Operating Procedures (SOPs) that describes how these rules are operationalised within that organisation.

The purpose of this policy is to outline the Trusts' and associated Commissioners' requirements and standards for managing patients' access from any commissioner to secondary care services, from referral to treatment, and discharge to primary care. The policy covers the processes for booking, notice requirements, patient choice and Waiting List management for all stages of a referral to treatment pathway (RTT).

The Elective Care Access Policy sets out best practice in managing the flow of patients through the Trusts from first referral to discharge and Member Trusts' Performance and Accountability Frameworks, with particular emphasis on COVID stabilisation and recovery and reduction of health inequalities.

The intention of the policy is to create a fair and transparent process to ensure that the best interests of the patient are priority at all times. The pathways described ensure that the Trusts deliver best patient care.

This policy incorporates the principles and values of the NHS Constitution for England (March 2012 updated October 2015) and national contract changes. This policy does NOT supersede national Referral to Treatment (RTT) and Cancer Waiting Times (CWT) guidance and rules in anyway. We have taken every care to avoid any contradiction with national rules but if there are any ambiguities, the national rules take precedence. It also acknowledges the latest interim patient choice guidance as at the time of publishing.

Clinical Prioritisation & Health Inequalities

The Trusts will ensure that the management of patient access to services is equitable and managed according to clinical priority. This includes taking account of known health inequalities, such as prioritising patients with learning disabilities.

This policy applies to all administration and clinical prioritisation processes relating to elective patient access managed by The Trusts, including outpatient, inpatient, day case, therapies and diagnostic services. The policy should be adhered to by all staff within the Trusts who are responsible for referring patients, managing referrals, adding to and maintaining waiting lists for the purpose of progressing a patient through their elective treatment pathway.

1.2 Important Points

The Trusts that comprise the West Yorkshire Association of Acute Trusts acute provider collaborative are committed to delivering high quality and timely elective care to patients.

This policy:

- Sets out the rules and principles for the six WYAAT Trusts under which elective access to outpatient appointments, diagnostics and elective inpatient or day case treatment is managed;
- Gives staff clear direction on the application of the NHS Constitution and NHS Choice Framework in relation to elective waiting times;
- Demonstrates how elective access rules should be applied consistently, fairly and equitably.

The WYAAT Trusts' Elective Access Policy will be reviewed and ratified on an annual basis, or earlier if there are changes to national elective access rules or locally agreed principles.

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

The West Yorkshire Association of Acute Trusts Elective Access Policy is underpinned by and linked to a comprehensive suite of detailed Standard Operating Procedures (SOP's) owned by each provider organisation that should be referenced in conjunction with this overarching policy. All clinical and non-clinical staff must ensure they comply with both the principles stated within this policy and the specific instructions within the provider SOP's.

The West Yorkshire Health and Care Partnership and the West Yorkshire Association of Acute Trusts are committed to promoting and providing services which meet the need of individuals and does not discriminate against any employee, patient or visitor.

1.2.1 West Yorkshire Association of Acute Trusts

The West Yorkshire Association of Acute Trusts (WYAAT) is part of West Yorkshire Health and Care Partnership.

West Yorkshire Association of Acute Trusts is an innovative provider collaborative which brings together six NHS trusts delivering acute hospital services across West Yorkshire and Harrogate.

The six hospitals trusts who make up WYAAT are:

- Airedale NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- Mid Yorkshire Hospitals NHS Trust

WYAAT was established in 2016 after it was agreed by the Executive Boards at each of the six trusts that something needed to be done to tackle variation and challenges across the region. Its vision is to create a region-wide, efficient, and sustainable healthcare system that embraces best practice to deliver the highest quality care and outcomes for patients.

WYAAT aims to organise services around the needs of people living in West Yorkshire and Harrogate as a whole, rather than planning at individual organisational level. This will enable our trusts to deliver more joined up care, high-quality, cost-effective care for patients.

WYAAT has a set of priority programmes covering corporate support, clinical support and clinical services across the six trusts.

WYAAT acts as the delivery mechanism for West Yorkshire and Harrogate Health and Care Partnership's hospitals working together programmes and also provides a strong voice for hospitals within the Partnership.

1.2.2 Scope

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

- Patients on a Referral to Treatment (RTT) pathway awaiting treatment;
- Patients not on an RTT pathway but still under review by clinicians;
- Patients on a cancer pathway;
- Patients who have been referred for a diagnostic investigation either by their GP or by a Clinician.

1.2.3 Purpose

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

As set out in the NHS Constitution, patients have the right to start Consultant-led treatment within maximum waiting times. The policies and procedures comprising this policy adhere to national best practice and provide a framework to ensure that patients are treated transparently, fairly and reasonably.

1.2.4 Covid-19 Recovery

The document incorporates a number of guidelines that have been put in place in the management of recovery of services after the Covid-19 pandemic. In the majority of cases, they have been incorporated within the body of the policy. These may be subject to change.

1.3 Policy structure

The policy is structured as follows:

1. General principles: referral to treatment and diagnostic pathways
2. Pathway specific principles: referral to treatment and diagnostic pathways
3. Cancer pathways

2. GENERAL PRINCIPLES: REFERRAL TO TREATMENT AND DIAGNOSTIC PATHWAYS

2.1 Introduction and overarching principles

2.1.1 Purpose

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

The policy:

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

2.1.2 Roles and responsibilities

Although responsibility for achieving standards lies with Trusts' Chief Operating Officers and ultimately the Trusts' boards, all staff with access to and a duty to maintain elective care information systems are accountable for their accurate upkeep.

- The WYAAT Chief Operating Officers group is responsible for identifying the need for the combined policy and identifying when it should be redrafted. This group should also identify the most appropriate author(s).
- Chief Operating Officers of WYAAT member Trusts are responsible for identifying the need for further policy / SOPs to support the implementation of this policy.
- Member Trusts' Heads of Planned Access are responsible for the development, update and consultation with internal and external stakeholders.
- Member Trusts' Divisional Directors are accountable for implementing, monitoring and ensuring compliance with the policy within their divisions.
- Member Trusts' Chief Information Officers are responsible for the timely production of patient tracking lists (PTLs) and information management reporting updates which support the divisions in managing waiting lists and RTT standards.
- Waiting List Administrators, including clinic staff, secretaries and booking clerks, are responsible to general managers for compliance with all aspects of the Trust's elective access policy.
- Waiting List Administrators for outpatients, diagnostics and elective inpatient or day care services are responsible for the day-to-day management of their lists and are supported in this function by the operational managers, general managers and divisional directors who are responsible for achieving access standards.
- General Managers and Divisional Directors are responsible for ensuring data is accurate and services are compliant with the policy.
- Operational Managers are responsible for ensuring the NHS e-referral service directory of services (DOS) is accurate and up to date.

- The Referral to Treatment Validation Teams are responsible for validating RTT pathways in line with the national guidance and local access policy.
- Outpatient Validation Teams are responsible for validating all overdue, cancelled and incomplete appointments.
- General Practitioners (GPs) and other referrers play a pivotal role in ensuring patients are fully informed during their consultation of the likely waiting times for a new outpatient consultation and of the need to be contactable and available when referred.
- ICB place teams are responsible for ensuring there are robust communication links for feeding back information to GPs. GPs should ensure quality referrals are submitted to the appropriate provider first time.

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

- Patients can make a significant contribution to their own, and their families', good health and wellbeing, and should take personal responsibility for it.
- Patients should be registered with a GP practice as this is the main point of access to NHS care as commissioned by NHS bodies.
- Patients should provide accurate information about their health, condition and status.
- Patients should keep appointments or cancel within a reasonable timeframe.

2.2 Staff competency and compliance

Competency

- As a key part of their induction programme, all new starters to the Trust should undergo contextual elective care training applicable to their role.
- All existing staff should undergo contextual elective care training on a regular basis as determined by the Trust.
- All staff should be asked to carry out competency tests that are clearly documented to provide evidence that they have the required level of knowledge and ability.
- This policy, along with the supporting suite of SOPs, will form the basis of contextual training programmes (refer to the elective care training strategy for more information).
- Support and guidance will be provided from RTT Leads and Clinical Divisions. RTT Training will be provided on induction using appropriate training materials, for the following staff groups:
    - New Consultants / locums
    - Medical Secretaries / pathway coordinators
    - Clinical Divisional Managers

Compliance

- Functional teams, specialties and staff will be performance managed against key performance indicators (KPIs) applicable to their role. Role-specific KPIs are based on the principles in this policy and specific aspects of the Trusts' standard operating procedures.
- In the event of non-compliance, a resolution should initially be sought by the team, specialty or individual's line manager. The matter should then be dealt with via the employing Trust's disciplinary or capability procedure.

2.3 General elective access principles

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

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

2.4 Individual patient rights

The NHS Constitution clearly sets out a series of pledges and rights stating what patients, the public and staff can expect from the NHS. A patient has the right to the following:

- choice of hospital and consultant
- to begin their treatment for routine conditions following a referral into a consultant-led service, within the average waiting time for treatment
- to be seen by a cancer specialist within a maximum of two weeks from a GP referral for urgent referrals where cancer is suspected.
- to begin their treatment within a maximum of 62 days from GP where cancer is diagnosed.
- If this is not possible, the NHS has to take all reasonable steps to offer a range of alternatives.

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

- if the patient chooses to wait longer
- if delaying the start of the treatment is in the best clinical interests of the patient (note that in both of these scenarios the patient's RTT clock continues to tick unless stated elsewhere in this policy)
- if it is clinically appropriate for the patient's condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage.

All patients are to be treated fairly and equitably regardless of race, sex, religion, age, disability, sexual orientation, pregnancy / maternity and gender reassignment. WYAAT Trusts are committed to making reasonable adjustments for all patients to ensure equity of access to NHS services.

The NHS Choice Framework states in Section 3 that patients can choose where they go for their first appointment as an outpatient, and in Section 4 that a patient can be asked to be referred to a different hospital if they have to wait more than 18 weeks before starting treatment and / or if they wait more than 2 weeks before seeing a specialist for suspected cancer. These are legal rights, but there are exceptions to be aware of detailed in the NHS Choice Framework.

2.4.1 Chronological Booking

Patients will be selected for booking appointments or admission dates according to clinical priority. This clinical priority will include ensuring patients with identified health inequalities are booked sooner to reduce existing inequities (please see section below). Patients of the

same clinical priority will be appointed/treated in RTT chronological order, i.e. the patients who have been waiting longest will be seen first.

2.4.2 Learning Disabilities

WYAAT Trusts have agreed to give priority for outpatient and elective admissions bookings to patients with learning disabilities.

People with learning disabilities should be able to expect high quality care across all services provided by the NHS: the same access to services and outcomes as the population as a whole. However, we know some people with learning disabilities encounter difficulties when accessing NHS services and can have much poorer experiences than the general population, leading to longer waits, worse clinical outcomes and a lowered quality of life.

Therefore, WYAAT Trusts will commit to prioritising the booking of patients with learning disabilities and autism (as set out in sections 4.1.3 and 4.7.5) and should ensure an individualised approach to care.

2.4.3 Patient eligibility

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

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

- have paid the immigration health surcharge
- have come to work or study in the UK
- have been granted or made an application for asylum.

Citizens of the European Union (EU) who hold a European Health Insurance Card (EHIC) are also entitled to free healthcare, although the Trust may recover the cost of treatment from the country of origin.

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

2.4.4 Treatment in the Independent Sector

Patients moving between NHS and private care

Patients can choose to move between NHS and private status at any point during their treatment without prejudice. Where it has been agreed, for example, that a surgical procedure is necessary the patient can be added directly to the elective waiting list if clinically appropriate. The RTT clock starts at the point the GP or original referrer's letter arrives in the hospital.

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

NHS treatment outsourced / insourced to independent providers

Patients may be offered the opportunity to be seen / treated by independent providers as agreed by member Trusts and commissioners. Patients can expect to receive the same experience as provided at the Trust.

Patients will remain on the Trust waiting list, with status updated as the patient is seen and/or treated in the independent sector. In order to reduce the length of waits of backlogs, the longest wait urgent and routine referrals will be assessed for independent sector suitability in the first instance.

2.4.5 Commissioner approved procedures

Patients referred for specific treatments where there is limited evidence of clinical effectiveness, or which might be considered cosmetic can only be accepted with the prior approval of the relevant ICB.

2.4.6 Military veterans

The Armed Forces Bill 2021 was passed through Parliament and became a statutory duty in November 2022. This means that it is now a legal duty for relevant UK public bodies to have due regard to the principles of the Armed Forces Covenant, a pledge to ensure the UK Armed Forces community is treated fairly.

Family members should retain their place on any NHS waiting list if moved around the UK due to the service person being posted. Veterans and war pensioners should receive priority access to NHS care for a condition which relates to their Military service, subject to clinical need. Military veterans should not need first to have applied and become eligible for a war pension before receiving priority treatment.

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

2.4.7 Prisoners

All elective standards and rules are applicable to prisoners. Delays to treatment incurred as a result of difficulties in prison staff being able to escort patients to appointments or for treatment do not affect the recorded waiting time for the patient.

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

2.4.8 Supporting Unpaid Carers

The Trust recognises the part that carers play in patient care. Staff will make every effort to take carers' needs into consideration, recognising that carers may have difficulty leaving the person that they care for to attend their own appointments, or take time off work to accompany the person they care for.

Where it is possible, it is important to offer some flexibility for carers:

- Arrange appointments at times in the day when carers can leave the people that they care for

- Consider offering carers early appointments to minimise waiting time

Where a patient is dependent on a carer attending hospital with them:

- Aim to accommodate the carers' availability (recognising that they may be a working carer and therefore have other commitments).
- Be mindful of the role a carer plays and the importance of enabling them to accompany the patient.

2.5 Service Standards

Please note: these are minimum service standards, and member Trusts or services may decide locally to adopt more ambitious standards.

Referral to Treatment Guidelines – Measuring the Average Wait Elective Standard.

New Referrals – Member Trusts aim to receive all GP referrals via the NHS E-referral Service. Clinicians reviewing referrals should do so within 2 working days of receipt into the Trust for urgent referrals or 4 working days for routine referrals.

Advice & Guidance – Member Trusts aim to respond to all advice and guidance requests within 3 working days of receipt.

DNA Management – a patient who did not attend (DNA) at 1st appointment and/or two consecutive DNAs at follow-up may result in the RTT clock being stopped and/or the patient being discharged to care of their GP. This will be individually reviewed by a responsible clinician in all cases, and clinical discretion will be applied.

Patient Cancellations – Patients who cancel more than one reasonable appointment should not be automatically removed from waiting lists or referred back to GP. Clinical review is recommended to determine what is clinically safe and in the patient's best interests.

Consultant to Consultant Referrals – Consultant to Consultant referrals should only be initiated where the referral is part of the same condition for which the patient was first referred or is clinically urgent.

RTT Validation – Member Trusts should complete routine validation of RTT pathways in line with national guidance and this policy.

Overdue or Cancelled Appointments and Incomplete Orders Validation – incorporates the requirement for clinical services to ensure that any patient waiting past their 'see by date' are validated, clinically assessed by the lead clinician, allocated a priority value and allocated an appointment within a safe timescale.

Reporting / monitoring – the use of regular and robust monitoring and escalation of the following areas:

- DNAs – new and follow-up
- Patient and Hospital Cancellations
- Overdue appointments
- Slot Utilisation
- Appointment Slot Issues (ASIs) – new referrals

- Incomplete Outcomes

Hospital cancellations on day of Surgery – patients should be rebooked within 28 days of the cancellation, in line with the national standards. Member Trusts may have locally agreed stretch targets.

Overseas Visitors – some patients do not qualify for free treatment under the NHS. All queries should be directed to the Trust Overseas Visitors lead / team.

The standards above are described in greater detail in Member Trust's associated SOPs and other procedural documentation.

2.5.1 Monitoring

Member Trusts' divisional operational and clinical directors will receive regular reports allowing them to monitor levels of capacity for each pathway milestone to ensure any shortfalls are addressed in advance. This will avoid poor patient experience, resource intensive administrative workarounds and, ultimately, breaches of the agreed national and local standards.

2.5.2 Governance

Performance is managed via through Member Trusts' Performance Management and Accountability frameworks.

2.5.3 Reasonableness

'Reasonableness' is a term applicable to all stages of the elective pathway. Reasonableness refers to specific criteria which should be adhered to when offering routine appointments and admission dates to patients to demonstrate that they have been given sufficient notice and a choice of dates. A reasonable offer is defined as a choice of two dates with at least three weeks' notice.

2.5.4 Communication

All communications with patients and anyone else involved in the patient's care pathway (e.g. GP or a person acting on the patient's behalf), whether verbal or written, must be informative, clear and concise. Copies of all written correspondence or a brief summary of all verbal conversations with the patient must be kept in the patient's electronic record.

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

3. NATIONAL REFERRAL TO TREATMENT AND DIAGNOSTIC STANDARDS

Referral to treatment Elective Care Standard	
Incomplete	Current – • Elective care waits of more than 104 weeks should have been eliminated from July 2022. • Elective care waits of more than 78 weeks should be eliminated from April 2023. • Elective care waits of more than 65 weeks should be eliminated from March 2024. • Elective care waits of more than 52 weeks should be eliminated from March 2025. Previous – (18 weeks RTT target – 92% of patient on an incomplete pathway (i.e. still waiting for treatment) to be waiting no more than 18 weeks (or 126 days)
Diagnostics	
Applicable to diagnostic tests	99% of patients undergo the relevant diagnostic investigation within 5 weeks and 6 days (or 41 days from the date of decision to refer to appointment date).

In addition to the elective care standards above, there are separate cancer standards which must be adhered to. The cancer standards are listed in the cancer pathways section.

While the aim is to treat all elective patients within an average timescale referral to treatment, the national elective access standards are set to allow for the following scenarios:

- **Clinical exceptions**: when it is in the patient's best clinical interest to wait more than the average waiting time for their treatment.
- **Choice**: when patients choose to extend their pathway beyond the average waiting time by declining reasonable offers of appointments, rescheduling previously agreed appointment dates/admission offers, or specifying a future date for appointment/admission.
- **Co-operation**: when patients do not attend previously agreed appointment dates or admission offers (DNA) and this prevents the Trust from treating them within the average waiting time.

3.1 Overview of national referral to treatment rules

The figure below provides a visual representation of the chronology and key steps of a typical RTT pathway.

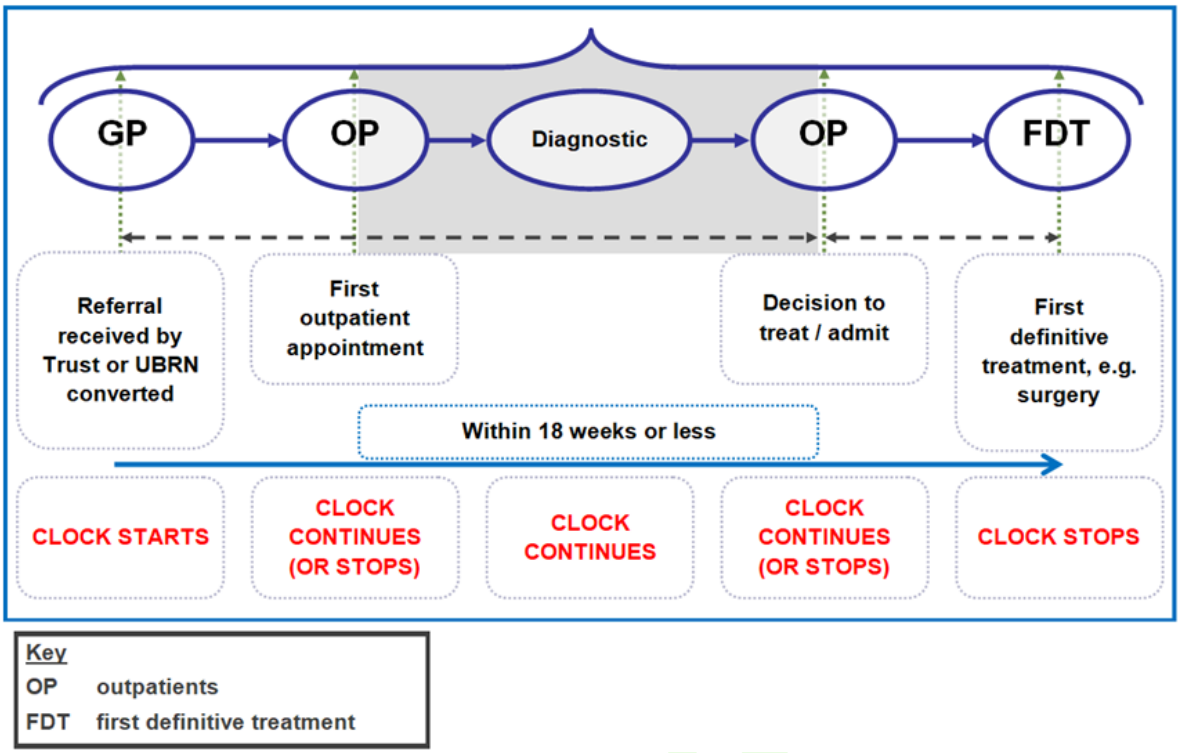


Figure 1 The chronology and key steps of a typical RTT pathway

The section below references the rules in the RTT rules suite published by the Department of Health and Social Care. Please see the link in the references table.

3.1.1 RTT Clock Starts

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

Rule 1: Referrals by care professionals or services

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

Rule 2: Self-referrals

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

Rule 3: The need for a new clock

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

a) when a patient becomes fit and ready for the second of a consultant-led bilateral procedure
b) upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan. This will start a new RTT

pathway clock and the patient shall receive their first definitive treatment within the average waiting time for treatment

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

d) when a decision to treat is made following a period of active monitoring. Some clinical pathways require patients to undergo regular monitoring or review diagnostics as part of an agreed programme of care. These events would not in themselves indicate a decision to treat or a new clock start. If a decision is made to treat after a period of active monitoring/watchful waiting, a new RTT clock would start on the date of decision to treat (DTT).

e) when a patient rebooks their appointment following a first appointment did not attend (DNA) that stopped and nullified their earlier clock (see New Patient Appointment DNA / WNB).

3.1.2 RTT Clock Stops

Rule 4: Clock Stops for Treatment

An RTT clock stops the following has taken place:

- First definitive treatment starts. This could be:
  - treatment provided by an interface service
  - treatment provided by a consultant-led service
  - therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions
- A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

Rule 5: Clock stops for non-treatment

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

- it is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care
- a decision is made to start the patient on a period of active monitoring
- a patient declines treatment having been offered it
- a clinical decision is made not to treat
- a patient did not attend (DNA) for a first appointment following the initial referral that started their waiting time clock, provided it can be demonstrated that the appointment was clearly communicated to the patient
- A patient DNAs any other appointment and is subsequently discharged back to the care of their GP, provided that:
  - the provider can demonstrate that the appointment 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 local, publicly available or published policies on DNA.
  - these local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (for example, children).

3.1.3 Exclusions

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

- obstetrics and midwifery
- planned patients
- referrals to a non-consultant led service
- referrals for patients from non-English commissioners
- genitourinary medicine (GUM) services
- emergency pathway non-elective follow-up clinic activity e.g. fracture clinic

3.1.4 Planned patients

All patients added to the planned list will be given a due date by when their planned procedure/test should take place. Where a patient requiring a planned procedure goes beyond their due date, they will be transferred to an active pathway and new diagnostic clock (if applicable) and RTT clock will be started.

Furthermore they should also be clinically prioritised by the responsible clinician for their care. The detailed process for management of planned patients is described in the relevant standard operating procedure.

3.1.5 Active monitoring

Active monitoring may be appropriate in the following situations:

- When a period of monitoring is appropriate before further action is needed, and the patient does not require any form of diagnostic or clinical intervention within a short period of time (i.e. a month or less).
- When a patient declines two reasonable offers of treatment dates and wishes to delay treatment. In this situation the patient should be reviewed by the consultant who may agree a period of active monitoring with them. This discussion with the patient should include an appropriate timeframe for further follow up or review.

When a decision to begin a period of active monitoring is made and communicated with the patient, the RTT clock stops. Active monitoring may apply at any point in the patient's pathway. Stopping a patient's clock for a period of active monitoring requires careful consideration on a case-by-case basis and needs to be consistent with the patient's perception of their wait.

Patients may remain on active monitoring for any period of time, however, where this extends past 12 weeks a clinical review should be undertaken to check the patients' condition and confirm that active monitoring remains appropriate. The pathway should be visible on a relevant PTL or waiting list report for non-RTT pathways.

In all scenarios a new waiting time clock will start when a new decision to treat is made with the patient following a period of active monitoring. For patients who have been placed on active monitoring due to unavailability, once the patient wishes to go ahead with treatment, they should be reinstated on the waiting list with a new RTT clock starting at zero. The provider should offer a new offer for treatment date, acting as if the patient is on the waiting list at the point that they previously left.

When a patient is placed on active monitoring, they should be provided with written contact details and a clear process for two-way communication between them and the clinician in the event that their condition or circumstances change.

3.2 Patient-initiated delays

3.2.1 Non-attendance of appointments / did not attend (DNA) / was not brought (WNB)

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

New Patient Appointment DNA / WNB

For patients booked via the E-Referral Service who fail to attend their first outpatient appointment, their referral will be reviewed by a responsible clinician and the decision made whether to offer another appointment or discharge back to GP.

In all cases when a patient DNAs their first appointment, if the provider can demonstrate that the appointment was clearly communicated to the patient (in line with the 'reasonableness' criteria), this will stop and nullify the RTT clock.

After a first appointment DNA, if:

- after clinical review, the clinician indicates another first appointment should be offered, or
- the patient subsequently contacts the Trust to rebook their first appointment,

a new RTT clock will be started on the day the new appointment is agreed with the patient (or when it is agreed a new appointment will be offered, if an appointment cannot be offered at the moment of contact).

If it is decided the patient should be discharged back to the referrer, the RTT clock will be stopped; the patient's details will appear on the referrer's work list along with a notification of DNA/WNB and the referrer can re-refer should they feel this necessary. A letter will be sent to the GP and the patient to advise of the DNA/WNB.

If the patient makes contact within two weeks of the DNA, a new pathway will be opened using the original referral and a new RTT clock will be started. Under these circumstances the patient must still be seen within the maximum waiting time for the service / specialty. Where possible, the Trust should offer a date for a further New Outpatient appointment to take place within four weeks of the patient contacting the Trust, regardless of their current RTT clock status.

If a further appointment is to be offered the bookings team will attempt to make verbal contact with the patient to negotiate an appointment. If the team is unable to contact the patient, an appointment will be booked, and an appointment letter will be sent.

Subsequent (follow-up) DNAs/WNB

When follow-up patients DNA the consultant should review the clinical record and make the necessary clinical decision whether to discharge the patient back to the care of their GP. The

clock does not stop when a review/follow up patient DNAs and a further appointment should be allocated within the appropriate timescale to achieve the average waiting time target.

In the majority of cases, no more than two consecutive DNAs should be permitted, and the patient should be discharged back to their GP. However, this decision should only be made after clinical review.

DNA/WNB for remote (video / telephone) appointments

For remote appointments, patients should be asked to be available outside the immediate appointment time so as to accommodate late-running clinics. Member Trusts should determine their own standard based on local systems and processes, ensuring a balance of making a reasonable request of a patient with the expectation that some clinics will not keep entirely to time.

Please note – patients should be offered an appointment time for a remote appointment in the same way as for a face-to-face appointment.

Clinicians should make two attempts to contact the patient remotely. If the patient is still not available within the agreed reasonable time frame and by the method stated in the appointment letter, the attendance should be recorded as a DNA.

Vulnerable Patients Not Brought to Appointment

For paediatric / vulnerable adult patients who DNA (were not brought), further appointments will be at the discretion of the consultant with reference to local Safeguarding Policy e.g. children and vulnerable adults.

Maternity

Member Trusts' maternity services will adopt a local pathway that meets the needs of their women and families.

Cancelling, declining or delaying appointment and admission offers

Patients can choose to postpone or amend their appointment or treatment if they wish, regardless of the resulting waiting time. Such cancellations or delays have no impact on reported RTT waiting times. However, clinicians will be informed of patient-initiated delays to ensure that no harm is likely to result from the patient waiting longer for treatment (clinicians may indicate in advance, for each specialty or pathway, how long it is clinically safe for patients to delay their treatment before their case should be reviewed). Where necessary, clinicians will review every patient's case individually to determine whether:

- the requested delay is clinically acceptable (clock continues)
- the patient should be contacted to review their options – this may result in agreement to the delay (clock continues) or to begin a period of active monitoring (clock stops)
- the patient's best clinical interest would be served by discharging them to the care of their GP (clock stops)

The general principle of acting in the patient's best clinical interest at all times is paramount. It is generally not in a patient's best interest to be left on a waiting list for an extended period, and so where long delays (i.e. of many months) are requested by patients, a clinical review should be carried out, and preferably the treating clinician should speak with the patient to discuss and agree the best course of action. Patients should not be discharged to their GP, or otherwise removed from the waiting list, unless it is for clinical reasons.

3.2.2 Patients who are unfit for surgery

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

Short-term illnesses

If the clinical issue is short-term and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold, isolating due to positive test for Covid-19), the RTT clock continues.

Longer term illnesses

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

- if it is clinically appropriate for the patient to be removed from the waiting list (This will be a clock stop event via the application of active monitoring.)
- if the patient should be optimised/treated within secondary care (active monitoring clock stop) or if they should be discharged back to the care of their GP (clock stop).

If a clinical decision is made to stop the RTT clock for active monitoring, the patient's next steps should be agreed, including timescale for further review or follow up to assess the patient's condition. The pathway should remain visible on the relevant PTL or waiting list report to support ongoing management.

Patients who become fit for surgery

For patients who are on active monitoring, when they become fit and ready to be treated for the original condition, a new RTT clock would start on the day this decision is made and communicated to the patient.

For patients who have been discharged to the GP, if the GP determines they have become fit for surgery within a period of time (defined by each place / member Trust – up to six months recommended), the GP will contact the clinical specialty or pre- assessment service and the patient will be added directly back onto the waiting list using the original referral. A new RTT clock will begin at this point. Member Trusts, based on a clinical review, will determine if the patient needs to be seen again as an outpatient. If the GP determined the patient has reached a suitable level of fitness after the defined period of time has passed, a new referral will be required.

4. PATHWAY-SPECIFIC PRINCIPLES REFERRAL TO TREATMENT AND DIAGNOSTIC PATHWAYS

4.1 Non admitted pathways

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

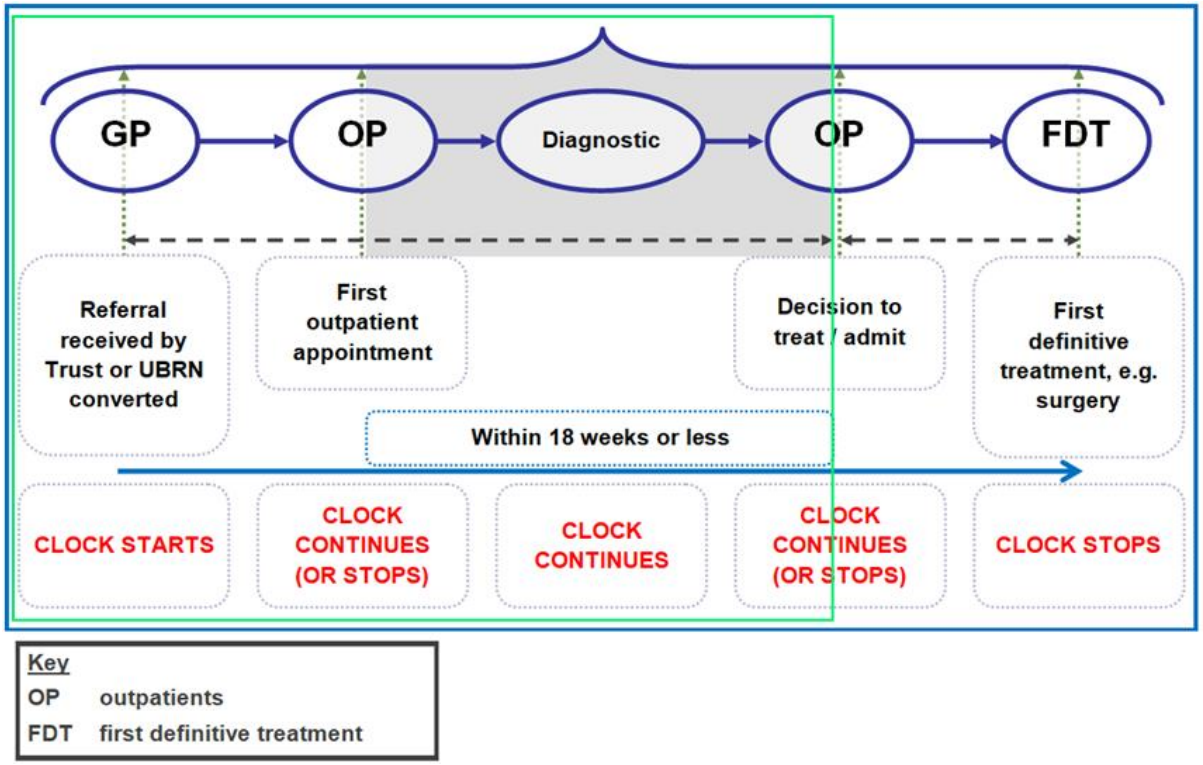


Figure 2 – Non-admitted stages of the patient pathway

4.1.1 Receipt of outpatient referrals

The NHS e-Referral Service (e-RS) is the preferred method of receiving referrals from GPs and Referral Management Centres (RMCs) – paper referrals should not be accepted from these sources, in line with NHS England requirements. Paper-based referrals may be accepted from other healthcare providers.

Where clinically appropriate, referrals should be made to a service rather than a named clinician. Referring to services is in the best interest of patients as pooling referrals promotes equity of waiting times and allows greater flexibility in booking appointments and resource.

NHS e-referrals (e-RS)

All NHS e-referrals should be reviewed and accepted or rejected by clinical teams within 2 working days for urgent referrals or 4 working days for routine referrals.

Where there is a delay in reviewing e-referrals this will be escalated to the relevant clinical / management team and actions agreed to address it.

Inappropriate referrals

Where a consultant deems that a patient has been inappropriately referred, the referral should either be:

- Discharged back to the referrer, and the referrer should be advised as to the most appropriate management of the patient.
- Transferred to the appropriate specialty (either within or outside of the Trust). The referrer will be notified by letter.

Paper based referrals

Please note that Trusts will not accept paper referrals from GPs. Paper GP referrals should be returned to the GP and a request made for the referral to be made via e-referral.

Referrals from other providers (e.g. dentists, optometrists and AHPs) are accepted in paper form and must be date stamped on receipt at the Trust. For patients referred by paper, the referral received date is the point that the RTT clock starts.

Consultant to consultant referrals

Consultant to consultant referrals should be treated in clinical priority alongside other referrals being received into the Trust.

Consultant to consultant referrals should only be initiated in limited circumstances:

- If the referral is for treatment or investigation of the same present complaint for which the patient was first referred,
- If the referral is for the treatment, management or investigation of cancer or suspected cancer, or
- If it is clinically urgent.

If a consultant identifies a serious medical condition which requires a different specialty input and referring the patient back to the GP would be detrimental to the patient, then a referral should be created and classified as a new referral as this is a second condition.

For unrelated or non-life-threatening conditions the patient must be returned back to their GP.

Referral Assessment Services (RAS) / Clinical Assessment Services (CAS)

A referral to a RAS or a CAS starts an RTT clock from the day the referral is received. If the patient is referred on to the Trust from a referral management service, having not received any treatment in that other service, the Trust inherits the RTT wait for the patient.

Clinical Assessment and Referral Assessment Services should follow published standard operating procedures.

Inter-provider transfers (IPTs) / Mutual Aid

All IPT referrals to member Trusts should be sent / received through an agreed secure electronic route (such as a generic IPT NHS.net email).

Member Trusts should ensure that incoming IPTs are processed within three working days to avoid any unnecessary delays in the patient's pathway. Where practical, IPTs should be

sent within 8 weeks from the date of the original referral in order that the receiving Trust can fulfil their RTT pathway requirements, or as early as possible in other circumstances.

When patients at risk of breaching RTT waiting time standards are considered for transfer into a Trust, local agreement should be reached between the two providers on reporting arrangements. If a long-waiting patient is being transferred as mutual aid in the context of elective recovery, there should be an agreement between the two Trusts that the patient can be treated within an agreed timescale. In this case, it would be expected that the sending Trust should retain responsibility for reporting that breach. The receiving Trust should process the mutual aid request within three working days and agree which patients can be treated within the required timescales.

Member Trusts would also expect the above to apply to transfers to independent sector providers.

Member Trusts should include and expect to receive an accompanying Minimum Data Set (MDS) pro-forma with the IPT, detailing the patient's current RTT status (the Trust will inherit any RTT wait already incurred at the referring Trust if they have not yet been treated) and if the patient has been referred for a new treatment plan for the same condition (where a new RTT clock will start upon receipt at this Trust). The patient's pathway identifier (PPID) should also be provided.

Where patients are transferred to a Trust without an MDS pro-forma or with a form with insufficient data as above, the referrer will be contacted twice over one working week to obtain the missing information. If following this process, the missing data has not been received, a new waiting time clock will be started from the date of the receipt of the transfer to LTHT.

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

Appointment Slot Issues

If a referral is made to a directly bookable service and there are insufficient slots available for the selected service at the time of attempting to book (or convert their Unique Booking Reference Number (UBRN)), the patient will appear on the Appointment Slot Issue (ASI) work list. The RTT clock starts from the point at which the patient attempted to book. Patients on the ASI list will be contacted within two working days to inform them that the Trust is aware of their referral and will be making an appointment as soon as available.

4.1.2 Advice and Guidance (A&G)

Advice and Guidance is a communication between primary and secondary care clinicians which should be created when a GP is uncertain as to whether a patient requires a referral or not or needs specialist input into a patient's treatment in primary care. A&G is a function of the NHS e-Referral System, but other systems or processes can be used to communicate specialist advice to primary care clinicians.

A&G requests received into a member Trust will be viewed and responded to within 3 working days of receipt.

Reasons why a GP may wish to seek advice from a secondary care specialist include:

- Asking another clinician / specialist for their advice on a treatment plan and or the ongoing management of a patient

- Asking for clarification (or advice) regarding a patient's test results
- Seeking advice on the appropriateness of a referral for their patient (e.g. whether to refer, or what the most appropriate alternative care pathway might be)
- Identifying the most clinically appropriate service to refer a patient into (and how to find that service – e.g. what clinical term to use to search).

An A&G request does not start an RTT clock, as no referral has been made into the Trust.

Within eRS, GPs are able to include the option to convert an A&G request into a referral if required. The conversion should be undertaken by the consultant as part of the A&G review process within eRS. In this instance, the RTT clock will start only when the A&G request is converted into a referral.

A&G should not be used for a patient who is already in the system for the condition – instead contact should be made directly with the relevant clinical team.

4.1.3 Booking Outpatient Appointments

Across all member Trusts, patients should be scheduled for admission in the following order:

1. Patients with the highest clinical priority (P1 then P2)
2. Patients who have a learning disability
3. Routine priority patients (P3 & P4), booked in chronological order of RTT waiting time. Within this group of routine-priority patients, member Trusts should follow locally agreed policies on prioritising cohorts of patients
    a. who may have higher clinical risk such as risk of deterioration
    b. other identified health inequities or
    c. for whom a longer wait would significantly reduce their independence

Local priorities related to scheduling should be clearly identified in procedural or policy documentation within member Trusts.

Patients will be offered a choice of at least 2 dates with 3 weeks' notice within the maximum waiting time for the specialty concerned. Appointments can be offered with less than 3 weeks' notice and if the patient accepts, this can be classed as 'reasonable'.

Where there is insufficient capacity to offer an appointment within the maximum waiting time for the specialty, this should be escalated to the relevant service manager and added to the ASI (new appointments) list.

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

Methods of delivery available are

- Phone
- Video
- Face to Face (in person).

Patients should only be offered an in-person appointment where remote (phone/video) would be inappropriate.

Booking remote outpatient appointments (video / telephone)

Outpatient appointment letters where the patient is asked to attend for an appointment remotely (by telephone or video) should state an appointment time in the same way as for a face-to-face appointment. These letters should also ask for the patient to be available outside the immediate appointment time so as to accommodate late-running clinics.

Member Trusts should determine their own standard based on local systems and processes, ensuring a balance of making a reasonable request of a patient with the expectation that some clinics will not keep entirely to time.

As with any appointment, every attempt should be made to begin the appointment at the booked time, and where possible the patient should be contacted if the clinic is running late.

4.2 Clinic attendance and outcome

Every patient, new and follow-up, whether attended or not, will have an attendance status and outcome recorded on the Trust electronic patient record or PAS system. This may be recorded directly by the clinician by the end of the clinic or may be completed by administrative staff based on the recorded output of the clinic. Clinics should be fully 'outcomed' or 'cashed up' within one working day of the clinic taking place.

Clinic outcomes (e.g. discharge, further appointment) and the patient's updated RTT status should be recorded using the locally agreed method (e.g. EPR, paper outcome form). Ethnicity and residency status should also be captured.

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

<u>Patients on an open pathway</u>

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

<u>Patients already treated or with a decision not to treat</u>

- New clock start if a decision is made regarding a new treatment plan.
- New clock start if the patient is fit and ready for the second side of a bilateral procedure.
- No RTT clock if the patient is to be reviewed following first definitive treatment.
- No RTT clock if the patient is to continue under active monitoring
- Accurate and timely recording of these RTT statuses at the end of the clinic are therefore critical to supporting the accurate reporting of RTT performance.

Outcomes – Outpatient Coding

To ensure that the correct tariff is applied to an outpatient appointment it is imperative that the RTT outcome and any procedure codes (OPCS) is completed for every relevant patient.

A reconciliation of incomplete outcomes should be completed to ensure that all patients that have attended or DNA have an outcome. Any incomplete outcomes should be highlighted to the doctor in clinic.

Missing outcomes will be reported in the appropriate information system at each member Trust and should be reconciled at the first opportunity.

4.2.2 Booking follow-up appointments

Patients on an open pathway (RTT active)

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

Patients not on an open pathway (non-RTT)

Patients who have already been treated or who are under active monitoring and require a follow-up appointment may be entered on to a follow up waiting list. This process will be clearly explained to the patient.

If there are no appointment slots available, the patient will be added to the follow-up ASI list, and admin validated and clinically reviewed as appropriate. Additional capacity will be sought through the specialty operational manager as required.

Patient-initiated Follow-up (PIFU)

Where appropriate, patients should be offered a PIFU / Open Appointment with an option to book an appointment if their condition deteriorates within a set time-period (e.g. 3/6/12 months) after of the last consultation. It should be explained to the patient by the clinician under what clinical circumstances should be used for patients to initiate a follow-up appointment, and how that appointment should be initiated.

Patients on a PIFU pathway should be recorded on the Trust's electronic patient record or PAS. As standard, the patient will be discharged at the end of the pre-defined period, though it may be desirable to extend the period or to book a follow-up appointment on clinical review. The patient should be contacted at the end of the period of PIFU, and the GP notified that they have been discharged from the Trust.

Individual services should develop their own guidance, criteria and protocols on when to use PIFU and be clear that it should not be used as a substitute for the appropriate timely discharge of patients.

4.2.3 Did Not Attend (DNA) / Was Not Brought (WNB)

All DNAs and WNBs – both new and follow-up – will be reviewed by the clinician by the end of clinic in order for a clinical decision to be made regarding next steps. Paediatric and vulnerable patients who do not attend appointments should be managed with reference to trust's relevant safeguarding policy/ies.

Please see section 3.2 Patient-initiated delays above.

4.2.4 Appointment changes and cancellations initiated by the patient

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

If, after the patient cancels or requests a change to an appointment, a further appointment is needed, this will be booked with the patient at the time of the cancellation or as soon as possible afterwards.

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

If the patient has never been seen and advises they do not wish to progress their pathway, they will be removed from the relevant waiting list and discharged – the clock will be stopped and nullified. The patient will be told that their consultant and GP will be informed of this.

If because of the patient cancelling, a delay is incurred which is equal to or greater than a clinically unsafe period of delay, the patient's pathway should be admin validated and reviewed by their consultant. Upon clinical review, the patient's consultant should indicate one of the following:

- Clinically safe for the patient to delay: continue progression of pathway. The RTT clock continues.
- Clinically unsafe length of delay: clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues.
- Clinically unsafe length of delay: in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP.

Patients who cancel more than one appointment should not be automatically removed from waiting lists or referred back to GP. Clinical review is recommended as above.

4.2.5 Appointment changes initiated by the hospital

Hospital-initiated changes to appointments will be avoided as far as possible as they are poor practice and cause inconvenience to patients.

The only acceptable reason for any clinic to be cancelled is due to the absence of medical staff. This cancellation can result from planned annual leave or study leave, planned audit sessions, unplanned sickness absence or other clinical commitments.

- Clinicians are actively encouraged to book annual leave and study leave as early as possible. Clinicians must provide at least 6 weeks' notice of a clinic to be cancelled or reduced.
- Patients will be contacted immediately if the need for the cancellation is identified and offered an alternative date(s) that will allow patients on open RTT pathways to be treated within the average waiting time. Equally, this will allow patients not on open pathways to be reviewed as near to the clinically agreed timeframe as possible.
- Where capacity issues prevent rebooking of the cancelled appointment in a timely manner, the patient will be added back to the waiting list and highlighted to the Divisional teams for resolution and clinical assessment.
- Where urgent patient appointments are to be cancelled the medical staff must review the clinical record of the patient to be cancelled and decide when they should be seen in line with clinical need.

4.2.6 Outpatient Waiting List Validation

Regular validation of Outpatient Waiting Lists will take place to ensure that accurate information on waiting times is available to support access targets (local and national) are met. This validation may have three stages:

- Technical (to ensure there is no duplication of referrals or other issues that can be identified from the perspective of a booking clerk)
- Administrative (the patient contacted to confirm if they wish to remain on the waiting list)
- Clinical (to ensure that the patient's previous clinical priority level is still appropriate and to re-prioritise if required).

This information will also be utilised to identify the volume of additional capacity required and acts as a safety net to ensure that all patients are accounted for.

Mode of consultation should also be identified (phone/video/face to face).

The specialty operational manager is responsible for securing capacity and discussions with Lead Clinicians as required.

4.2.7 Dictated Letters

As per the national standard contract all dictated letters following outpatient attendance will be transmitted electronically to GPs within, at most, 10 days of dictation.

Clinic letters must be sent by direct electronic transmission as structured messages using standardised clinical headings.

4.3 Diagnostics

This section concentrates on the diagnostic phase of the patient pathway.

The section within the green border on the diagram below represents the diagnostic stage of the RTT pathway which forms part of the non-admitted pathways. It starts at the point of a decision to refer for a diagnostic test and ends on the results/report from the diagnostic procedure being available to the requester.

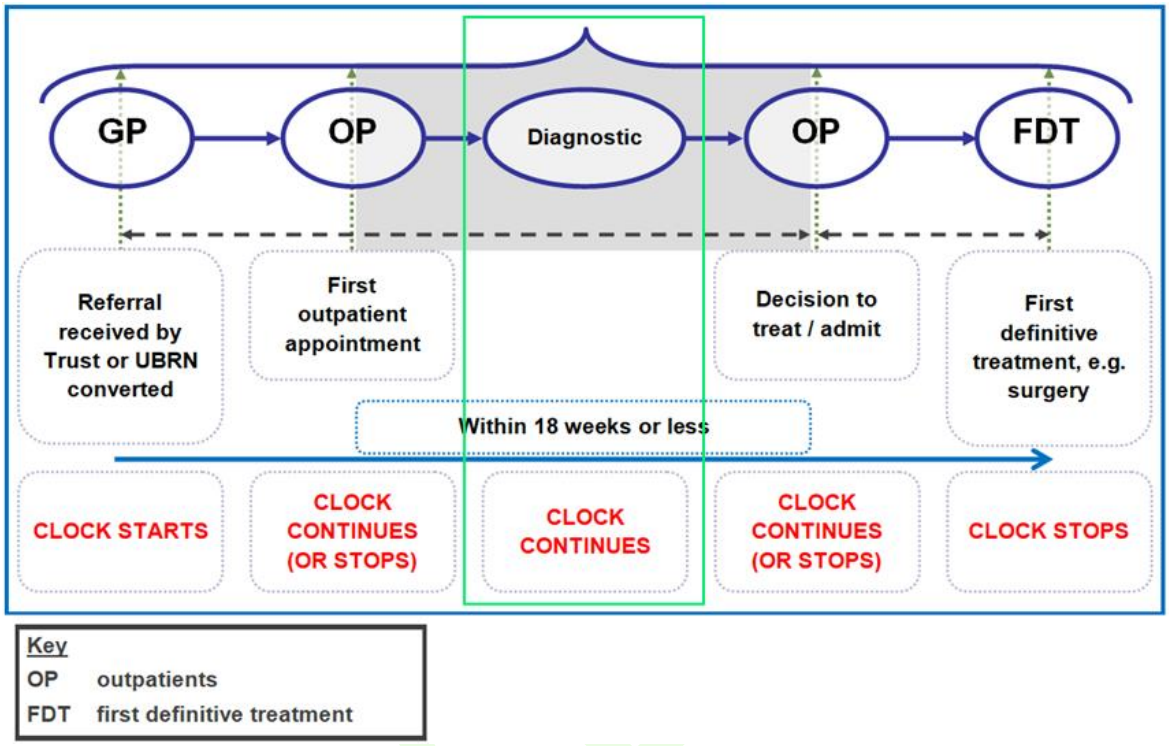


Figure 3: Diagnostic phase of the pathway

It is important to note, however, that patients can also be referred for some diagnostic investigations directly by their GP where they might not be on a RTT pathway. This will happen when the GP has requested the test to inform future patient management decisions (i.e. GP has not made a referral to a consultant-led service at this time).

4.3.1 Patients with a diagnostic and RTT clock

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

- the RTT clock which started at the point of receipt of the original referral
- the diagnostic clock which starts at the point of the decision to refer for diagnostic test (often at the first outpatient consultation).

National diagnostic clock rules

- Diagnostic clock start: the clock starts at the point of the decision to refer for a diagnostic test by either the GP or the consultant.
- Diagnostic clock stop: the clock stops at the point at which the patient undergoes the test.

4.3.2 Straight-to-test arrangements

For patients who are referred for a diagnostic test where one of the possible outcomes is review and if appropriate treatment within a consultant-led service (without first being reviewed by their GP) an RTT clock will start on receipt of the referral. These are called straight to test referrals.

Examples of such services may include (will differ between member Trusts):

- MRI
- Ultrasound
- DEXA
- Straight to test endoscopy
- Radiology imaging services

4.3.3 Patients with a diagnostic clock only (direct access referrals)

Patients who are referred directly for a diagnostic test (but not consultant-led treatment) by their GP, i.e. clinical responsibility remains with the GP, will have a diagnostic clock running only. These are called direct access referrals.

Patients may also have a diagnostic clock running only where they have had an RTT clock stop for treatment or non-treatment and their consultant refers them for a diagnostic test with the possibility that this may lead to a new RTT treatment plan.

4.3.4 Booking diagnostic appointments

Sending and receiving diagnostic referrals

- A clinical professional will ensure that the request is appropriate and adds value to the patient pathway and will validate requests. Incorrect or unsuitable referrals will be returned to the referrer.
- Patients will be informed that referrals will not be accepted if patient identification data is incomplete.
- Internal referrals for diagnostic tests should be sent electronically by order communications where possible. Internal referrals should be delivered to the appropriate department within 24 hours of being written.
- Direct Access referrals - initial contact should be made with patient within 5 days of acceptance of referral (AQP terms).

Booking and contacting patients

- Upon receipt, the patient will be contacted by letter or telephone call with appointment details. Clear and concise information about the procedure, including preparation if needed, will be given with the appointment letter
- Where multiple diagnostics are required (within one service, or crossing multiple diagnostic services), efforts will be made to minimise the inconvenience to the patient by compressing attendances into the fewest number of visits possible

4.3.5 Diagnostics Clinical Prioritisation

Patients will be booked for diagnostics in priority order as per the following waiting list priority status:

D1	**Emergency Patients:** *Potentially life threatening or time critical conditions e.g. cancer (i.e. spinal cord compression), acute heart failure with no recent imaging, significant bleeding, chest pain with murmur or heart failure and no recent imaging, renal failure, vision loss.*
D2	**Urgent or Fast Track Patients:** *Potential to cause severe disability or severe reduction of quality of life e.g., intractable pain.*
D3	**Routine Patients (4-6 weeks):** *Chronic complaints that impact on quality of life and may result in mild or moderate disability*
D4	**Routine Patients (6-12 weeks):** *Chronic complaints that impact on quality of life and may result in mild or moderate disability*

4.3.6 Diagnostic cancellations, declines and/or DNA/WNB for patients on open RTT pathways

Appointments will be booked in line with the agreed reasonableness criteria (see section 'Reasonableness').

If a patient declines, cancels or DNAs a diagnostic appointment, the diagnostic clock can be reset to zero and restarted from the date of the appointment that the patient cancelled / missed.

However:

- The Trust must be able to demonstrate that the patient's original diagnostic appointment fulfilled the reasonableness criteria for the clock start to be reset.
- Resetting the diagnostic clock start has no effect on the patient's RTT clock, even if a clinical decision is made to return them to the referring consultant. This continues to tick from the original clock start date.

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

<u>DNAs for 'straight to test' & 'direct access' diagnostics</u>
Patients who DNA / WNB a diagnostic appointment on a 'straight to test' pathway will have their RTT and/or diagnostic clocks nullified. These patients will not be automatically given a further appointment (a clinical review will be required, as below).

As standard, the referral will be cancelled and returned to the referring clinician by the diagnostic department concerned. In these cases, the provider must be able to demonstrate that the appointment offer was reasonable & clearly communicated to the patient. For direct access pathways, a new diagnostic clock starts on the date on which the provider receives notice of any subsequent re-referral. For straight to test pathways, a new RTT clock starts on the date on which the provider receives notice of any subsequent re-referral.

Patients may be offered another appointment without first being returned to the referring clinician if, in the clinical judgement of the consultant/healthcare professional:

- The patient needs to be offered another appointment on the grounds of clinical need, or

- The patient could be considered to be vulnerable due to age, reliance on carers, paediatric status, mental capacity etc. (See local Safeguarding Policy as appropriate).

Under these circumstances the patient must still be seen within the maximum waiting time for the service / specialty.

DNAs for diagnostics pathways referred from a consultant

Patients who fail to attend after referral from consultant to diagnostics will NOT be automatically offered a 2nd appointment. The referral will be cancelled and returned to the referring clinician by the diagnostic department concerned. The clinician is subsequently responsible for re-referral, bearing in mind that the RTT clock will still be running

Patients may be offered another appointment without first being returned to the referring clinician if, in the clinical judgement of the consultant/healthcare professional:

- The patient needs to be offered another appointment on the grounds of clinical need; or
- The patient could be considered to be vulnerable due to age, reliance on carers, paediatric status, mental capacity etc. (See local Safeguarding Policy as appropriate).
-

Under these circumstances the patient must still be seen within the maximum waiting time for the service/specialty.

If the Trust cancels an appointment, the wait for the patient does not reset and the calculation is still made from the date of receipt of referral.

Whenever the Trust cancels an appointment for non-medical reasons the patients must be given an explanation and a rearranged date as close to their original date as possible.

4.3.7 Active diagnostic waiting list

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

4.3.8 Planned diagnostic appointments

These patients are monitored on a planned waiting list and are transferred to an active waiting list, with a new diagnostic clock and RTT clock, if they go over their due date.

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

4.3.9 Therapeutic Procedures

Where the patient is solely waiting for a therapeutic procedure, for example in the radiology department, there is no 6-week diagnostic standard. However, for many patients there is a diagnostic element to their admission/appointment, and so these patients would still be required to have their procedure within 6 weeks.

In some cases the therapeutic procedure will stop the RTT clock e.g. diagnostic procedure that becomes therapeutic

4.4 Pre-Operative Assessment (POA)

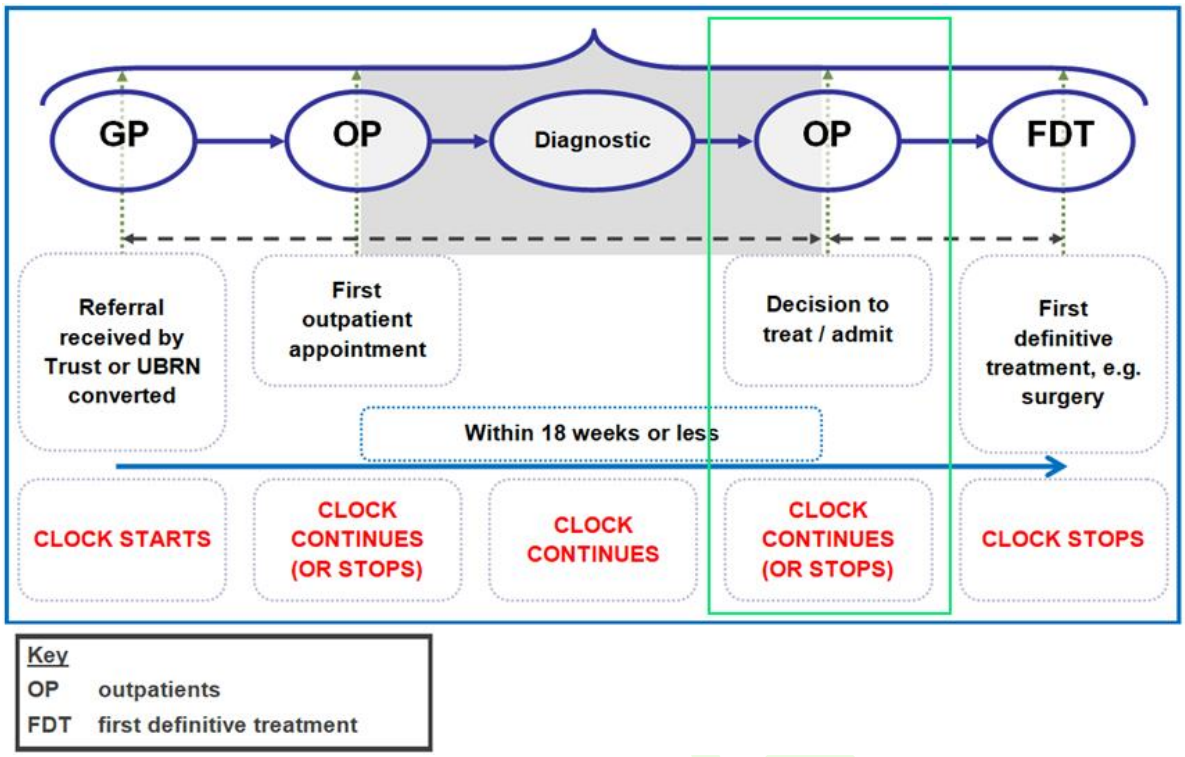


Figure 4: Stages in pre-operative assessment

All patients with a decision to admit (DTA) requiring a general anaesthetic will attend a Pre-Operative Assessment (POA) clinic to assess their fitness for surgery by appointment.

For patients with complex health issues requiring a POA appointment with a nurse consultant, the member Trust will aim to contact the patient to agree a date for assessment. Some patients will be contacted to arrange POA only once a date has been agreed for the surgical procedure.

Patients who fail to attend for a first POA appointment will be contacted, and a further appointment agreed. Patients who fail to attend for their second agreed appointment will be returned to the responsible consultant. The RTT clock continues to tick throughout this process.

4.4.1 Patient who are not fit for surgery

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

Short-term illnesses

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

Longer term illnesses

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

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

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

Patients who become fit for surgery

For patients who are on active monitoring, when they become fit and ready to be treated for the original condition, a new RTT clock would start on the day this decision is made and communicated to the patient.

For patients who have been discharged to the GP, if the GP determines they have become fit for surgery within a period of time (defined by each place / member Trust – up to six months recommended), the GP will contact the clinical specialty or pre- assessment service and the patient will be added directly back onto the waiting list using the original referral. A new RTT clock will begin at this point. Member Trusts, based on a clinical review, will determine if the patient needs to be seen again as an outpatient. If the GP determined the patient has reached a suitable level of fitness after the defined period of time has passed, a new referral will be required.

4.5 Acute Therapy Services

Examples of acute therapy services may include (will differ between member Trusts) physiotherapy, dietetics, speech and language, podiatry, orthotics and surgical appliances.

Referrals to these services can be:

- Directly from GPs: **an RTT clock would NOT be applicable**
- During an open RTT pathway where the intervention is either:
    - intended as first definitive treatment (**RTT clock stop**), or
    - interim treatment (**no RTT clock stop**)

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

4.5.1 Physiotherapy

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

For patients on an open pathway (e.g. in orthopaedics) referred for physiotherapy as interim treatment (as surgery will be required) the RTT clock continues when the patient undergoes physiotherapy.

4.5.2 Surgical Appliances

For patients on an open pathway referred from a consultant-led service for a surgical appliance with no other form of treatment agreed. In this scenario, the fitting of the appliance constitutes first definitive treatment and therefore the RTT clock stops after this has occurred.

4.5.3 Dietetics

If patients are referred to the dietician following a referral from a consultant led service and receive dietary advice with no other form of treatment, this would constitute an RTT clock stop.

Patients may receive dietary advice as an interim treatment step of a particular pathway (e.g. bariatric). In this case, the RTT clock could continue to tick, or it may be considered as active monitoring (which would stop the RTT clock), dependant on the particular pathway.

4.5.4 Speech and Language Therapy

If patients are referred to the speech and language therapist following a referral from a consultant-led service and receive advice with no other form of treatment, this would constitute an RTT clock stop.

4.6 Non-activity related RTT decisions

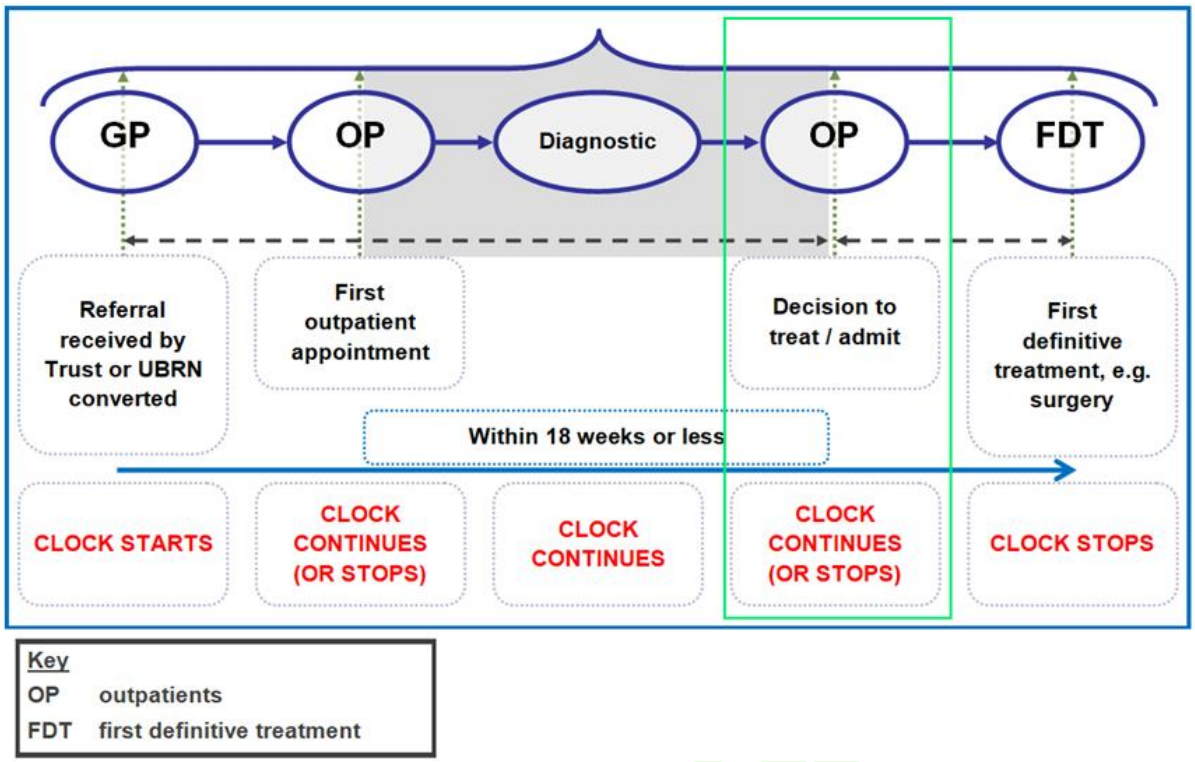


Figure 5: States in the management of non-activity related RTT decisions

Where clinicians review test results in an office setting and make a clinical decision not to treat, the RTT clock will be stopped on the day this is communicated in writing to the patient (electronic letters are permissible). This applies even if a clinician has communicated to the patient using virtual methods or if the information is passed on via the GP.

4.7 Admitted Pathways

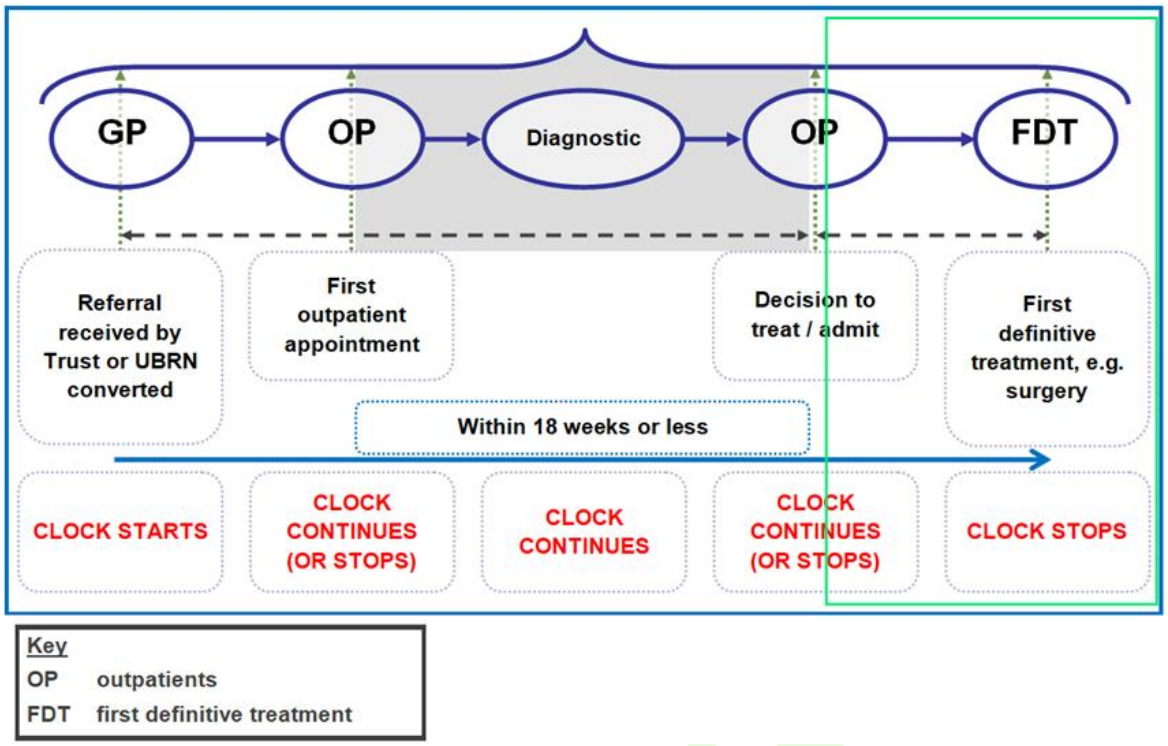


Figure 6: Stages in the management of admitted patients

The admitted stage of the pathway starts at the point of a decision to admit and ends on admission for first definitive treatment.

4.7.1 Adding patients to the active inpatient or day case waiting list

Patients should be fit, ready and available before being added to the admitted waiting list. However, they will be added to the admitted waiting list without delay following a decision to admit, regardless of whether they have undergone pre-operative assessment (see Pre-operative assessment section) or whether they have declared a period of unavailability at the point of the decision to admit (see Patient-initiated delays). The only exception is for planned patients, who are awaiting admission at a specific clinically defined time (See planned patients).

The active inpatient or day case waiting lists / PTLs includes all patients who are awaiting elective admission.

In terms of the patient's RTT clock, adding a patient to the inpatient or day case waiting will either:

- continue the RTT clock from the original referral received date
- start a new RTT clock if the surgical procedure is a substantively new treatment plan which did not form part of the original treatment package, providing that either another definitive treatment or a period of active monitoring has already occurred. The RTT clock will stop upon admission.

4.7.2 Clinical Prioritisation of Patients added to the Waiting List

All patients added to the waiting list should be clinically prioritised as per Royal College COVID guidelines:

Elective Inpatient/Day Case Priority Values	
P1	72 hrs
P2	<1 month
P3	<3 months
P4	>3 months

The Clinical Priority should be added at the point of addition to the Waiting List.

When determining the Clinical Priority status, health inequalities related issues should be considered alongside clinical need.

Patients that have exceeded the priority due date should be reviewed within the specialty to identify capacity for treatment. Patients that have been assigned a P1-4 status but ask to delay treatment for any reason should have their prioritisation value changed to C1-4 (the number reflecting the date shown on P1-4 as above).

Please see Interim Operational Guidance, below.

4.7.3 Patients requiring more than one procedure

If more than one procedure will be performed at one time by the same surgeon, the patient should be added to the waiting list with extra procedures noted. If different surgeons will work together to perform more than one procedure, the patient will be added to the waiting list of the consultant surgeon for the priority procedure with additional procedures noted.

If a patient requires more than one procedure performed on separate occasions by different (or the same) surgeon(s):

- The patient will be added to the active waiting list for the primary (first) procedure.
- When the first procedure is complete and the patient is fit, ready and able to undergo the second procedure, the patient will be added (as a new waiting list entry) to the waiting list, and a new RTT clock will start.

4.7.4 Patients requiring thinking time

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

It **may** be appropriate for the patient to be entered into active monitoring (and the RTT clock stopped) where they state they do not anticipate making a decision within a short period of time (i.e. a month or less). Trusts should make a common-sense judgement to differentiate between a short period of thinking time (no clock stop) and wanting to see how their condition can be managed or progresses before making a decision as to whether to proceed with the proposed treatment (clock stop for active monitoring).

The decision to place a patient on active monitoring can only be made by a clinician and on an individual patient basis with their best clinical interests in mind.

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

Delays because of patient choice are taken into account for achievement of the incomplete pathway waiting time operational standard (see prioritisation and interim guidance). Member Trusts will however maintain a local record of all patient-initiated delays to aid good waiting list management and to ensure patients are treated in order of clinical priority. Trusts will also wish to identify those patients who choose to delay the start of treatment, that is those who were offered a reasonable appointment within the average waiting time but chose to wait longer for personal or social reasons. A reasonable offer of an appointment is one for a time and date 3 weeks from the time that the offer was made.

Clinicians should provide secretaries / schedulers with guidelines as to how long (in general) patients should be allowed to defer their treatment without further clinical review.

Patients requesting a long delay (i.e. more than a few months) should have a clinical review to decide if this delay is appropriate. If the clinician is satisfied that the proposed delay is appropriate then the Trust should allow the delay, regardless of the length of wait reported. If the clinician is not satisfied that the proposed delay is appropriate, then the clinical risks should be clearly communicated to the patient and a clinically appropriate TCI date agreed. If the patient refuses to accept the advice of the clinician, then the responsible clinician must act in the best interest of the patient. If the clinician feels that it is in the best clinical interest of the patient to discharge the patient back to the care of their GP and inform them that treatment is not progressing, then this must be made clear to the patient.

4.7.5 Scheduling patients to come in for admission

Across all member Trusts, patients should be scheduled for admission in the following order:

1. Patients with the highest clinical priority (P1 then P2)
2. Patients who have a learning disability
3. Routine priority patients (P3 & P4), booked in chronological order of RTT waiting time. Within this group of routine-priority patients, member Trusts should follow locally agreed policies on prioritising cohorts of patients
    a. who may have higher clinical risk such as risk of deterioration
    b. other identified health inequities or
    c. for whom a longer wait would significantly reduce their independence

Local priorities related to scheduling should be clearly identified in procedural or policy documentation within member Trusts.

All patients will be identified from the Trust's PTLs, and subject to the clauses above about clinical and other local priorities, will be scheduled for admission in chronological order of RTT wait.

All patients undergoing a general anaesthetic will be scheduled for a pre-assessment, either within OP Clinic, Pre-assessment Clinic or via Telephone Assessment.

Patients will be offered a choice of at least two admission dates with three weeks' notice within the agreed milestone for the specialty concerned. Admission dates can be offered with less than three weeks' notice and if the patient accepts, this can then be defined as 'reasonable'.

If there is insufficient capacity to offer dates within the required milestone, this issue will be escalated to the relevant service manager. Every effort should be made to work with patients to find a mutually agreed plan to secure admission.

Every admission offer declined by a patient will be recorded and the Clinical Priority value reviewed by the Clinician. This is important for two reasons:

- Full and accurate record-keeping is good clinical practice.
- The information can also be used at a later date to understand the reasons for any delays in the patient's treatment, e.g. hospital or patient initiated.

4.7.6 Patients who are uncontactable

Two attempts should be made to contact the patient to verbally agree a TCI - the first in working hours and the second outside working hours where possible. A record should be kept of the times these calls were made.

If the patient cannot be contacted to verbally agree an appointment within two days, where possible the Trust should check for any alternative contact details with the GP surgery and on NHS Spine. If no other details can be found, a letter should be sent asking the patient to contact the Trust within a locally agreed time period (e.g. 10 or 21 days) and warning them they may otherwise be discharged. If the patient does not contact the Trust by that date, a clinical review should be carried out and the Trust should either

- Send a letter to the patient with a fixed TCI date with a further request for them to contact the Trust, or
- Remove the patient from the waiting list and discharge back to the GP

These processes should be clearly defined by member Trusts.

4.7.7 Patients declaring periods of unavailability whilst on the inpatient / day case waiting list

Please note – Interim Operational Guidance was published in November 2022 in response to the Covid-19 pandemic recovery. Please see Interim Operational Guidance, November 2022.

If patients contact a member Trust to communicate periods of unavailability for social reasons (e.g. holidays, exams), this period should be recorded.

Blanket rules cannot be applied outlining the maximum length of a patient-initiated delay. If the length of the period of unavailability is equal to or greater than a clinically unsafe period of delay (as indicated in advance by consultants for each specialty), the patient's pathway will be reviewed by their consultant.

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

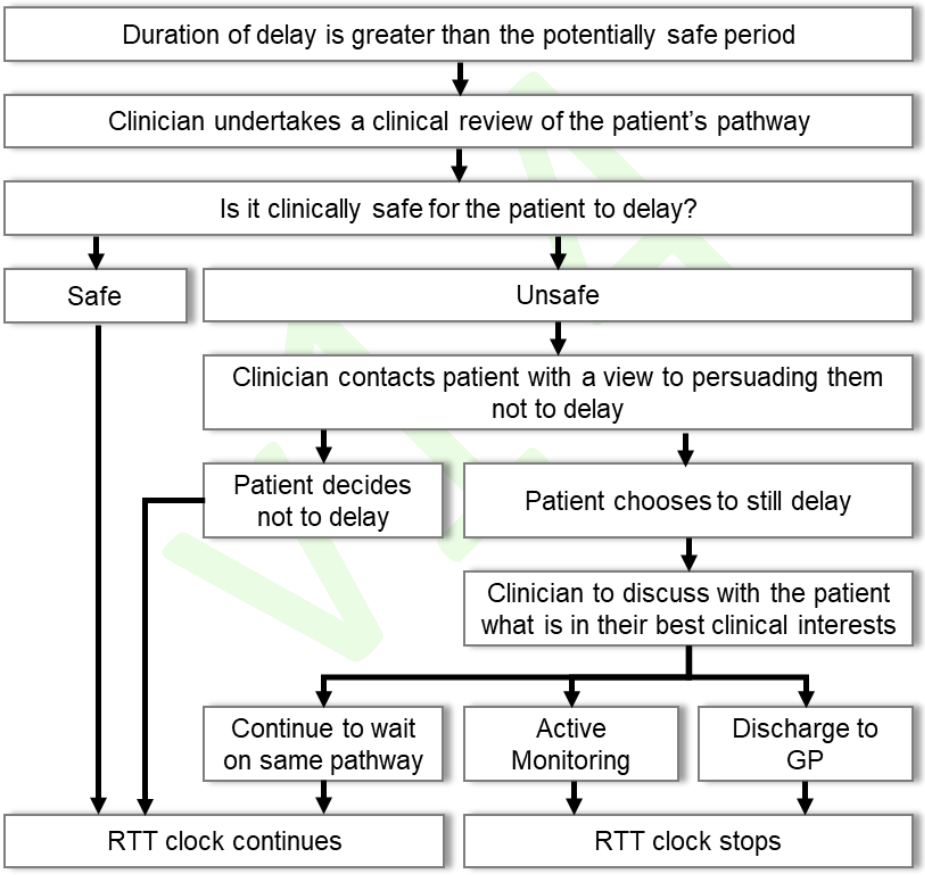
- Clinically safe for the patient to delay: continue progression of pathway. The RTT clock continues.
- Clinically unsafe length of delay: clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues. In exceptional circumstances if a patient decides to delay their treatment it may be appropriate to place the patient under active monitoring (clock stop) if the clinician believes the delay will have a consequential impact on the patient's treatment plan.
- Clinically unsafe length of delay: in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP. The patient could also be actively monitored within the Trust.

4.7.8 Patients who decline or cancel TCI offers

If a patient declines a TCI offer or contacts the Trust to cancel a previously agreed TCI, this will be recorded, and the RTT clock continues to tick.

A patient's RTT clock should not be stopped automatically because they decline or cancel a TCI date. Blanket rules cannot be applied and only the clinician can make the decision on an individual basis to stop the clock. In reaching a decision on an individual patient basis, clinicians should strike a balance between the Trust's responsibility for acting in the patient's best clinical interests and the fact that patients have a right to choose to delay. Every effort should be made to develop a bespoke plan with the patient to secure an admission date.

If, because of the patient declining or cancelling, a delay is incurred which is equal to or greater than a clinically unsafe period of delay (as indicated in advance by consultants for each specialty), the patient's pathway will be reviewed by their consultant. Upon clinical review, the patient's consultant will indicate one of the following:



*Active Monitoring – this may be applicable where the clinician ascertains that the patient no longer wishes to proceed with the originally agreed procedure or where the length of the delay incurred has a consequential impact on the original agreed procedure. In either of these scenarios, an appointment with a clinician should be arranged to agree an alternative treatment plan with the patient.

4.7.9 Patients who do not attend for admission (DNA)

Patients who fail to attend for admission will have their pathway reviewed by the consultant. If the consultant decides they should be offered a further admission date, the RTT clock will

continue to tick. If the consultant decides it is the appropriate outcome to be discharged back to the GP, the RTT clock is stopped.

4.7.10 On the day cancellations

It is the expectation that no patient will be cancelled by the hospital on day of surgery. However, where a patient is cancelled for non-clinical reasons, **they will be rebooked with 28 days of the original admission date.**

The patient must be given reasonable notice of the re-arranged date. The patient may choose not to accept a date within 28 days. Where appropriate, if it is not possible to offer the patient a date within 28 days of the cancellation, the Trust may offer to fund the patient's treatment at the time and hospital of the patient's choice.

4.7.11 Planned waiting lists

Patients will only be added to an admitted planned waiting list where clinically they need to undergo a procedure at a specific clinically defined time. The due date for their planned procedure will be included in the planned waiting list entry. Patients on planned waiting lists will be scheduled for admission at the clinically appropriate time and they should not have to wait a further period after this time has elapsed.

When patients on planned lists are clinically ready for their care to begin and reach their due date for their planned procedure, they will either be admitted for the procedure or be transferred to an active waiting list and a new RTT clock will start. For some patients (e.g. surveillance endoscopies) a diagnostic clock would also start.

4.7.12 Interim Operational Guidance, November 2022

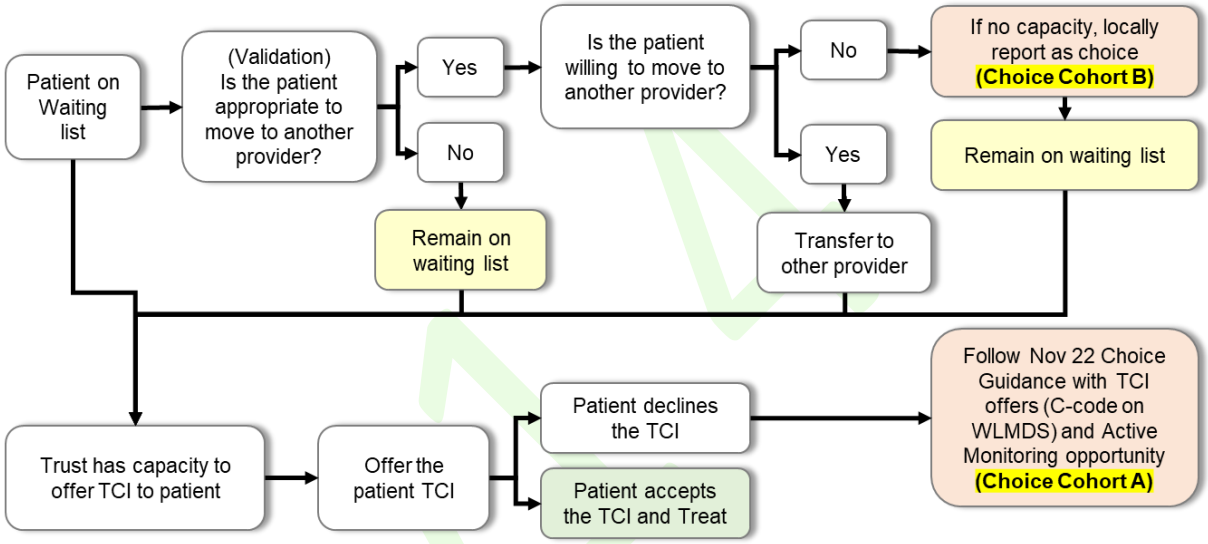
Please see Interim Operational Guidance

This interim guidance supports Trusts in the management of patients who either

- wish to delay their treatment for social reasons or
- have declined a TCI at an alternative provider to receive earlier treatment.

These are referred to below as 'Choice Cohort A' and may have a 'C-code' applied and be considered for active monitoring as per the diagram and sections below.

Please note that those patients in 'Choice Cohort B' below – who have declined the option of moving to another provider for earlier treatment – do not apply for 'C-code' and active monitoring unless they have also been offered and declined a TCI for social reasons. Those patients should be reported locally as choice.



Patients wishing to delay treatment (Formerly P6) – Choice Cohort A

In circumstances where a patient wishes to delay their treatment the following approach may be considered:

1. Following declining a first TCI, the patient should be recorded on the WLMDS as a 'C-code'.
2. A second TCI should be offered which is within 6 weeks of the first TCI.
3. If a second TCI is declined, it may be appropriate, following a clinical conversation and agreement with the patient, to consider placing a patient on active monitoring.
4. When a patient is placed on active monitoring, the RTT clock should be stopped.
5. If a patient wishes to go ahead with treatment, the provider should offer a new TCI date acting as if the patient is on the waiting list at the point which they previously left. I.e. they should not be returned to the beginning of the waiting list.

Where it is appropriate to place a patient on active monitoring, this should be for a maximum period of 12 weeks. Throughout the agreed active monitoring period, the patient should be advised of the process to follow should they wish to go ahead with treatment and be reinstated on the waiting list. Patients placed on active monitoring should be managed through local reporting and local clinical governance arrangements.

If a patient makes themselves unavailable for a longer period of time, and the Trust is able to offer two reasonable TCI dates within that period, it is not necessary to contact the patient to offer TCI dates that the Trust knows will be declined. The patient can be recorded as a 'C-code' and placed on active monitoring as above.

Patients declining earlier treatment at an alternative provider (choice category) – Choice Cohort A

Patients included within this cohort should be clinically validated to be appropriate (clinically and socially) to be offered earlier treatment at a reasonable one alternative provider.

Reasonableness in terms of alternative providers will be defined by each region recognising local geography and the patient's needs. Member Trusts should make provision to support patients with transport or travel costs if required.

In circumstances where a patient has been given a detailed offer of a first TCI for earlier treatment at an alternative provider and has declined the offer, the patient should be recorded on the WLMDS as a 'C-code' and steps 2-5 followed as above.

All TCI dates offered must include date, provider and team. It is not appropriate to start a period of active monitoring and stop the clock on the basis of a patient declining earlier treatment at a provider for which the detail has not been confirmed. Patients who have declared that they would be unwilling to move to any other provider prior to a detailed offer of a TCI being made either at their original Trust or the alternative provider make up 'Choice Cohort B' and should **not** be given a C-code nor considered for active monitoring. These patients should be recorded locally.

In implementing this interim guidance, Trusts should ensure a pragmatic approach is taken so that patients are not unreasonably disadvantaged.

5. CANCER PATHWAYS

5.1 Introduction and scope

This section describes how the member Trusts manage waiting times for patients with suspected and confirmed cancer, to ensure that such patients are diagnosed and treated as rapidly as possible and within the national waiting times standards. This policy is consistent with the latest version of the Department of Health and Social Care's *Cancer Waiting Times Guide* and includes national dataset requirements for both waiting times and clinical datasets.

5.1.1 Principles

As defined in the NHS Constitution, patients have the right to expect to be seen and treated within national operational standards ensuring timely diagnosis and treatment, equity of care and patient choice.

Patients will, wherever possible, be offered dates for appointment or treatment in chronological order, based on the number of days remaining on their cancer pathway, unless there are identified clinical exceptions.

Wherever possible, patients will be given reasonable notice and choice of appointments and TCI dates as defined within the policy.

Accurate data on the Trust's performance against the national cancer waiting times is recorded in the cancer management system and reported to the National Cancer Waiting Times Database within nationally predetermined timescales.

Where patients are at risk of breaching any of the cancer standards it is expected that all staff will follow the published cancer escalation policy.

5.1.2 Cancer Waiting Times

Following the Covid-19 pandemic, the NHS introduced elective recovery standards for elective and cancer treatment:

- The weekly backlog number of patients waiting more than 62 days from urgent referral for suspected cancer should return to pre-pandemic levels by March 2023.
- 75% of urgent GP referrals for suspected cancer should be diagnosed or ruled out within 28 days from March 2024.

In addition to these, there are key long-standing cancer waiting times standards that Trusts must comply with, outlined in the table below.

Current CWT Standards

Maximum two weeks from:		**Operational Standard**
Receipt of urgent referral for suspected cancer to first outpatient attendance		93%
Receipt of referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment		93%
Maximum 28 days from:		
Receipt of two week wait referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of two week wait referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer		75%
Maximum one month (31 days) from:		
Decision to treat first definitive treatment		96%
Decision to treat / earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is:	Surgery	94%
	Drug treatment	98%
	Radiotherapy	94%
Maximum two months (62 days) from:		
Urgent referral for suspected cancer to first treatment (62-day classic)		85%
Urgent referral from an NHS Cancer Screening Programme (breast, cervical or bowel) for suspected cancer to first treatment		90%
No separate operational standards set:		
Consultant upgrade of urgency of a referral to first treatment		
Maximum one month (31 days) from urgent referral to first treatment for rare cancers: acute leukaemia, testicular cancer and children's cancers		

5.2 Summary of the Cancer rules

5.2.1 Clock start

Two-week wait (2WW)
A two week wait clock starts at the receipt of referral.

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

- urgent two-week wait referral for suspected cancer
- urgent two-week wait referral for breast symptoms (where cancer is not suspected)
- a consultant upgrade
- referral from NHS cancer screening programme
- non-NHS referral (and subsequent consultant upgrade).

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

31 days
A 31-day cancer clock will start following:

- a decision to treat (DTT) for first definitive treatment
- a DTT for subsequent treatment
- an earliest clinical admission date (ECAD) following a first definitive treatment for cancer.

If a patient's treatment plan changes, the DTT can be changed, i.e. if a patient had originally agreed to have surgery but then changed their mind and opted for radiotherapy instead.

5.2.2 Clock stops

A 62-day cancer clock will stop following:

- delivery of first definitive treatment
- placing a patient with a confirmed cancer diagnosis onto active monitoring
- patient death prior to treatment

Removals from the 62-day pathway (not reported):

- making a decision not to treat
- a patient declining all diagnostic tests
- confirmation of a non-malignant diagnosis.

A 31-day cancer clock will stop following:

- delivery of first definitive treatment
- placing a patient with a confirmed cancer diagnosis onto active monitoring
- confirmation of a non-malignant diagnosis.

For a more detailed breakdown of the cancer rules please read the latest Cancer waiting times guidance or the cancer operational policy.

5.2.3 GP/GDP suspected cancer 2-week wait referrals

All suspected cancer referrals should be referred by the GP/GDP, optometrist & any other source as agreed locally on the relevant cancer pro forma provided and submitted via e-referral.

Day 0 is the date the referral was received.

The first appointment can be either an outpatient appointment with a consultant or investigation relevant to the referral, i.e. 'straight to test'.

All 2WW referrals will be checked for completeness by the 2WW team within 24 working hours of receipt of referral.

For 2WW referrals received by the Trust without key information the 2WW team will contact the relevant GP surgery by phone within 48 hours of receipt of referral to obtain the missing information.

Any 2WW referral received inadvertently by the Provider which was meant for another Trust will be sent electronically to the intended provider with a copy for information sent to the referring GP electronically within 24 hours of receipt.

5.2.4 Screening pathways

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

- breast: receipt of referral for further assessment (i.e. not back to routine recall)
- bowel: receipt of referral for an appointment to discuss suitability for colonoscopy with a specialist screening practitioner (SSP)
- cervical: receipt of referral for an appointment at colposcopy clinic.

5.2.5 Downgrading referrals from two-week wait

If a consultant thinks the two-week wait referral is inappropriate this should be discussed with the referrer. Only the referrer can downgrade or withdraw a referral.

5.2.6 Consultant upgrades

A consultant or an authorised member of the consultant team can upgrade a patient if cancer is suspected. The date of the upgrade then starts the 62-day clock.

An upgrade can come from any source other than:

- two week wait referrals for suspected cancer
- two week wait referrals for breast symptoms (not suspicious of cancer)
- urgent screening referrals

An upgrade can take place anywhere within the RTT period:

- on reading the referral letter
- after seeing the patient for the first time
- after seeing test results (before or after seeing the patient)
- after discussing the patient's case at a multidisciplinary team meeting

5.2.7 Subsequent treatments and earliest clinical appropriate date (ECAD)

A subsequent treatment is each separate cancer treatment following first definitive cancer treatment and should be treated within 31 days from DTT (decision to treat) or ECAD date.

The member of the consultant team liaising with the patient about the treatment in question would set the ECAD.

For patients waiting for subsequent treatments the ECAD can be set at a number of points:

- at the clinical review with the patient following the preceding treatment. If it is not possible to make a decision at the review a further review could be arranged
- at the start of the preceding treatment if the patient will not be reviewed between treatments
- at the Multi-Disciplinary Team (MDT) meeting if it is possible to identify the likely ECADs between treatments in an agreed package
- following receipt of test results and prior to discussing with the patient if this is an appropriate date

5.2.8 Reasonableness

For patients on a cancer pathway, an offer will be deemed reasonable if 48 hours' notice of appointment/diagnostic test/admission is given.

5.2.9 Pauses

There are only two adjustments allowed on a cancer pathway, one in the 2WW pathway and the other in the 62-/31-day pathway:

- 2WW: If a patient DNAs their initial (first) outpatient appointment or attendance at diagnostic appointment, e.g. endoscopy, the clock start date can be reset to the date the patient rebooks their appointment (the date the patient agrees the new appointment not the new appointment date), or the date the appointment is rebooked
- An adjustment for treatment can be applied if a patient declines a 'reasonable' offer of admission for treatment (for both admitted and non-admitted)

If during a consultation, or at any other point, while being offered an appointment date, the patient states that they are unavailable for a set period of time (e.g. due to holiday or work commitments), a pause can be applied from the date that would have been offered to the patient to the date that they are available. This will apply to admitted treatments only (reference: *Cancer Waiting Times Guidance* version 11).

An adjustment / pause may be applied if it is deemed clinically essential to treat another medical condition before treatment for cancer can be given, after a decision to treat the cancer has been made. In such cases the pause can be applied from the date at which it is confirmed that a patient needs treatment for the other medical condition, to the point at which after receiving treatment for this condition the patient is deemed clinically fit to commence their cancer treatment (reference: *Cancer Waiting Times Guidance* version 11).

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

5.2.10 Patient cancellations

If the patient gives any prior notice that they cannot attend their appointment (even if this is on the day of clinic), this should be recorded as a cancellation and not DNA. The member Trust will make every effort to reschedule patient appointments at the convenience of the patient. If a patient cancels an appointment the following guidance must be followed.

First appointment cancellations

2WW referral patients who cancel their first appointment should be offered another appointment within the two weeks of the referral being received.

Subsequent cancellations

Patients who cancel an appointment/investigation date will be offered an alternative date within seven days of the cancelled appointment (no waiting time adjustment will apply).

Multiple cancellations

All patients who are referred on a 62-day GP pathway, screening pathway or breast symptomatic referral who cancel two consecutive appointments (i.e. outpatient, diagnostic investigation) will be contacted by an appropriate member of staff to identify any factors that may be stopping the patient attending. Another appointment will be offered if the patient agrees.

Patients can be discharged after multiple (two or more) appointment cancellations if this has been agreed with the patient. However, where a patient has cancelled multiple appointments on a 62-day GP pathway, screening pathway or breast symptomatic referral (i.e. outpatient, diagnostic investigation), an appropriate member of staff will contact the patient to identify any factors that may be stopping the patient attending and another appointment will be offered if the patient agrees. Local safeguarding policies should be considered here.

5.2.11 Patient DNAs

Patients will be recorded as a DNA if they do not turn up to a clinic or diagnostic appointment, turn up late or turn up in a condition where the Trust cannot carry out whatever was planned for them: for example, if they have not taken a preparation they needed to take before the appointment. (This also includes patients who have not complied with appropriate instructions prior to an investigation.)

First appointment

All patients referred as suspected cancer including 2WW, screening, upgrade and breast symptomatic who DNA their first outpatient appointment should be offered an alternative date within 14 days of the DNA.

A waiting-time adjustment applies from receipt of referral to the date the patient makes contact to rearrange the appointment and all details must be recorded on the cancer management system.

If a patient DNAs their first appointment for a second time they will be escalated to the consultant in clinic for a decision on the next step which may include discharge back to the GP.

Subsequent appointments

If a patient DNAs any subsequent appointment they should be escalated to the consultant in clinic for a decision on the next step which may include discharge back to the GP.

5.2.12 Patients who are uncontactable

If the patient is uncontactable at any time on their 62-/31-day pathway, a record of the time and date of the call to them should be made at the time of the call.

Two further attempts should be made to contact the patient to verbally agree a TCI - the first in working hours and the second outside working hours where possible. A record should be kept of the times these calls were made.

If the patient cannot be contacted to verbally agree an appointment within 2 days, where possible the Trust should check for any alternative contact details with the GP surgery and on NHS Spine.

If no other details can be found, a letter should be sent asking the patient to contact the Trust within a locally agreed time period (e.g. 10 days) and warning them they may otherwise be discharged. If the patient does not contact the Trust by that date:

- For first appointments: An appointment will be sent to the patient offering an appointment within the 2WW standard (if possible, considering the delay in contacting), stating that the Trust has attempted to offer a choice of appointment, and that the patient should contact the 2WW office to rearrange the appointment if it is inconvenient.
- For all subsequent appointments: the Consultant should decide either:
    - to send a letter to the patient with a fixed TCI date with a further request for them to contact the Trust, or
    - to discharge the patient back to the GP.

5.2.13 Patients who are unavailable

If a patient indicates they will be unavailable for 28 days or more on their pathway after their first appointment, and the clinician has any concern over the delay they will contact the patient to discuss if they can make themselves available. Patients will not be discharged if they make themselves unavailable.

5.2.14 Diagnostics

The Trust will maintain a 2WW for all diagnostic ‘straight to tests’ for patients on a cancer pathway and a 10-day turnaround for all subsequent diagnostic tests on a patient’s 62-/31-day pathway.

Refusal of a diagnostic test

If a patient refuses a diagnostic test, the refusal will be escalated to the managing clinician to discuss with the patient. If the patient refuses all diagnostic tests, they will be removed from the cancer pathway and discharged back to their GP.

Managing the transfer of private patients

If a patient decides to have any appointment in a private setting, they will remove themselves from the cancer pathway.

If a patient transfers from a private provider onto an NHS waiting list and they have not made a DTT, the consultant wants them to be managed against the 62-day target they will need to be upgraded.

If a DTT has been made in a private setting the 31-day clock will start on the day the referral was received by the Trust.

5.2.15 Tertiary referrals

Process

Inter provider transfer (IPT) forms will be used for all outbound referrals for patients on a cancer pathway and information uploaded onto the appropriate cancer information management system.

A minimum dataset and all relevant diagnostic test results and images will be provided when the patient is referred.

6. GLOSSARY

6.1 Terms

2WW	Two-week wait: the maximum waiting time for a patient's first outpatient appointment or 'straight to test' appointment if they are referred as a 62-day pathway patient.
28-day pathway / Faster Diagnosis Standard (FDS)	Maximum four weeks (28 days) from receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer, breast symptomatic referral or urgent screening referral, to point at which patient is told they have cancer, or cancer is definitively excluded.
31-day pathway	The starting point for cancer 31-day standard is the date a patient agrees a plan for their treatment or the date that an earliest clinically appropriate date (ECAD) is effected for subsequent treatments.
62-day pathway	Any patient referred by a GP with a suspected cancer on a 2WW referral pro-forma, referral from a screening service, a referral from any healthcare professional if for breast symptoms or where a routine referral has been upgraded by a hospital clinician, must begin treatment within 62 days from receipt of referral
Active monitoring	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures.
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.
Advice & 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.
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 which ends when a patient is seen/receives their first treatment outside the 14-day first seen, 62-day referral to treatment and/or 31-day decision to treat to treatment target times.
Cancer outcomes and services dataset (COSD)	The key dataset designed to define and deliver consistency in data recording, data submission and analysis across cancer in the NHS, including diagnostics, staging, treatment and demographic information. Data is submitted to the cancer registry and used for national reporting.
Chronological booking	Refers to the process of booking patients for appointments, diagnostic procedures and admission in date order of their clock start date.
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 and responsibility of care remains with the GP
Earliest Clinically Appropriate Date (ECAD)	The date that it is clinically appropriate for an activity to take place. ECAD is only applicable to subsequent treatments.
Evidence Based Interventions (EBIs)	List of diagnostics/treatments that have been identified as having limited clinical value and therefore require prior approval funding.
Elective care	Any pre-scheduled care which doesn't come under the scope of emergency care.
First definitive treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgement in consultation with the patient.
Fixed appointments	Where an appointment or admission date is sent in the post to the patient without the opportunity to agree a date.
Full booking	Where an appointment or admission date is agreed either with the patient at the time of the decision or within 24 hours of the decision.
Incomplete pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage.
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night
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 near to the time it is due.
Patient-initiated delay	Where the patient cancels, declines offers or does not attend appointments or admission. This in itself does not the stop the RTT clock. A clinical review must always take place.
Planned 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.
Reasonable offers	A choice of two appointment or admission dates with three weeks' notice.
Straight to Test	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an RTT pathway.

6.2 Abbreviations / Acronyms

Term	Definition
ASIs	Appointment Slot Issues (list): 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.
CWT	Cancer Waiting Times
DNA	Did Not Attend: patient who does not give prior notice of their non-attendance
DTA	Decision to Admit: Where a clinical decision is made to admit the patient for either day case or inpatient treatment.
DTT	Decision to Treat: the date on which the clinician communicates the treatment options to the patient and the patient agrees to a treatment
ECAD	Earliest Clinically Appropriate Date that is appropriate for an activity to take place. ECAD is only applicable to subsequent treatments
EBIs	Evidence Based Interventions. List of treatments/diagnostics of limited clinical value.
E-RS	(National) E-Referral Service
FDS	Faster Diagnosis Standard
GDP	General Dentist Practitioner
GP	General Practitioner
IPT	Inter-Provider Transfer – electronic transfer of patient referral data
MDT	Multidisciplinary Team meeting where individual patient care plans are discussed
MDS	Minimum Data Set: minimum information required to process a referral
OPCS	Office of Population Consensuses and Surveys - Classification of interventions and procedures.
PPC	Patient Pathway Co-ordinator (Cancer pathway)
PTL	Patient Tracking List. A tool for monitoring, scheduling and reporting on patients on elective pathways
RTT	Referral to Treatment: National standard for treatment time, as defined above
TCI	To Come In (date). The date for admission for elective procedure or operation
WNB	Was Not Brought: a patient who does not give notice prior to their non-attendance at an appointment, but who would be expected to be brought to their appointment (i.e. by a parent or carer).
UBRN	Unique Booking Reference Number (E-referral)

6.3 References and Further Reading

Title	Published by	Publication date	Link
Referral to treatment consultant led waiting times Rules Suite	Department of Health	October 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	NHS England	April 2021	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/05/Recording-and-Reporting-guidance-April_2021.pdf
Recording and reporting referral to treatment (RTT) waiting times for consultant led elective care: Frequently Asked Questions	NHS England	October 2015 Updated August 2017	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2017/10/Accompanying-FAQs-v7.32-ASI-FAQ-update.pdf
The NHS Constitution	Department of Health	July 2015 Updated January 2021	https://www.gov.uk/government/publications/the-nhs-constitution-for-england
Diagnostics waiting times and activity **Guidance on completing the 'diagnostic waiting times & activity' monthly data**	NHS England	March 2015	https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/
Diagnostics Frequently Asked Questions on completing the Diagnostic Waiting Times monthly data collection	NHS England	February 2015	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01-FAQs-v-3.0.pdf
Equality Act 2010	Department of Health	June 2015	https://www.gov.uk/guidance/equality-act-2010-guidance
Overseas Visitor Guidance	Department of Health	December 2018	https://www.gov.uk/government/publications/overseas-nhs-visitors-implementing-the-charging-regulations
Cancer Waiting Times guidance version 11	Department of Health	September 2020	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/cancerwaitingtimescwt
Delivering cancer waiting times good practice guide	NHS Improvement	July 2016	https://improvement.nhs.uk/documents/192/Delivering_cancer_waiting_times_update_July_2016.pdf

Armed Forces Covenant	Ministry of Defence	July 2015	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/49469/the_armed_forces_covenant.pdf
RTT measurement and Guidance COVID	NHSE	March 2020	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/03/C0009-RTT-measurement-and-COVID-19.pdf
Evidence Based Interventions	Academy of Medical Royal Colleges	2023	https://ebi.aomrc.org.uk
Clinical Guide to Surgical Clinical Prioritisation	Federation of Surgical Specialty Associations	November 2020	https://fssa.org.uk/_userfiles/pages/files/covid19/prioritisation_master_27_11_20.pdf https://fssa.org.uk/_userfiles/pages/files/covid19/recovery_prioritisation_matrix_rpm_v_260620.pdf
Interim Operational Guidance: Management of patients on the waiting list choosing to decline offered treatment dates at current provider or an alternative provider	NHS England	October 2022	https://future.nhs.uk/ElectiveRecovery/view?objectId=40150608
National Clinical Prioritisation Programme (Including Evidence Based Interventions) – FAQ, v3	Academy of Medical Royal Colleges	November 2020	https://www.aomrc.org.uk/ebi/wp-content/uploads/2021/05/National_Clinical_Validation_Programme_FAQ_1120.pdf
Delivery plan for tackling the COVID-19 backlog of elective care	NHS England	February 2022 – May 2023	https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care
The NHS Choice Framework	Department of Health and Social Care	January 2020	https://www.gov.uk/government/publications/the-nhs-choice-framework
Elective care model access policy v2	NHS England	April 2023	https://future.nhs.uk/ElecCareIST/view?objectId=76307333

7. APPENDICES

7.1 Appendix 1 – Reviewees (WYAAT / West Yorkshire ICS)

Version Reviewed	Group	Name(s)	Date
v0.3	NHS England Elective Care Improvement Support Team (IST)	Matthew Noonan	January 2023
V0.3	WYAAT Elective Coordination Group members & Access Leads	Including Rebecca Friar (AFT), James Taylor (BTHFT), Tom Strickland (CHFT), Russell Nightingale, James Wright (HDFT), Rob Armstrong (LTHT), Keely Robson (MYHT)	February 2023
V0.4	West Yorkshire Planned Care Place Leads	Catherine Thompson, Vicky Dutchburn, Andrew Bottomley, Joanna Bayton-Smith, Ian Wallace, Simon Rowe	February 2023
V0.4	WYAAT Chief Operating Officers Group		February 2023
V1.1	West Yorkshire Planned Care Transformation Group		March 2023
V1.3.1	WYAAT Elective Coordination Group members & Access Leads		July 2023
V1.4			