	NHS East Lancashire Hospitals NHS Trust TRUST WIDE
Delete as appropriate	**Trust Operating Policy**
DOCUMENT TITLE:	**JOINT ACCESS POLICY** **Managing Referral to Treatment, Diagnostic and Cancer Pathway Waiting Times**
DOCUMENT NUMBER:	**ELHT / C020 V5.1**
DOCUMENT REPLACES Which Version	**ELHT/C020 Version 4**
LEAD EXECUTIVE DIRECTOR DGM	**Director of Operations**
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TARGET AUDIENCE:	All Healthcare economy wide staff involved in the recording and management of elective care patient pathways
DOCUMENT PURPOSE:	This access policy is a collaborative agreement for the management of access to healthcare services for the population of East Lancashire. To ensure that all patients that are referred and treated within the Trust receive high quality care, fair and equitable access and services in line with The NHS Constitution, 18 week Referral to Treatment, Diagnostic and the Cancer Waiting Time Standards where applicable. To provide the Trust with a coherent approach to the scheduling and booking across the organisation and management of waiting lists.
To be read in conjunction with (identify which internal documents)	See Appendix 1

SUPPORTING REFERENCES	See Glossary

CONSULTATION		
	Committee/Group	**Date**
Consultation	This policy has been developed and consulted jointly within Blackburn with Darwen and East Lancashire Clinical Commissioning Groups and East Lancashire Hospitals NHS Trust. This has included representation from all departments that the policy covers	
Approval Committee	Access and Choice meeting	7/8/18
Ratification date at Policy Council:	October 2018	
NEXT REVIEW DATE:	October 2021	
AMENDMENTS:	Front cover updated	

Contents

1. GENERAL PRINCIPLES: REFERRAL TO TREATMENT AND DIAGNOSTIC PATHWAYS 7

1.1. INTRODUCTION 7
1.2. PURPOSE 8
1.3. ROLES AND RESPONSIBILITIES 8
1.3.1. East Lancashire Hospitals NHS Trust: 8
1.3.2. CCG & General practitioners (GPs): 9
1.3.3. The NHS Constitution recommends the following actions patients can take to help in the management of their condition: 9
1.4. COMPETENCY 9
1.5. COMPLIANCE 9
1.6. GENERAL ELECTIVE ACCESS PRINCIPLES 10
1.7. INDIVIDUAL PATIENT RIGHTS 10
1.8. PATIENT ELIGIBILITY 10
1.9. PATIENTS MOVING BETWEEN NHS AND PRIVATE CARE 11
1.10. MILITARY VETERANS 11
1.11. PRISONERS 12
1.12. SERVICE STANDARDS 12
1.13. PATHWAY MILESTONES 12
1.14. MONITORING 13
1.15. GOVERNANCE 13
1.16. REASONABLENESS 13
1.17. COMMUNICATION 14
1.18. NATIONAL REFERRAL TO TREATMENT AND DIAGNOSTIC STANDARDS 14
1.19. CLOCK STARTS 15
1.20. EXCLUSIONS 16
1.21. NEW CLOCK STARTS FOR THE SAME CONDITION: 16
1.21.1. Following active monitoring 16
1.21.2. Following a decision to start a substantively new treatment plan 16
1.21.3. For second side of a bilateral procedure 16
1.21.4. For a rebooked new outpatient appointment 16
1.23. CLOCK STOPS FOR FIRST DEFINITIVE TREATMENT 16
1.24. CLOCK STOPS FOR NON-TREATMENT 17
1.25. ACTIVE MONITORING 17
1.26. OPEN ACCESS TO APPOINTMENTS 17
1.27. FOLLOW-UP APPOINTMENTS AFTER AN ADMISSION 17
1.28. PATIENT-INITIATED DELAYS 17
1.28.1. Non-attendance of appointments/did not attend (DNAs) 17
1.28.2. First appointment DNAs 17
1.28.3. Subsequent (follow-up) appointment DNAs 18
1.28.4. Cancelling, declining or delaying appointment and admission offers 18
1.29. PATIENTS WHO ARE UNFIT FOR SURGERY 18
1.29.1. Short-term illnesses 18
1.29.2. Longer term illnesses 18

2. PATHWAY-SPECIFIC PRINCIPLES REFERRAL TO TREATMENT AND DIAGNOSTIC PATHWAYS 19

2.1. ADVICE AND GUIDANCE 19
2.2. RECEIPT OF REFERRAL LETTERS 19
2.3. METHODS OF RECEIPT 19
2.3.1. NHS e-Referrals (e-RS) 19
2.3.2. Paper-based referrals 20
2.3.3. Rejection of inappropriate Paper-based referrals 20
2.4. BOOKING NEW OUTPATIENT APPOINTMENTS 20
2.4.1. E-referral service 20
2.4.2. Paper-based referrals 21
2.4.3. Alerting Providers of Patient's Special Circumstances/Requirements 21
2.5. CLINIC ATTENDANCE AND OUTCOMES (NEW AND FOLLOW-UP CLINICS) 21
2.5.1. Patients on an open pathway 22
2.5.2. Patients already treated or with a decision not to treat 22
2.6. BOOKING FOLLOW-UP APPOINTMENTS 22
2.6.1. Patients on an open pathway 22
2.6.2. Patients not on an open pathway 22

2.6.3. Did not attends ... 22
2.7. APPOINTMENT CHANGES AND CANCELLATIONS INITIATED BY THE PATIENT. ... 23
2.7.1. Rebooking patients that attend for appointments and cannot wait to be seen ... 23
2.7.2. Reinstatement to a PTL ... 24
2.8. APPOINTMENT CHANGES INITIATED BY THE HOSPITAL ... 24

DIAGNOSTICS ... 24

2.9. DIAGNOSTIC CLASSIFICATION ... 25
2.10. PATIENTS WITH A DIAGNOSTIC AND RTT CLOCK ... 25
2.11. DIAGNOSTIC SERVICE INCLUSION CRITERIA WITHIN 18 WEEKS ... 25
2.12. DIAGNOSTIC SERVICE EXCLUSION CRITERIA FROM 18 WEEKS ... 25
2.13. MINIMUM DATA SET FOR DIAGNOSTIC REFERRALS ... 25
2.14. INTERNAL MANAGEMENT OF PATIENTS WAITING FOR DIAGNOSTIC TESTS ... 26
2.14.1. Request Management ... 26
2.14.2. Inappropriate Requests ... 26
2.15. MAKING AN OFFER FOR A DIAGNOSTIC TEST ... 26
2.15.1. Contacting patients to offer appointments for diagnostic tests ... 26
2.15.2. Verbal Offers / Short Notice ... 26
2.15.3. Written offers ... 26
2.16. HOSPITAL-INITIATED CANCELLATIONS FOR DIAGNOSTIC PATIENTS ... 26
2.17. PATIENT INITIATED DELAYS AND PATIENTS WHO DO NOT ATTEND (DNA) DIAGNOSTIC TESTS ... 27
2.18. NO LONGER REQUIRE THE APPOINTMENT ... 27
2.18.1. Patients who cancel a diagnostic appointment or are unavailable for a period of 6 weeks or more 27
2.18.2. Patients who do not attend (DNA) their mutually agreed diagnostic appointment ... 28
2.18.3. Elective Inpatient and Day Case Diagnostic Services ... 28
2.18.4. Recording Waiting Time Information after Tests ... 28
2.19. PLANNED DIAGNOSTIC APPOINTMENTS ... 28
2.20. THERAPEUTIC PROCEDURES ... 29

ADMITTED PATHWAYS ... 29

2.21. DECISION TO ADMIT ... 29
2.21.1. Adding Patients to the Inpatient/Day Case waiting list ... 29
2.21.2. Timeliness of Adding Patients to the waiting list ... 29
2.21.3. Determining Priority ... 29
2.21.4. Expediting patients ... 29
2.22. PATIENTS WHO ARE ADDED TO AN INPATIENT WAITING LIST MUST BE CLINICALLY AND SOCIALLY READY FOR ADMISSION. ... 29
2.23. MANAGEMENT OF PATIENTS WHO ARE NOT MEDICALLY OR SOCIALLY READY FOR ADMISSION ... 29
2.24. DECISION OF PRE-OPERATIVE ASSESSMENT ... 30
2.25. PRE-OPERATIVE ASSESSMENT ... 30
2.26. ACUTE THERAPY SERVICES ... 30
2.26.1. Physiotherapy ... 31
2.26.2. Surgical appliances ... 31
2.26.3. Dietetics ... 31
2.27. ELECTIVE INPATIENT AND DAY CASE ADMISSIONS, INCLUDING ENDOSCOPY ... 31
2.27.1. Contacting patients to offer admission dates ... 31
2.27.2. Verbal Offers / Short Notice / EROD ... 31
2.27.3. Written offers ... 32
2.27.4. Offers of inpatient and day case admissions ... 32
2.28. MANAGING INPATIENT/DAY CASE PATIENTS WAITING FOR TREATMENT ... 32
2.28.1. Selecting Patients for Admission ... 32
2.28.2. Evidence Based Referrals ... 32
2.28.3. Planned Patients ... 33
2.28.4. Planned follow up appointments: ... 33
2.28.5. Patients listed for bilateral procedures ... 33
2.28.6. Patients starting new or substantially different treatment ... 33
2.28.7. Patients on more than one waiting list in different specialties – *undertaken separately* ... 33
2.28.8. Patients on more than one waiting list in different specialities – undertaken together ... 34
2.28.9. Patients requiring two different procedures as part of a single pathway ... 34
2.29. HOSPITAL-INITIATED CANCELLATIONS FOR INPATIENT OR DAY CASE PATIENTS ... 34
2.29.1. Inpatient and Day Case Admissions Cancelled for Non-Clinical Reasons. ... 34
2.29.2. Hospital Cancellation on Day of Admission ... 34

2.29.3. Hospital Cancellation prior to day of Admission 35
2.29.4. Cancelling Cancer, Clinically Urgent or Patients that have already been Cancelled Under the 28 Day Rule 35
2.30. PATIENTS NOT FIT/READY FOR TREATMENT FOLLOWING DECISION TO ADMIT 35
2.30.1. Patients medically unfit for treatment 35
2.30.2. Simple condition 35
2.30.3. Complex condition 35
2.30.4. New Condition identified at Pre-Operative Assessment (POA) 36
2.30.5. Patient unfit on day of surgery or for diagnostic procedure 36
2.30.6. Pregnancy 36
2.31. PATIENT INITIATED DELAYS / DNAS AND REINSTATEMENT TO A PTL 36
2.31.1. No longer require treatment 36
2.31.2. Patients who cancel a mutually agreed admission offer or are unavailable for a period of 6 weeks or more 36
2.31.3. Patients who DNA for a mutually agreed admission or POA 37
2.31.4. Reinstatement to a PTL 37
2.32. SPECIALTIES FAILING THE 18 WEEK INCOMPLETE RTT OR 6 WEEK DIAGNOSTIC STANDARDS 37

3. CANCER SERVICES AND THE NHS CONSTITUTION 38

3.1. PRINCIPLES 38
3.2. ROLES AND RESPONSIBILITIES 38
3.2.1. Chief Executive: 38
3.2.2. Director of Operations: 38
3.2.3. Trust lead cancer clinician: 38
3.2.4. Trust cancer lead nurse: 38
3.2.5. Divisional General Manager responsible for Cancer: 38
3.2.6. Directorate managers: 38
3.2.7. Hospital consultants: 39
3.2.8. Clinical nurse specialists: 39
3.2.9. Assistant Director of Delivery & Informatics: 39
3.2.10. Directorate Manager – Cancer Services & Oncology: 39
3.2.11. 2WW office team and those designated to make 2WW outpatient appointments: 39
3.2.12. Booking clerks/medical secretaries: 39
3.2.13. MDT co-ordinators: 39
3.2.14. All staff (to whom this document applies) 39
3.3. TRAINING/COMPETENCY REQUIREMENTS 40
3.4. CANCER WAITING TIMES STANDARDS 40
3.5. CLOCK START 40
3.5.1. 2WW 40
3.5.2. 62 day 40
3.5.3. 31 day 41
3.6. CLOCK STOPS 41
3.7. SUSPECTED CANCER REFERRALS AND SYMPTOMATIC BREAST REFERRALS 41
3.8. DOWNGRADING REFERRALS FROM TWO-WEEK WAIT 42
3.9. TWO REFERRALS ON THE SAME DAY 42
3.10. SCREENING PATHWAYS 42
3.11. PATIENTS UPGRADED TO MONITORING WITHIN CANCER STANDARDS 42
3.11.1. Who can upgrade patients onto a 62-day pathway 43
3.11.2. Responsibilities 43
3.12. SUBSEQUENT TREATMENTS 43
3.13. REASONABLENESS 43
3.14. WAITING-TIME ADJUSTMENTS 43
3.14.1. Pauses 43
3.15. PATIENT CANCELLATIONS 44
3.16. PATIENT DNAS 44
3.16.1. DNA First or New Appointments 44
3.16.2. Declining of appointment 44
3.16.3. Subsequent Cancellations 44
3.16.4. Multiple cancellations 45
3.17. PATIENTS WHO ARE UNCONTACTABLE 45
3.18. PATIENTS WHO ARE UNAVAILABLE 45
3.19. DIAGNOSTICS 45
3.20. MANAGING THE TRANSFER OF PRIVATE PATIENTS 46
3.21. TERTIARY REFERRALS 46

GLOSSARY **47**
ACRONYMS **49**
APPENDIX 1: **51**
APPENDIX 2: **53**
APPENDIX 3 ..... **54**

1. General Principles: referral to treatment and diagnostic pathways

1.1. Introduction

The Trust is committed to delivering "Safe Personal and Effective" care to patients and ensuring that their needs are the heart of everything that we do. This policy:

- sets out the rules and principles under which the Trust manages elective access to outpatient appointments, diagnostics and elective inpatient or day case treatment
- gives staff clear direction on the application of the NHS constitution in relation to elective waiting times
- demonstrates how elective access rules should be applied consistently, fairly and equitably.

The Trust's elective access policy was developed following consultation with staff, clinical leads from East Lancashire Clinical Commissioning Group and Blackburn with Darwen Clinical Commissioning Group (CCGs), general practitioners, and CCG lay members. It will be reviewed and ratified at least annually or earlier if there are changes to national elective access rules or locally agreed principles.

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

The access policy is underpinned by a comprehensive suite of detailed standard operating procedures (SOPs). All clinical and non-clinical staff must ensure they comply with both the principles within this policy and the specific instructions within SOPs.

The Trust is committed to promoting and providing services which meet the needs of individuals and does not discriminate against any employee, patient or visitor.

The Trust's Values are summarised as "Safe, Personal, Effective". This document sets out guidance to follow for General Practitioners (GPs)/General Dental Practitioner's (GDPs), Trust staff and patients to help us deliver that commitment for outpatient appointments, admissions to hospital and tests.

- patients will be treated equally, according to clinical priority and regardless of whether they are for their first treatment or are on long-term follow up
- all patients will be referred by a GP/GDP, unless by agreed self-referral routes
- the management of any access plan will be consistent with the appropriate national patient quality and experience standards and the guidelines which apply to these standards
- the management of patients on access plans will be consistent and transparent, and communication with patients should be informative and clear
- patients seen in outpatients, diagnostics or admitted for treatment will be seen according to clinical priority and chronological order on the 18 week RTT pathway or when clinically appropriate for follow up – whilst acknowledging the right of the individual to agree a date to suit their personal circumstances and this could be in excess of 18 weeks
- internal consultant to consultant referrals will only be made if a patient is required to be seen urgently or as part of the same pathway of care for the same clinical condition; all other instances will be referred back to the GP with an indication that a new referral is required

- patients will only be added to a PTL if there is an expectation of treating them and they are clinically fit and ready to undertake the treatment
- patients may be referred back to their GP if they do not attend appointments or are not fit or ready for their treatment – whilst allowing for appropriate safeguarding of vulnerable patient groups

1.2. Purpose

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

The policy:

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

1.3. Roles and responsibilities

Although responsibility for achieving standards lies with the Divisional Triumvirate and ultimately the Trust board, it is the responsibility of all staff to ensure that patient access to services and a duty to maintain information systems are accountable for their accurate upkeep and is managed according to this policy.

1.3.1. East Lancashire Hospitals NHS Trust:

- will see patients in order of clinical priority
- will mutually agree with patients, or give reasonable notice, for all appointments, tests or admission dates for treatment
- will offer patients treatment within national waiting times standards, or where that is not possible, give them an opportunity to choose to go elsewhere for their treatment
- will keep both GP's and patients informed if patients do not attend for appointments or make themselves unavailable for treatment
- Divisional Triumvirate are accountable for implementing, monitoring and ensuring compliance with the policy within their divisions.
- The chief information officer is responsible for the timely production of patient tracking lists (PTLs) which support the divisions in managing waiting lists and RTT standards.
- Waiting list administrators, including clinic staff, secretaries and booking clerks, are responsible to general managers for compliance with all aspects of the Trust's elective access policy.
- Waiting list administrators for outpatients, diagnostics and elective inpatient or day care services are responsible for the day-to-day management of their lists and are supported in this function by the Directorate managers and Divisional Triumvirate who are responsible for achieving access standards.
- Directorate managers and Divisional Triumvirate are responsible for ensuring data is accurate and services are compliant with the policy.
- Directorate managers are responsible for ensuring the NHS e-referral service directory of services (DOS) is accurate and up to date.

- The information team is responsible for producing and maintaining regular reports to enable divisions to accurately manage elective pathways, and ensure compliance with this policy.

1.3.2. CCG & General practitioners (GPs):

- will refer patients into the Trust via the electronic referral system (e-RS) or if excluded via other appropriate means, in line with national and local policy.
- GPs and other referrers play a pivotal role in ensuring patients are fully informed during their consultation of the likely waiting times for a new outpatient consultation and of the need to be contactable and available when referred.
- check the patient's demographic information to ensure that this is accurate and up to date prior to the referral to the Trust
- will inform patients referred on a suspected cancer proforma of the reason for referral and the importance of attending an appointment within the next 2 weeks, so that patients will be ready, willing and able to attend if required, at the time of the referral
- CCG's are responsible for ensuring there are robust communication links for feeding back information to GPs. GPs should ensure quality referrals are submitted to the appropriate provider first time.
- In order to avoid delays and improve patient experience, will provide information about any particular requirements of patients or their carers
- will manage patients and review them as appropriate, when informed by ELHT that the patient has DNA'd their admission/appointment, is unavailable, not responded to an admission letter or not clinically fit to have their procedure and has been removed from the waiting list

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

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

1.4. Competency

- as a key part of their induction programme, all new starters to the Trust will undergo mandatory contextual elective care training applicable to their role.
- all existing staff should undergo training to update their knowledge as required.
- all staff will carry out competency tests that are clearly documented to provide evidence that they have the required level of knowledge and ability.
- this policy, along with the supporting suite of SOPs, will form the basis of contextual training programmes (refer to the elective care training strategy for more information).

1.5. Compliance

- directorate teams, specialties and staff will be performance managed against key performance indicators (KPIs) applicable to their role. Role- specific KPIs are based on the principles in this policy and specific aspects of the Trust's standard operating procedures.

- in the event of non-compliance, a resolution should initially be sought by the team, specialty or individual's line manager. The matter should then be dealt with via the Trust's disciplinary or capability procedure.

1.6. General elective access principles

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

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

1.7. Individual patient rights

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

- choice of hospital and consultant
- to begin their treatment for routine conditions following a referral into a consultant-led service, within a maximum waiting time of 18 weeks to treatment
- to be seen by a cancer specialist within a maximum of two weeks from a GP referral for urgent referrals where cancer is suspected.

If this is not possible, the NHS has to take all reasonable steps to offer a range of alternatives.

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

- if the patient chooses to wait longer
- if delaying the start of the treatment is in the best clinical interests of the patient (note that in both of these scenarios the patient's RTT clock continues to tick)
- 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. See section 1.25 for further information.

All patients are to be treated fairly and equitably regardless of race, sex, religion or sexual orientation.

1.8. Patient eligibility

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

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

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

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

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

1.9. Patients moving between NHS and private care

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

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

If a patient is transferred to an independent sector provider as part of a NHS funded ELHT agreed additional activity route, then the patient activity and RTT pathway must be recorded on the Trust's IT systems, as if they were having treatment at one of our hospitals.

Patients referred for specific treatments where there is limited evidence of clinical effectiveness, or which might be considered cosmetic can only be accepted with the prior approval of the relevant CCG. See section 2.28.2 for further information.

1.10. Military veterans

The Armed Forces Community should enjoy the same standard of, and access to, healthcare as that received by any other citizen in the area in which they live. They should retain their relative position on any NHS waiting list if moved around the UK due to being posted.

In line with the Armed Forces Covenant, published in 2015, all veterans and war pensioners should receive priority access to NHS care for any conditions related to their service, subject to the clinical needs of all patients. Under long-standing arrangements, war pensioners in England, Scotland and Wales have been given priority NHS treatment for the conditions for which they receive a war pension, subject to clinical need.

When referring a patient who they know to be a Veteran for secondary care, GPs have now been asked to consider if, in their clinical opinion, the condition may be related to the patient's military service. Where this is the case, and where the patient agrees, it should be made clear in the referral.

Where secondary care clinicians agree that a veteran's condition is likely to be Service-related, they have been asked to prioritise veterans over other patients with the same level of clinical need. Veterans will not be given priority over other patients with more urgent clinical needs. It is for the clinician in charge to determine whether a condition is related to Service and to allocate priority.

1.11. Prisoners

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

It is acknowledged that prisoners are more likely to wait longer than 18 weeks for their treatment, due to the logistics around arranging attendance at hospital appointments. If a prisoner waits longer than 18 weeks for treatment due to the prison not being able to arrange secure transport and escort, then the patient will still breach under the RTT waiting times rules.

Prisoners are a vulnerable group of patients and it is the Prison Service's responsibility to ensure transport and escort services are available in order to treat the patient in a timely manner. ELHT staff should liaise closely with the prison health care representatives to minimise delays through clear and regular communication channels and by offering a choice of appointment or admission date in line with reasonableness criteria.

1.12. Service standards

Key business processes that support access to care will have clearly defined service standards, monitored by the Trust. Compliance with each service standard will support effective and efficient service provision, and the achievement of referral to treatment standards.

Key standards for implementation include the following:

- referral receipt and registration (within 24 hours)
- referral vetting and triage (within 48 hours of registration)
- addition of urgent outpatient referrals to waiting list (within 48 hours of registration)
- addition of routine outpatient referrals to waiting list (within 5 days of registration)
- If required, patients will have their pre-operative assessment a maximum of 5 days after addition to the waiting list
- urgent diagnostic reporting (within 24 hours)
- routine diagnostic reporting (within 48 hours).

The standards above are described in greater detail in the Trust's SOPs

1.13. Pathway milestones

To achieve treatment within 18 weeks of receipt of referral, pathways should be designed with key milestones and sufficient capacity agreed with clinicians and commissioners.

For example, you could break down a surgical pathway into the milestones shown in Figure 1.

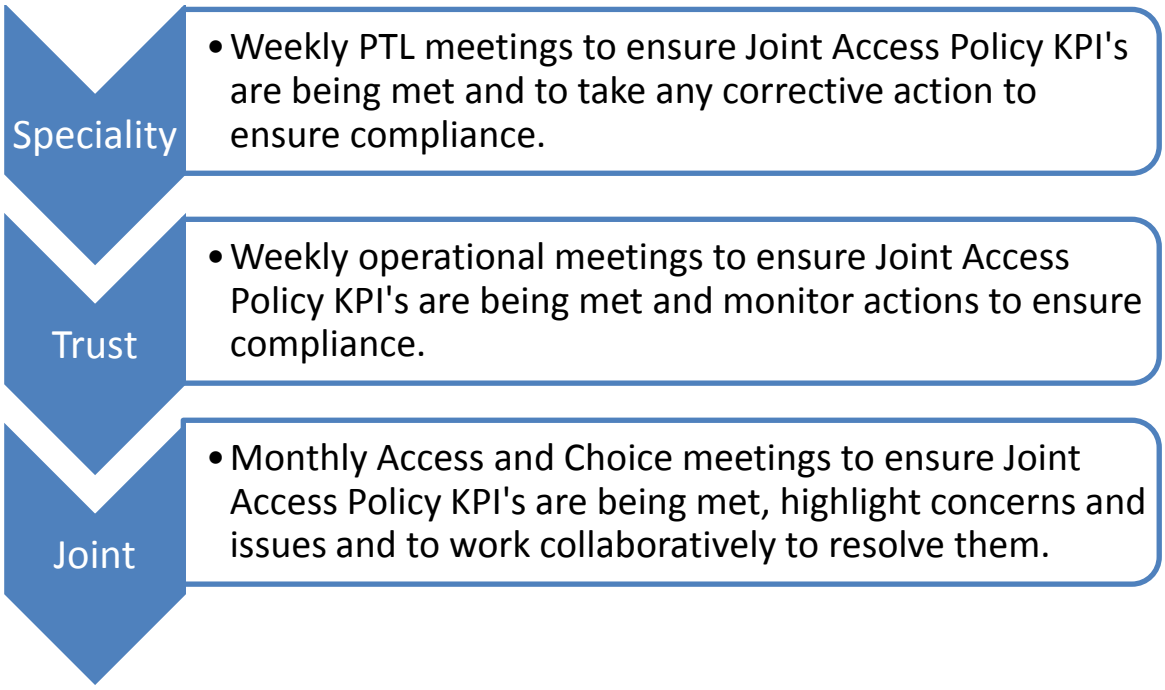
Figure 1: Key milestones on a surgical pathway

Week		1 to 4	5 to 8	9 to 10	11 to 12	13 to 18
Event	Referral	First appointment	Diagnostic Test	Listed for operation	Pre-admission appt	First definitive treatment
Wait Reason	Wait for first appointment		Wait for diagnostic test	Test reported	Wait for operation	

1.14. Monitoring

Directorate management teams will regularly and continuously monitor levels of capacity for each pathway milestone to ensure any shortfalls are addressed in advance. This will avoid poor patient experience, resource intensive administrative workarounds and, ultimately, breaches of the RTT standard.

1.15. Governance



1.16. Reasonableness

'Reasonableness' is a term applicable to all stages of the elective pathway. Reasonableness refers to specific criteria which should be adhered to when offering routine appointments and admission dates to patients to demonstrate that they have been given sufficient notice and a choice of dates. A reasonable offer is defined as a choice of two dates with at least three weeks' notice. A record of all the reasonable offers must be marked up on the Trust's IT system (or other system used by the Diagnostic Service to record their activity).

Patients of the same clinical priority will be appointed/treated in RTT chronological order, i.e. the patients who have been waiting longest will be seen first. Patients will be selected using the Trust's patient tracking lists (PTLs) only. They will not be selected from any paper-based systems.

1.17. Communication

All communications with patients and anyone else involved in the patient's care pathway (e.g. general practitioner (GP) or a person acting on the patient's behalf), whether verbal or written, must be informative, clear and concise. Copies of all correspondence with the patient must be kept in the patient's clinical notes or stored electronically for auditing purposes.

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

1.18. National referral to treatment and diagnostic standards

The NHS Constitution contains 25 rights for patients and the public, covering all aspects of care from access to services to quality of care. It also contains 14 pledges, which express ambitions to improve, going above and beyond the legal rights.

From the 1st April 2010 all patients referred for an elective care procedure are entitled to be treated within 18 weeks. The principles and definitions of the 18 week target count the referral to treatment (RTT) waiting times in totality. This was a positive step and allows the Trust to focus on delivering shorter waits and quality care for patients.

The length of time a patient needs to wait for hospital treatment is an important patient quality and experience issue and is a viable and public indicator of the efficiency of the hospital services provided by the Trust.

Referral to treatment	
Incomplete	92% of patients on an incomplete pathway (i.e. still waiting for treatment) to be waiting no more than 18 weeks (or 127 days)
Diagnostics	
Applicable to diagnostics tests	99% of patients to undergo the relevant diagnostic investigation within 5 weeks and 6 days (or 41 days) from the date of decision to refer to appointment date

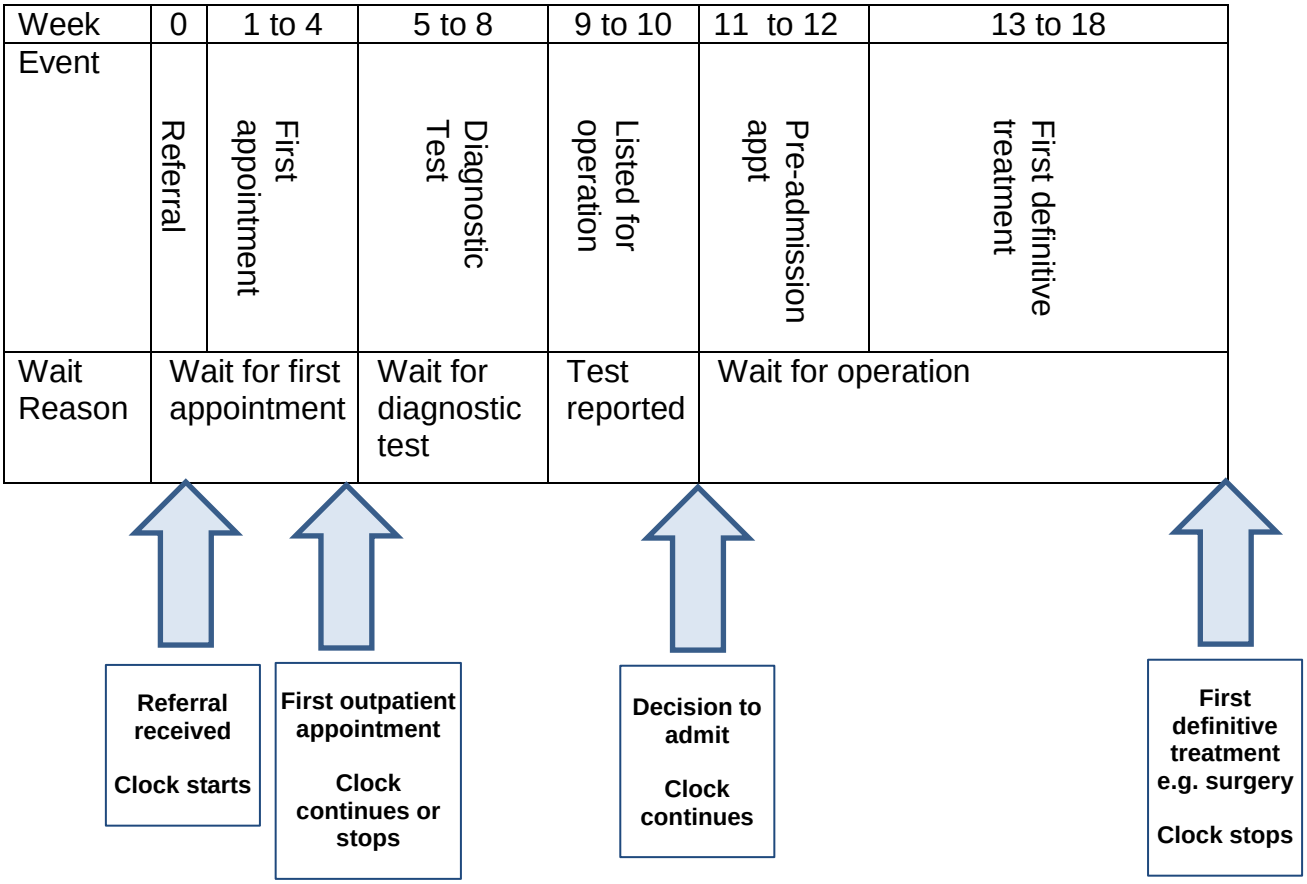
In addition to the elective care standards above, there are separate cancer standards which must be adhered to. The cancer standards are listed in the Section 3, Cancer pathways.

While the aim is to treat all elective patients within 18 weeks, the national elective access standards are set at less than 100% to allow for the following scenarios:

- **Clinical exceptions:** when it is in the patient's best clinical interest to wait more than 18 weeks for their treatment.
- **Choice:** when patients choose to extend their pathway beyond 18 weeks by declining reasonable offers of appointments, rescheduling previously agreed appointment dates/admission offers, or specifying a future date for appointment/admission.
- **Co-operation:** when patients do not attend previously agreed appointment dates or admission offers (DNA) and this prevents the Trust from treating them within 18 weeks.

Figure 2 below provides a visual representation of the chronology and key steps of a typical RTT pathway.

Figure 2: The chronology and key steps of a typical RTT pathway



1.19. Clock starts

All referrals to consultant led services should be received via NHS e-referrals (e-RS). The RTT clock starts is the earliest of the following:

- The date of the first successful appointment booking (referral)
- The date of the first defer to provider (ASI)
- The date the triage request (via Referral Assessment Service (RAS) or Clinical Assessment Services (CAS) functionality) first appeared on a Referrals For Review worklist.

A referral is received into a consultant-led service, regardless of setting, with the intention that the patient will be assessed and if appropriate, treated before clinical responsibility is transferred back to the referrer.

1.20. Exclusions

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

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

1.21. New clock starts for the same condition:

1.21.1. Following active monitoring

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

1.21.2. Following a decision to start a substantively new treatment plan

If a decision is made to start a substantively new or different treatment that does not already form part of that patient's agreed care plan this will start a new RTT pathway clock and the patient shall receive their first definitive treatment within a maximum of 18 weeks from that date.

1.21.3. For second side of a bilateral procedure

A new RTT clock should be started when a patient becomes fit and ready for the second side of a consultant-led bilateral procedure.

1.21.4. For a rebooked new outpatient appointment

See first appointment DNAs in section 1.28

1.22. Planned patients

All patients added to the planned list will be given a due date by when their planned procedure/test should take place. Where a patient requiring a planned procedure goes beyond their due date, they will be transferred to an active pathway and a new RTT clock started. The detailed process for management of planned patients is described in the relevant standard operating procedure.

1.23. Clock stops for first definitive treatment

An RTT clock stops when:

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

1.24. Clock stops for non-treatment

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

- it is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care
- a clinical decision is made not to treat
- a patient did not attend (DNA) which results in the patient being discharged
- a decision is made to start the patient on a period of active monitoring
- a patient declines treatment having been offered it.

1.25. Active monitoring

If, as part of the follow-up consultation, the Consultant in conjunction with the patient, agrees that no treatment is required at the moment and that the patient needs to be re-assessed in a set period of time in the future, then the patient is put on active monitoring and the 18 week clock stops. If the patient requires treatment when they are reviewed at the point of time in the future, a new 18 week clock can be started for the patient.

It is vital that the patient and the GP is informed and understands that they are on a period of active monitoring and that this is adequately documented on the Trust's IT system.

The use of active monitoring is not confined to follow-up stages of treatment and can be started at any point of the patient pathway, from first appointment onwards.

1.26. Open Access to Appointments

Where a patient has a long term condition that still requires infrequent monitoring by acute services, it is sometimes clinically appropriate for the patient to self-refer for a follow-up appointment when they have an exacerbation of their condition. These patients will be identified as appropriate to be placed on a "Patient Triggered Review" (PTR) PTL that specifies a clinical review date of "31/12/2099". These patients will **only** be discharged back to the care of their GP where clinically safe or as identified within the SOP.

1.27. Follow-up Appointments after an Admission

Patients who require follow-up appointments after an admission to hospital must be added to a PTL, with an appropriate indicative review date reflecting when the patient needs to be clinically reviewed. Some patients may need to be followed up by more than one Consultant or Specialty after an admission. In these instances, particular care must be used to ensure that patients are added to the required PTL's for all of the relevant follow-up appointments.

1.28. Patient-initiated delays

1.28.1. Non-attendance of appointments/did not attend (DNAs)

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

1.28.2. First appointment DNAs

The RTT clock is stopped and nullified in all cases (as long as the Trust can demonstrate the appointment was booked in line with reasonableness criteria). If the clinician indicates

another first appointment should be offered, a new RTT clock will be started on the day the new appointment is agreed with the patient.

1.28.3. Subsequent (follow-up) appointment DNAs

The RTT clock continues if the clinician indicates that a further appointment should be offered. If patients wait more than 18 weeks as a result of such delays, the 8% tolerance is in place to account for this. The RTT clock stops if the clinician indicates that it is in the patient's best clinical interests to be discharged back to their GP/referrer and they are informed in writing.

1.28.4. Cancelling, declining or delaying appointment and admission offers

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

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

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

1.29. Patients who are unfit for surgery

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

1.29.1. Short-term illnesses

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

1.29.2. Longer term illnesses

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

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

2. Pathway-specific principles referral to treatment and diagnostic pathways

2.1. Advice and Guidance

Prior to making a formal referral, GP's may choose to use the Advice and Guidance service, for example, asking another clinician/specialist for their advice on a treatment plan and/or the ongoing management of a patient or seek advice on the appropriateness of a referral for their patient. It provides a secure email service for primary care to initiate requests for specialist advice from secondary care. It also provides an audit trail of ad-hoc conversations between primary and secondary care. The use of the Advice and Guidance service does not start an 18 week pathway for patients. GPs should consider the use of the Advice and Guidance Service, where available, should they have any doubt over the need to refer a patient.

Non-admitted pathways

There are several different stages of care before a patient receives their treatment and an indicative pathway with milestones can be found in figure 2 on page 14. Not all patients will experience all of these stages.

This section of the Joint Access Policy refers to patients referred for their first or new outpatient appointment.

2.2. Receipt of referral letters

The NHS e-Referral Service (e-RS) is the preferred method of receiving referrals from GPs and Referral Management Centres (RMCs). Paper referrals to consultant led services should only be received for referrals made outside of England and for those identified and agreed on exclusion list as part of the paper switch off (PSO) programme. For referrals to other clinicians or on the exclusion list, paper based referrals will continue to be accepted and will be sent to a central point of referral and all referrers will be informed of this requirement and its location. The Trust and CCG's aspire to move to a paperless referral system. Where an inappropriate paper referral is received then this will be escalated and managed in line with the agreed protocol identified in Appendix 3.

Where clinically appropriate, referrals will be made to a service rather than a named clinician. Services have agreed clinical criteria to support triage and vetting, and patients will then be allocated to the most appropriate clinician, taking into account waiting times. Referring to services is in the best interests of patients as pooling referrals promotes equity of waiting times and allows greater flexibility in booking appointments.

2.3. Methods of receipt

2.3.1. NHS e-Referrals (e-RS)

All referrals to consultant led services should be made via the e-RS system, unless they are referred from outside of England or as jointly agreed on the exclusion list as part of the PSO programme. Each speciality service has a specified directory of service (DOS) which sets out how referrals will be managed and assessed. These DOS's will be reviewed and signed off on an annual basis to ensure the information is relevant and up to date.

GP's making a referral through e-RS will undertake this within 1 working day for all urgent referrals and 3 working days for all routine patients. All required and relevant information will be included in the referral prior to it being submitted.

Depending on the service, some patients will have their appointment directly booked on leaving the GP's surgery; however, some referrals may require a review or triage. Where a reviewed and accepted or rejected by clinical teams is required, this will be done within one working day for urgent referrals or two working days for routine referrals. Should there be a delay in reviewing e-referrals this will be escalated to the relevant clinical / management team and actions agreed to address it.

If an NHS e-Referral is received for a service not provided by the Trust, it will be rejected back to the referring GP advising that the patient needs to be referred elsewhere. This will stop the patient's RTT clock.

2.3.2. Paper-based referrals

For referrals to other clinicians or on the PSO exclusion list, paper based referrals will continue to be accepted and will be sent to the centralised booking office.

Referrals must be date stamped on receipt at the Trust. If an appropriate paper-based referral is received directly into a specialty, the specialty must date stamp the referral and forward to the centralised booking office within one working day of receipt. For patients referred by paper, the referral received date is the point that the RTT clock starts.

Once paper-based referrals have been recorded on the Trust's patient administration system (PAS) they will be directed to one of the following:

- 2WW team in central booking office for immediate booking of an appointment where the referral is suspected cancer or breast symptomatic. No vetting is required.
- A consultant or clinical team for vetting. This will be undertaken within the number of days specified locally of receipt in order for the referrals to be returned to the central booking team for booking as early as possible in patient's RTT pathway.

2.3.3. Rejection of inappropriate Paper-based referrals

Where a paper referral has been received for a consultant led services which should have been made via the e-RS system, the referring GP practice will be contacted by a member of staff from ELHT and request that it is rereferred via the e-RS. A log will be kept of these referrals to ensure that an appropriate e-RS referral is received. See appendix 3.

2.4. Booking new outpatient appointments

2.4.1. E-referral service

Patients who have been referred via e-RS should be able to choose, book and confirm their appointment before the Trust receives and accepts the referral.

If there are insufficient slots available for the selected service at the time of attempting to book (or convert their Unique Booking Reference Number UBRN), the patient will appear on the appointment slot issue (ASI) work list. The RTT clock starts from the point at which the patient attempted to book. Patients on the ASI list, where possible, should be contacted within two working days by the central booking office to agree an appointment. Where there are capacity issues and patients are unable to be contacted within two working days, this will be escalated to the Directorate manager for action to be taken and to advise the booking centre.

If a patient's appointment has been incorrectly booked on the NHS e-Referral system into the wrong service at the Trust by the referrer, the referral should be electronically re-

directed in the e-Referral system to the correct service. A confirmation letter of the appointment change will be sent to the patient. The patient's RTT clock will continue to tick from the original date when they converted their UBRN.

2.4.2. Paper-based referrals

Appointments will be booked in order of clinical priority (urgent before routine) and then in chronological order of referral received date.

Patients will be selected for booking from the Trust's patient tracking list (PTL) only.
Should the patient not make contact, the demographic details should be confirmed with the GP. Three attempts will then be made to contact the patient, one of which made in the evening. If still unsuccessful, a second 'invitation to call' letter will be sent to the patient and a copy sent to their GP.

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

Where there is insufficient capacity to offer an appointment within the required milestone, this should be escalated to the relevant Directorate manager.

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

2.4.3. Alerting Providers of Patient's Special Circumstances/Requirements

Referrals should include any information on a patient's special circumstances or requirements, for example with requesting an interpreter, transport, childcare, disabilities etc. This should be included in the "Additional Requirements" within e-RS. Should a patient have mobility issues, for example, are wheelchair bound, then this should be included on the "Advocacy" section within e-RS. This would provide Clinicians with further information when they are assessing safeguarding requirements for vulnerable patients.

2.5. Clinic attendance and outcomes (new and follow-up clinics)

Every patient, new and follow-up, whether attended or not, will have an attendance status and outcome recorded on PAS at the end of the clinic. Clinics will be fully outcomed or 'cashed up' within one working day of the clinic taking place or the next working day for clinics held out of hours and outreach clinics.

Clinic outcomes (e.g. discharge, further appointment) and the patient's updated RTT status will be recorded by clinicians on the agreed clinic outcome form (COF) and forwarded to reception staff immediately.

The completion of the COF and the recording of the outcome code on the Trust's IT system are essential for monitoring the patients' 18 week pathway. The Trust has a number of data quality checks in place where patient's outcomes and next steps are checked to ensure that patient's care is not delayed.

When they attend the clinic, patients may be on an open pathway (i.e. waiting for treatment with an RTT clock running) or they may already have had a clock stop due to receiving treatment or a decision not to treat being agreed. It is possible for patients to be

assigned any one of the following RTT statuses at the end of their outpatient attendance, depending on the clinical decisions made or treatment given/started during the consultation:

2.5.1. Patients on an open pathway

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

2.5.2. Patients already treated or with a decision not to treat

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

2.6. Booking follow-up appointments

2.6.1. Patients on an open pathway

Where possible, follow up appointments for such patients should be avoided, by discussing likely treatment plans at first outpatient appointment, and/or use of telephone/written communication where a face-to-face consultation is not clinically required. Where unavoidable, such appointments must be booked to a timeframe that permits treatment by week 18 (unless the patient choses a later date).

Follow-up appointments should be agreed with the patient prior to leaving the clinic. This provides the best opportunity for patient choice to be accommodated within the required timescale for achievement of the RTT standard. Where insufficient capacity is available, the clinic receptionist will escalate in line agreements set by the speciality.

2.6.2. Patients not on an open pathway

Patients who have already been treated or who are under active monitoring and require a follow-up appointment should be managed via the follow-ups PTL process. Before they leave the clinic, the process will be clearly explained to the patient:

- They will be added to the follow-up waiting list and will be sent an appointment closer to the indicated time.
- Up to 6 weeks before their follow up appointment, they will be sent an appointment letter detailing their follow-up appointment.
- If the appointment is not convenient then they will be invited to contact the booking centre to rearrange a more convenient time.

2.6.3. Did not attends

All did not attends (DNAs) (new and follow-up) will be reviewed by the clinician at the end of clinic in order for a clinical decision to be made regarding next steps (see page 18 for the application of RTT rules regarding DNAs). Paediatric and vulnerable patient DNAs should be managed with reference to the Trust’s safeguarding policy

2.7. Appointment changes and cancellations initiated by the patient.

If the patient has never been seen and advises they do not wish to progress their pathway, they will be removed from the relevant waiting list and a clock stop and nullification applied. The patient will be informed that their consultant and GP will be informed of this.

If the patient decides they no longer require their appointment, this is deemed as a patient cancellation and should be noted as such on the PAS system and the GP informed in writing. The RTT pathway will be stopped as the patient declined treatment, the referral and patient pathway closed.

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

If the patient requires a further appointment, this will be booked with the patient at the time of the cancellation. These patients will not have their 18 week clock stopped.

If there is a delay in booking a further appointment date because a patient has either cancelled mutually agreed appointments or is unavailable to attend over a 6 week period, then the patient should be escalated for clinical review regarding discharging them back to the care of their GP. Referral back to the GP should always be a clinical decision, based on the patient's best interest and weighing up potential harm by patients repeatedly cancelling or failing to attend appointments. The GP and patient will be informed of the discharge and the reason for removal. The 18 week clock will stop for these pathways.

When reviewing children for discharge due to unavailability over a 6 week period, the clinician will be responsible for determining that no safe guarding issues are affected before returning the child to the GP. If a decision is made to return the child to the GP, this will be treated as a child discharge and the GP and appropriate multi-disciplinary teams notified by letter. The 18 week clock will stop for these pathways.

If a patient DNAs an appointment which was not mutually agreed or communicated effectively with the patient, then a new appointment must be mutually agreed with the patient within target time. Patients' contact details and demographics must be checked. The 18 week clock continues to tick for these patients.

If within 3 weeks it is identified that patients have been recorded as DNA, when they have actually cancelled their appointment beforehand, then the policy relating to cancelled appointments should be followed.

2.7.1. Rebooking patients that attend for appointments and cannot wait to be seen

Every effort must be made to schedule patients according to agreed booking rules, so that outpatient clinics run to time and patients do not have to wait unacceptably long times to be seen.

Patients should plan to wait up to 60 minutes after their appointment time, to allow time for tests etc., as stated in clinic appointment letters.

Occasionally, due to unforeseen circumstances, clinics do run late and when this happens some patients may choose to leave before being seen. If this does occur, then the patient should ideally be rebooked there and then before they leave and at the latest

be rebooked within 48 hours. They should not be automatically discharged back to their GP. The RTT clock should not be stopped in this circumstance, but should keep ticking.

This applies equally to patients attending and leaving before being seen for new and follow-up appointments.

2.7.2. Reinstatement to a PTL

Patients who have been removed from a PTL without being treated can be reinstated in exceptional circumstances. This may be if it is felt to be clinically appropriate to do so or if it is discovered there has been an administrative error.

2.8. Appointment changes initiated by the hospital

The appropriate management of short notice appointment cancellations and reductions in capacity for patient activity is crucial for the Trust to maintain the 18 week maximum waiting time target and reduce unnecessary expenditure.

Capacity should not be reduced or cancelled unless absolutely unavoidable. Clinicians are actively encouraged to book annual leave and study leave as early as possible. Clinicians must provide 6 weeks' notice of a clinic has to be cancelled or reduced. Any short-notice requests for reductions in clinic capacity (less than 6 weeks' notice) will be subject to a "Check and Challenge" process by the Directorate Manager or nominated deputy for the service concerned to ensure no alternative cover can be found and to authorise the cancellation of the clinic. Short notice cancellations are escalated and discussed at the Trust weekly operations meeting to see how these might be prevented in the future.

It is important to remember that the 18 week clock will not be adjusted for hospital cancellations and therefore new appointment dates must be offered before the 18 week breach date.

If an agreed appointment needs to be cancelled the patient will be contacted either verbally or in writing dependent on time constraints. In either instance the patient will be offered an alternative date within the target period and the opportunity to re-arrange this if it is inconvenient. This action will be clearly recorded on PAS.

Diagnostics

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

It is important to note, however, that patients can also be referred for some diagnostic investigations directly by their GP where they might not be on an 18-week RTT pathway. This will happen where the GP has requested the test to inform future patient management decisions, i.e. have not made a referral to a consultant-led service at this time.

Diagnostic Services Access

For the purpose of this policy, a diagnostic test is defined *'as a circumscribed procedure, which provides objective information to assist the diagnosis and treatment plan for a clinical condition. It does not imply effective intervention or amelioration.'*

The statutory target for diagnostic patients is that no patient to wait more than 6 weeks for diagnostics after the test has been requested.

2.9. Diagnostic Classification

The policy describes 'diagnostic services' as a generic term that covers the tests that fall into the following categories:

- Imaging (MRI, CT, X-Ray, Ultrasound)
- Physiological Measurement (Cardiac Physiology, GI Physiology, Neurophysiology, Ophthalmic and Vision Science, Respiratory /Sleep Physiology, Urodynamics, Vascular Technology, Audiology)
- Endoscopy (Gastroscopy, Flexible Sigmoidoscopy and Colonoscopy)

2.10. Patients with a diagnostic and RTT clock

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

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

2.11. Diagnostic Service Inclusion Criteria within 18 Weeks

- 'Straight to Test' diagnostics services, where there is agreement between the local CCG and other Commissioners that if a GP is referring a patient to see a consultant for an outpatient appointment for treatment on an 18 week RTT pathway, the GP can book the patient concurrently for a diagnostic test with the hospital, so that the investigation results will be available to the Consultant Team at the time of the outpatient appointment
- Other diagnostic services that form part of the 18 Week RTT clinical pathways

2.12. Diagnostic Service Exclusion Criteria from 18 Weeks

'Direct Access' diagnostic services where there is agreement between the CCG and other Commissioners that a GP can refer a patient directly to the hospital for a diagnostic test/procedure and the GP will use the results of the test to inform decision making around the patients' continuing care. Requests to Radiology as part of the Advice and Guidance service between GP's and the Trust's imaging services are excluded from and 18 week pathway.

The range of services available to book as 'Direct Access' are listed in the Directory of Services on the NHS e-Referral Service website.

2.13. Minimum Data Set for Diagnostic Referrals

All diagnostic service requests will be managed by the ELHT diagnostic appointment teams. Commissioners shall agree a minimum set of information to be included on the diagnostics request: GP practice, Referring GP, NHS number, ethnic code, full patient demographics (including day time, evening and/or mobile telephone numbers), current drug regime, clinical question to be answered and significant past medical history, interpreter services required.

2.14. Internal Management of Patients Waiting for Diagnostic Tests

2.14.1. Request Management

Diagnostic requests will be registered and allocated to the designated the appropriate PTL within 24 hours of receipt. It is essential that the date of receipt of request is registered to ensure that correct access times can be calculated and audited.

2.14.2. Inappropriate Requests

Any inappropriate (service not provided by the hospital) or unjustified diagnostic requests (radiation standards) will be returned to the referral source with an explanation of the criteria for rejection.

2.15. Making an offer for a Diagnostic test

2.15.1. Contacting patients to offer appointments for diagnostic tests

Given the short waiting times for diagnostic tests, wherever possible, patients should be contacted by phone to agree a mutually convenient time for their appointment. Contact by phone should be attempted on at least 2 occasions and at different times of the day. If contact with the patient is not possible by telephone, then a letter should be sent to the patient inviting them to make contact to agree an appointment date

2.15.2. Verbal Offers / Short Notice

Patients should be given at least 3 weeks' notice and a choice of two separate dates as a minimum. **N.B. this does not apply to suspected cancer patients as any offer is deemed reasonable.**

Short notice offers may be preferred by some patients. These should be mutually agreed verbal offers in the following circumstances:-

- When waiting times are less than 3 weeks
- When a slot is made available due to a cancellation
- When an extra session is available at short notice

Provided that it can demonstrate that the short notice offer was mutually agreed and the patient accepted the date, then it is deemed a reasonable offer.

Short notice offers not mutually agreed are made **at risk.** If the patient does not attend, these offers are not deemed reasonable and the patient's clock will not be altered.

If the patient **rejects** a short notice offer, the patient should remain in their current position on the waiting list and should (during the same telephone call) be offered at least two dates on separate days with at least 3 weeks' notice.

All reasonable offers and patient choice must be recorded on the Trust's IT system (or other system used by the Diagnostic Service to record their activity).

2.15.3. Written offers

Written offers should only be used by exception. Any offers should be made with a minimum of 3 weeks' notice with the option for the patient to agree an alternative date if necessary.

2.16. Hospital-Initiated Cancellations for Diagnostic Patients

The appropriate management of short notice appointment cancellations and reductions in capacity for patient activity is crucial for the Trust to maintain the diagnostic 6 week and 18 week referral to treatment waiting time target and reduce unnecessary expenditure.

Capacity should not be reduced or cancelled unless absolutely unavoidable. It is important to remember that the diagnostic and 18 week clock will not be adjusted for hospital cancellations and therefore new appointment dates must be offered before the relevant breach date.

A minimum of six weeks' notice should be given for any cancellation or reduction in activity, in line with the Trust Leave Policy.

If an agreed appointment needs to be cancelled the patient will be contacted either verbally or in writing dependent on time constraints. In either instance the patient will be offered an alternative date within the target period and the opportunity to re-arrange this if it is inconvenient. This action will be clearly recorded on the Trust's IT system (or other system used by the Diagnostic Service to record their activity) as a hospital initiated cancellation to enable audit to be carried out.

2.17. Patient Initiated Delays and Patients who do Not Attend (DNA) Diagnostic Tests

2.18. No longer require the appointment

If the patient decides they no longer require their appointment for a diagnostic test and they do not want to be followed up by the referring Clinician, this is deemed as a patient cancellation and should be noted as such on the Trust's IT system (or other system used by the Diagnostic Service to record their activity). The GP and the referring Clinician must be informed in writing. The RTT pathway and 6 week diagnostic wait will be stopped as the patient declined treatment and the referral closed.

If the patient decides that they no longer want their diagnostic appointment, but that they still require follow-up with the referring Clinician, then the referring Clinician will be informed that the patient has not had the diagnostic test but requires follow-up. The patient will be removed from the diagnostic access plan which stops the clock for the diagnostic 6 week wait, but the RTT 18 week clock keeps ticking.

2.18.1. Patients who cancel a diagnostic appointment or are unavailable for a period of 6 weeks or more

Patients who cancel a diagnostic appointment should be given an alternative date at the time of cancellation within the target time. These patients will not have their 18 week clock stopped. If the diagnostic appointment was a "reasonable" offer (3 weeks' notice), then the diagnostic 6 week waiting time will stop and restart again from the date of the appointment that was cancelled.

If there is a delay in booking a further appointment date because a patient has either cancelled mutually agreed appointments or is unavailable to attend over a 6 week period, then the patient should be escalated for clinical review regarding discharging them back to the care of their GP. Referral back to the GP should always be a clinical decision, based on the patient's best interest and weighing up potential harm by patients repeatedly cancelling or failing to attend appointments. The GP and patient will be informed of the discharge and the reason for removal. The diagnostic 6 week clock will stop for this patient, but the RTT clock will keep ticking and will only stop if/when the patient is discharged back to the GP

When reviewing children for discharge due to unavailability over a 6 week period, the clinician will be responsible for determining that no safeguarding issues are affected before returning the child to the GP. If a decision is made to return the child to the GP, this will be treated as a child discharge and the GP and appropriate multi-disciplinary teams notified by letter. The 18 week clock will only stop when the patient is discharged back to the GP.

2.18.2. Patients who do not attend (DNA) their mutually agreed diagnostic appointment

These patients must be contacted for one further appointment to be arranged rather than another appointment being sent. If the patient DNAs again the patient should be sent back to the referring Clinician. The diagnostic 6 week clock will stop for these patients, but the RTT clock will keep ticking. The referring Clinician then needs to clinically review the patient within 5 working days and decide whether the patient is to be discharged back to the GP or not.

Patients can be re-appointed at the consultant/clinician's discretion and exceptions and vulnerable patient groups apply – these include:-

- babies / children up to the age of 16 years
- two week rule suspected cancer referrals
- urgent referrals
- other clinical exceptions as denoted by consultants

If a patient DNAs an appointment which was not mutually agreed or communicated effectively with the patient, then a new appointment must be mutually agreed with the patient within target time. Patients' contact details and demographics must be checked. The 18 week and diagnostic 6 week clocks continue to tick for these patients.

If within 3 weeks it is identified that patients have been recorded as DNA, when they have actually cancelled their appointment beforehand, then the policy relating to cancelled appointments should be followed.

2.18.3. Elective Inpatient and Day Case Diagnostic Services

An inpatient or day case admission for a procedure that is purely diagnostic will not stop an 18 week RTT clock. The diagnostic appointment booking teams will ensure that the booked dates and outcomes of the inpatient/day case tests are updated on the RTT 18 week patient pathway.

The above guidelines for diagnostic appointments apply equally for inpatient or day case procedures that are purely diagnostic.

2.18.4. Recording Waiting Time Information after Tests

RTT status must be recorded to capture clinical decisions made outside clinics and at all other appropriate points in the patient's journey. For example, if a Consultant reviews a patient's tests and decides the patient does not need to return to clinic for the result, then this must be communicated to the patient for the RTT clock to stop. This can be done by telephone or letter. It is essential the Medical Secretary is informed so that the RTT clock can stopped, PAS is updated, the referral closed and the GP informed.

2.19. Planned diagnostic appointments

Patients who require a diagnostic test to be carried out at a specific point in time for clinical reasons are exempt from the diagnostic clock rules and will be held on a planned

waiting list with a clinically determined due date identified. However, if the patient's wait goes beyond the due date for the test, they will be transferred to an active waiting list and a new diagnostic clock and RTT clock will be started.

2.20. Therapeutic procedures

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

Admitted Pathways

2.21. Decision to Admit

2.21.1. Adding Patients to the Inpatient/Day Case waiting list

All patients added to an inpatient or day case access plan must be recorded on the Trust's IT system to ensure full and accurate recording of our patients' data. The decision to add a patient to a PTL must be made by the Consultant, or his or her team, in conjunction with the patient. Additions to the access plan must only be recorded by authorised staff who have received appropriate training.

2.21.2. Timeliness of Adding Patients to the waiting list

Following a decision to add a patient to the access plan, the patient must be added to the access plan within 24 hrs. The date of addition to the access plan should always be the date the decision was made, not the date of the Trust's IT system entry.

2.21.3. Determining Priority

All patients who are added to the access plan must be given a clinical priority. Patients should only be classified as 'Urgent' or 'Routine'.

2.21.4. Expediting patients

GP's can request expediting of their patient's treatment. When these requests are received, Clinicians must review the clinical appropriateness of the request and advise the booking staff accordingly, as patients should not be expedited for social reasons

2.22. Patients who are added to an inpatient waiting list must be clinically and socially ready for admission.

The following information about the patient should be obtained when the decision to admit is made:

- whether the patient is socially ready for admission, or the dates of any holidays booked or other personally mitigating factors that may affect the decision to admit offer
- any special circumstances requiring longer notice than usual for admission (e.g. carer's responsibilities, transport arrangements etc.)

Patients can access more information on claiming help for transport costs and eligibility for patient transport on the NHS Choices website.

2.23. Management of Patients who are not Medically or Socially Ready for Admission

If a patient is not medically fit or socially ready for admission on the date of the decision to admit, they must not be added to an inpatient inpatient waiting list. If the patient is not

fit or available they should either be discharged to their GP or added to a follow-up waiting list to be reviewed at a set time in the future, as appropriate.

A patient may only defer for a maximum period of 6 weeks, before triggering a clinical review regarding discharge to the care of the patient's GP.

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

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

2.24. Decision of Pre-operative Assessment

All patients who require a surgical intervention will be risk stratified when listed for surgery which will indicate whether a patient requires a pre-operative assessment or not. The EMIS summary which will have been included in the GP's initial referral letter will contain relevant information on a patient's fitness for a surgical procedure. Patients who require a pre-operative assessment will either attend a pre-operative assessment on the same day as being listed in clinic or they will receive an appointment for a later date.

2.25. Pre-Operative Assessment

All patients who require a surgical intervention will complete a health screening questionnaire which will be triaged against set criteria by a Pre-Operative Assessment Nurse. GP's should include relevant information on a patient's fitness for a surgical procedure in their initial referral letter.

The set criteria include; all patients over the age of 60 who are having a General Anaesthetic and all patients having major surgery. All patients identified as having other previous medical conditions with cause for concern will have a face to face Pre-Operative Assessment.

The RTT clock continues to tick throughout this process.

2.26. 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.

2.26.1. Physiotherapy

For patients on an orthopaedic pathway referred for physiotherapy as **first definitive treatment** the RTT clock stops when the patient begins physiotherapy. For patients on an orthopaedic pathway referred for physiotherapy as **interim treatment (as surgery will definitely be required),** the RTT clock continues when the patient undergoes physiotherapy.

2.26.2. Surgical appliances

Patients on an orthopaedic pathway referred for a surgical appliance with no other form of treatment agreed. In this scenario, the fitting of the appliance constitutes first definitive treatment and therefore the RTT clock stops when this occurs.

2.26.3. 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.

2.27. Elective Inpatient and Day case admissions, Including Endoscopy

This section outlines the policy for managing elective inpatient and day care patients including Endoscopy.

2.27.1. Contacting patients to offer admission dates

Patients should be contacted by telephone to agree a mutually convenient time for their admission. Contact by telephone should be attempted on at least 2 occasions and at different times of the day. If contact with the patient is not possible by telephone, then a letter should be sent to the patient inviting them to make contact to agree an admission date.

If a patient does not return contact within 3 weeks, a letter must be sent to the patient and the GP explaining that the patient had not made contact. Their **18 week clock will stop**.

Exceptions and vulnerable patient groups apply – these include:-

- babies/children up to the age of 16 years
- two week rule suspected cancer referrals
- urgent referrals
- other clinical exceptions as denoted by consultants

Patients can be re-listed at the consultant/clinician's discretion and the clock continues to tick.

2.27.2. Verbal Offers / Short Notice / EROD

Patients should be given at least 3 weeks' notice and a choice of two separate dates as a minimum. **N.B. this does not apply to Cancer patients as any offer is deemed reasonable.**

Short notice offers may be preferred by some patients. These should be <u>mutually agreed verbal offers</u> in the following circumstances:-

- When waiting time is less than 3 weeks
- When a slot is made available due to a cancellation
- When an extra session is available at short notice.

Provided that we can demonstrate that the short notice offer was mutually agreed and the patient accepted the date, then it is deemed a reasonable offer. **A record of all the reasonable offers must be marked up on the Trust's IT system.**

Patients may be offered TCIs at any of the hospital sites and be treated by any of the Clinicians within a service.

Short notice offers not mutually agreed are made **at risk.**
If the patient does not attend, these offers are not deemed reasonable and the patient's clock will not be reset.

If the patient **rejects** a short notice offer, the patent should remain in their current position on the waiting list and should (during the same telephone call) be offered at least two dates on separate days with at least 3 weeks' notice.

If a patient declines a reasonable offer of appointment because they choose to wait for a specific Consultant or site, then this constitutes a decline of a reasonable offer.

The abolition of the admitted clock stop waiting time measure from April 2015 onwards means that Trusts are no longer able to adjust RTT waiting times when a patient declines 2 reasonable offers. This means that the EROD date (Earliest Reasonable Offer Date) is now redundant.

All offers and patient choice must be recorded on the Trust's IT system.

2.27.3. Written offers

Written offers should only be used by exception. Any offers should be made with a minimum of 3 weeks' notice with the option for the patient to agree an alternative date if necessary. If a patient cancels and rebooks their appointment the clock will not reset.

2.27.4. Offers of inpatient and day case admissions

All offers of admission and hospital or patient initiated changes to the admission date must be immediately and accurately recorded on the Trust's IT system to enable performance monitoring and audit of the 18 week / Cancer pathways.

Directorate Managers are responsible for ensuring that additional capacity is available when required to enable the offer of timely admission dates to patients.

2.28. Managing Inpatient/Day case Patients Waiting for Treatment

2.28.1. Selecting Patients for Admission

All patients waiting for treatment will be managed so that urgent patients are seen first and routine patients seen in chronological order of their 18 week breach date.

2.28.2. Evidence Based Referrals

The CCG's has a Value Based Clinical Commissioning Policy which aims to limit interventions of low clinical value. The Policy document, which has been developed across the whole of the North West, lists procedures where there is evidence that interventions are not clinically effective, procedures where there is a lack of evidence for their effectiveness, and procedures that are effective for some patients and not others. This is to assist GPs in making referral decisions. These policies are also included in contracts between commissioners and providers and will be regularly monitored by the

contracting teams. Where GPs make referrals, or providers treat patients outside the criteria and indications of the policy, there is no guarantee of payment.

More detail on Commissioning Policies is given in Appendix 2.

2.28.3. Planned Patients

Patients on an admission type “planned” access plan are outside the scope of 18 weeks. Planned procedures are part of an agreed programme of care which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency (e.g. repeat endoscopies).

When patients on planned lists are clinically ready for their care to commence and reach the date for their planned appointment, they should either receive that appointment or be transferred to an active waiting list and a waiting time clock should start (and be reported in the relevant waiting time return). The key principle is that where patients' treatment can be started immediately, then they should start treatment or be added to an active waiting list. When a patient is listed for planned treatment, they must be given a clear expectation of the timeframe for this, as required by best clinical evidence.

2.28.4. Planned follow up appointments:

The *“holding list”* is used by the Trust to manage planned follow up outpatient appointments. These are instances where a patient does not have an appointment booked for a follow up appointment at the time of their visit, but is given an indicative review date by the clinician.

The holding list aims to ensure patients are being reviewed and managed appropriately for their condition. Key to the management of this is a process to ensure that clinical teams regularly review, prioritise and plan patients to manage the risk of harm. For further information on managing a holding list, please see *ELHT’s Guidance for Managing Holding List.*

2.28.5. Patients listed for bilateral procedures

Patients will only be put on a PTL for one procedure at a time. The 18 week clock will stop when the first definitive treatment begins (i.e. when the first procedure is carried out).

When the patient becomes fit and ready to have the second of a bilateral procedure then a new clock starts. This decision may be made either immediately following the first procedure or when the patient is reviewed in outpatients.

2.28.6. Patients starting new or substantially different treatment

After receiving their first definitive treatment, a patient can have a new clock started for the same condition if they are listed for a new or substantially different treatment that was not part of the original treatment plan. This ensures that subsequent patient treatments are covered by the 18 week standard guarantee.

2.28.7. Patients on more than one waiting list in different specialties – *undertaken separately*

If the patient has been referred in for two entirely separate procedures:

- The procedure that has highest clinical priority takes precedence for scheduling purposes

- If both procedures can be carried out within similar timescales without clinically affecting each other, then the patient will be added to both waiting lists and booked according to clinical priority
- If the clinical priority procedure means that the patient will not be fit and ready for the routine procedure, the patient should be discharged back to the GP for the routine procedure, to be re-referred when fit

2.28.8. Patients on more than one waiting list in different specialities – undertaken together

If both procedures can be done at the same time, by the same surgeon, then the patient should be added to the access plan for the main procedure and the other procedures recorded as secondary procedures as part of the same episode of care.

If:-

a) surgeons from more than one specialty will be needed to carry out a single procedure
or
b) the patient will need more than one procedure done while in theatre and each procedure will be carried out by a surgeon from a different specialty

The patient should be added to the waiting list of the consultant surgeon for the main procedure, recording the other procedures in the second (and third) place.

2.28.9. Patients requiring two different procedures as part of a single pathway

If the decision to treat involves two different procedures as part of a single pathway of treatment (e.g. in T&O insertion of metal work and subsequent planned removal) then the clock stops when the first treatment starts (e.g. metal work inserted). The subsequent procedure is undertaken based on clinical need as part of the same pathway, but this will not be on an 18 week RTT pathway, as the clock has stopped ticking at metal work insertion. The subsequent procedure should be put on a planned access plan.

2.29. Hospital-Initiated Cancellations for Inpatient or Day Case Patients

The appropriate management of short notice cancellations and reductions to patient activity is crucial for the Trust to maintain the 18 week maximum waiting time target and reduce unnecessary expenditure.

Capacity should not be reduced or cancelled unless absolutely unavoidable. It is important to remember that the 18 week clock will not be adjusted for reductions/cancellations, and therefore new dates for admission must be offered before the 18 week breach date.

2.29.1. Inpatient and Day Case Admissions Cancelled for Non-Clinical Reasons.

A minimum of six weeks' notice should be given for any cancellation or reduction in activity, in line with the Trust Leave Policy.

Every effort must be made not to cancel patients for non-clinical reasons at the last minute e.g. on the day of admission or the day of surgery.

Hospital cancellation will not reset the patient's clock

2.29.2. Hospital Cancellation on Day of Admission

Any patients who have their operation cancelled on the day of admission/surgery for non-clinical reasons will be offered another binding date within a maximum of 28 days or the

Trust will fund and arrange the patient's treatment at the time and hospital of the patient's choice.

Where cancellation of patients on the day is being considered, all possible options for avoiding cancellation must be considered. If the decision is taken to cancel, a new date must be offered to the patient by the relevant waiting list staff either at the time of cancellation or within a maximum of 24 hours of the date of cancellation.

2.29.3. Hospital Cancellation prior to day of Admission

If an admission needs to be cancelled prior to the day of admission, the patient will be contacted by telephone and a new date offered.

Patients that have been previously cancelled should not be cancelled a second time.

No urgent operation should be cancelled for a second time.

2.29.4. Cancelling Cancer, Clinically Urgent or Patients that have already been Cancelled Under the 28 Day Rule

Cancellation of patients with cancer, those who are clinically urgent or those who have already been cancelled under the 28 day rule can only be authorised by the relevant Divisional General Manager or nominated deputy.

Patients in this category who have been cancelled on the day of treatment must be spoken to personally by the Theatre team leader / Consultant / Theatre Directorate manager or nominated deputy, who must also inform the Director of Operations. The cancellation will be reported on the daily SITREP return, so the Information Manager or nominated deputy must be informed. These patients must be re-admitted within 7 days of the original TCI date.

An exception report should be completed by the Directorate Management Team with a root cause analysis of why the patient was cancelled and actions to prevent further occurrences. The Trust agreed action plan template must be forwarded immediately to the Head of Operational Performance or deputy in their absence.

2.30. Patients Not Fit/Ready for Treatment Following Decision to Admit

2.30.1. Patients medically unfit for treatment

Patients may become unfit whilst on the waiting list for treatment. This may be picked up at pre-operative assessment or the patient/GP may inform the Trust that they are unwell or unfit.

2.30.2. Simple condition

If the patient informs the Trust they are temporarily unfit but would be expected to recover within 28 days (for example viral infections, cold, flu, D&V) and are unable to attend for their procedure, the patient will be offered an alternative date within the target period for when they are fit and the clock continues ticking.

2.30.3. Complex condition

If a patient becomes unfit for surgery and their condition needs to be managed in primary care (MRSA, hypertension), the patient should be discharged back to their GP and the clock will stop. When they become fit for surgery they can be referred back to the Trust via the reinstatement to a PTL procedure. A new clock will start on receipt of re-referral.

2.30.4. New Condition identified at Pre-Operative Assessment (POA)

If a new condition is picked up at POA that requires treating before surgery can go ahead, the original 18 week clock will keep ticking until the patient is discharged back to the GP as unfit, or the operation takes place. If the new condition means that the patient is not fit for surgery and needs to be managed in primary care, the patient should be discharged back to their GP. If the new condition is identified as being clinically urgent then the internal Consultant to Consultant referral process is followed.

2.30.5. Patient unfit on day of surgery or for diagnostic procedure

If a patient is cancelled by the hospital on the day of admission/diagnostic procedure due to a clinical condition, this is not a patient initiated delay. The patient will be offered an alternative date within the target period for when they are fit and the clock continues ticking. If the clinical condition is complex, the patient will be referred back to the GP.

2.30.6. Pregnancy

Patients who are unavailable for surgery due to pregnancy will be removed from the access plan and a letter sent to the GP suggesting referral when the patient is once again ready, fit and able.

2.31. Patient Initiated Delays / DNAs and Reinstatement to a PTL

2.31.1. No longer require treatment

If the patient decides they no longer require their admission, this is deemed as a patient cancellation and should be noted as such on the Trust's IT system and the GP informed in writing. The clock will be stopped as patient declined treatment and the referral closed.

2.31.2. Patients who cancel a mutually agreed admission offer or are unavailable for a period of 6 weeks or more

Patients who cancel their mutually agreed date of admission should be offered reasonable alternative dates at the time of cancellation. These patients will not have their 18 week clock stopped.

If there is a delay in booking a further TCI date because a patient has either cancelled mutually agreed dates or is unavailable to attend over a 6 week period, then the patient should be escalated for clinical review regarding discharging them back to the care of their GP.

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

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

When reviewing children for discharge due to unavailability over a 6 week period, the clinician will be responsible for determining that no safeguarding issues are affected before returning the child to the GP. If a decision is made to return the child to the GP,

this will be treated as a child discharge and the GP and appropriate multi-disciplinary teams notified by letter. The 18 week clock will stop for these pathways.

The 18 week clock will not reset if a patient cancels a TCI date. If the patient is unable to agree an alternative date at the time of cancellation the Trust will contact the patient in 7 days to agree a new date.

2.31.3. Patients who DNA for a mutually agreed admission or POA

Patients who DNA their POA appointment will be contacted and a further appointment agreed. If they DNA again, they will be returned to the responsible consultant for review.
The RTT clock continues to tick throughout this process.

Patients can be re-appointed at the consultant/clinician's discretion and exceptions and vulnerable patient groups apply – these include:-

- babies/children up to the age of 16 years
- two week rule suspected cancer referrals
- urgent referrals
- other clinical exceptions as denoted by consultants

If a child does not attend for admission or POA, their 18 week clock will continue to tick until the referral has been reviewed and assessed by the clinician. The clinician will be responsible for determining that no safe guarding issues are affected before returning the child to the GP. If a decision is made to return the child to the GP, this will be treated as a child discharge and the GP and appropriate multi-disciplinary team notified by letter. The 18 week clock will stop for this pathway.

If within 3 weeks it is identified that patients have been recorded as DNA when they have actually cancelled prior to their admission, then the policy relating to patient cancelled admissions should be followed.

2.31.4. Reinstatement to a PTL

Patients who have been removed from the access plan without being treated can be reinstated in exceptional circumstances. For example, if it is felt to be clinically appropriate to do so, or if it is discovered there has been an administrative error.

2.32. Specialties Failing the 18 Week Incomplete RTT or 6 Week Diagnostic Standards

Where a specialty has failed the RTT Incomplete standard or a service has failed the 6 week diagnostic standard, an exception report and action plan should be completed by the Directorate Management Team detailing the reasons for the failure and actions planned to ensure that the standard is met sustainably going forward. This must be forwarded immediately to the Trust RTT lead. The report and action plan will be shared with commissioners.

3. Cancer Services and the NHS Constitution

3.1. Principles

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

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

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

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

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

3.2. Roles and responsibilities

3.2.1. Chief Executive:

The chief executive has overall responsibility and accountability for delivering access standards as defined in the NHS Constitution and Operating Framework.

3.2.2. Director of Operations:

Responsible for ensuring that there are robust systems in place for the audit and management of cancer access standards against the criteria set out in this cancer access policy and procedure document.

3.2.3. Trust lead cancer clinician:

Responsible for ensuring high standards of cancer clinical care across the organisation in a timely manner, leading the development of the cancer strategy. Responsible for ensuring clinical pathways are designed to deliver treatment within 62 days of referral. Responsible for reviewing the outputs of any breach route cause analysis to develop actions to resolve any delays to patients.

3.2.4. Trust cancer lead nurse:

Responsible for development of the cancer nursing strategy with professional line management responsibility for the Trust's cancer clinical nurse specialists.

3.2.5. Divisional General Manager responsible for Cancer:

Responsible for the monitoring of performance in the delivery of the 14-day, 31-day and 62-day standards alongside all cancer screening programmes and for ensuring the clinical directorate delivers the activity required to meet the cancer waiting time standards.

3.2.6. Directorate managers:

Responsible for the monitoring of performance in the delivery of the cancer standards and for ensuring the specialties deliver the activity required to meet the waiting list standards. They are also responsible for ensuring all patients are booked within 14 days by ensuring adequate capacity is available and reviewing twice-weekly reports and

resolving any breaches. In addition to this, they are responsible for evaluating the impact of any process or service changes on 62- or 31-day pathways.

3.2.7. Hospital consultants:
Shared responsibility with their Directorate managers for managing their patients' waiting times in accordance with the maximum guaranteed waiting time.

3.2.8. Clinical nurse specialists:
Shared responsibility with their consultants and Directorate managers for managing their patients' waiting times in accordance with the maximum guaranteed waiting time.

3.2.9. Assistant Director of Delivery & Informatics:
Responsible for administering data required for managing and reporting cancer waiting times, activity and cancer outcomes. The informatics team ensures there is a robust standard operating procedure for the external reporting of performance.

3.2.10. Directorate Manager – Cancer Services & Oncology:
Responsible for monitoring delivery of key tasks by the MDT co-ordinators and the 2WW office team and for running daily audits of all 2WW referrals and highlighting:

- patients booked past 14 days.
- patients with no appointment
- any data entry issues
- producing twice-weekly reports for Directorate managers to resolve potential breaches
- Review process to move to booking patients within 7 days
- producing weekly reports showing compliance with 2WW standard in preceding week for discussion at weekly PTL meeting.

3.2.11. 2WW office team and those designated to make 2WW outpatient appointments:
Responsible for receiving 2WW and breast symptom outpatient referrals and ensuring they are managed to comply with the ELHT cancer access policy and in line with their job descriptions.

3.2.12. Booking clerks/medical secretaries:
Responsible for ensuring waiting lists are managed to comply with this policy and procedure document and in line with their job descriptions.

3.2.13. MDT co-ordinators:
Responsible for monitoring the cancer pathway for patients following the first attendance, ensuring it is managed in line with this policy and assisting in the proactive management of patient pathways on PAS and the cancer management system.

3.2.14. All staff (to whom this document applies)
All staff have a duty to comply fully with this policy document and are responsible for ensuring they attend all relevant training offered.

All staff are responsible for bringing this policy to the attention of any person not complying with it.

All staff will ensure any data created, edited, used, or recorded on the Trust's IT systems in their area of responsibility is accurate and recorded in accordance with this policy and other Trust policies relating to collection, storage and use of data to maintain the highest standards of data quality and maintain patient confidentiality.

All 2WW patient referrals, diagnostics, treatment episodes and waiting lists must be managed on the Trust's systems. All information relating to patient activity must be recorded accurately and in a timely manner.

3.3. Training/competency requirements

All staff involved in the cancer pathway will be expected to undertake initial cancer waiting times training within the first three months of appointment within the Trust. All relevant staff will have annual refresher cancer waiting times training.

3.4. Cancer waiting times standards

Table 1 outlines the key cancer waiting times standards that the Trust must comply with.

Table 1: Key cancer waiting time standards

Service standard	Operational Standard
Maximum 2WW from urgent GP referral for suspected cancer to first appointments	93%
Maximum 2WW from referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment	93%
Maximum 31 days from decision to treat to first definitive treatment	96%
Maximum 31 days from decision to treat/earliest clinically appropriate date (ECAD) to start of subsequent treatment(s) where the subsequent treatment is surgery	94%
Maximum 31 days from decision to treat/ECAD to start of subsequent treatment(s) where the subsequent treatment is drug treatment	98%
Maximum 31 days from decision to treat/ECAD to start of subsequent treatment(s) where the subsequent treatment is radiotherapy	94%
Maximum 62 days from urgent GP referral for suspected cancer to first treatment	85%
Maximum 62 days from urgent referral from an NHS cancer screening programme for suspected cancer to first treatment	90%
Maximum 62 days from consultant upgrade of urgency of a referral to first treatment	No operational standard as yet
Maximum 31 days from urgent GP referral to first treatment for acute leukaemia, testicular cancer and children's cancers	No separate standard, monitored as part of 62 days from urgent GP referral.

3.5. Clock start

3.5.1. 2WW

A two week wait clock starts at the receipt of referral.

3.5.2. 62 day

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

- urgent two-week wait referral for suspected cancer
- urgent two-week wait referral for breast symptoms (where cancer is not suspected)
- a consultant upgrade

- referral from NHS cancer screening programme
- non NHS referral (and subsequent consultant upgrade).

3.5.3. 31 day

A 31-day cancer clock will start following:

- a DTT for first definitive treatment
- a DTT for subsequent treatment
- an ECAD following a first definitive treatment for cancer.

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

3.6. Clock stops

A 62-day cancer clock will stop following:

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

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

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

A 31-day cancer clock will stop following:

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

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

In some cases where a cancer clock stops the 18-week RTT clock will continue, i.e. confirmation of a non-malignant diagnosis.

3.7. Suspected Cancer Referrals and Symptomatic Breast Referrals

All patients meeting the criteria for an urgent GP referral for suspected cancer (2 week wait) must be seen by the appropriate care professional within 14 days of the referral receipt date (this may not be a Consultant if it is more appropriate for the patient to have tests first).

All Urgent GP Referrals for Suspected Cancer will be sent via e-RS (unless on the exclusion list) and either have an appointment booked directly by their GP or will be referred into the Trust for triage.

For the Trust to achieve the required standards, GP's need to ensure:

- Referrals will be received at the hospital within 24 hours of the GP deciding to refer

- Referrals will be clearly identified as per cancer services protocols using the tumour specific proformas
- Any patient who is being referred understands the reason for referral and the importance of attending an urgent appointment within the next 2 weeks
- If the GP is aware that the patient cannot attend within 14 days or has limited avaialbility for their first appointment then they can defer the referral until the patient is available
- The patient should be given a copy of the 2 week postcard "Your Fast Track Appointment", to help them prepare for what to expect after their suspected cancer referral

Community or independent sector referrals for suspected cancer patients should be urgently referred on specific non-GP 2 week wait pro-forma, so that although the patients are not reported as 2 week wait patients, they are treated within the same timescales as GP referrals.

3.8. Downgrading referrals from two-week wait

Unless specifically agreed between the Trust and the CCG's, e.g. lung 2WW referrals, the Trust cannot downgrade 2WW referrals. If the consultant believes the referral does not meet the criteria for a 2WW referral they must contact the GP to discuss. If it is decided and agreed the referral does not meet the 2WW criteria, the GP can retract it and refer on a non 2WW referral pro forma. (It is, however, only the GP who can make this decision.)

3.9. Two referrals on the same day

If two referrals are received on the same day, both referrals must be seen within 14 days and, if two primary cancers are diagnosed, treatment for both cancers must start within 62 days of receipt of referral if clinically appropriate.

3.10. Screening pathways

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

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

3.11. Patients Upgraded to Monitoring Within Cancer Standards

Where a patient has not been referred into ELHT on a suspected cancer referral and a Clinician suspects that the patient may have cancer, the patient can be upgraded to a 62 day treatment pathway and monitored accordingly, in the same timescales as patients that were referred on a 2 week wait referral. These patients make up the "Consultant Upgrade" national cancer standard.

Patients can be upgraded to this 62 day pathway at any stage of their treatment, for example: on triaging the referral letter, after an emergency admission, after discussion at a Multi-Disciplinary Team Meeting or after receiving test results.

The 62-day pathway starts (day 0) from the date the patient is upgraded.

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

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

3.11.1. Who can upgrade patients onto a 62-day pathway

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.

3.11.2. Responsibilities

The consultant or delegated member of the team upgrading the patient is responsible for informing the MDT co-ordinator (by completing the upgrade pro forma) that an upgrade has occurred, in order for the patient to be tracked on the correct pathway.

If a patient has been upgraded to a 62-day pathway this must be communicated with the patient so they understand why they are being upgraded, and the GP should be notified by the upgrading clinician.

3.12. Subsequent treatments

If a patient requires any further treatment following their first definitive treatment for cancer (including after a period of active monitoring) they will be monitored against a 31-day subsequent treatment clock. The clock will start following the patient agreeing a treatment plan with their clinician. This will be the decision to treat (DTT) date.

In some circumstances it may be appropriate for the clinician to set an ECAD (earliest clinically available date) which is when a patient needs to recover following their first definitive treatment. An ECAD can be adjusted but only if the date has not passed. The 31 day clock start date should be the same as the ECAD date for these patients.

3.13. Reasonableness

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.

3.14. Waiting-time adjustments

Unlike RTT it is possible to make adjustments (pauses) to patient clocks in two instances. Both of these instances are included below. The Trust should make sure that these adjustments are understood by their operational teams and are defined in their processes and documentation.

3.14.1. Pauses

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

- 2WW: If a patient DNAs their initial (first) outpatient appointment or attendance at diagnostic appointment, e.g. endoscopy, the clock start date can be reset to the date the patient rebooks their appointment (the date the patient agrees the new appointment not the new appointment date).
- 62-/31-day pathways: If a patient declines admission for an inpatient or day case procedure, providing the offer of admission was 'reasonable' the clock can be paused from the date offered to the date the patient is available.

If the patient during a consultation, or at any other point, while being offered an appointment date states that they are unavailable for a set period of time (e.g. due to holiday or work commitments), a pause can be applied from the date that would have been offered to the patient to the date that they are available. This will apply to admitted treatments only (reference: *Cancer Waiting Times Guidance* version 9).

If a treatment is to be delivered in an outpatient setting such as an outpatient procedure or radiotherapy, a pause **cannot** be applied. No adjustments are permissible for medical illness.

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

3.15. Patient cancellations

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

3.16. Patient DNAs

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

3.16.1. DNA First or New Appointments

Cancer waiting time adjustments are only valid if a patient DNA's their first appointment. In this instance a cancer waiting time adjustment can be applied from the date of referral receipt to the date the patient re-books their revised appointment. The patient should not be sent back to the GP (or Health Care Professional) after the first DNA, but rebooked within 14 days of receipt of referral. If the patient DNA's twice they should be referred back to the GP (or Health Care Professional) at the consultant's discretion.

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

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

3.16.2. Declining of appointment

If the patient declines an offered appointment then an alternative date must be offered within 14 days of the referral receipt date. If the patient declines all offered appointments within 14 days then the patient will breach the cancer or breast symptomatic 2 week wait target. The dates of offered appointments should be recorded on the Trust's PAS system.

3.16.3. Subsequent Cancellations

If the patient cancels an agreed appointment / investigation date and gives prior notice that they are unable to attend, then an alternative appointment must be booked within 7 days

of the referral receipt date, as no cancer waiting time adjustments can be made for patient cancellations.

3.16.4. Multiple cancellations

All patients who are referred on a 62-day GP pathway, screening pathway or breast symptomatic referral who cancel multiple (two or more) appointments (i.e. outpatient, diagnostic investigation) will be contacted by an appropriate member of staff to identify any factors that may be stopping the patient attending. Another appointment can be offered if the patient agrees. If the patient declines the offer of another appointment or there is a clinical decision to do so, the patient will be discharged back to their GP.

3.17. Patients who are uncontactable

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

Two further attempts will be made to contact the patient by phone, one of which must be after 5.00pm.

Each of these calls must be recorded in real time on PAS. These attempted contacts must be made over a maximum two-day period.

If contact cannot be made by such routes, the GP surgery must be contacted to ask for alternative contact routes.

If the patient remains uncontactable:

- For first appointments: An appointment will be sent to the patient offering an appointment within the 2WW standard, stating the Trust has attempted to offer a choice of appointment, and that the patient should contact the 2WW office to rearrange the appointment if it is inconvenient
- Appointments (other than first) on 62-/31- day clinical pathway: Attempts to contact patient will be made as outlined above. If contact cannot be made, the consultant should decide to either or:
  – to send a 'no choice' appointment by letter

  – to discharge the patient back to the GP.

3.18. Patients who are unavailable

If a patient indicates they will be unavailable for 28 days or more on their pathway after their first appointment, the patient's healthcare records will be reviewed by the managing clinician to ascertain if the delay is safe for the patient. If the clinician has any concern over the delay they will contact the patient to discuss if they can make themselves available. Patients will not be discharged if they make themselves unavailable.

3.19. Diagnostics

Following the first appointment, either outpatient or direct to test, all subsequent investigations should be booked in accordance with agreed timed clinical pathways. All diagnostic service requests will be managed by the ELHT diagnostic appointment teams and should where appropriate be marked with a "red cross" so that they are identified as a "2 week wait".

If the patient declines an offered appointment then an alternative date must be offered within a maximum of 7 days of the declined date, due to the urgent nature of their care.

However, “reasonable” appointment offers apply equally to cancer patients, so that they have a right to an appointment with 3 weeks’ notice if they choose. If the patient declines reasonable dates offered, then by prior agreement with the consultant, the patient should be referred back to the GP or referring Health Care Professional.

If a patient DNA’s a diagnostic test, then they should be offered a further appointment within 7 days of the DNA. Patients should not be referred back to the GP or Health Care Professional after one DNA.

If the patient DNA a diagnostic test twice they should only be referred back to the GP (or Health Care Professional) with prior agreement of the consultant.

3.20. Managing the transfer of private patients

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

If a patient transfers from a private provider onto an NHS waiting list they will need to be upgraded if they have not made a DTT and the consultant wants them to be managed against the 62-day target. If a DTT has been made in a private setting the 31-day clock will start on the day the referral was received by the Trust.

3.21. Tertiary referrals

Inter provider transfer (IPT) forms will be used for all outbound referrals for patients on a cancer pathway.

Where possible, information will be transferred between Trusts electronically. Transfers will be completed via a named NHS contact.

A minimum dataset and all relevant diagnostic information will be included in any transfer referral.

Glossary

A section on glossary of terms and acronyms will need to be included for readers unfamiliar with NHS terms. The Trust will need to make sure that any cultural or local terminology is included and consistent with the descriptions (which are based on national or common understanding between Trusts).

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.
31-day pathway	The starting point for 31-day standard is the date a patient agrees a plan for their treatment or the date that an earliest clinically appropriate date (ECAD) is effected for subsequent treatments
62-day pathway	Any patient referred by a GP with a suspected cancer on a 2WW referral pro-forma, referral from a screening service, a referral from any healthcare professional if for breast symptoms or where a routine referral has been upgraded by a hospital clinician, must begin treatment within 62 days from receipt of referral
Active monitoring	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures
Active waiting list	The list of elective patients who are fit, ready and able to be seen or treated at that point in time. Applicable to any stage of the RTT pathway where patients are waiting for hospital resource reasons.
Bilateral procedures	Where a procedure is required on both the right and left sides of the body.
Breach	A pathway which ends when a patient is seen/receives their first treatment outside the 14-day first seen, 62-day referral to treatment and/or 31-day decision to treat to treatment target times.
Chronological booking	Refers to the process of booking patients for appointments, diagnostic procedures and admission in date order of their clock start date.
Consultant-led service	A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse-led clinics which come under the umbrella of consultant-led services.
Day case	Patients who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.
Decision to admit	Where a clinical decision is made to admit the patient for either day case or inpatient treatment.
Direct access	Where GPs refer patients to hospital for diagnostic tests only. These patients will not be on an open RTT pathway.
Elective care	Any pre-scheduled care which doesn't come under the scope of emergency care.
First definitive treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgement in consultation with the patient.
Fixed appointments	Where an appointment or admission date is sent in the post to the patient without the opportunity to agree a date.
Full booking	Where an appointment or admission date is agreed either with the patient at the time of the decision or within 24 hours of the decision.

Incomplete pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage.
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night
Nullified	Where the RTT clock is discounted from any reporting of RTT performance.
Oncology	The branch of science that deals with tumours and cancers.
Partial booking	Where an appointment or admission date is agreed with the patient near to the time it is due.
Patient-initiated delay	Where the patient cancels, declines offers or does not attend appointments or admission. This in itself does not the stop the RTT clock. A clinical review must always take place.
Planned waiting list	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18-week RTT pathway.
Reasonable offers	A choice of two appointment or admission dates with three weeks' notice.
Straight to test	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an RTT pathway.

Acronyms

ASIs	Appointment slot issues (list): a list of patients who have attempted to book their appointment through the national E-Referral Service but have been unable to due to lack of clinic slots.
CAS	Clinical Assessment Services, a system within the electronic referral system which allows for a clinical triage to be undertaken
CATS	Clinical assessment and treatment service
CCGs	Clinical commissioning groups: commission local services and acute care.
CNS	Clinical nurse specialists: use their knowledge of cancer and treatment to co-ordinate the patient's care plan and act as the patient's 'keyworker'.
COF	Clinic outcome form
COSD	Cancer outcomes and services dataset: the key dataset designed to define and deliver consistency in data recording, data submission and analysis across cancer in the NHS, including diagnostics, staging, treatment and demographic information. Data is submitted to the cancer registry and used for national reporting.
DNA	Did not attend: patients who give no prior notice of their non-attendance.
DTT	Decision to treat (date): the date on which the clinician communicates the treatment options to the patient and the patient agrees to a treatment.
ECAD	Earliest clinically appropriate date that it is clinically appropriate for an activity to take place. ECAD is only applicable to subsequent treatments.
EMIS	GP patient administration system
E-RS	(National) E-Referral Service
FOBT	Faecal occult blood test: part of the bowel screening pathway, checks for hidden (occult) blood in the stool (faeces).
GDP	General dental practitioner (GDP): typically leads a team of dental care professionals (DCPs) and treats a wide range of patients, from children to the elderly.
GP	General practitioner: a physician whose practice consists of providing ongoing care covering a variety of medical problems in patients of all ages, often including referral to appropriate specialists.
The cancer management system	A database system used to record all information related to patient cancer pathway by MDT co-ordinators, CNSs and clinicians.
IOG	Improving outcomes guidance: NICE guidance on the configuration of cancer services.
IPT	Inter-provider transfer
MDT meeting	A multidisciplinary team meeting where individual patients care plans are discussed and agreed.
MDS	Minimum dataset: minimum information required to be able to process a referral either into the cancer pathway or for referral out to other Trusts.
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.
MDT co-ordinator	Person with responsibility for tracking patients, liaising with clinical

	and clinical assessment unit staff to ensure progress on the cancer pathway, attending the weekly patient tracking list (PTL) meeting, updating the Trust database for cancer pathway patients and assisting with pathway reviews and changes. Also co-ordinates the MDT meeting and records the decision for progress along the cancer pathway.
NCWTDB	National cancer waiting times database: all cancer waiting times general standards are monitored through this
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.
PPID	Patient pathway identifier
PTL	Patient tracking list: a complex spreadsheet used to ensure that cancer waiting times standards are met by identifying all patients on 62-day pathways and tracking their progress towards the 62- or 31-day standards.
PTL	Patient tracking list. A tool used for monitoring, scheduling and reporting on patients on elective pathways (covering both RTT and cancer).
PTR	Patient Triggered Reviews. Patients with stable chronic conditions are not routinely reviewed but have open access to a review should their condition be exacerbated
RACPC	Rapid access chest pain clinic
RAS	Referral Assessment Service, a system within the electronic referral system which allows for a clinical triage to be undertaken
RCA	Root cause analysis: defines steps on a patient's pathway and identifies breach reasons. In the context of this policy, this is not the same as the level of investigation involved in an RCA for, for example, a Serious Incident (SI).
RMC	Referral management centre
RTT	Referral to treatment
RXR number	Trust patient identification number
SMDT	Specialist multidisciplinary team meeting: where individual patients' care plans are discussed and agreed; takes place across multiple organisations and involves support from a centre specialising in treating a particular tumour type.
TCI	To come in (date). The date of admission for an elective surgical procedure or operation.
TIA	Transient ischaemic attack: a mini stroke caused by a temporary disruption in the blood supply to part of the brain.
TSSG	Tumour site specific group
UBRN	Unique booking reference number

Appendix 1:

References and further reading

Title	Published by	Publication date	Link
Referral to treatment consultant-led waiting times Rules Suite	Department of Health	October 2015	www.gov.uk/government/uploads/system/uploads/attachment_data/file/464956/RTT_Rules_Suite_October_2015.pdf
Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care	NHS England	October 2015	www.england.NHS.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting-RTT-guidance-v24-2-PDF-703K.pdf
Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care: frequently asked questions	NHS England	October 2015	www.england.NHS.uk/statistics/wp-content/uploads/sites/2/2013/04/Accompanying-FAQs-v7.2.pdf
The NHS Constitution	Department of Health	July 2015	www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf
Diagnostics waiting times and activity Guidance on completing the 'diagnostic waiting times & activity' monthly data collection	NHS England	March 2015	www.england.NHS.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/
Diagnostics FAQs Frequently Asked Questions on completing the 'Diagnostic Waiting Times and Activity' monthly data collection	NHS England	February 2015	www.england.NHS.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and- www.england.NHS.uk/statistics/statistical-work-

			areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/
Equality Act 2010	Department of Health	June 2015	www.gov.uk/guidance/equality-act-2010-guidance
Overseas Visitor Guidance	Department of Health	April 2016	www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations
Cancer waiting times guidance Version 9 Addendum	Department of Health	October 2015 April 2018	https://digital.NHS.uk/cancer-waiting-times https://digital.nhs.uk/binaries/content/assets/website-assets/services/cancer-waiting-times/addendum-to-national-cancer-waiting-times-monitoring-data-guidance-v9.0.pdf
Delivering cancer waiting times good practice guide	NHS Improvement	July 2016	https://improvement.NHS.uk/resources/delivering-cancer-waiting-times-good-practice-guide/
Armed Forces Covenant	Ministry of Defence	July 2015	www.gov.uk/government/uploads/system/uploads/attachment_data/file/49469/the_armed_forces_covenant.pdf

Appendix 2:

Commissioning Policies


ELCCG_Com03 General Policy for IFR


ELCCG_Com04 Policy for considering applic

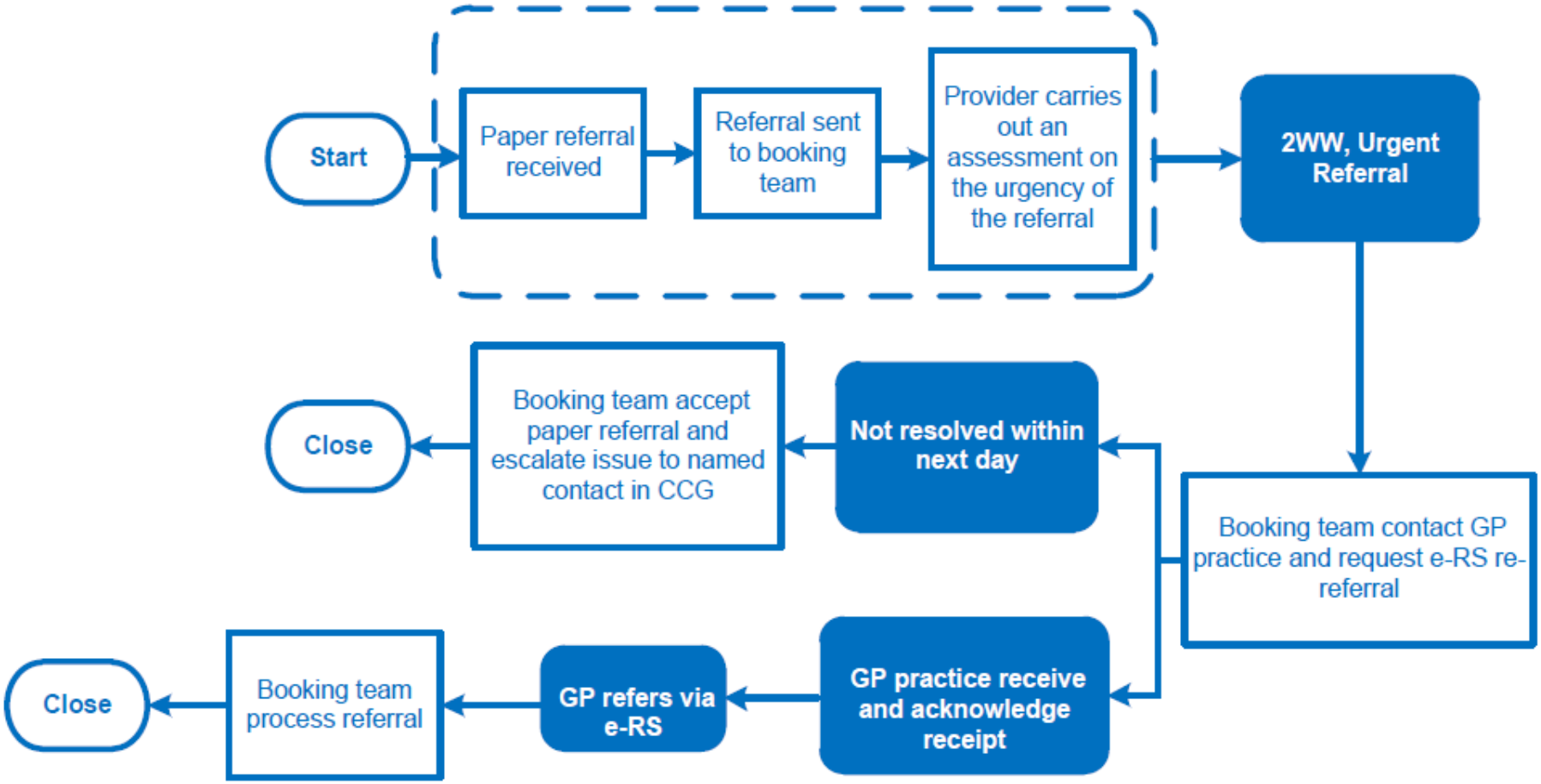

ELCCG_Com05 Policy for Commissioning He


ELCCG_Com05A Procedures and Treat

Appendix 3

From 1st June 2018

Paper return process for 2 Week Wait and Urgent Referrals



From 1st August 2018

Paper Return Process for Routine Referrals