



Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath

Clinical Area / Department	Operations
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath
Reference Number	ADM035
Ratification Date	17/08/2026
Version Number	3.0
Reviewed By (name and job role)	Samuel Harrison – Associate Director of Operations
Review Due	17/08/2029
Reviewed By (committee)	Clinical Governance Risk Management Committee (CGRMC)
Policy Author and Job Role	Samuel Harrison – Associate Director of Operations

Version	Date	Summary of changes
1		Original Circle Bath Policy
2	23rd August 2023	Re branded to Sulis Hospital
3	August 2026	The updated 2026 Access Policy represents a substantial modernisation and brings Sulis Hospital Bath into full alignment with contemporary national guidance, ICS expectations, and local service developments including the CDC. It provides a robust, clinically safe, equitable, and legally compliant framework for the management of all NHS patient pathways.
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5		



In developing this policy, the following legislation has been duly considered:

GDPR / Data Protection Act 2018

Data Protection issues have been considered with regard to this policy. Adherence to this policy will therefore ensure compliance with the GDPR / Data Protection Act 2018 and internal Data Protection Policies.

Diversity & Equality Policies

Equality issues have been considered regarding this policy. Adherence to this policy will therefore ensure compliance with Equal Opportunity legislation and internal Equal Opportunity policies.

Freedom of Information Act 2000

Freedom of Information issues have been considered regarding this policy. Adherence to this policy will therefore ensure compliance with the Freedom of Information Act 2000 legislation and internal Freedom of Information policies.

Health and Safety Act 1974

Health and Safety issues have been considered regarding this policy. Adherence to this policy will therefore ensure compliance with Health and Safety legislation and internal Health and Safety policies.

Human Rights Act 1998

The Human Rights Act 1998 has been considered with regard to this policy. Proportionality has been identified as the key to Human Rights compliance. This means striking a fair balance between the rights of the individuals and those of the rest of the community. There must be a reasonable relationship between the aim to be achieved and the means used.

Equality Act 2010

The Equality Act 2010 has been considered regarding this policy. Adherence to this policy means that the company will eliminate discrimination on the grounds of race and will promote race equality and good race relations.

The Employment Equality (Age) Regulations 2006

Circle Healthcare acknowledges that the age profile of the United Kingdom and therefore the local community is changing. The company is committed to equality of opportunity both in service delivery and employment and we have made a commitment to promoting age diversity. Adherence to this policy means that the company will challenge the general acceptance of “ageism” in order to eliminate age stereotyping.

The Mental Capacity Act 2005

Has been considered when developing this policy to ensure the guiding principles of the act are adhered to with reference to testing and assessment of capacity, consulting others and protecting the best interests of the patient. The Mental Capacity Act provides a statutory framework to empower and protect vulnerable people who cannot make their own decisions. It makes it clear who can take decisions, in which situations, and how they should go about this. It enables people to plan ahead for a time when they may lose capacity.

Accessible Information Standard (AIS)

The Accessible Information Standard (AIS) has been incorporated into this policy to ensure all patients, service users, carers and parents with information or communication needs related to a disability, impairment or sensory loss receive information in a format they can understand.

NHS England’s Waiting Times & RTT Guidance

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
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This policy has been developed in alignment with NHS England's national Waiting Times and Referral to Treatment (RTT) operational guidance. These standards set out the rules for how waiting times must be measured, reported and managed to ensure patients receive timely and safe access to consultant-led services.

NHS Constitution Principles

The NHS Constitution has been considered throughout the development of this policy. The Constitution establishes patient rights, including the right to access NHS services within maximum waiting times, the right to informed choice, and the right to be treated with dignity and respect.

NHS England Elective Recovery Plan (2022–2026) & Updated RTT Rules

The Elective Recovery Plan, alongside updated RTT and long-waiter standards, has been taken into account in designing this policy. The plan sets national expectations for reducing long waits, improving access to high-volume elective procedures, expanding patient choice, and strengthening digital-first pathways. This policy ensures that Sulis Hospital Bath aligns with system-wide expectations for managing 52-week, 65-week and 78-week pathways, delivering clinically validated Patient Tracking Lists, and supporting elective recovery through efficient outpatient, diagnostic and surgical scheduling processes. It promotes proactive management of capacity and demand to ensure timely treatment.

Health and Care Act 2022 (ICS Formation)

The Health and Care Act 2022 and the formation of Integrated Care Systems (ICSs) have been taken into account in designing this policy. The Act places responsibilities on providers to work collaboratively within their ICS to improve population health outcomes, reduce inequalities, and ensure system-wide

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CONTENTS

1. INTRODUCTION	6
2. EXECUTIVE SUMMARY	6
3. SCOPE	6
4. AIMS AND OBJECTIVES	6
5. KEY PRINCIPLES	7
6. DUTIES AND RESPONSIBILITIES.....	7
7. REFFERAL TO TREATMENT (RTT) RULES OVERVIEW.....	10
7.1 Pathway definitions	10
7.2 Scenarios Excluded from RTT Standards	10
7.3 Starting an RTT Clock.....	10
7.3.1 Consultant-to-Consultant Referrals	10
7.3.2 End of Active Monitoring	10
7.5 Clock Stops.....	11
7.6 Private Patient Pathways Converting to NHS	12
8. REFERRAL PATHWAYS.....	13
8.1 Minimum Data Set (MDS) Requirements	14
8.2 Referral Criteria for Outpatients.....	14
8.3 Referral Criteria.....	14
9. APPOINTMENT BOOKING PROCESS	14
9.1 Unavailability of Appointments	15
9.2 Reasonable Offers of Appointments.....	15
10. CONTACTING PATIENTS AND MANAGING CHOICE.....	15
10. 1 Active Monitoring.....	15
10.2 Verbal Contact Attempts	15
10.3 Non-Verbal Contact Attempts.....	15
10.4 Sequential Appointments	16
10.5 Appointment Letters	16
10.6 Patient-Initiated Cancellations and Changes.....	16
10.7 New Appointments	16
10.8 Follow-Up Appointments	16
10.9 Hospital-Initiated Cancellations (Non-Clinical Reasons).....	17
10.10 Monitoring of Cancellations	17

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations

10.11 Clinical Cancellation and Session Reductions	17
10.12 Patient Who Does Not Attend (DNA)	17
10.13 Consultant-to- Consultant Referrals	18
10.14 Inter-Provider Transfers (IPTs)	18
11 DIAGNOSTICS	18
11.1 Definition	18
11.2 National Diagnostic Standards and Rules	18
11.3 Community Diagnostic Centre (CDC) Access Pathways	19
11.4 Referrals from the Royal United Hospitals (RUH) Bath	19
11.5 Direct GP Access via ICE	19
11.6 GP Access via eRS (Electronic Referral Service)	19
11.7 Reasonable Offer of Diagnostic Appointment	19
11.8 DNAs (Did Not Attend) for Diagnostic Appointments	20
11.9 Patients Under 18	20
11.10 Supporting Vulnerable Patients	20
12. ADMITTING PATIENTS	21
12.1 Selecting Patients for Admission	21
12.2 Patients with a Decision to Treat (DTT)	21
12.3 Information to the Patient (TCI Letters)	22
12.4 Patients Who Become Clinically Unfit Before Admission	22
12.5 Reasonable Offers of Admission	22
12.6 Patient Unavailability & RTT Expectations	22
12.7 Hospital-Initiated Cancellations of Admissions	23
12.8 Method of Admission	23
12.9 Supporting Vulnerable Patients	23
12.10 Transfers Between Clinicians and Providers	23
12.11 Multiple Procedures	24
12.12 Bilateral Procedures	24
12.13 Discharge of Day Case / Inpatient Patients	24
12.14 Closing Day Case / Inpatient Sessions	24
APPENDIX 1: EQUALITY IMPACT ASSESSMENT	25

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations



1. INTRODUCTION

The successful management of patients who wait for outpatient appointments and elective treatment is the responsibility of the Sponsor to which the patient belongs. Commissioners must ensure that long-term service agreements are established with sufficient capacity to ensure that no patient waits more than the guaranteed maximum time. Sulis Hospital Bath recognises it has a responsibility to deliver this requirement on behalf of the Sponsors and its key role in contributing to effective patient care. This is a comprehensive responsibility from receipt of a patient referral or Inter Provider Transfer to the return of the patient to primary care.

Treating patients and delivering a high quality, efficient and responsive service as well as ensuring prompt communications with patients is a core responsibility of Sulis Hospital Bath and the wider local health community.

The accuracy of data is paramount and as such, all transactions made in the Compucare Patient Administration System (PAS) will be performed by staff in accordance with this access policy (AP) and the supporting Standard Operating Procedures (SOPs). The most up to date versions of the AP will be accessible to staff and the general public.

The SOPs define the processes and procedures that Sulis Hospital Bath will undertake to support the functions and achieve the outcomes of the AP. In essence, the Access Policy sets the standards for referral management and the SOPs detail how they are achieved.

There is a detailed SOP document designed to support the Sulis Hospital Bath Access Policy. This will be referenced within this document.

2. EXECUTIVE SUMMARY

The length of time a patient needs to wait for investigation and treatment of a medical/surgical condition is an important quality issue. Waiting times are a visible and public indicator of efficiency for Sulis Hospital Bath and are often the basis on which some patients make a decision in choosing a provider.

3. SCOPE

This is an important document. It is intended for use by all staff in Sulis Hospital Bath and is available for information and guidance in managing patient pathways. It is expected that all staff involved in the treatment of patients, and managing the patient process, adhere to the Access Policy and associated SOPs. This policy is made available to patients as a published document, either on request or via the Sulis Hospital Bath website.

4. AIMS AND OBJECTIVES

This Policy ensures that all patients entering care pathways are part of a comprehensive set of management processes supported by robust IM&T systems to deliver the required outcomes.

The policy defines the roles and responsibilities of staff and establishes good practice guidelines to assist staff with the effective management of the patient pathway.

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations



5. KEY PRINCIPLES

- The General Manager is responsible for ensuring compliance of this policy, contracted obligations detailed, and its associated SOPs. It should be reviewed annually, in line with Information Standards Notifications (ISNs) or upon receipt of any contractual change. These are then translated into the Access Policy.
- The management of patients and their referral pathway will be equitable and transparent and communication with patients will be clear and concise to allow informed choices and decisions to be made.
- The Access Policy describes and supports the relevant reporting requirements to ensure that Sulis Hospital Bath fulfils its obligations.
- This Policy details how Sulis Hospital Bath will manage patients who are waiting for treatment on an admitted, non-admitted and/or diagnostic pathway.
- Sulis Hospital Bath will work to ensure fair and equal access to services for all patients, thereby giving priority to clinically urgent patients and treating everyone else in turn.
- Sulis Hospital Bath will work to meet and reduce the maximum waiting times set by the Department of Health for all groups of patients.
- Sulis Hospital Bath will negotiate appointment and admission dates and times with patients wherever possible.
- Sulis Hospital Bath will ensure that Management Information of all 18-week waiting lists and activity is recorded on the Compucare PAS.
- Achievement of the 18-week pathway will be monitored through Patient Tracking Lists, which measure the patient's length of wait.
- In most circumstances patients should not be referred to for acute services unless they are fit, ready and willing to access services within a maximum of 18 weeks.
- The polling ranges on the National Choose and Book system should be set at a relevant number of days/weeks that support delivery of the 18-week RTT pathway.

6. DUTIES AND RESPONSIBILITIES

The Sulis Hospital Bath Hospital Director is accountable for the delivery of this policy and adherence to relevant Key Performance Indicators.

The Sulis Hospital Bath Associate Director of Operations will support and advise the Hospital Director in the above role and on all aspects of referral management, including scheduling and the administrative function to support discharge and onward referral.

The NHS Administration Lead will support and advise the Associate Director of Operations and will be accountable for managing the systems in place to monitor the application of this policy and to ensure that patients are treated consistently and fairly in accordance with national guidance. He/she has accountability to manage the systems, processes and administration staff in accordance with this policy and is supported by the SOPs.

In particular, the Administration Co-ordinators are responsible for the following:

- Acts as a point of contact for external enquiries (sometimes urgent).
- Ensures that the process of transferring patients to other providers is carried out appropriately.
- Ensures the management of systems for patient tracking, including where patients are delayed on the pathway but not rejected.
- Oversee the management of all administrative staff associated with the Sulis Hospital Bath, ensuring all staff receive the appropriate training and development to continually improve the patient's experience.
- Defines staff competencies and provides access to training and development

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations



- Supervises performance monitoring and audit reporting to ensure compliance to standards.
- Manages the review process of audit reports, which monitors the patient pathway.
- Manage all administrative staff associated with the pathways.
- Define staff competencies in adherence with the Access Policy and provide access to training and development.
- Work collaboratively with clinical leads to ensuring all patients progress their pathway in a timely manner from referral receipt to an appropriately scheduled appointment.
- Supervise performance monitoring and audit reporting to ensure compliance to standards.
- Ensure that all patients are offered appointments in line with their clinical priority, scheduling urgent referrals prior to routine referrals
- Ensure that session closure systems are in place and that outcomes are correct and up to date.
- Escalate any referral with a clinical priority that cannot be scheduled appropriately to the Administration Lead/Head of Commercial Operations
- Manage capacity and demand for outpatient and Day Case sessions.

Outpatient Booking Co-ordinators will work with the Outpatients Bookings Supervisor to manage the flow of patient referrals and Inter Provider Transfers into Sulis Hospital Bath, ensuring all referrals are registered in a timely fashion. The Outpatient Booking Co-ordinators will be responsible for the following:

- Receive all referrals and ensure registration onto Compucare within **1 business day**.
- Manages referral Minimum Data Set compliance, (i.e.) ensuring that all referrals received contain the obligatory minimum dataset required for treatment at Sulis Hospital Bath, including checks against age thresholds as stated in the PA.
- Acts as a point of contact for external sponsors or GP enquiries and ensures that patients progress smoothly on their pathway.
- Administer the patient pathway within Compucare.
- Record any Sulis Hospital Bath or patient-initiated cancellation/DNA and reschedule or refer patient back to GP as appropriate.
- Ensure that Compucare reflects up-to-date, accurate information.
- Escalate any action diverting a patient from their pathway and agreed treat by date to the Outpatient Bookings Supervisor to ensure appropriate action is taken.

Hospital Receptionists

- Provide a first point of contact for patients at reception, playing a key role in ensuring that the service runs smoothly and efficiently.
- Update patient information/data on Compucare.

Patient Administrators

- Book follow-up appointments for patients, ensuring that they are provided with a choice of date/time in the clinically appropriate timeframe.
- Ensure all patients either leave with an appointment or information pertaining to the partial booking process
- Conduct the clinic closure process in accordance with the Administration Standard Operating Procedures.
- Ensure all patients are appropriately tracked through with accurate outcomes assigned

Systems & Data Team

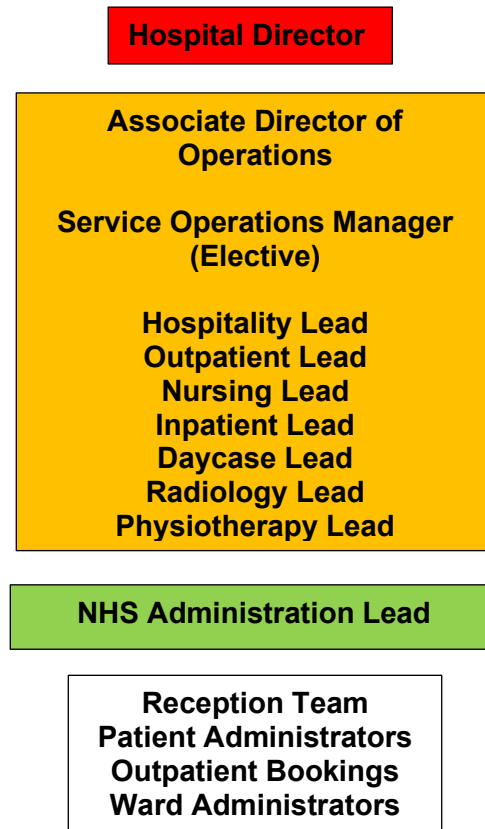
- Support the operational teams by providing staff with timely, accurate and appropriate information.

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations



- Ensure that mechanisms are in place to collect data accurately according to the requirements of the Department of Health.
- Produce and distribute the weekly Patient Tracking List (PTL) to the NHS Administration Lead, Head of Operations and Hospital Director.

SULIS HOSPITAL BATH ESCALATION PROCESS



The Structural chart indicates the escalation process for the issues/ incidents relating to the Referral Management Function.

- White: escalate to Green
- Green: escalate to Amber
- Amber: escalate to Red

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations



7. REFFERAL TO TREATMENT (RTT) RULES OVERVIEW

The NHS Constitution states that patients have the right to start consultant-led treatment within a maximum of 18 weeks from referral, and providers must take all reasonable steps to support this standard. The current national rules governing RTT measurement are set out in NHS England's Referral to Treatment Consultant-Led Waiting Times Rules Suite (October 2022), supported by updated recording/ reporting guidance issued between 2023–2025.

RTT waiting times apply to patients whose care is commissioned by the English NHS and only to pathways that are consultant-led.

Sulis Hospital Bath is fully committed to operating within these standards.

7.1 Pathway definitions

7.1.1 Non-Admitted Pathway - A pathway in which first definitive treatment is delivered without admission, resulting in an RTT clock stop—for example, treatment delivered in an outpatient setting.

7.1.2 Admitted Pathway - A pathway that results in a day-case or inpatient admission for first definitive treatment, generating an RTT clock stop at the point of treatment.

7.2 Scenarios Excluded from RTT Standards

The following remain excluded from RTT measurement, consistent with national rules:

- Emergency admissions
- Planned/surveillance procedures carried out at pre-determined intervals
- Ongoing care for a diagnosis where first definitive treatment has already occurred
- Periods of Active Monitoring, where the patient and clinician have agreed that treatment is not currently appropriate

7.3 Starting an RTT Clock

An RTT clock starts when the provider receives a referral to a consultant-led service, regardless of referral route. Updated 2024–2025 national guidance clarifies rules for clock starts, including:

- Referrals made by GPs, nurse practitioners, AHPs and other clinicians if locally agreed.
- Referrals made via the NHS e-Referral Service (eRS), including referrals appearing on the Appointment Slot Issues (ASI) list.
- Referrals from non-consultant clinicians do start an RTT clock when they refer into a consultant-led service.
- Consultants retain overall clinical responsibility for consultant-led activity even when not physically present.

7.3.1 Consultant-to-Consultant Referrals

If a consultant refers a patient to another consultant for a new, unrelated condition, a new RTT clock begins. This remains consistent with national definitions.

7.3.2 End of Active Monitoring

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations



When a period of Active Monitoring ends because the patient and clinician agree treatment should begin, a new RTT clock starts. Updated guidance (2023-2025) reinforces the correct use of Active Monitoring.

7.4 Patient-Initiated Delays & Unavailability (Clock Pauses Removed)

Previous national rules allowed clock pauses when patients delayed their admission.

These rules were abolished on 1 October 2015, and the 2022 Rules Suite reaffirm that no RTT clock pause is permitted under any circumstances. Therefore:

- If a patient declines a reasonable offer, the RTT clock continues.
- Delays must be recorded locally for operational management only, not applied to RTT reporting.
- Terms such as “maximum period of unavailability” no longer apply under national RTT rules.
- Patients wishing to delay care may be placed into Active Monitoring following a clinical discussion.

7.5 Clock Stops

An RTT clock stops only when one of the following occurs, in line with updated RTT rules:

- **First Definitive Treatment**
 - The patient receives the first intervention intended to manage their condition. This is a treatment clock stop.
- **Active Monitoring / Watchful Waiting**
 - When clinicians and patients agree that treatment is not currently required, the RTT clock stops and the patient enters Active Monitoring. No diagnostic testing is usually undertaken during this period.
- **DNAs for First Appointment**
 - Under updated February 2025 rules, a DNA at the first appointment does not automatically stop the RTT clock. This replaces the former rule that required a stop and restart.
 - A clinical review is required to determine:
 - Whether the patient should be discharged
 - Whether the appointment should be rebooked.
- **DNAs for Subsequent Appointments**
 - A DNA later in the pathway requires a clinical decision on whether to continue care or discharge the patient.
 - If discharged, the RTT clock stops; if the patient is rebooked, the clock continues in line with updated rules.
- **Decision Not to Treat**
 - If a clinician decides no treatment is required, the RTT clock stops. The patient may remain under consultant care or be discharged to the GP.
- **Patient Declines Offered Treatment**
 - If a patient declines treatment after discussion, the clinician decides whether to:
 - Move the patient to Active Monitoring, or
 - Discharge the patient back to the GP

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations



National guidance now states that patients declining treatment may be placed into Active Monitoring rather than being automatically discharged.

7.6 Private Patient Pathways Converting to NHS

Sulis Hospital Bath permits private patients to transfer into an NHS-funded RTT pathway; however, this process must be managed in a way that maintains full equity across all NHS patients and ensures that no individual is advantaged by starting their care privately.

When a patient who has already received private outpatient consultation, diagnostics, or other episodes of care elects to transfer into NHS treatment:

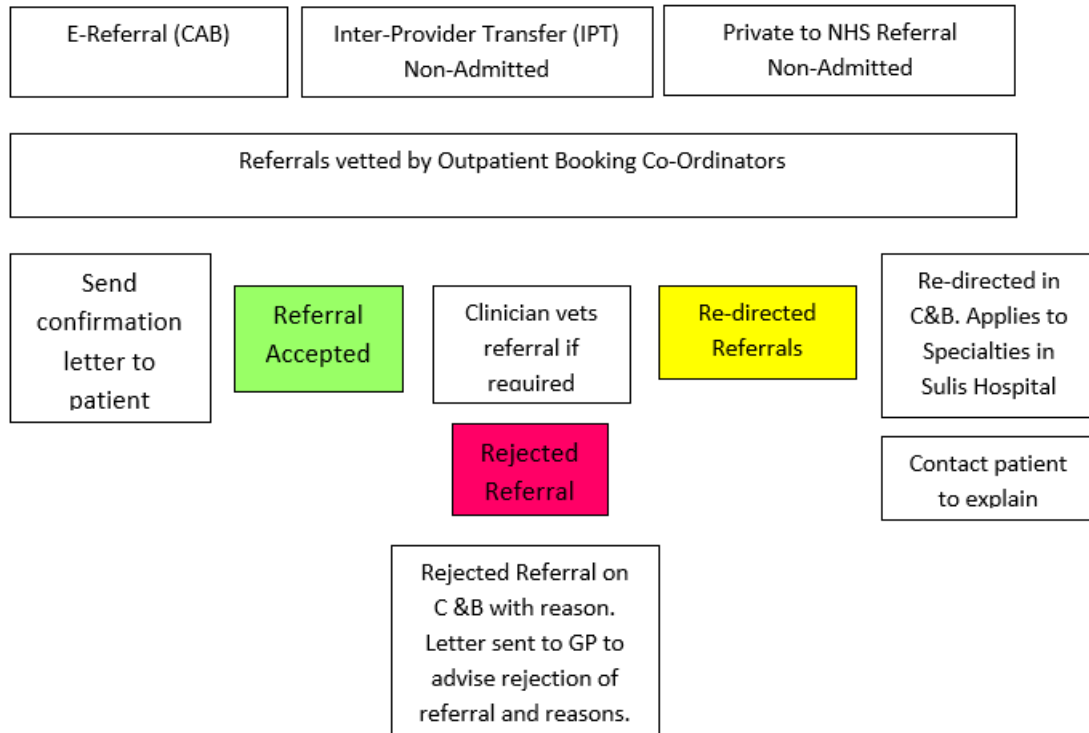
- A new RTT clock will begin on the date the NHS referral is received, in accordance with NHS England guidance that RTT clocks only start when an English NHS commissioner becomes responsible for the patient's care.
- RTT time cannot be backdated to reflect private consultations, tests, or waiting periods. NHS England's rules confirm that providers must not backdate RTT clocks to periods where the patient was not under NHS commissioning responsibility.
- Patients transferring from private care will not be prioritised ahead of NHS patients already on the waiting list. Their position in the waiting list will be based on clinical priority only, and not on any prior private activity. This ensures fairness, consistent with the NHS Constitution principle that patients should be treated in order of clinical need, not by ability to pay.
- To ensure equity and avoid queue displacement, a minimum waiting period may be applied so that the patient's first NHS treatment slot is comparable to the point at which an NHS-referred patient would ordinarily reach that stage of care. This prevents any advantage gained from completing early pathway stages privately.

This local approach aligns with the national RTT position that the NHS must manage waiting lists in a manner that supports fairness, transparency, and consistent application of clinical priority, while ensuring that private care does not confer accelerated access to NHS treatment.

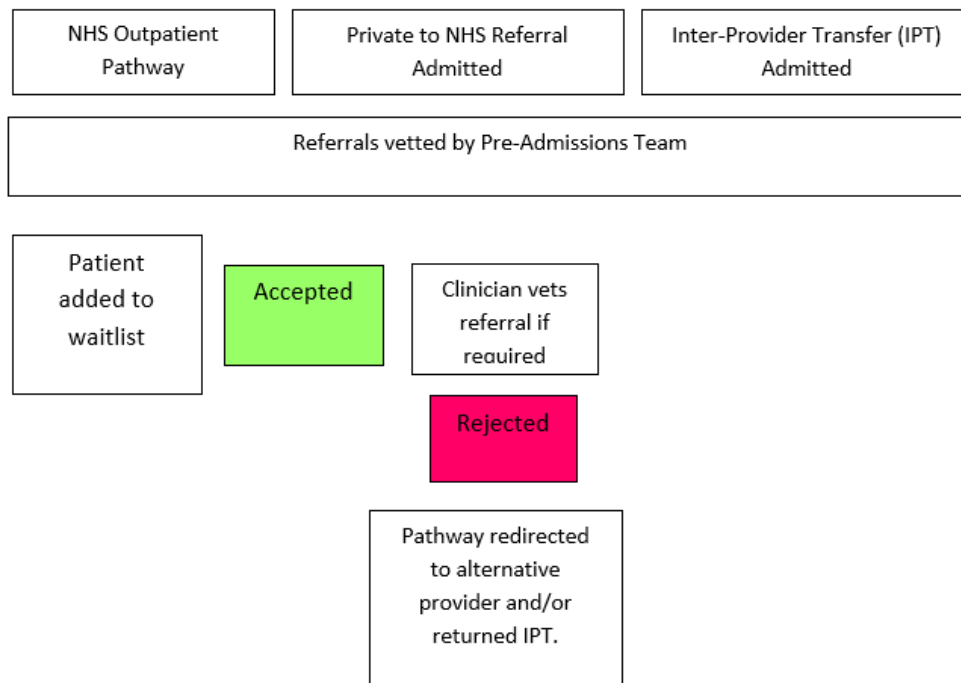
Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations

8. REFERRAL PATHWAYS

Non-Admitted Pathway



Admitted Pathway



Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
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8.1 Minimum Data Set (MDS) Requirements

All referrals received by Sulis Hospital Bath will have a fully completed MDS.

8.2 Referral Criteria for Outpatients

The following criteria for outpatient referrals indicate the minimum dataset items:

- The outpatient specialty for which the patient is referred
- Name, date of birth, NHS number, full address (including postcode) and contact telephone number
- GP address
- Any other relevant information including additional requirements such as communication disability needs and transport requirements
- The reason for the referral and the priority
- Details of relevant medical history
- Medication which the patient is known to be currently taking
- Known allergies
- The date of the referral

Additionally, the referring body will ensure the referral adheres to the Sulis Hospital Bath exclusion criteria.

8.3 Referral Criteria

8.3.1 Internal Service Request

For patients who require a procedure following an outpatient consultation at Sulis Hospital Bath, the clinician will complete a conversion to surgery form (Health Questionnaire). The clinician must ensure the patient meets the criteria outlined below for general or local anaesthesia.

8.3.2 Inter- Provider Transfers (IPTs)

To follow relevant pathway depending on referral route, Mutual Aid and or Sub-contract. Refer to pathway documents.

General Anesthesia

- Have access to a telephone 24 hours a day
- Have a responsible adult carer for 24 hours post procedure
- Have a responsible adult escort home and suitable transport
- Be ASA 1, 2, 3 stable.
- Not have a BMI greater than 40.

Local Anesthesia

- Have access to a telephone 24hrs/day
Also recommended –
- Have a responsible adult carer for 24hrs post operation
- Have a responsible adult escort home

9. APPOINTMENT BOOKING PROCESS

Patients referred through the NHS e-Referral Service (eRS) will normally have booked their first appointment

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
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directly. The booking team must ensure that all eRS referrals are registered promptly on Compucare and that any Appointment Slot Issues (ASI) are actioned in accordance with operational procedures.

9.1 Unavailability of Appointments

Where no clinic slots are available to book a patient within the required timeframe, the Outpatient Bookings Supervisor must be informed immediately. Appropriate actions may include:

- adjusting polling ranges
- identifying additional clinical capacity
- reinstating cancelled sessions
- seeking ad-hoc clinic support

These steps should ensure timely access without impacting RTT reporting.

9.2 Reasonable Offers of Appointments

Sulis Hospital Bath defines a “reasonable offer” for outpatient appointments as follows:

- Written offer: appointment is offered with at least 3 weeks’ notice.
- Verbal offer: appointments are offered with at least 2 weeks’ notice and a minimum of three date options provided.
- Where a patient elects to attend sooner than these notice periods, the offer remains reasonable.

10. CONTACTING PATIENTS AND MANAGING CHOICE

Patients may request to defer appointments for personal reasons. Operationally, Sulis Hospital Bath will offer alternative dates when capacity allows. Where delays could impact clinical safety, cases should be escalated for clinical review.

Any impact on RTT measurement, including patient-initiated delays, Active Monitoring, or referral return, must be managed strictly in accordance with Section 2 (RTT Rules).

10.1 Active Monitoring

Where a consultant and patient jointly agree that treatment is not currently required, the patient may enter a period of Active Monitoring. This must reflect a genuine clinical decision and be recorded clearly in Compucare.

10.2 Verbal Contact Attempts

For referrals that do not originate via e-RS, Outpatient Booking Co-ordinators must attempt to contact the patient by telephone on **three separate occasions** (two during daytime, one after 5pm). All attempts should be documented.

10.3 Non-Verbal Contact Attempts

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations



If telephone contact is unsuccessful, a letter will be issued with the next available appointment date. Patients may rearrange by contacting the bookings team.

For follow-up appointments due beyond 12 weeks, a partially booked process will be used:

- A reminder letter is issued six weeks before the expected date.
- If the patient does not respond within three weeks, a further attempt will be made by phone.
- If unsuccessful, the case is escalated for clinical review.

10.4 Sequential Appointments

Where a pathway requires multiple appointments (e.g., diagnostics followed by review), each step must be linked to the original referral within Compucare to ensure full tracking and governance.

10.5 Appointment Letters

Once an appointment is booked, a letter must be generated in Compucare and sent to the patient. All letters must include:

- patient name
- date of issue
- appointment date and time
- clinic location
- contact details for queries
- Responsible clinician

This serves as an essential audit trail.

10.6 Patient-Initiated Cancellations and Changes

When new patients cancel their appointment, an alternative date should be offered where possible. All offers and declines must be documented in Compucare.

If a patient repeatedly cancels or is unavailable for a reasonable offer, the case must be managed in accordance with the RTT principles.

10.7 New Appointments

When new patients cancel their appointment, an alternative date should be offered where possible. All offers and declines must be documented in Compucare.

If a patient repeatedly cancels or is unavailable for a reasonable offer, the case must be managed in accordance with the RTT principles.

10.8 Follow-Up Appointments

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations



Follow-up cancellations should be rebooked promptly with consideration of clinical urgency and pathway requirements.

10.9 Hospital-Initiated Cancellations (Non-Clinical Reasons)

Where Sulis Hospital Bath cancels an outpatient appointment for non-clinical reasons, patients must be rescheduled:

- New patients: in accordance with their RTT pathway requirements
- Follow-up patients: within 28 days of the cancelled appointment

10.10 Monitoring of Cancellations

The NHS Administration Lead will monitor cancellations and escalate recurring or systemic capacity issues to the Head of Operations and Finance Lead.

10.11 Clinical Cancellation and Session Reductions

10.11.1 Standard Cancellations

A minimum of **6 weeks' notice** is required for planned clinic reductions or cancellations. A formal cancellation proforma must be completed and issued to the booking team

10.11.2 Short-Notice / Emergency Cancellations

If a clinic cancels within 6 weeks:

- Clinical notes must be reviewed for urgency
- Patients should be rebooked in order of clinical priority and wait time
- Additional capacity may need to be secured
- The NHS Administration Lead and Head of Operations must be notified immediately

Clinicians must not leave site or abandon scheduled clinics without escalation.

10.12 Patient Who Does Not Attend (DNA)

First Appointment DNA - A clinician must review all first-appointment DNAs to determine whether a further appointment is appropriate or whether the patient should be discharged.

Subsequent DNAs - Repeat DNAs require clinical review to determine appropriate next steps, including discharge where clinically appropriate.

Patients under 18 - Sulis Hospital Bath does not treat NHS patients under 18.

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations



Late Arrivals - Patients arriving **within 15 minutes** of their appointment time may still be seen at clinician discretion. Late arrivals beyond this threshold may require rebooking.

Outpatient Tracking - All patients must be “tracked out” in Compucare at the end of their appointment. Clinicians must document required RTT outcomes within 48 hours to ensure accurate reporting. Clinic letters must be generated and filed in the medical record.

Arrived but Did Not Wait - Patients who attend but leave before being seen must be recorded as “not seen” in Compucare.

10.13 Consultant-to- Consultant Referrals

Referrals between consultants must:

- be agreed by the consultant responsible
- be discussed with the patient
- be documented clearly in the patient record
- follow internal processes for logging and tracking

10.14 Inter-Provider Transfers (IPTs)

Inter-Provider Transfers must include a complete IPT pack, including required RTT status details and pathway information.

10.15 The Vulnerable Patient

Vulnerable patients must have needs identified at referral and supported using appropriate communication, liaison with other agencies, and reasonable adjustments as required.

11 DIAGNOSTICS

11.1 Definition

A diagnostic test is a clinical investigation undertaken to identify or confirm a patient’s condition to enable diagnostic clarity and support clinical decision-making.

For diagnostics subject to waiting-time standards, the diagnostic waiting time begins when a valid request for the test is received and ends when the test is completed.

11.2 National Diagnostic Standards and Rules

Sulis Hospital Bath adheres to the national 6-week diagnostic waiting-time standard, which requires the majority of patients referred for key diagnostic tests to receive their investigation within 6 weeks of request.

The following remains excluded from the diagnostic standard:

- Planned/surveillance diagnostic reviews performed as part of a long-term management plan

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations



- Routine screening programme tests (e.g., breast screening, cervical screening)
- Obstetric monitoring related to maternity care
- Diagnostics delivered as part of an emergency or unscheduled inpatient episode

Diagnostic waiting times cannot be paused for any reason.

Where a diagnostic test forms part of an RTT pathway, the RTT rules defined in Section 2 apply.

Diagnostic tests undertaken in:

- Outpatients → follow Section 4 operational procedures
- Day case / inpatient settings → follow Section 6 procedures

11.3 Community Diagnostic Centre (CDC) Access Pathways

Sulis Hospital Bath operates as part of the Community Diagnostic Centre (CDC) diagnostic network, providing increased access to diagnostics across multiple pathways.

CDC referrals are accepted via the following routes:

11.4 Referrals from the Royal United Hospitals (RUH) Bath

The CDC accepts referrals from RUH through agreed digital referral mechanisms, which vary by modality.

Each modality (e.g., CT, MRI, Ultrasound, Cardiac Diagnostics, Respiratory Diagnostics) has a defined digital workflow for referral, vetting, and scheduling.

11.5 Direct GP Access via ICE

GPs may request direct access diagnostics through the ICE system for specific services:

- Phlebotomy
- Radiology (modality-dependent and subject to availability & clinical criteria)

All GP ICE referrals must meet eligibility criteria and clinical appropriateness standards before acceptance.

11.6 GP Access via eRS (Electronic Referral Service)

For certain diagnostic specialties, GPs may refer directly through eRS:

- Respiratory
- Sleep Service
- Cardiology (including ECG, Holter, Echocardiography, and other listed tests)

Acceptance of referrals is dependent upon:

- local referral criteria
- clinical safety requirements
- availability of the specific diagnostic test

CDC referrals do not bypass diagnostic prioritisation and are managed equitably alongside all other NHS diagnostics.

11.7 Reasonable Offer of Diagnostic Appointment

Where possible, diagnostic investigations should be booked on the same day as an outpatient assessment.

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations



Where a same-day booking is not possible:

- At least two telephone attempts will be made to contact the patient.
- If unsuccessful, an appointment letter will be issued by post with an offered date.
- A diagnostic appointment is considered a reasonable offer if issued with a minimum of 3 weeks' notice, unless the patient chooses to attend sooner.

Any capacity issues preventing timely booking must be escalated promptly to the Operations Manager.

11.8 DNAs (Did Not Attend) for Diagnostic Appointments

If a patient does not attend their diagnostic appointment and no reason is provided:

1. Radiology/Diagnostics staff will attempt to contact the patient to determine the cause.
2. Depending on clinical need, the referring clinician will be consulted to determine whether:
 - another appointment should be offered, or
 - the patient should be discharged / returned to GP care.

If a patient DNAs two consecutive diagnostic appointments, the request will be closed and the referring clinician informed.

Further access will require a new referral if clinically appropriate.

11.9 Patients Under 18

Sulis Hospital Bath does not provide NHS diagnostic services for patients under 19 years of age. However, patients aged 16–17 years may be seen for non-invasive, plain diagnostic procedures (e.g., plain X-ray or basic imaging) where this is clinically appropriate and safe to perform within the competencies of the service.

Sulis Hospital Bath **cannot** undertake invasive diagnostic tests on adolescents, including but not limited to endoscopic, interventional radiology, or other procedures requiring sedation, anesthesia, injections or specialist paediatric environments.

Where exceptions exist for limited investigations (e.g., simple non-complex assessments), these must adhere to locally agreed service specifications and be delivered only where appropriate safeguarding, consent, and clinical governance arrangements are in place.

11.10 Supporting Vulnerable Patients

The needs of vulnerable patients must be identified at referral and accommodated appropriately.

This includes:

- cognitive, learning or mental health difficulties
- communication or language needs
- physical or mobility impairments
- sensory loss requiring reasonable adjustments
- patients with unstable medical conditions requiring additional planning
- elderly or socially dependent individuals

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations



- any identified factor that may affect safe access to diagnostics

Where appropriate, diagnostic teams should liaise with carers, community services, advocates, or interpreters to ensure safe access

12. ADMITTING PATIENTS

12.1 Selecting Patients for Admission

Patients will be managed in chronological order under the care of the lead clinician, unless clinical urgency requires prioritisation. Urgent cases, as identified by the consultant, must be scheduled ahead of routine cases in line with clinical priority.

A reasonable offer of admission requires:

Written offer: minimum 2 weeks' notice

Verbal offer: minimum 2 date options, each with at least 2 weeks' notice

(See Section 2 for RTT rules relating to reasonable offers and patient-initiated delays.)

12.2 Patients with a Decision to Treat (DTT)

Only a consultant, or a clinician acting under an agreed delegation arrangement, may make the decision to admit a patient for a day case or inpatient procedure.

Patients must be clinically and socially fit for admission at the point the DTT is made. If further optimisation or assessment is required, this must be incorporated into the patient's pathway planning.

12.2.2 Pre-Operative Assessment

All patients requiring pre-operative assessment must have an electronic service request raised for both pre-operative assessment and the planned procedure.

Patients must complete a **health questionnaire** prior to their assessment.

12.2.3 DNAs for Pre-Operative Assessment

Where a patient does not attend their scheduled pre-operative assessment:

- Two contact attempts will be made (one daytime, one after 5pm).
- If unsuccessful, a new appointment will be generated and confirmed in writing.

If a patient DNAs **two consecutive** pre-operative assessments, their case must be reviewed by the treating consultant to determine whether:

- the appointment should be rebooked, or
- the patient should be returned to the GP.

12.2.4 Outcome of Pre-Operative Assessment

If a patient is clinically or socially unfit for the planned procedure:

- They may be placed into Active Monitoring where clinically appropriate, with clear communication to the GP regarding any required optimisation.
- If they remain unfit after this period, the referral will be returned to the GP with explanation.
- (See Section 2 for RTT implications of Active Monitoring.)

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations



12.3 Information to the Patient (TCI Letters)

A **To Come In (TCI)** letter will be issued once an admission date is confirmed. TCI letters must include:

- Patient name
- Date letter was issued
- Date and time of admission
- Name of responsible consultant
- Contact information for queries
- Any relevant clinical or procedural instructions
- Educational leaflets or procedure-specific information must be included.

12.4 Patients Who Become Clinically Unfit Before Admission

If a patient becomes unfit after being scheduled for admission:

- The treating team must assess whether the unfitness is short-term or long-term.
- If unfit for more than **2 weeks**, the patient will normally be discharged back to the GP with clear instructions for re-referral when appropriate.

This ensures safe, clinically appropriate scheduling.

12.5 Reasonable Offers of Admission

A reasonable offer is defined as:

- **Written offer:** at least 2 weeks' notice
- **Verbal offer:** at least 2 date options, each with 2+ weeks' notice
- If the patient chooses to attend sooner, the offer remains reasonable.

12.6 Patient Unavailability & RTT Expectations

Under national RTT rules, clock pauses are not permitted. If a patient declines an admission date:

- The RTT clock continues (see Section 2).
- The delay is recorded locally for operational purposes only.

If a patient declines two reasonable admission offers, they may be moved into Active Monitoring following a clinician-led discussion. This does not stop or pause the RTT clock.

Exceptions may occur where:

- the patient elects to delay treatment, or
- clinical complexity or co-morbidities require deviation from standard timelines.

Such cases must be documented clearly and managed within Sulis operational tolerance to ensure equitable and clinically safe care.

12.6.1 Patient-Initiated Cancellations

If a patient cancels an admission date:

- A replacement date must be offered within clinically appropriate timeframes.
- If a patient cancels **twice**, the referral may be completed and the patient discharged back to their GP, following consultant review.

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations



- If a patient cancels within 24 hours of admission, the event is logged as patient-initiated but not a DNA; the RTT clock is managed in line with Section 2.

12.6.2. DNAs for Day Case / Inpatient Admission

If a routine patient DNAs their admission (TCI date):

- The team must contact the patient to assess reason and clinical risk.
- The consultant must review the case before making any discharge decision.
- If clinically safe, the patient may be discharged to their GP.
- Clinical priority patients must be rescheduled urgently.
- A second DNA will normally result in discharge back to the GP.

12.6.3 Patients Under 18

Sulis Hospital Bath does **not** accept NHS patients under the age of **18** for day case or inpatient procedures.

12.7 Hospital-Initiated Cancellations of Admissions

If Sulis Hospital Bath cancels admission on the day of surgery for non-clinical reasons:

- The cancellation must be recorded as a hospital-initiated cancellation, and
- The patient must be offered treatment within 28 days or before the end of their RTT pathway, whichever is sooner.

12.8 Method of Admission

Elective admissions are categorised as:

- **Waiting List Admission:** patient added without a predetermined admission date.
- **Booked Admission:** patient given a date at the point where the decision to admit is made.
- **Planned Admission:** part of a planned clinical sequence with a known future date.

Emergency admissions occur unpredictably due to immediate clinical need.

12.9 Supporting Vulnerable Patients

Vulnerable patients must have individual needs identified and supported, including:

- cognitive or mental health difficulties
- communication or language barriers
- mobility or physical disabilities
- elevated anaesthetic risk
- reduced mental capacity
- social dependency or requirement for community support

Staff must ensure appropriate adjustments, liaison with support services, and clear documentation.

12.10 Transfers Between Clinicians and Providers

12.10.1 Transfers Between Clinicians

Patients may only be transferred between consultants with their explicit agreement, and both the originating and

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations



receiving consultants must approve the transfer.

12.10.2 Transfers to NHS Providers

Transfers to other NHS providers require a complete Inter-Provider Transfer (IPT) form and supporting documentation.

12.10.3 Transfers to Private Providers

Where treatment is transferred to another private provider on an NHS basis:

- The patient must consent,
- An IPT must be completed, and

If the patient declines transfer, Sulis must continue to manage their care within RTT requirements.

12.11 Multiple Procedures

Patients requiring procedures across multiple specialties must have separate referrals created for each condition or anatomical site.

12.12 Bilateral Procedures

Where bilateral procedures cannot be completed within a single admission:

- The first side is scheduled upon DTT, and
- A new RTT clock begins at post-operative review for the second procedure.

12.13 Discharge of Day Case / Inpatient Patients

A discharge summary must be completed for every patient and uploaded to their record. Patients must also be tracked as discharged on the system.

12.14 Closing Day Case / Inpatient Sessions

Ward Administrators must record all outcomes in the PAS system immediately following discharge.

Consultants are responsible for ensuring 100% capture of clinical outcomes to maintain accurate RTT reporting.

STAKEHOLDER APPROVAL

	Name	Title	Signature	Date
1.	Matt Sims	Service Operations Manager – Elective Care	<i>M. Sims</i>	August 2026
2.	Wendy Steer	Admin and Scheduling Lead	<i>W. Steer</i>	August 2026

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations

APPENDIX I: EQUALITY IMPACT ASSESSMENT

Equality Impact Assessment Tool		Yes/ No	Comments
1.	Does the policy affect one group less or more favorably than another on the basis of:		
	• Race	No	
	• Ethnic origins (including gypsies and travelers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment, and mental health problems	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4.	Is the impact of the policy/guidance likely to be negative?	No	
5.	If so, can the impact be avoided?	N/A	
6.	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	

Clinical Area / Department	Operations	Version Number	3.0
Policy Title	Access Policy for the Management of NHS Patients Accessing Services at Sulis Hospital Bath	Review Date	17/08/2029
Reference Number	ADM035	Authorised By (committee)	CGRMC
Ratification Date	17/08/2026	Policy Author & Job Role	Samuel Harrison – Associate Director of Operations