NWL Elective Access Policy

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NAME OF AUTHORS:	Senior Programme Manager for Elective Care, Tim Billins with expertise input and feedback from: RM Partners NWL RTT Technical group NWL Elective Care Board NWL Outpatients Group NWL Clinical Advisory Group NWL Primary Care Executive Group ICHT Lay Partners NWL Elective Care Programme NWL Diagnostics Programme
STAKEHOLDERS INVOLVED:	Operational managers, Trust clinicians, Trust executive directors, commissioners and GPs. This policy is applicable to all clinical and administrative staff with responsibility for patient pathway delivery.

EQUALITY IMPACT ASSESSMENT OUTCOME	No negative impact. EHIA checklist approved by NWL Equality and Quality Lead

DOCUMENT REVIEW HISTORY:

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30 June 2020	v02		Incorporates comments from NWL Elective Board members. v02 to be reviewed by COO and Medical Directors
15 July 2020	v03		Update Guidance (Section 4.4) following discussion at Elective Care Board on 10 July 2020
4 August 2020	v04		Updated with Appendix 4 *Management of patients who decline to attend citing Covid risk concerns* following review by the Clinical Quality Leadership Group on 22 July 2020
DRAFT Apr 2023	v05	Tim Billins	Review and update of policy for 2022/23. Incorporates input from NWL RTT Technical, Gynecology Clinical Reference Group, RM Partners for cancer expertise, NWL Diagnostics Programme, ICHT Lay partners, NWL Elective Care Programme and NWL Outpatients Group.
DRAFT Aug 2023	v06	Tim Billins	Review and update of draft with feedback from the NWL Clinical Advisory Group and NWL Primary Care Executive Group incorporated.
Sep 2023	v07	Tim Billins	Policy approved by NWL Elective Care Board and Planned Care Board.

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Section 1: Policy Introduction

1.1. Executive Summary

NW London shall ensure that access to hospital-based services is equitable across the North West London sector. This shall include ensuring that patients are given the option to select services locally, where these are offered, but are also offered the opportunity to access to services with the shortest waiting times in the sector. Referrals into clinical services shall follow agreed sector wide clinical guidelines, where published, and these same guidelines shall be applied to all referrals made outside of the sector.

This policy document and all associated policies, guidelines and standard operating procedures can be accessed via the North West London Integrated Care System (NWL ICS) website: https://www.nwlondonics.nhs.uk
All patients have a right to exercise choice under the NHS Constitution. NW London will support patients in the exercising of their constitutional right (please see Section 2.3. NWL Approach to choice for details)

1.2. Policy Aim

The aim of the policy is to provide clear expectations around roles, responsibilities, pathways and processes to ensure that national elective waiting time's guidance and good practice are followed across all NHS Providers in North West London to ensure that patients are treated promptly, efficiently and equitably.

1.3. Introduction

All NW London Trusts are dedicated to providing exemplary clinical services, recognising that the key principle is that patients must be referred, diagnosed and treated as soon as possible and ensuring that the appropriate clinical prioritisation is in place reflecting any external factors outside of the control of the NW London provider trusts.

All Trusts are committed to reducing waiting times, which includes offering timely and reliable access to services in line with the NHS Constitution, Clinical prioritization, and national waiting time standards.

This policy sets out the rules and principles under which all NW London Trusts manages elective access to routine, urgent and suspected cancer;

- advice and refer
- outpatient appointments
- diagnostics
- elective inpatient treatment
- day case treatment

This policy is designed to ensure management of elective patient access to services is transparent, fair, and equitable and managed according to clinical priority. Patients with the same clinical priority should be treated in date order (with the longest waiting patient treated first)

This document has been written in conjunction with all NW London Trusts and replaces any previous Access Policy. It will be reviewed and ratified annually or earlier if there are changes to national elective access rules or locally (NWL wide) agreed principles

This document defines the accountabilities and responsibilities of those involved in the processes detailed in this policy as well as what is expected from the patient and their referrer.

1.4. Application and compliance with policy

This policy is intended to be used by all individuals, both clinical and administrative within NW London that are responsible for;

- Referring patients;
- Receiving and managing referrals;
- Adding to and maintaining waiting lists.

This includes outpatient, inpatient, day case, therapies and diagnostic service settings. Each clinical service must follow this policy to deliver high quality, consistent care to patients across North West London.

Accountability for this policy sits ultimately with the individual Trust's Board with operational responsibility delegated to the appropriate committee/group with responsibility for elective access.

Any specific roles and responsibilities are identified in relevant sections of the policy.

There will be a suite of reports, regularly generated and/or accessible to staff to support the monitoring of Elective pathways and operational performance.

1.5. Roles and Responsibilities

All staff have a responsibility for ensuring that the principles outlined within this document are consistently applied. This policy applies to all members of staff who are involved in any aspect of referral management, patient booking or waiting list management.

Chief Executive	Primary responsibility for ensuring the waiting time data the organisation submits to NHS England is accurate.
Chief Operating Officer	The COO is the named executive officer with strategic and operational responsibility for delivery of waiting times targets, reporting to the Trust Board on waiting times performance, themes, and the associated training strategy for staff across the organisation.
Divisional Directors of Operations	Accountable for performance within their divisions with review of performance on a monthly basis through the Divisional Performance Review with executive directors.
General Manager for Patient Access	Accountable for the delivery of elective waiting list management and ensuring compliance with the policy within the admin structure
Director of Performance & Information	Provides assurance that data has been verified and validated prior to submission to the executive board.
Operational Managers	Accountable for implementing waiting list management and ensuring compliance with the access policy. Responsible for ensuring that services have adequate capacity to see patients within maximum wait times. Responsible for ensuring staff within their remit have accessed regular relevant training.
Clinical Administrative staff	Responsible for ensuring the accurate and timely input of data into trust electronic systems (PAS) in order to record the patient activity through their pathway. Identifying and escalating through the relevant divisional management structures when they are unable to

	accommodate patients within the appropriate identified timescales and identify any other relevant blocks to pathway delivery.
All clinical staff	Responsible for ensuring they comply with their responsibilities as outlined in this Policy and ensuring that the patient is kept informed of their care and progress.
Information and Data Quality Team	Responsible for providing operational reports and guidance to Divisions, services and their associated clinical admin teams to help them manage their pathways effectively and efficiently, and to ensure both current and prospective information is provided. Responsible also for undertaking a programmed and timely approach to auditing the application of the rules.
The Patient/Carer	The patient/carer is responsible for: • making themselves available for appointments and admissions with reasonable notice. • ensuring the hospital has up to date contact details including a mobile number. • providing accurate information about their health, condition and status. • Taking an active role in shared decision making with regards to their care.
The patient's GP and/or referrer	The patient's GP and/or referrer is responsible for: • referring the patient at the point where they are fit, willing and able to undertake further investigation or treatment • ensuring quality referrals are submitted to the appropriate provider first time. • communicating any outcomes of advice and refer provided to them by the Trust, including specialist advice, virtual or in-person consultation
Integrated Care Board	• Responsible for ensuring all patients are aware of their right to treatment at an alternative provider in the event that their RTT wait goes beyond 18 weeks or if it is likely to do so. • Responsible for taking all reasonable steps to offer a suitable alternative provider(s) able to see or treat patients more quickly that the provider to which they were referred • Responsible for reviewing and updating the policy annually or in line with national changes

1.6. Escalation of Elective Access Issues

Clear escalation is in place to ensure that capacity challenges can be raised and resolved. There are clear roles and responsibilities to ensure appropriate action and where necessary, escalation is taken to avoid unnecessary patient delays. All other barriers to delivering national waiting times are managed through the elective access governance structure.

Any issues or concerns relating to the delivery of patient pathways will be escalated to the Service Manager (or nominated deputy) in the first instance. Further escalations will be made to the relevant General Manager.

1.7. Performance monitoring and reporting structure

All aspects of elective care are reported through the Trust Elective Access Group. Cancer performance is reported through this same structure but also through the Trust Cancer Board, to the

Cancer Registry and NHS England. Both elective and cancer performance is reported on a monthly basis to the Trust Board as a part of the Board Report.

1.8. Data Quality

All Trusts have implemented a rolling check into the data integrity of their waiting lists. Findings and recommendations from these audits will be taken through the Trust Elective Governance where themes will be identified and appropriate action taken to rectify any identified issues.

Section 2: General Elective Access Principles and Service Standards

2.1. General Elective Access Principles

The NHS has set maximum waiting time standards for elective access to care (including cancer) and these come under two headings;

- The individual patient rights (NHS constitution)
- The standards by which individual providers and commissioners are held accountable by NHS Improvement and NHS England

2.2. Individual Patient Rights

NHS patients have the right to make choices about their healthcare. These patient choice rights are intended to give individuals more control over their treatment and enable them to make informed decisions about their care. Patients can choose which hospital or clinic from a shortlist of an average of five choices, where this is practicable, clinically appropriate and preferred by the patient, they receive treatment at, which consultant or specialist they see, and in some cases, which type of treatment they receive. These rights also include the right to access their medical records and the right to be involved in decisions about their care. NWL aims to ensure that patients are fully informed about their choices and can make decisions based on clear and accurate information. Ultimately, patient choice rights are an important aspect of the NHS's commitment to providing patient-centered care that meets the needs and preferences of each individual.

In addition to patient choice rights, NHS patients also have rights regarding Referral To Treatment (RTT) standards. This means that once a patient has been referred for treatment, they have the right to receive that treatment within a specific timeframe. Patients should receive non-urgent consultant-led treatment within 18 weeks of referral. If this timeframe is not met, patients have the right to be given the option of an alternative provider or treatment option. The RTT standards also require that patients are assessed and treated based on clinical need, rather than their ability to pay or any other non-clinical factors. These rights are designed to ensure that patients receive timely and appropriate care, regardless of their circumstances or background. (for further details please see Section 3: National Waiting Time Standards: Referral to Treatment)

NHS patients also have rights regarding cancer waiting times. These waiting time standards ensure that patients with suspected cancer are seen by a specialist and receive their first treatment within a specific timeframe. For example, patients with an urgent referral for suspected cancer should be seen within 2 weeks (14 days) and should receive their first treatment within 62 days of their referral. Patients have the right to alternative providers if their cancer waiting time targets are not met. These waiting time standards are designed to ensure that patients with suspected cancer receive timely and effective care, which can significantly improve their chances of survival and recovery. (for further information please see Section 5 National waiting time standards: Cancer)

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

- If the patient chooses to wait longer (for personal reasons, to be seen at a specific site, to be seen by a specific consultant or specialist)
- If delaying the start of the treatment is in the best clinical interests of the patient
- 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 have the right to be treated fairly and equitably as per the 9 protected characteristics as defined in the Equality Act 2010. NWL is committed to promoting equality and diversity, and ensuring that everyone is treated with dignity and respect, regardless of their background or characteristics.

2.3. NWL approach to choice

North West London (NWL) reserves the right to introduce an elective care management service, which would seek to ensure that activity is balanced across the sector and that services are delivered on behalf of NWL rather than as specific providers. NWL will offer our patients choice at the most appropriate site to allow them to be seen in the fastest time. If the service is offered at a different site but sending the patient there would result in delays in treatment, the patient may choose this but must be made aware that this will delay their care and that this choice will mean that their right to maximum waiting times no longer applies.

Patients will be made a reasonable appointment offer (for a definition of reasonable offers, see Section 7.2. Reasonable offers) within the NWL sector. Patients who have select a specific site should be offered at this site, but may also be offered an earlier appointment on other sites which they may elect to accept. As above a patient's choice to delay treatment will waiver their rights to maximum waiting times.

In some cases, patients may choose to be referred to services outside of the NW London sector, and this may include NHS funded independent sector providers. This is permitted through the NHS constitution but, in order that equity of access is maintained, it is important that any referrals made meet the most stringent of the following:

- Any published NW London referral guidelines
- Out of area provider specific referral guidelines

The referring practitioner must ensure that this compliance is documented in the referral and in the patients GP record. In addition, the GP will discuss suitable referral locations during the referral consultation.

2.4. Clinical Responsibility

Responsibility for the patient remains with the GP until a referral has been accepted into the Trust. The referral to treatment clock begins at receipt of referral.

On acceptance of the referral, it is the Trust's responsibility to contact the patient and book them into the most appropriate clinic.

Specialists are responsible for ensuring that they operate within their competence and for providing advice and refer which is clinically appropriate and can be delivered within a primary care environment using the skills and facilities available to a General Practitioner.

GPs are encouraged to explain to their patients when they are requesting advice and refer and to ensure that there is an understanding that advice and refer may not result in a referral to the hospital specialist.

Where there are extended waiting times for an appointment, as demonstrated on the Electronic Referral System (ERS), it is important that patients are advised to contact their GP if their condition changes. If there are changes that change the nature of the patient's condition, or increase the urgency, it is advised that the GP retract and re-refer stating the new details and/or urgency.

2.5. Patient Eligibility

All GPs and 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.

The GP will check every patient's eligibility for treatment. Therefore, at the first point of entry the patients will be asked questions that will help the trust assess "ordinary resident status". Some visitors from abroad. Who do not meet the "ordinary resident status" criteria, may receive 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) may be entitled to NHS healthcare paid for by a EU country (Norway, Iceland, Liechtenstein or Switzerland, if they were living in the UK on or before the 31st December 2020.

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

2.6. Patients moving between NHS and Private Healthcare

Patients can choose to move between NHS and private status at any point 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 GP/Clinician must refer the patient to the hospital and the RTT clock will start at the point the referral is received by the Trust.

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.

2.7. Mutual Aid

Mutual aid refers to provider requesting the transfer of resources or capacity/activity between NHS providers to support and provide patient care. NWL providers are to work together to ensure patients receive their elective care in a timely manner and to support this mutual aid may be requested to help manage large backlogs of patients and to shorten waiting times. Please see the NWL Elective Patient Transfers guidance for further details.

2.8. Armed Forces Covenant

The North West London sector is committed to the Armed Forces Covenant, which is a promise by the nation ensuring that those who serve or who have served in the UK Armed Forces, and their families, are treated fairly.

The Armed Forces Covenant has two key principles:

1. The Armed Forces community should not face disadvantage compared to other citizens in the provision of public and commercial services

2. Special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved. Veterans and their families should not be disadvantaged from accessing appropriate health services, for example, if they are on a waiting list and are moving. The NHS will always prioritise people with the most urgent clinical need first, but following this, should ensure that armed forces service related injuries receive timely treatment.

2.9. Prisoners

All elective standards and rules are applicable to prisoners. Delays to treatment incurred as a result of difficulties in bringing the prisoner to their appointments do not affect their right to the maximum wait time standards.

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

2.10. Vulnerable Patients

Patient who are vulnerable and/or require additional support may require additional communication between the trust clinician and the GP or other referrer. Such patients may be identified at the point of referral or during their acute pathway.

Staff should always refer to related polices and resources relating to vulnerable or at risk patients available on the trust safeguarding policies as follows: Safeguarding children and young people and safeguarding adults.

Patients with specific information, communication or accessibility needs because of a disability, impairment or sensory loss should be flagged via their electronic record, in accordance with Accessible Information Standards.

The Trusts should regularly review functionality of their electronic patient record to ensure patients are not disadvantaged.

2.11. Transitions between Paediatric and Adult services

NWL follows the recommendations for the transition from paediatric to adult services outlined by the National Institute for Health and Care Excellence (NICE) published February 2016. For further details, please consult the NICE website (Guideline NG34).

2.12. Service Standards

NWL is held to the following national elective access service standards:

Referral To Treatment waiting times for non-urgent consultant-led treatment	
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%
28 Day Hospital Initiated Surgery Cancellation Rebook	
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons, to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient' choice	N/A

Diagnostic test waiting times	
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%
Cancer waits – 2 week wait	
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%
Cancer waits – 31 days	
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%
Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%
Cancer waits – 62 days	
Maximum two month (62-day) wait from urgent referral for suspected cancer to first treatment for all cancers	85%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers –	90%
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	N/A

Section 3: National Waiting Time Standards: Referral to Treatment in NWL

3.1. Referral to Treatment (RTT)

North West London follows the definitions for waiting times published in the Department of Health's, Referral to Treatment Consultant- led waiting Times Rules Suite October 2022. For further information please and/or any updates to the national rules, please consult the RTT rules suite via the Department of Health website

3.2. Non RTT

Non RTT wait lists are managed through the electronic wait lists in the PAS.

3.3. Planned waiting lists

All patients added to the planned list will be given and informed of, a due date by when their planned procedure/test should take place. Patients are added to the RTT patient tracking list if and when the due date is passed.

Where a patient requiring a planned procedure goes beyond their due date, they will be transferred to an active pathway and a new RTT clock started. The detailed process for management of the planned patients is described in the relevant standard operating procedure.

Section 4: National Waiting Time Standards: Diagnostics

4.1. Diagnostic Waiting Times

Diagnostic appointments have their own waiting time standard of 6 weeks from when the referral is made. This DOES NOT supersede Referral to Treatment waiting times and can often take place as part of an RTT pathway meaning the patient will have an RTT pathway and diagnostics pathway running simultaneously. Patients on cancer pathways will be required to be seen quicker than the national diagnostic waiting times or RTT waiting times stipulate. The cancer waiting times DO supersede RTT and diagnostics waiting time standards and are covered in a separate section of this policy. (see Section 5: National Waiting Time Standards- Cancer)

Diagnostic wait times for all diagnostic tests will be monitored on a diagnostic PTL. The following diagnostic tests will be monitored in line with the 6 week wait metric:

- Imaging: Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Non-obstetric ultrasound (US), Barium Enema & DEXA Scan.
- Physiological Measurement: Audiology Assessments, Echocardiography, Electrophysiology, Peripheral neurophysiology, Sleep studies & Urodynamics.
- Endoscopy – Colonoscopy, Flexi sigmoidoscopy, Cystoscopy & Gastroscopy

4.2. Requesting diagnostic tests

Referrals for diagnostic tests/procedures are accepted from the following sources:

- GPs, referral management centres or direct access
- Consultant referral (internal to Trust)
- Consultant referral (between NW London trusts)
- Consultant referral (tertiary)

Patients should only be referred to a diagnostic department if they are ready and available to attend their appointment in the next 6 weeks, unless the diagnostic test is planned for a specific time. It is the responsibility of the referrer to ensure the patient is made aware of this.

Clinicians, or designated members of the clinical team, hold responsibility for placing the order and upon making a request for any diagnostic test must ensure that the clinical status of the patient is clearly denoted on that request i.e. if the patient is on a routine, urgent or planned i.e. surveillance pathway. For all urgent suspected cancer referrals, the request must be clearly marked as ‘suspected cancer’ in the clinical history section of the request form/template.

Where available diagnostic tests must be made using electronic systems, for example ICE for primary care referrals, through e-RS, email or other electronic means.

Where possible the request for examination should include the current status of the patients 18-week pathway.

4.3. National diagnostic clock rules

- Diagnostic clock start: the clock starts at the point of the decision to refer for a diagnostic test or procedure by either the GP or the consultant.

- Diagnostic clock stop: the clock stops at the point at which the patient undergoes the test or procedure

A large proportion of patients referred for a diagnostic test will also be on an open RTT pathway. The 6-week diagnostic clock is not the same as an RTT 18 week waiting list clock which will continue to tick. In these circumstances, the patient may have multiple clocks running concurrently.

If a patient undergoes a diagnostic procedure, during which treatment is also carried out, then the 6-week waiting time target still applies in accordance with the National Diagnostic Waiting Times Guidance. The completion of the procedure during this appointment will stop the patients 18 week RTT clock.

Where a patient's RTT pathway is closed (treatment already completed), and it is decided during a follow- up appointment that a new diagnostic is required, then a new diagnostic clock would start at the point of request. It is the outcome of the clinic appointment that will determine whether a new RTT clock needs to be started as well.

4.4. Diagnostics results reporting

Results reporting must be available in time to allow progress through all likely stages of the RTT pathway. The standard policy is for routine results to be made available within 5 working days of the examination and for urgent cases less than 24 hours.

4.5. Patients due to have planned diagnostic procedures

- Patient waiting lists will be reviewed on a weekly basis to identify all patients due to be contacted for a planned (surveillance) procedure in six weeks' time.

- Patients will be contacted according to the principles outlined in the above sections and are to be offered dates within 2 weeks on either side of the planned test date

- When patients on planned lists are clinically ready for their diagnostic test and reach their target treatment date, they will either receive their diagnostic test or procedure or be transferred to the active diagnostic waiting list and the appropriate clock will start (DM01).

4.6. Multiple procedures

Patients waiting for more than one procedure will be listed as follows:

- Procedures to be done on different admissions will have 2 independent waiting time clocks / waitlist entries – one for each test/procedure.
- Procedures to be done on same admission will have 1 waiting time clock / waitlist entry for both procedures

Section 5: National Waiting Time Standards: Cancer

5.1. 2 Week Waits

The maximum waiting time for suspected cancer is 2 weeks from the day your appointment is booked through the NHS e-Referral Service, or when the hospital or service receives your referral letter.

Referrals for investigations of breast symptoms, where cancer is not initially suspected, are not urgent referrals for suspected cancer and therefore fall outside the scope of this standard.

As with all breaches of national waiting time standards, patients have the legal right to ask to be seen or treated by a different provider if they are likely to wait longer than the maximum waiting time.

5.2. 62 Day Cancer Clocks

The 62-day pathway is a national guideline to ensure individuals are seen ***and*** treated within a set time.

The 62-day standard combines all urgent and non-urgent referrals into one target time of 62 days or less. This means, that when cancer is first suspected, everyone should have a confirmed diagnosis and start treatment within 62 days. The following action can start a 62-day cancer clock:

- A 2 week wait referral for suspected cancer
- A 2 week wait referral for breast symptoms where cancer is not suspected
- A consultant upgrade to a non 2 week wait referral
- A referral from the NHS cancer screening programme

If a cancer is diagnosed then the individual's case will be discussed at a multi-disciplinary team meeting (MDT). This involves many professionals, who will review all of your test results and consider all your personal needs and requirements. From this discussion, the best treatment option for the patient will be documented and this will then be discussed with them at a follow up appointment, either by the consultant or a cancer nurse specialist.

5.3. 31 Day Cancer Clocks

The 31-day cancer clock relates to the timeframe between a decision to treat and the date first treatment occurs. A 31-day cancer clock can start following:

- A decision to treat for first definitive treatment
- A decision to treat for subsequent treatment
- An Earliest Clinically Appropriate Date (ECAD) following a first definitive treatment

5.4. 28-day Faster Diagnosis Standard

The 28-day faster diagnosis standard for cancer is a crucial target established by the NHS England to expedite the diagnosis of suspected cancer cases and ultimately enhance patients' chances of successful treatment. The objective of this standard is to ensure that patients are either diagnosed or ruled out within 28 days of referral.

After a referral by their general practitioner (GP) has been made, patients with suspected cancer (as stated above) should receive an appointment for their initial consultant outpatient clinic within 2 weeks of the referral being received by the hospital. Following this, prompt diagnostic tests, such as biopsies or imaging scans, should be performed within a maximum of 28 days from the date of referral.

Adherence to the 28-day standard does not guarantee cancer diagnosis or treatment within that timeline, as the clinical complexity and unique circumstances of each case may vary. Every effort should be made to streamline access to all diagnostics, including the more complex, to ensure that people are diagnosed within the 28 days from referral.

It is also pertinent to mention that if cancer is diagnosed, treatment should begin within 62 days of the referral, as stated above, although this timeline may vary depending on the type and stage of cancer

the expected standard is that every effort is made to ensure treatment begins within 62 days. The 28-day faster diagnosis standard plays a pivotal role in NWL's and the NHS's as a whole, efforts to optimise cancer care and patient outcomes, and as such, is an important benchmark for the NWL to strive towards.

5.5. Inappropriate referrals / Downgrading referrals from 2 week wait

The trust cannot downgrade 2 week wait referrals. If a consultant deems a 2 week wait referral as not meeting the appropriate criteria, they must contact the GP to discuss. The GP is the only party able to retract or downgrade the 2 week wait referral; unless the GP undertakes this retraction the referral must stand as a 2 week wait referral and seen appropriately within the cancer waiting times.

Trusts shall undertake audit work to identify the volume of inappropriate 2 week wait referrals by:

- Specialty
- GP Practice

These audits shall be shared with the ICB, who shall be responsible for taking appropriate action to reduce the number of inappropriate referrals.

5.6. Consultant upgrades

A consultant upgrade is when a hospital specialist upgrades a patient from the RTT 18-week pathway onto the 62-day cancer pathway because there is a suspicion of cancer. It applies to patients who are referred routinely by GPs/GDPs or referrals from other specialties where there was originally no suspicion of cancer.

The specialist team receiving the referral or reviewing the patient or diagnostic result can delegate the responsibility to upgrade the patient. This could be:

- Specialist nurse/practitioner, either by triaging the referral form/letter or at nurse led initial clinic.
- Specialist registrar either by triaging the referral form/letter or at initial clinic.
- Radiologist/histologist/other trust clinicians on reviewing patients and/or diagnostics

The 62-day pathway for these patients' starts on the date the decision to upgrade is made.

Upgrade must occur before the decision to treat date. Patients not upgraded at this point will be measured against the 31-day decision to treat date to first definitive treatment.

An upgrade is intended for suspected new primaries only, not those who may be suspected of a recurrence.

5.7. Subsequent treatments

NWL Trust's must comply with the cancer performance measure for subsequent cancer treatments. These are anti-cancer interventions aimed at reducing tumour bulk or delaying the growth or spread of the tumour e.g. surgery, chemotherapy or radiotherapy.

The cancer performance standard is that these treatments must commence within 31 days of the treatment decision being agreed with the patient, or the earliest clinically appropriate date (ECAD) to start a second or subsequent treatment e.g. radiotherapy is planned to start six weeks after surgery.

Subsequent treatment starts a 31 day cancer clock from decision to treat date or earliest appropriate date and ends when definitive treatment is delivered which could be:

- An anti-cancer intervention aimed at shrinking a tumour or delaying the growth or spread of cancer
- Provision of palliation for the cancer symptom
- Active monitoring (in no other treatment is appropriate)
- Symptomatic support by non NHS palliative care services

5.8. Earliest clinically appropriate date (ECAD)

The earliest clinically appropriate date applies to patients whose treatment plan involves a sequence of more than one treatment modality, but where further decision to treat dates are not applicable.

It can be either:

- A pre-determined date, set by the clinician responsible for the patient's care when it is anticipated that the patient will be fit to start the next stage of the care pathway
- A date set during the clinical review on receipt of test results, when it is anticipated the patient will be fit to start the next stage of care pathways
- An ECAD date can be changed once it is set, but only if the date has not passed. ECAD starts a **31 day** cancer clock

Section 6: Referrals

6.1. Advice and Refer

Advice and Refer (A&R) enables GPs to access a specialist opinion in the first instance, without making a referral. GPs are strongly advised to use A&R services prior to making a referral to ensure that they are referring to the correct service and that the referral is necessary. A&R will be provided within a contractually defined turnaround time, and no RTT clock is applicable. Should an A&R submission require an outpatient appointment, it can be converted to a referral by the Trust providing there is sufficient clinical information.

Should a referral be required this shall be made through e-RS or Rego, with the referrer including details of the received clinical advice.

Requests into Referral Assessment Service (RAS) clinics represent a request for clinical assessment, an extended form of advice and refer. The outcome of a RAS clinic request may be advice for local management, or the Trust accepting the referral into a clinic, direct to a diagnostic or direct to a clinical intervention.

The provision of advice and refer will allow for timely care for patients, avoiding waits for, and travel to, outpatient appointments. It further acts as a form of clinical education and provides relationship building opportunities between professionals.

In NW London referrers are strongly encouraged to ask for advice prior to making a referral. The service will offer advice from a specialist around a patient's treatment plan and/or the on-going management of a patient in the following ways:
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 the response to advice and refer requests is likely to include:

- General service advice
- Patient specific advice, up to and including treatment plan advice for patients who could avoid being referred
- Specific pre-referral advice, including confirmation from a specialist that a referral is warranted and advice as to which service / clinic the referral should be directed

Advice and refer will be requested by the GP through an existing service (e-RS or Rego). No referral is deemed to have been made and responsibility for future referral remains with the General Practitioner. Local turnaround time targets are in place, but no RTT clock is started.

6.2. Referral into a Referral Assessment Service (RAS)

GPs looking to access acute services should normally refer via RAS. Receipt of referral instigates a referral to treatment clock. The provider will assess next steps including onward booking into the service. It is not a request for advice but a referral, albeit an outcome of RAS might be a rejection of the referral with advice. The provider clinician reviews the referral content and responds within 5 working days:

- If the clinician assesses that the patient requires an appointment, they will be added to the appointment for booking list. The RTT pathway clock continues to tick.
- If the clinician assesses that the patient does not need secondary care, the referral will be returned to the GP. The RTT pathway clock will stop.
- The exception to the clock start from a Referral Assessment Service is when a clinician returns to the referrer (GP) with advice from a RAS.

Post-operative queries about issues / complications are excluded from Advice & Refer requests. In this case the request should be sent through directly to the operating surgeon, including the surgeons administrative support.

6.3. E-Referrals (e-Rs)

All referrals to Outpatients from GP surgeries, including suspected cancer referrals are sent via the e-Referral systems (or vantage rego, which uses ERS). Referrals sent by email, or paper will not be accepted, apart from where it has been contractually agreed that other referral routes are accepted. The Head of Patient Access or a member of their team will regularly review services open to e-RS and liaise with the relevant divisions to make additional services available to ensure there is the capacity for primary care to directly refer patients into Outpatient clinics

6.4. Internally Generated Referrals

Clinician to clinician referrals must follow the guidelines outlined by the Clinical Advisory Group (CAG) for North West London in the Clinician to Clinician Referral Policy. Please consult Clinician to Clinician Referral policy, via the North West London ICB website (www.nwlondonicb.nhs.uk) for further details and any changes or updates relating to internally generated referrals.

6.5 Diagnostic Referrals/Requests

The decision to add patients to the diagnostic waiting list must be made by the consultant or designated clinical member of the team. It is the responsibility of the clinician (or designated clinical team member) to refer the patient to enable them to be added to the waiting list.

6.6. Direct Access Referrals for Diagnostics

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.

These referrals cannot not result in treatment within a Consultant-led service and as such, direct access referrals are exempt from the national RTT standards. Direct access referrals are still held to the national diagnostic waiting time standards.

6.7. Straight-to-test arrangements

Straight-to-test arrangements refers to 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). As treatment within a consultant-led service is possible, an RTT clock will start on receipt of the referral.

Section 7: Scheduling

7.1. Booking Rules

Clinical priority will be assessed as part of the triage process by the Trust clinical service on receipt of referral. It should be noted that the outcome of triage may be returning the referral to the GP with advice and refer, if it is deemed an outpatient appointment (in-person or virtual) is not required. If a GP feels that an outpatient appointment is still warranted, however, they can overrule the advice and make the referral as the clinical risk holder.

Patients will be selected for booking appointments, diagnostic tests or admission dates according to clinical priority. Patients of the same clinical priority will be appointed/treated in RTT, Cancer and/or diagnostic clock chronological order, i.e. the patients who have been waiting longest will be seen first.

Patients will be selected using the trust's patient tracking lists (PTLs) only. They will not be selected from any paper-based systems.

Patients should be given at least two reasonable offers when they are being booked.

Where individuals have specific communication needs, services will provide help and information in formats that they can understand.

These rules apply to all elective appointment types. (including but not limited to face-to-face outpatients, virtual outpatients, diagnostics and surgical)

7.2. Reasonable offers

'Reasonableness' is a term applicable to all stages of the elective pathway.

Reasonableness refers to specific criteria which should be adhered to when offering appointments and admission dates to patients to demonstrate that they have been given sufficient notice and a choice of dates. A reasonable offer is an 'offer of two or more appointments at a time and date of three or more weeks from the time the offer was made'. This does not preclude offering patients earlier offer dates, any date that is mutually agreed with a patient is considered a reasonable offer

regardless of the period of notice. Reasonable offers may include appointments at another NWL site as long as the above criteria is adhered to. Two appointment offers is the minimum requirement for reasonableness but as each pathway and patient are different and waiting times may differ greatly, user discretion is advised and providing more offers may be appropriate.

Patients who decline one reasonable offer must be offered at least one further reasonable date. If the patient declines both reasonable offers, the patient should be informed that this may result in a discharge from the service. (See Section 7.4. Patient that are unavailable to attend)

For patients on a cancer pathway, an offer will be deemed to be reasonable if 48 hours' notice of an appointment/diagnostic test/admission is given. (See Section 5 Cancer waiting times for further details on cancer)

All appointments will be confirmed in writing. Short notice appointments will be agreed and confirmed by telephone and recorded on the Patient Administration System (PAS).

7.3. Patient that cannot be contacted

If the patient cannot be contacted (following unsuccessful telephone contact) the patient will be given an available appointment with at least 3 weeks' notice and notified by letter.

7.4. Patients that are unavailable to attend

Patients who are not available for an appointment within their current RTT, Cancer or Diagnostic clock as a result of having declined two reasonable offers, may be discharged back to their GP unless it is agreed by the patient's consultant that this is contrary to their best clinical interest, or it is agreed that the patient is considered to be vulnerable. Where it is identified that a patient is not available to attend, the consultant responsible for the patient's care should be informed as soon as possible and a decision made regarding discharge or rebooking the patient.

If the patient is to be discharged, a discharge letter is to be sent to the patient and to their GP or original referrer.

7.5. Patient Initiated Cancellations

Patients can choose to postpone or amend their appointment (face-to-face or virtual), diagnostics test or procedure if they wish, regardless of the resulting waiting time. Such cancellations or delays have no impact on reported RTT waiting times. Patients should be offered a new appointment as soon as practical. Patients who cancel or reschedule their appointments beyond 8 weeks may have a clinical review to decide if this is appropriate (this applies to both admitted and non-admitted pathways). If the clinician finds that waiting is contrary to the patient's best clinical interest, the patient may be discharged back to the care of their GP with clinical advice.

Patients are able to cancel/reschedule their appointment (in-person and virtual) on one occasion for any reason. Any subsequent patient cancellation/reschedule may result in the patient being discharged to the referring clinician. This decision should be undertaken on a case-by-case basis by the clinician responsible for the patients care, with the reasons for cancellations taken into account and should be in the patient's best clinical interests. In all cases a letter to the GP will be sent to inform them of the decision.

7.6. Hospital Initiated Cancellations

A minimum of 6 weeks' notice is required from all Clinicians, in all circumstances, to cancel or reduce any direct clinical care (DCC) session. This includes all face to face and virtual appointment types.

The consultant cancelling the clinic must specify at this point where any patients require rebooking can be accommodated.

For non-cancer referrals, the appointment should be rebooked as close to the original date a possible to enable treatment to still take place in within diagnostics and/or 18 week waiting times.

No patient should be cancelled on more than two occasions consecutively because of Trust actions. If cancelling a clinic will cause a patient to have more than two cancellations, administrative teams will escalate to the clinician and relevant manager to investigate alternative arrangements.

7.7. Did Not Attend (DNA) Patients

A DNA is defined as a patient failing to give prior notice that they will not be attending their appointment (face to face or virtual), diagnostic test or procedure, or who arrive too late for their appointment to proceed. Patients who give ***prior*** notice (irrespective of how short the period of notice they give) are not classed as DNAs and this will be treated as a patient cancellation and as such follow that part of the policy.

All cases where the patient does not attend their appointment must be reviewed by the clinician. The clinician will review the patient's notes or referral information and make a decision regarding next steps, taking into account the individual circumstances. A further appointment would not be routinely offered and the patient will be discharged back to the GP / original referrer, where the following criteria is met:

A further appointment would not be routinely offered where the following criteria are met:

- The clinician judges that there is a low risk of harm to the patient by not automatically rebooking the appointment;
- The patient is given an option to contact the Trust directly to rebook the appointment without having to be re-referred by their GP and/or the advice that they should discuss with their GP if they continue to have symptoms that are concerning or bothersome.

A further appointment should not be offered where the clinician or administrative team have contacted the patient who then verifies that they no longer wish to be seen in that clinic.
If a patient contacts the Trust after being informed that their missed appointment is not routinely being rebooked, and requests an appointment (including where there are extenuating circumstances), this should be discussed with a senior member of the clinical team, and where possible the appointment should be rebooked without the patient having to see their GP again for a referral.

7.8. New Appointments

If the patient DNAs their first appointment, their RTT clock can be stopped and nullified on the date of the DNA'd appointment provided the criteria described above has been met (applies to all face to face and virtual appointment types). If the criteria is not met then the RTT pathway must continue. If the criteria is met and the clinician decides another first appointment should be offered, a new RTT clock will be started (at zero) on the day the new appointment is scheduled with the patient. If a patient DNAs at any other point on the RTT pathway will not stop the RTT clock, unless the patient is being discharged (following clinical review) back to the care of their GP. The appointment must be agreed with the patient within 5 working days of the decision to rebook.

7.9. Follow up, Admitted and Pre-operative assessment appointments

If a patient DNAs a follow-up, admitted or pre-operative assessment appointment the RTT clock continues if the clinician indicates that a further appointment should be offered. As with first appointments, this must be agreed within 5 working days of the decision to rebook.

If the clinician indicates another appointment should not be offered, the RTT clock stops on the date that the patient is discharged back to the care of their GP or other referrer.

The above applies to both in-person and virtual appointments for follow ups and pre-operative assessments. Patients that DNA a pre-operative assessment will be removed from the admitted waiting list following clinical review.

7.10. Further considerations to DNA policy

Additional considerations may be taken into account for adult patients who are vulnerable. Trust should undertake the following in these circumstances:

- 1st DNA: Offer another appointment or consider discharge after making contact with the patient / carer to understand circumstances relating to the DNA. Clinicians should also discuss with referrer specific patient risks and mitigations.

If the patient has been referred on a suspected cancer pathway:

- 1st DNA: Offer another appointment or consider discharge after making contact with the patient / carer to understand circumstances relating to the DNA. Clinicians should also discuss with referrer specific patient risks and mitigations.
- 2nd DNA: Clinical risk review to identify whether the patient should be discharged

For children and young people (Age <18 including transition patients aged 16-17), a review against any local safeguarding policies should take place and the RTT rules suite (See section: 3.3 RTT Pathway clock stops).

7.11. Specific DNA considerations for virtual appointments

A failed telephone appointment shall be defined as a telephone call that is unanswered, this includes calls that go through to messaging services or are diverted.

At least 3 attempts should be made to contact a patient by telephone within 2 hours of their booked appointment time. If more than one telephone number has been provided these attempts should be across all numbers. If these criteria are met, then the normal DNA rules shall apply.

Video consultations shall be considered part of a scale of appointment types, and where a patient does not ‘log on’ to a video appointment every effort should be made to convert the booked appointment into a telephone contact. This safety net will cover patients who are unable to use the video consultation service as a result of technical challenges.
Early termination of video consultations due to technical issues should not be treated as a DNA and an alternative appointment made. Where appropriate this may include contacting the patient by telephone to continue the ‘failed’ video consultation.

7.12. Patient Initiated Follow Up (PIFU)

The Patient Initiated Follow-Up (PIFU) model allows a patient (or their carer) to initiate a follow-up appointment as and when required, e.g. when symptoms change. PIFU can be recommended by a clinician or requested by the patient.

PIFU is not suitable for all patients and can only be initiated if a patient meets certain criteria:

- All treatment must be completed, including any surgery and post-op follow up
- The patient is on a non-active/closed RTT pathway

The agreement to add a patient to a PIFU pathway must be a joint decision between the clinician and patient/carer and should be clearly documented in the patient's healthcare record. It is not appropriate to add a patient to a PIFU pathway retrospectively

PIFU does not replace discharging patients who would normally be discharged at the end of their treatment/care.

Section 8: Adding patients to the admitted waiting list

8.1. The Decision to add a patient to the waiting list

The decision to add patients to the waiting list must be made by the consultant or designated clinical member of the team. The patient must have accepted the clinician's advice on elective treatment prior to be added to the waiting list.

Once a decision to treat has been made the scheduling team should add the patient to the waiting list within two working days. It is the responsibility of the clinician (or designated clinical team member) to inform the scheduling team appropriately to enable them to be add the patient to the waiting list.

Clinicians must make an assessment that the patient is clinically fit for the proposed surgical procedure and that routine pathway patients are available to be admitted.

Patients who are not clinically fit for the proposed procedure should not be added to the waiting list and will need either to continue to be managed in outpatients or should be referred back to their GP for re-referral at a later date when clinically fit. This may start a period of active monitoring if the patient needs further tests, reviews or treatment for underlying medical reasons stopping them from being fit for surgery. As with all episodes of active monitoring this MUST be a clinical decision based on the length of time required to address the issue and the steps taken. This would not include any steps of the pre-operative assessment process such as anaesthetic reviews, lung function test, cardiac test etc.

Patients must not be added to the elective admission list if:

- They are unfit for procedure
- Not ready for the surgical phase of treatment
- They need to lose weight/stop smoking / change lifestyle prior to surgery
- Funding has been declined for the intended treatment or the patient does not fit criteria where funding is required.
- The patient does not have the capacity to consent to the procedure

If a patient cannot be added to the waiting as a result of one of the above criteria, a clinical decision needs to be made with regards to the next best steps for the patient.

8.2. Removals from the waiting list

The removal of a patient from a waiting list is a clinical decision; i.e. made by the patient' consultant / clinical team and as such require clinical review and discussion with the patient where required before taking place. If a patient informs the Trust that they wish to be removed from the waiting list, the patient's consultant/clinical team must be informed along with the patients GP.

8.3. Inpatient and Day Case Booking Standards

All surgery dates will be booked in clinical urgency, which for admitted patients is determined by their priority level (see Section 8.6. Surgical Priority Levels) and then longest waiter. The following internal targets;

- Routine elective surgical procedures will be booked before their 18 week RTT breach date or in line with the assigned priority level, whichever is sooner.
- Urgent elective surgical procedures will be booked 2 weeks from decision to admit date.
- Cancer patients awaiting their first definitive treatment will be booked within 31 days of the decision to treat date or within 62 days following receipt of the cancer referral, whichever is sooner.
- For cancer patients where surgical treatment is a subsequent treatment the admission date will be booked within 31 days from the decision to treat date.

Patients will be contacted by telephone to arrange their admission date and this date confirmed in writing.

Where individuals have specific requirements for communication needs, accessibility etc. services will provide help and information in formats that they can understand and work with the patients to address concerns and issues.

8.4. Patients' unavailability for personal and social reasons

Some patients will turn down admission dates because they wish to plan their treatment around personal or social circumstances. Patients who declare an extended period of unavailability (over 8 weeks) must be brought to the attention of the clinical team to be reviewed. The patient can be discharged back to their GP with advice and the RTT clock will stop, unless it is agreed by the consultant that this is contrary to their best clinical interest.

Ultimately, patients will be considered on a case-by-case basis however it is generally not in a patient's best interest to be left on a waiting list for extended periods of time (i.e. several months). There must be specific protection for the clinical interests of suspected cancer patients; children and young people under 18 years and vulnerable adults.

If a decision to discharge is made the reason should be made clear in the letter to the referrer and to the patient.

8.5. Hospital initiated cancellations on the day of surgery

Should it be necessary to cancel operations on the day for non-clinical reasons, priority will be based on clinical need with consideration of high priority patients.

High priority patients includes clinically urgent cases, cancer, patients previously cancelled on the same pathway (28 day rebooks), and long waiters.

If it is not possible to perform the operation then a verbal explanation together with an apology must be given to the patient by the consultant, surgeon or anaesthetist (or senior member of the clinical

team). The discussion with the patient (and their family) should include information about what to expect next and who to contact about any concerns. This applies to patients cancelled for clinical reasons as well as patients cancelled for non-clinical reasons.

In the case of elective operations cancelled by the Trust for non-clinical reasons on the day of admission, after admission or on the day of surgery the patient must be offered an admission date that is within 28 days of the cancellation in order to meet the NHS Constitution guarantee on cancelled operations. This should be noted on the waiting list record to ensure that the patient is not cancelled again.

Where a patient cannot be re-booked within 28 days, this must be escalated to the relevant senior managers.

Please see appendix 3 for further details on elective surgical patient cancellations.

8.6. Patients that wish to delay their treatment

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

- The patient is offered 2 reasonable notice dates and expresses that they wish to delay beyond these dates.
- If this is the case, following a clinical conversation and agreement with the patient, consider placing a patient active monitoring. This decision must come from the clinical team and the Trust must agree that this is appropriate with supporting processes in place to facilitate it.
- Where it is appropriate to place a patient on active monitoring, this should be for a maximum period of 12 weeks.
- Where this is not appropriate (or the process is not supported by the Trust) this must be clearly communicated to the patient and made clear that this may result in removal from the waiting and being discharged.
- If a patient is placed on active monitoring the RTT clock should be stopped.
- Patients placed on active monitoring should be managed through local reporting and local clinical governance arrangements.
- 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.
- 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 ie. They should not be returned to the beginning of the waiting list.

TCI date 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.

8.7. Surgical priority levels

All patients being added to an admitted PTL will be classified according to priority and with a local assessment made of the risk associated.

Priority levels will be defined as follows:

- Priority 1 a: is for patients, who treatment needs to be completed within 24 hours.

- Priority 1 b: is for patients whose treatment needs to completed within 72 hours.

- Priority 2: is for patients whose treatment needs to be completed within 1 month
- Priority 3: is for patients whose treatment needs to be completed within 3 months
- Priority 4: is for patients whose treatment can be completed in greater than 3 months' time

Prioritisation ensures that patients are treated in line with their clinical need. Prioritisation does not inform nor impact the RTT clock stop and whilst prioritisation may impact waiting times the overarching national RTT measurements and rules remain unchanged and continue to apply to all Trusts services. It is also considered good practice to inform the patient of their prioritisation to manage waiting time expectations and keep them informed.

8.8. Patients due to have planned procedures

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

Planned activity can include inpatient or day case surgical procedures, diagnostic tests and outpatient consultations. Examples include dialysis, or a 6-month repeat colonoscopy following removal of a malignancy or tumour, or a flexible cystoscopy carried as an outpatient appointment as part of a non-RTT follow-up.

There are strong clinical governance and safety reasons for the correct inclusion of patients onto the planned waiting list, and why planned activity should not be deferred beyond the clinically determined dates.

Patients will only be added to an admitted planned waiting list where clinically they need to undergo a procedure at a specific time. The due date for their planned procedure will be included in the planned waiting list entry.

When patients on planned lists are clinically ready for their care to begin and reach their target treatment date for their planned procedure, they will either be admitted for the procedure or be transferred to the relevant active waiting list and appropriate clock will start i.e. RTT or DM01 6-week wait.

Patients waiting for a planned (or surveillance) test or procedure who do not receive the test within this timeframe will start an active waiting time clock.

Planned waiting lists are to be reviewed on a weekly basis to identify all patients due to be contacted for a planned therapeutic (as opposed to diagnostic) procedure in eight weeks' time.

8.9. Record keeping

All patient contact must be recorded accurately on the PAS system including all dates offered and the patient's response to those offers. This record is a critical part of the audit trail for all changes and particularly in the management of on the day cancellations (28 day cancellations).

A copy of all letters should be sent to the patient, GP or any other referrers must be filed in the patients clinical record.

Section 9: Acute Therapy Services

9.1. RTT and acute therapy services

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

- Directly from GPs where an RTT clock would NOT be applicable
- During an open RTT pathway where the intervention is intended as first definitive treatment or interim treatment.

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

9.2. Physiotherapy

For patients on an orthopaedic pathway referred for physiotherapy as first definitive treatment that avoids further intervention, the RTT clock stops when the patient begins physiotherapy.

For patients on an orthopaedic pathway where the referral to physiotherapy is interim until surgery can take place, the RTT clock continues until the surgery takes place.

9.3. Surgical Appliances

For patients on an orthopaedic pathway referred for a surgical appliance with no other form of treatment agreed, the fitting of the appliance can constitute first definitive treatment and, in this scenario, the RTT clock stops when this occurs.

9.4. Dietetics

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

Section 10: Waiting list validation

10.1. Inability to contact patients

It is important for all Trust's to keep clean and accurate PTLs. In some circumstances this may require the use of patient led validation. These processes are used to contact patients who may have not been reachable. This can be via a validation letter or digitally enabled equivalent process (text message or e-mail).

If the patient does not respond within the locally agreed timeframe or states that they no longer require an appointment they will be brought to the attention of the clinical team to confirm whether in the absence of any contact with the hospital, it would be appropriate to discharge the patient back to the care of their GP or other referrer. This discharge must be communicated by letter to the patient and GP in a timely manner and where the patient has stated they no longer require the appointment, this should be stated in the letter. This decision would stop the original RTT clock.

Where individuals have specific communication needs, services and clinical staff should ensure the patients preferred method of communication is reviewed and provide information in alternative formats or consider other specific requirements.

Section 11: Extreme Events

11.1. Extreme events definition

Extreme events represent specific exceptional circumstances which will be characterised by periods of significant activity changes (for example suspension and prioritization) followed by periods of recovery.

The introduction of this section in the policy was instigated as a result of the Covid-19 Pandemic (March 2020) but can be appropriately applied to any extreme event (e.g. civil unrest, extreme weather). The Integrated Care System (ICS) will declare when a system is under an extreme event.

Where clinically appropriate urgent and Cancer pathways shall remain in place during extreme event, and other pathways will be clinically reviewed to determine whether they can be safely and effectively delivered during the period.

Following an extreme event there will be a period of recovery, as services return to normal operations.

During these 'restart' periods, key elements of difference may include:

- Consolidation and simplification of service offerings, including limited site service offering where services will be available for NWL but may not be offered at all pre-incident sites. This will support differentiation between 'hot' and 'cold' sites but may result in patient choice being restricted. This may include patients being asked to attend for NHS funded activity at Independent Sector providers.

- Reasonable notice for appointments and procedures may be reduced

- Specific precautions may be required to address infection control guidelines, for example periods of isolation prior to a procedure

Resumption of elective procedures and interventions will be coordinated across the sector, and services may need to be reconfigured in response to the incident.

Reconfiguration of services may mean that the system is unable to honour some patient choice requests, in these cases patients should be contacted and advised of the changes (and the reason for changes). Where reconfiguration requires patients to travel significantly further distances to access care, appropriate patient transport policies shall apply and there may need to be considerations to mitigating travel costs or providing alternative arrangements to enable access to care.

Where a patient is not willing to accept an appointment at a reconfigured service, provided the appointments offered meet the reasonable notice rules, it should be considered that the patient declined the offer and standard RTT rules shall apply. However, it is strongly recommended that a clinician speaks to patient to understand any specific concerns regarding site / Trust changes as these can often be overcome upon discussion. This should also include counselling the patient on the protective measures that have been put in place by the Trust and the potential risk to the patient's health if they delay care. If the patient still declines care then they will be discharged back to their GP with advice. See appendix 4 for further details.

11.2. Elective referrals

Some extreme events will result in the suspension of elective activity for a period of time. Under some circumstances this suspension may be for an extended period and a decision made, across NW London, to suspend elective referrals.

11.3. New referrals

All routine referrals should be reviewed by a suitable clinician. Those referrals which are considered routine and can be safely managed in primary care will be returned to the GP, with advice, for local management.

The highest risk patients should continue to be referred to the appropriate specialist (e.g. suspected cancer). All urgent referrals will be booked into the applicable service.

For patients referred into a service that is not currently running due to the declaration of an extreme event, a clinical decision will need to be made as to the safest option between returning to GP/Community care or remaining under the consultants care until the service restarts or a reconfigured service can be arranged.

11.4. Follow ups

In cases where it is safe to do so, patients will be discharged back to primary care with appropriate discharge advice. If GPs need advice following a patient discharge, this can be accessed either through the Advice and refer service or by contacting the discharging consultant.

Patients should not be discharged mid-pathway (e.g. during a diagnostic / investigative phase), unless a definitive decision has been made and discussed with the referrer and patient.

11.5. Cancer

All Trusts must maintain essential cancer services in line with NICE Guidance 12 Suspected Cancer: recognition and referral and using the additional principles below:

Essential and urgent cancer treatments must continue. Cancer specialists should discuss with their patients whether it is riskier for them to undergo or to delay treatment at this time, balancing the urgency of cancer surgery against the risks of the procedure, particularly the risk of complications and a requirement for intensive care support.

Where referrals or treatment plans depart from the normal practice, safety netting must be in place so that patients can be followed up.

Urgent consideration should be given to consolidating cancer surgery in a NWL hub, ensuring equity across the local healthcare system with capacity maximised and operating centralised triage to prioritise patients based on clinical need.

At all times ensuring the safety of patients, especially with regard to infection control and access to critical care as required and safety of staff undertaking surgery and other care.

11.6. 2 Week Wait Referrals and Cancer Diagnostics

All patients should be considered on the basis of clinical need, and the level of risk, both patient- and service-related.

In primary care, where a patient meets the criteria for urgent referral under NG12 but, in view of current circumstances, the GP in discussion with the patient decides not to make a suspected cancer

referral because this might be more clinically risky for the patient, the general practice should ensure the patient is appropriately safety netted, monitored and can be followed up if symptoms worsen or do not resolve.

Where a patient is referred as a suspected cancer referral and assessed virtually/by telephone, and a decision is taken not to undertake diagnostics currently due to risk to the patient, the secondary care provider should keep this patient on their patient tracking list (PTL) to ensure they can be appropriately followed up. Patients should be fully involved in reaching this decision and given advice on how to report worsening or new symptoms.

If a patient is referred as a suspected cancer referral and is not available or declines a diagnostic or other appointment due to self-isolation or shielding guidance, they should remain on the secondary care provider PTL to enable their appropriate and proactive follow-up.

Where a diagnosis of cancer is confirmed, and to minimise the patient's overall risk they are not listed for treatment immediately, then the patient should remain on the trust PTL and a decision to treat recorded if the patient has agreed to treatment. Again, patients should be involved in reaching this decision and given advice on how to report worsening or new symptoms.

It is essential that all Trusts retain records of those people who need urgent investigation for possible cancer, so that they can be followed up and diagnosed or have cancer ruled out at the earliest opportunity.

11.7. Cancer Surgery Hubs

NWL wide surgical hub(s) should be developed and implemented incorporating the following features:

a) A central triage points

- Any patient recommended for cancer surgery should be referred to a central, clinically led triage point
- The triage system will prioritise patients for surgery on the basis of clinical need, and the level of risk, both patient- and service-related; and match patients with appropriate surgical specialisms and capacity across the cancer system.

b) Consolidation of cancer surgery on 'clean' sites

- Where local circumstances permit, cancer surgery should be consolidated on a 'clean', virus-free site (in the event of a pandemic) within the local system. This could include independent sector provision where this has been secured.
- Virus testing for all potential admissions 48 hours before surgery
- For any cancer patient found to be positive, clinicians will need to decide locally when that patient will be considered fit for surgery, and be considered alongside other urgent surgery within a hospital treating patients with a positive result.

11.8. Diagnostics

Routine hospital attendances for patients may be restricted. As such Trusts should plan to minimise non-urgent imaging as they will have fewer staff available and more demand for in-patient services. Consideration should also be given to community based services in order to lower hospital attendances. GP's should discuss with the patient the need to attend in person for a diagnostic appointment at the point of the referral. If the patient is unwilling to attend due to the nature of the extreme event, then they are not ready willing and able to be referred to the Trust.

11.9. Postponing imaging for groups of patients until after the event

A local decision to postpone imaging for a certain group of patients should only be made in conjunction with referring clinicians and Trust management.

This decision should be recorded by the radiology department in a specific register as a decision taken during the extreme event.

11.10. Postponing imaging for individuals until after the event

If a decision is taken to postpone an imaging procedure, for each procedure the justification for the decision to should be recorded on the Radiology Information System (RIS) and coded appropriately,

The referrer should be informed of the decision to postpone imaging.

The patient should be informed of the decision to postpone imaging and who to contact in case of concerns. Patients should be advised that a further appointment for their test, if still indicated, will be sent to them when services resume.

11.11. Imaging for cancer diagnosis and staging

Local cancer MDTs should agree appropriate diagnostic and staging imaging pathways with their MDT radiologists. As these will be subject to change, MDTs should reconsider these pathways on a weekly basis and record any changes.

MDTs should consider:

- National specialist society guidance if available.
- Locally available imaging techniques.
- Availability of treatment options – will imaging change treatment?
- Likely yield – which tests can be omitted?

11.12. Imaging for cancer treatment and follow up

- Imaging to assess response to treatment should be reviewed on an individual basis to see if it can be avoided or delayed. It should be avoided if response can be assessed in other ways (e.g. symptoms, blood tests).
- If imaging is required to assess response, request the simplest test possible (e.g. CXR not CT chest where appropriate).
- Routine cancer follow-up imaging in the absence of new symptoms should be delayed (see 21.3)
- Radiology departments should agree pathways for imaging cancer patients with new symptoms with referring teams.

11.13. Re-booking patients after the event

- Careful recording of all patients and patient groups with imaging postponed should ensure patients receive any required imaging test requested once the extreme event has passed.
- Through multidisciplinary team meetings (MDTMs) services should establish the number of patients whose imaging has been postponed, but is still indicated; and of those, who should be prioritised. This should provide the service with information to understand demand, including the number of patients needing urgent imaging.
- Patients should be stratified on degree of urgency and where imaging can facilitate prompt treatment, particularly if the latter has been delayed.

The following categories should be used to prioritise the urgency of a cancer patient's need:

Priority	Description
CP1	High probability of potentially life-threatening condition
CP2	High probability of condition potentially causing significant long-term harm
CP3	Possibility of potentially life-threatening condition
CP4	Possibility of condition potentially causing significant long-term harm
CP5	Unlikely to be life threatening or cause significant long-term harm

- For each patient, services should validate with the referrer and/or patient the continued need for imaging deferred because of the extreme event, to ensure it is still appropriate.
- Notwithstanding this, services should review the indication and consider alternative imaging modalities as appropriate.
- For follow-up imaging, services should prioritise the first follow-up imaging test after treatment.

Section 12: Appendices

12.1 Appendix 1- Definitions

Term	Definition
2WW	Two-week wait: the maximum waiting time for a patient's first outpatient appointment or 'straight to test' appointment if they are referred as a 62- day pathway patient.
18 Weeks	The maximum waiting time for a patient to begin their treatment for routine conditions following a referral into a consultant-led service.
Active monitoring	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention.
Active waiting list	The list of elective patients who are fit (for treatment), 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.
Bilateral procedures	Where a procedure is required on both the right and left sides of the body
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.
Elective care	Any pre-scheduled care which doesn't come under the scope of emergency care.
Fire-break clinics	These are clinics which are left empty in case a fully booked clinic needs to be cancelled and rearranged due to unforeseen reasons. Patient appointments are moved to the fire break clinic, minimising the amount of rebooking/administrative work required.
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.
Interface or assessment service	Any arrangement that incorporates an intermediary level of clinical triage, assessment and treatment in or between traditional primary and secondary care. In the context of RTT, if the service in question accepts referrals that would otherwise have traditionally been provided by a consultant or consultant-led team; and the referrals may go on to be onward referred to a consultant-led service, then then this should be classed as an 'interface service', and a consultant-led waiting time clock should start on receipt of referral.
Minimum dataset	Minimum mandated information required to be able to process a referral either into the cancer pathway or for referral out to other trusts
Nullified	Where the RTT clock is not included in any reporting of RTT performance.
Patient-initiated delay	Where the patient cancels, declines offers, does not attend appointments or admission or requests to defer their admission for social or personal reasons. This in itself does not the stop the RTT clock.
Planned inpatient waiting list (for diagnostic or surgical procedures)	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. Note this does not apply to 2WW referrals

12.2. Appendix 2- Abbreviations

Term	Definition
ICB	Integrated Care Board.
CDL	Clinical document library: Trust electronic repository to store correspondence with patients and referrers.
DNA	Did not attend: patients who give no prior notice of their non - attendance.
e-RS	(National) E-Referral Service. The NHS e-Referral Service combines electronic booking with a choice of place, date and time for first hospital or clinic appointments. Patients can choose their initial hospital or clinic appointment, and book it in the GP surgery at the point of referral.
IGD	Internally Generated Demand: Sets out locally agreed rules governing non-GP referrals for treatment.
MDS	Minimum dataset: minimum information required to be able to process a referral including IPT.
MDT	Multidisciplinary team: here describing a group of doctors and other health professionals with expertise in a specific cancer, who together discuss and manage an individual patient's care.
PAS	Patient administration system: records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient.
SOP	Standard operating procedure: Step by step instructions to help Trust staff to carry out routine tasks, for example RTT and waiting list management in accordance with elective access policy.
UBRN	Unique booking reference number: The unique booking reference number assigned by the e-Referral system when a patient accepts an appointment date offered - via the e-Referral system.
RTT	Referral to treatment
RMC	Referral management centre: A referral management centre or assessment service is a specific type of interface service that does not provide treatment, but accepts GP (or other) referrals and provides advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient.

12.3. Appendix 3- Elective Surgical Patient Cancellation Policy

This policy seeks to provide clarification on the processes that must be followed when an elective patient's surgery is cancelled.

Reasons for cancellation of elective surgical patients can broadly be divided into medical and non-medical reasons.

Medical

Surgical – the surgeons determines that it is not appropriate for the patient to have surgery
Anaesthetics – the anaesthetist for the list determines that the patient is not fit for surgery due to concurrent illness or due to inappropriate preoperative assessment

Patient – the patient is ill on the day of surgery, declines surgery or is inappropriately starved

Non-medical

- Lack of staff – for example due to illness or tiredness (such as after a busy night on-call)
- Lack of equipment or fit-for-purpose theatre space
- Lack of time – due to inappropriate booking of the list, complicated surgery taking longer than expected, complex anaesthetic requirements taking longer than expected.
- Lack of suitable post-operative bed – the patient requires admission postoperatively and there is no bed available on a surgical ward or High Dependency Unit / Intensive Care Unit (ICU).

Before a patient is informed that he/she has been cancelled, the Theatres General Manager (GM) and Specialty GM (Planned Surgery and Paediatrics) must be informed. An escalation chart will be displayed in all theatres, with the names of the people in those positions named. All patients who are cancelled (regardless of the reason) need a Datix completed by the most appropriate member of the operating team i.e. Surgeon, anaesthetist, scrub team, operating department practitioner or theatre staff.

Reason for cancellation should also be documented on the most appropriate electronic medical record. Cancellation must be recorded on the PAS. The member of staff instigating the cancellation must ensure this happens and the appropriate cause of cancellation is documented.

All cancellations must be reported to the nurse in charge for the theatre complex. Please note it is not the responsibility of the theatre nursing staff to inform patients that they are being cancelled. This conversation must be led by the specialty operational team with the support of the nursing staff if required. All patients should be offered a new TCI date (where possible) before leaving the Trust.

All cancellations must be reported back to the appropriate scheduler. If a patient is cancelled on the day of surgery and leaves the Trust without a new TCI date, the scheduler must call them within two working days to re-book. All on the day cancellations must be re-booked within 28 days of cancellation unless the surgical plan has changed (for example the proposed surgery is no longer required).

In the case of medical cancellation, if the appropriate manager is not immediately available to discuss the cancellation with, it is appropriate to cancel the patient as long as the managers are notified in due course and above other steps are followed.

Specifics steps for non-medical reasons

Lack of staff (at beginning of list) – As soon as it is identified that there is a lack of whichever staff, this must be escalated to the appropriate medical and non-medical line- managers.
E.g. if the anaesthetist is ill, then this is escalated to the duty consultant, the departmental operational lead, the service director and the GM for theatres, anaesthetics and ICU. If all avenues for cover have been exhausted and no cover was found for the list, then the patient/s will be cancelled and Datix and PICIS completed.

Lack of time – I.e. if continuing on with the list will result in an overrun. As soon as it is felt (by whomever in the team) that the list may overrun and patient cancellation may be required, this must be escalated. Communication is key, and all the team members need to be aware of the potential for cancellation and overrun, i.e. most senior surgeon, most senior anaesthetist, most senior scrub nurse and ODP. Even if there is concern about a possible overrun at the outset of a list, patient/s should not be cancelled at the beginning of the list but a re-assessment made as the list proceeds to see if the patient/s can /cannot be accommodated either on the planned list or potentially in another theatre.

The issues must be escalated to the theatre team and onwards to the appropriate clinical division.

If it is agreed that all staff are able to stay in case of a list overrun, then the patient is not cancelled. Depending on the length of overrun, there are several options of remuneration and these will be discussed with the line manager for each team member. For example, for an anaesthetist, an overrun may be counter balanced by a different list finishing early, financial remuneration pro rata, leave remuneration or an adjustment to a job plan if there is a persistent acknowledged overrun with a job-planned list.

Every effort should be made to avoid cancellations on even overrunning lists, especially in the case of cancer patients and those with previous cancellations.

In the case that a member of the team cannot stay for a significant overrun, then, in the 1st instance, escalation to the medical and non-medical managers mentioned above must be made, who will then explore if there are other team members that can take over the care of the patient. If all avenues have been exhausted and no one can take over the patient care, then, as a last resort, the patient is cancelled and a DATIX and PAS entry are completed.

12.4. Appendix 4- Management of patients who decline to attend reconfigured services

Background

With the resumption of clinical services there is evidence that patients are declining to attend elective hospital services, citing concerns about covid risks. This has been raised in a number of Clinical Reference Groups as an issue that is being seen amongst all referral types.

Principles

- Support patients to attend any necessary appointments
- All clinicians have a communication role

o The GP needs to discuss with the patient they may need to attend the hospital this should be clear at the advice and refer stage

- Patients for outpatient and admission will be treated differently
- Avoid multiple loops for patients (send back to GP and GP re-refers)
- Virtual where possible

NOTE: Further work will be required to understand the operational process flows at each Trust to support this approach
Outpatient (First Attendance)

The GP or Primary care clinician will seek advice and refer as appropriate.

If a specialist opinion is required, the GP will discuss with the patient that they may need to attend in person prior to referring through ERS.
If the patient consents to attending in person, they will be referred into the service through ERS (or other agreed referral routes).
If the patient is unwilling to attend, following discussion with their GP, further advice and refer will be sought to either support the GP in managing the patient in primary care (until such time as the situation changes), or to agree that a virtual consultation can be used.

Should the outcome be a virtual consultation the patient will need to be referred into the service.

Outpatient (Follow Up)

These should normally be virtual. If the consultant identifies that a face to face follow up is required, and the patient does not consent to this the secondary care clinician shall see them virtually and discharge them back to the GP with an on-going plan.

Admission or Procedure

If the patients is required to attend the hospital for an admission or procedure, and does not wish to do so due to concerns about Covid-19, the secondary care clinician will risk stratify them according to clinical urgency (urgent or routine).

Clinically Urgent

The secondary care clinician must contact the patient to discuss the risks and benefits of attending for admission or procedure. Should the patient subsequently agree to attend, due process for recording this on hospital systems will be followed.
If, following discussion with the secondary care clinician, the patient is still not willing to accept an appointment, the clinician will write to the patient's GP to advise of their decision and ask the GP to contact the patient to discuss this further. The GP must provide feedback on the outcome of this conversation. If the patient is willing to accept a date, due process will be followed.
If the patient is still not willing to accept a date, the clinician and the GP will jointly agree on whether this patient should remain on the waiting list or should be discharged back to primary care:

- Remaining on the waiting list: reviewed by the relevant clinical team, at least every 4 weeks, until a date can be mutually agreed. This information must be recorded on EPR/PAS.
- Unable to agree a date: If a patient still refuses to attend after 4 weeks then a call shall be arranged between the GP, secondary care clinician and patient to agree the way forwards. This may result in removal from the waiting list.

Clinically Routine

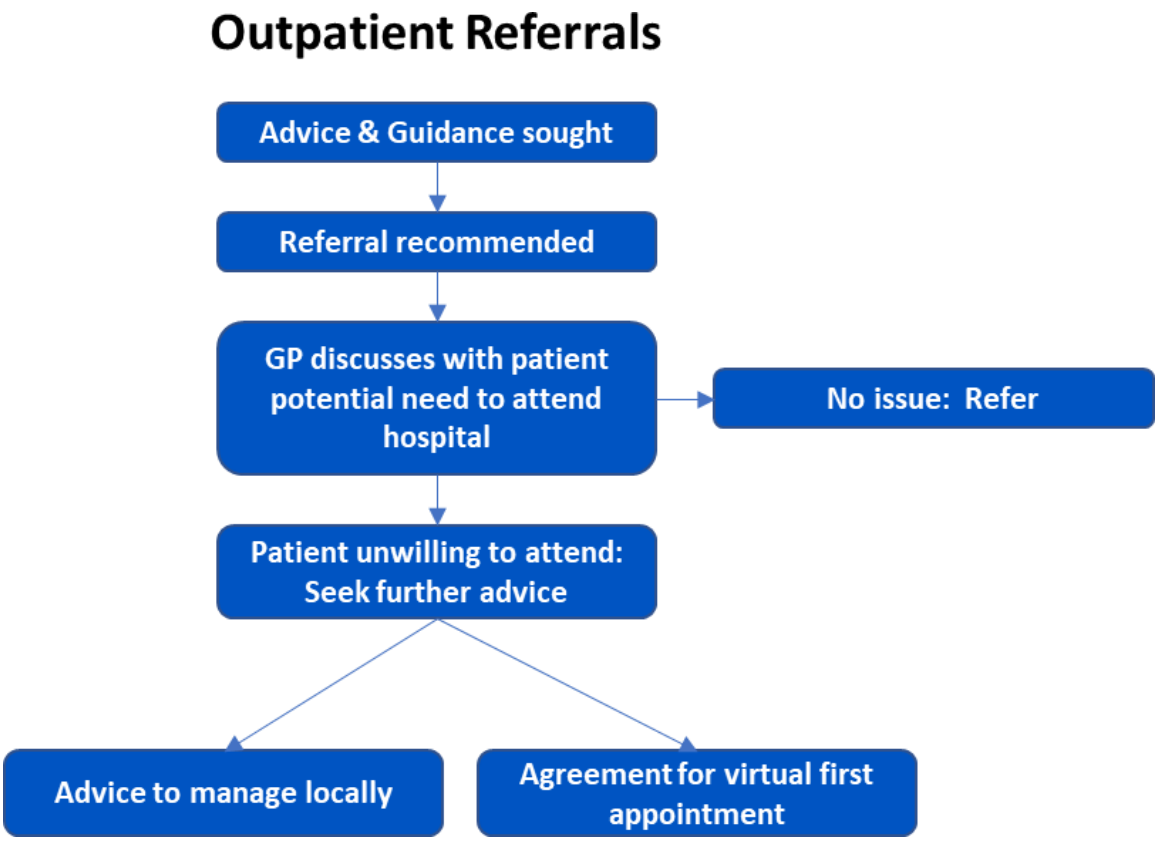
Should the patient be deemed clinically routine, a non-clinical member of staff will contact the patient. If the patient is still unwilling to attend their case will be clinically reviewed, and they may be discharged back to the care of their GP, stopping the 18 week pathway.
If, within 6 months of this decision being made, either:

- The GP believes the patient is in a position to agree a date, or
- The patient feels that they are ready to attend the hospital

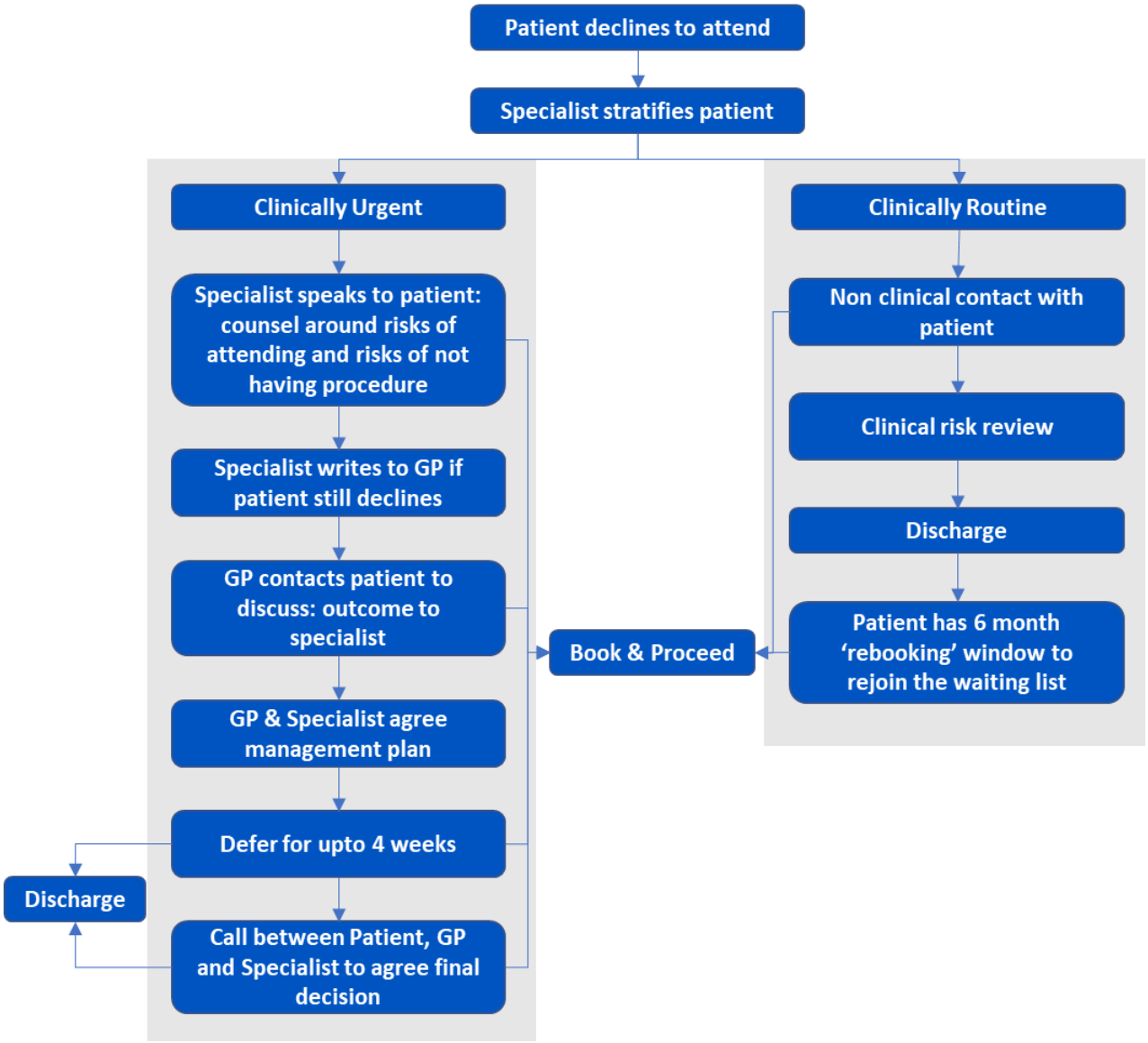
The relevant admissions team should be contacted and the patient will be reinstated on the waiting list and a further date identified. The addition to the admitted waiting list will start a new 18 week

pathway. The patient must be contacted by telephone and informed of this decision and a letter sent to the patient and the GP explaining the process.

Please see the summary flow charts below.



Admissions & Procedures



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