University Hospitals of Derby and Burton
NHS Foundation Trust

TRUST POLICY FOR PATIENT ACCESS

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Version / Amendment History	**Version**	**Date**	**Author**	**Reason**
	V1.0	1 Jul 18	Roger McBroom	New issue as a result of Trust merger
	V1.1	30 May 19	Roger McBroom	Receipt of updated NHS Improvement model access policy and implementation of the NHS England Paper Switch-off Programme. Changes have been highlighted for ease of reference
	V1.2	29 Jul 19	Roger McBroom	Changes have been highlighted for ease of reference
	V1.3	16 Oct 19	Roger McBroom	New Consultant to Consultant policy.
	V1.4	24 Feb 21	Nicola Windscheffel	Routine review of policy.
	V1.5	06 May 22	Nicola Windscheffel	Updates to Patient-Initiated Delays approved at Gold for quick implementation.
	V1.6	18 Oct 22	Nicola Windscheffel	Updates to Patient-Initiated Delays & Provision of Care Across All of Our Sites.
	V1.7	18 Apr 23	Nicola Windscheffel	Definition of 2WW updated. Link to Safeguarding Adult Policy.
	V1.8	30 Nov 23	Nicola Windscheffel/Raman Chhokar	• Updates to Cancer Standards • Updates to Reasonableness • Updates to Patient Choice • Updates to Non-attendance of appointments/DNAs
Intended Recipients: All staff involved in a patient's care pathway.				
Training and Dissemination: Policy will be formally launched via trust Communique and presented to the Patient Access Group. Implementation and any training responsibilities are clearly articulated in the policy.				
To be read in conjunction with: References provided in the main body of the policy.				
In consultation with and Date: Trust Delivery Group – 1 Jun 21 Elective Care Improvement Group – 20 Apr 21 Planned Care Delivery Board – 11 Mar 21 Patient Access Group – 4 Mar 21 Medical Advisory Committee –Apr 21 via email out of committee RTT Education & Validation Team – 4 Mar 21				

Gold Command – 6 May 22 Outpatient Recovery Silver – 12 Oct 22 Lead Executive – 08 Nov 22 Lead Executive - 18 Apr 23 Lead Executive - 29 Sept 23	
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Contact for Review	Roger McBroom Head of Patient Access & Administration
Executive Lead Signature	 Andrew Hall, Interim Executive Chief Operating Officer

Contents

Introduction

This policy has been produced collaboratively with local health communities and sets out the standards for the Trust, referrers and patients by which we manage access to our services. This policy also gives Trust staff clear direction and expectations on all aspects of patient access in line with patient rights as set out in the NHS Constitution and Accessible Information Standard. The Trust will use this policy to demonstrate how rules are applied fairly and with equity in the provision of planned care. This policy should be read in conjunction with other related policies, which can be accessed via the links provided at the end of this document.

We also provide patient information publications on a range of conditions, procedures and services and these are available to patients in the respective departments and via the Trust's website.

Important points

This policy focuses on patients. It aims is to promote timely access to care, while also fully respecting patient choice regarding time and place of treatment.

It does not supersede national referral to treatment (RTT) guidance and rules in any way and we have taken every care to avoid any contradiction with national RTT rules, but if there are any ambiguities, the national rules take precedence.

Policy structure

The policy is structured as follows:

1. General principles: referral to treatment and diagnostic pathways

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

3. Cancer pathways

4. Glossary

1. General principles: referral to treatment and diagnostic pathways

Introduction and overarching principles

1.1 Introduction

The trust is committed to delivering high quality and timely elective care to patients. 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 patient access policy was developed following consultation with staff, our lead commissioner and copied to other clinical commissioning groups (ICBs) stakeholders, general practitioners and hospital clinicians. It will be reviewed and ratified at least every three years 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 induction and 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 that meet the needs of individuals and does not discriminate against any employee, patient or visitor.

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 directors and ultimately the trust board, all staff with access to and a duty to maintain elective care information systems are accountable for their accurate upkeep. For example:

- Divisional directors 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) that 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 general managers and divisional directors who are responsible for achieving access standards
- General Managers and divisional directors are responsible for ensuring data is accurate and services are compliant with the policy
- Business Unit Managers are responsible for ensuring the NHS e-referral service directory of services (DOS) is accurate and up to date
- The business intelligence team is responsible for producing and maintaining regular reports to enable divisions to accurately manage elective pathways, and ensure compliance with this policy
- General practitioners (GPs) and other referrers play a pivotal role in ensuring patients are fully informed during their consultation of the likely waiting times for a new outpatient consultation and of the need to be contactable and available when referred
- ICBs are responsible for ensuring that all patients are aware of their right to treatment at an alternative provider in the event that their RTT wait goes beyond 18 weeks
- In the event that patients' RTT waits go beyond 18 weeks, ICBs must take all reasonable steps to offer a suitable alternative provider, or if there is more than one, a range of suitable alternative providers, that would be able to see or treat patients quicker than the provider to which they were referred. A suitable alternative provider is one that can provide clinically appropriate treatment and is commissioned by a clinical commissioning group or NHS England
- The ICBs are responsible for ensuring there are robust communication links for feeding back information to GPs. GPs should ensure quality referrals are submitted to the appropriate provider first time

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

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

1.4 Staff competency and compliance

Competency

- As a key part of their local induction programme, all new starters with a role or responsibility for the management of patient pathways will undergo contextual elective care awareness training applicable to their role
- This policy, along with the supporting suite of SOPs, will form the basis of contextual training programme

Compliance

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

Validation and education

- The Trust employs a team of validation officers who validate each individual patient pathway to make sure that the pathway is correct and no clock stops have been missed. This helps to make sure that any 18 week breaches that the Trust reports to NHS England per month are genuine. The team also highlight any training issues to the RTT educators who can provide training sessions for staff on RTT rules
- The team also communicates out to the business units on a monthly basis what the top 10 validation errors are that their staff members are making which the management teams should tackle within their own areas by suggesting further training/guidance

1.5 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

1.6 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. Patients have the legal right to choose where they have their treatment. They can also choose a clinical team led by a consultant or named healthcare professional, as long as that team provides the treatment they require. This choice should always be offered at the point of referral and an opportunity to discuss the options with the person referring them should be facilitated. When a patient is referred to UHDB, they could be seen or treated at any of the trust's sites, so that a patient is waiting for the least amount of time.

- Patient choice also includes offers at independent sector and mutual aid providers within a 50-mile radius to ensure patients are waiting the least amount of time.
- 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
- Maximum two weeks from receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer to first outpatient attendance
- Maximum two weeks from receipt of referral of any patient with breast symptoms (where cancer is not suspected) to first hospital assessment

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

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

1.7 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'. Some visitors from abroad, who are not ordinarily resident, may receive free healthcare, including those who:

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

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

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

1.8 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.

From 1 October 2018, providers will only be paid for activity resulting from referrals made through the NHS e-Referral Service (e-RS).

Private Patients (PP) may be referred directly into NHS services under the following circumstances:

- Where the referring consultant is aware of local referral policies, processes and criteria and refers into NHS services adhering to the above (e.g PLCV, prior approval)
- For follow-up care, i.e. when the patient has already had treatment carried out (for example; have had a joint replacement or been prescribed medications for a condition). *These should be booked as a New appointment*
- Where there are urgent problems for which delay would be detrimental to the patients' health (in line with what would be sent as an urgent referral)
- Suspected cancer (2 week wait referrals)

NHS patients seen in a private setting (e.g. Nuffield Hospital)

Where a patient has had an initial OP appointment on the NHS in a Private setting and then needs to be referred in to this Trust to continue their treatment, the referral should be clearly marked as an NHS patient and be classed as either:

- A Consultant-to-Consultant referral if the original appointment was the Trust's activity; or
- An Inter-provider Transfer (IPT) if it wasn't this Trust's activity. An IPT form must accompany the referral

In both instances, these should be booked as a new appointment.

Referral triage and support services (e.g. MSK-CATS)

Where there is a referral triage and support service in place, applicable private patients must go through this route, rather than be directly referred into secondary care. However private consultants can refer direct in to the MSK-CATS pathway without having to refer back to the GP.

Where patients do not fit the scenarios listed above, the patient should be referred in via their own GP. When private providers/consultants send a patient back to the GP to be referred into an NHS service, they are asked to make it clear in the communication/notes back to the GP that the patient has been assessed by a private specialist and does not necessarily need to be physically seen and re-assessed by the GP - although this will remain at the discretion of the GP.

Dental & Ophthalmology

Current practice endures; those requiring a GP referral to a consultant led 1st OP appointment must go back to their GP and be referred in via eRS. All others are referred in as they are now as referrals from dentists and optometrists are excluded from eRS.

Note. From the Standard Contract Q&A:

- Are referrals from dentists and/or optometrists into first outpatient appointments covered by SC6.2A?
- No. SC6.2A affects GP referrals to consultant-led services only. Therefore SC6.2A does not apply to referrals originating from other primary care clinicians such as dentists and optometrists

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.

1.9 Commissioner-approved procedures

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

1.10 Military veterans

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. Military veterans should not need first to have applied and become eligible for a war pension before receiving priority treatment.

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

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

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 7 working days)
- 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)
- urgent diagnostic reporting (within 24 hours)
- routine diagnostic reporting (within 48 hours)

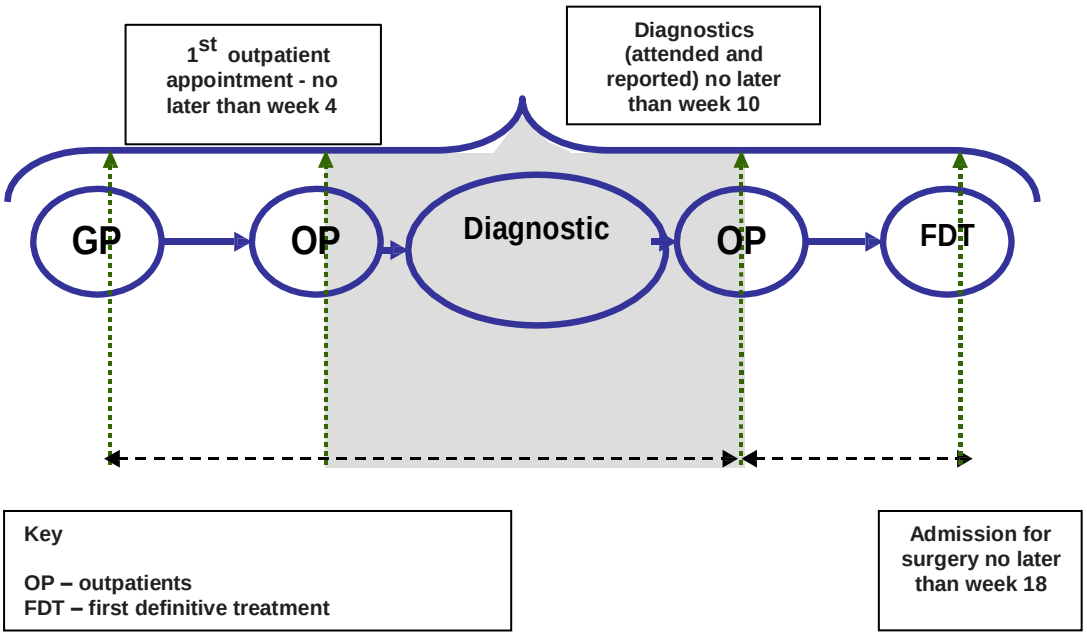
The standards above are described in greater detail in the trust's SOPs

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, a surgical pathway could be broken down into the milestones shown in Figure 1.

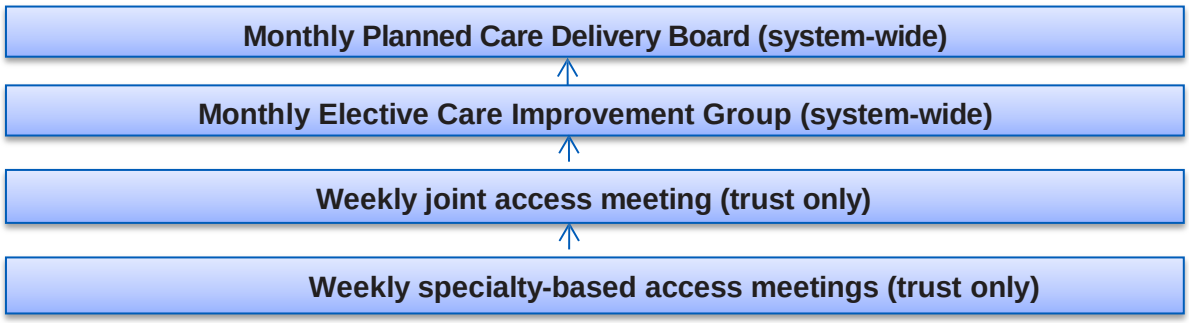
Figure 1: Key milestones on a surgical pathway



1.14 Monitoring

Operational 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 and Uncontactable Patients

'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.

Where we are attempting to contact a patient to arrange an appointment and they cannot be reached, either by telephone or letter, they should be discharged. Two attempts should be made by telephone, on different days and at different times (ideally one out of hours). If the patient still cannot be reached, a letter should be sent giving the patient three weeks' notice to make contact to book their appointment. If the patient does not make contact within those three weeks, the Trust will assume that the appointment is no longer required and the patient will be discharged and, if applicable, their clock stopped.

1.17 Chronological booking

Patients will be selected for booking appointments or admission dates according to clinical priority. Patients of the same clinical priority will be appointed/treated in RTT chronological order, i.e. those 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.

1.18 Communication

All communication 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. It should also take account of any learning

disabilities, autism or both. Staff should check the alert flags in the patient administration systems and ensure the necessary reasonable adjustments are recorded in the patient's record and staff should be prepared to act upon those alerts where necessary.

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. 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.

1.19 National referral to treatment and diagnostic standards

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 126 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 that must be adhered to. The cancer standards are listed in the Section 3. Cancer pathways.

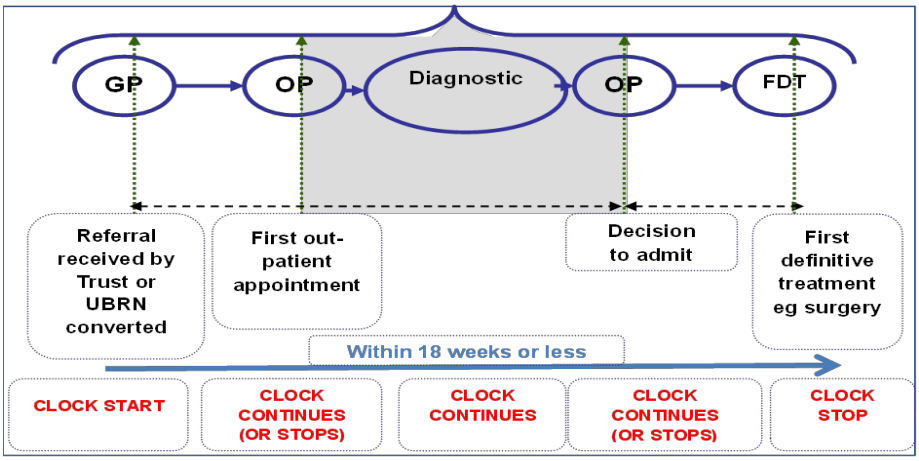
While the aim is to treat all elective patients within 18 weeks, the national elective access standards are set at less than 100% to allow for the following scenarios:

- **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

1.20 Overview of national referral to treatment rules

Figure 2 below provides a visual representation of the chronology and key steps of a typical RTT pathway that staff and patients may find helpful.

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



Key

OP – outpatients
FDT – first definitive treatment

1.21 Clock starts

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

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.

A referral is received into an interface or referral management assessment centre that may result in an onward referral to a consultant-led service before clinical responsibility is transferred back to the referrer.

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

1.22 Exclusions

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

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

1.23 New clock starts for the same condition

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).

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.

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.

For a rebooked new outpatient appointment

See first appointment DNAs.

1.24 Planned patients

All patients added to the planned list will be given a due date by when their planned procedure/test should take place.

1.25 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.

1.26 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 when:

- 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 DNAs their first new appointment. 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.
- a decision is made to start the patient on a period of active monitoring
- a patient declines treatment having been offered it

1.27 Active monitoring

Active monitoring is where a decision is made that the patient does not require any form of treatment currently, but should be monitored in secondary care. When a decision to begin a period of active monitoring is made and communicated with the patient, the RTT clock stops. Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made.

It is not appropriate to stop a clock for a period of active monitoring if some form of diagnostic or clinical intervention is required in a couple of days' time, but it is appropriate if a longer period of active monitoring is required before further action is needed. Stopping a patient's clock for a period of active monitoring requires careful consideration case by case and needs to be consistent with the patient's perception of their wait.

1.28 Non-attendance of appointments/DNAs

If a patient does not attend (DNA) or was not brought by carers, to their appointment (new or follow up) or admission once, the trust policy is to discharge patients back to their referrer, provided that it can be demonstrated that the appointment was clearly

communicated to the patient with reasonable notice. All such patients' notes must be clinically reviewed prior to discharge to ensure it is in the best interest for the patient.

Other than at first attendance, DNAs have no impact on reported waiting times. Every effort should however be made to minimise DNAs, and it is important that a clinician reviews every DNA on an individual patient basis at the end of the clinic before making any decision on whether to discharge the patient.

DNAs for first new appointment in a pathway

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

Subsequent (follow-up) appointment DNAs

The RTT clock continues if the clinician indicates that a further appointment should be offered.. 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

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. Both the patient and GP will be notified of this in writing to ensure the referring GP is aware and can action further management of the patient if necessary.

1.29 Patient-initiated delays

Cancelling, declining or delaying appointment and admission offers

Patients who choose to delay their treatment by 8-12 weeks depending on circumstances, will be subject to a review by the treating clinician and offered a patient-initiated follow-up appointment to be activated when the patient decides they are ready to continue their pathway. The clinician may decide that clinically the patient needs to remain on an active course of treatment and in this case the patient will be encouraged not to delay their treatment as they have a condition which needs to be treated urgently.

Before being removed from an active RTT pathway the patient will be given a contact number/details so when they are ready for their treatment pathway to re commence, they can contact the appropriate department to agree a suitable outpatient appointment with their treating clinician (either F2F or virtually). If the patient chooses to delay treatment and is removed from an active waiting list this will be recorded electronically in the patient's record.

When a patient has initiated a follow-up appointment because they are ready for treatment, the clinician will see the patient and decide what further treatment is required and what the clinical priority of the patient's condition is. This will be agreed with the patient and may require further review before the patient is ready to be listed for a procedure (e.g., if the

patient is required to lose weight or stop smoking etc.). The patient will then be placed back onto an active waiting list and their waiting time prioritised according to their clinical need.

Patients who decline two reasonable offers of treatment dates will be reviewed by their treating clinician and a decision made to refer the patient back to their GP or continue a treatment pathway if deemed the patient requires urgent treatment.

Managing patients who choose to delay treatment whilst on an RTT pathway

1. Patient informs the Trust that they are not ready to come in for their treatment within the next 12 weeks.
2. The patient is discussed with the treating clinician and a decision made to remove patient from an active RTT pathway.
3. Patient is given added to patient choice delay review list with a due date of 12 months, and the contact number to call back within 12 months when they are ready to recommence on their pathway.

4. This is recorded in the patient recorded and flagged on the BIP RTT Long waiter report
5. The patient contacts us as they are ready to continue their pathway
6. The patients is booked for a F2F or virtual outpatient appointment -the appointment is booked within 6 weeks of the patient making contact
7. The patient is reviewed, and a decision made to continue with treatment. If it is deemed not appropriate to continue with treatment alternative arrangements will be made to continue their care
8. The patient clock is reset from that point, and the patient is placed on the waiting list in order of their clinical priority - P2/P3/P4

Where a patient doesn't make contact within 12 months, all attempts will be made to follow this up and validate whether surgery is still required. A copy of the letter will be sent to the GP.

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, for admission offers, clinical support staff will inform clinicians 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.

1.30 Patients who are unfit for surgery

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

Short-term illnesses

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

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 in the event via the application of active monitoring)

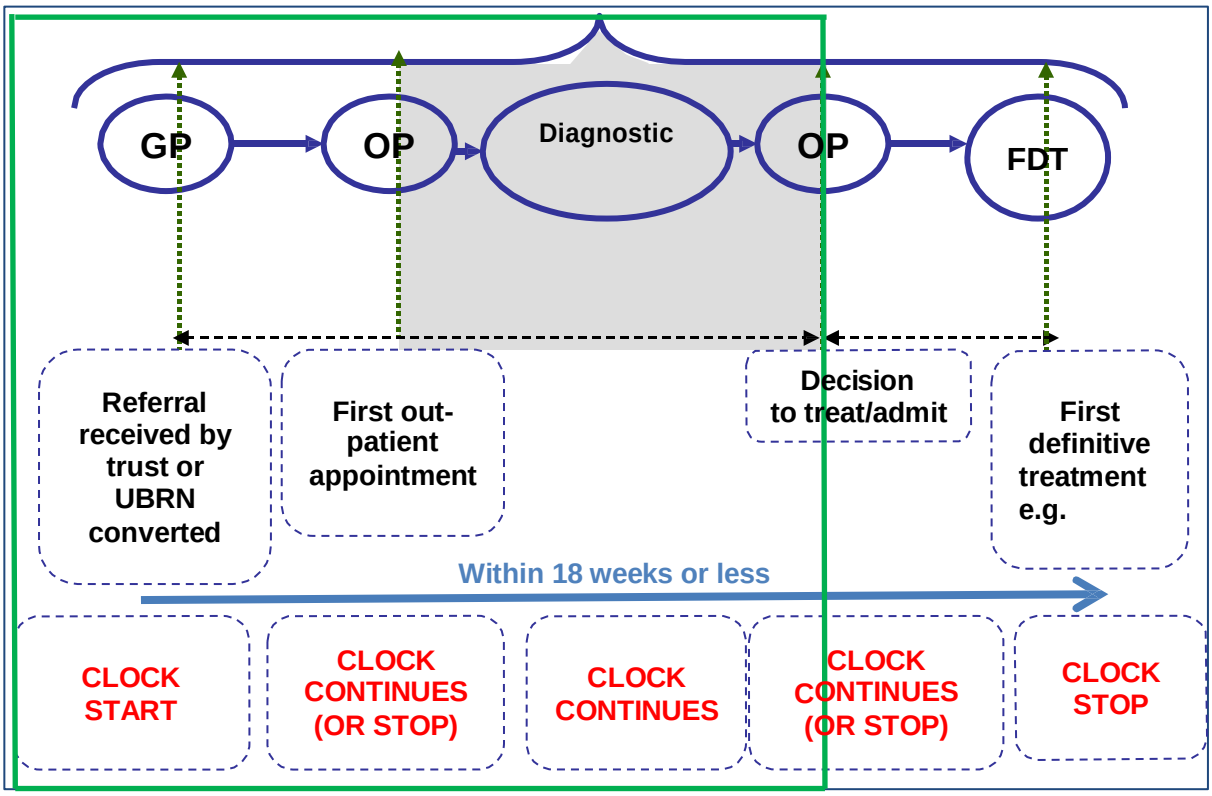
- If the patient should be optimised/treated within the secondary care (active monitoring clock stop) or if they should be discharge back to the care of their GP (clock stop)

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

Non-admitted pathways

The non-admitted stages of the patient pathway (see Figure 3) comprise both outpatients and the diagnostic stages, as highlighted by the section with the green border around it in the diagram below. It starts from the clock start date (i.e. the date the referral is received) and ends when either a clock stop happens in outpatients (this could be the first, second or a further appointment) or when a decision to admit is made and the patient transfers to the admitted pathway.

Figure 3: Non-admitted stages of the patient pathway



Key

OP – outpatients
FDT – first definitive treatment

2.1 Receipt of referral letters

Less for those services on the published exceptions list, the NHS e-Referral Service (e-RS) is the only method of receiving referrals from GPs and Referral Management Centres (RMCs) to 1st consultant-led outpatient appointments. Any remaining paper-based referrals will be sent to a central point of referral and all referrers will be informed of this requirement and its location.

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.

2.2 Methods of receipt

NHS e-referrals

From 1 October 2018, all referrals from GPs to first consultant led outpatient appointment, should be made electronically through the national e-Referral Service (e-RS) as the trust will no longer be paid for activity which results from GP referrals made other than through e-RS less those services listed on the exclusions list available on our website.

All NHS e-referrals must be reviewed and accepted or rejected by clinical teams within 7 working days.

Where there is a delay in reviewing e-referrals this is to 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.

Paper-based referrals

All routine and urgent referral letters should be sent to the relevant referral team.

Referrals must be date stamped on receipt at the trust. If a paper-based referral is received directly into a specialty, the specialty must date stamp the referral and forward to the relevant registration team within one working day of receipt without consultant triage. All referrals should be received and graded within 7 working days. 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 patient administration system (PAS), a consultant or clinical team should vet them. This will be undertaken within 7 working days of receipt in order for the referrals to be returned to the relevant referral management team for booking as early as possible in the patient's RTT pathway.

2.3 Referral types

Local SOPs will detail any unique referral types or services that may have differing processes.

Consultant-to-consultant referrals

Consultant-to-consultant referrals must follow these guidelines as agreed locally with commissioners. Situations in which Consultant to Consultant referral would be appropriate:

- Further investigation of the referral complaint. Cases where further investigation of the presenting signs and symptoms is considered necessary in order to commence treatment but where these further investigations could not be conducted by either the GP or the first consultant
- Very specialised treatment in Tertiary referral
- Cross speciality referrals related to the original condition, such as where cross-speciality referral is part of a recognised pathway, for example: a patient referred by a cardiologist for cardiac surgery; a mastectomy patient requiring breast reconstruction
- Urgent problems for which delay would be detrimental to the patient health.
- Confirmed or suspected cancer
- Patients in whom the anaesthetist has identified during their pre-operative work up a condition that needs further specialist investigation prior to their surgery being undertaken and these investigations or treatment are not appropriate to be undertaken in Primary Care
- Pre-operative assessments, including in other specialities such as cardiology
- Within a multi-disciplinary team, which should not be recorded as a new outpatient appointment but as a follow up appointment
- Referrals within a specialty for the same condition

GPs are asked to provide comprehensive information in the referral letter and refer to a specialty, rather than a specific consultant, as far as possible.

Staff who screen the referrals are asked to ensure that referrals are directed to the appropriate specialist.

Any patient referred onto a consultant to consultant referral must be initiated and carried out only by a consultant or senior doctor.

Where a referral from one consultant to another is considered to be the required action, this decision must be taken or authorised by the consultant only, rather than a member of his/her team. The patient's GP must be informed of the referral via a copy of the consultant referral letter.

Where a patient has had an initial NHS outpatient appointment in a private setting and then needs to be onward referred back to a NHS site to continue their treatment the referral should be clearly marked as 'NHS Patient'.

Inter-provider transfers (IPTs)

Across our organisation, clinical teams work across all of our sites. As such, it is necessary that sometimes patients need to be offered services on differing hospital sites or with a different clinician within the team. This is often because of access times, or availability of particular equipment, space, or people. Not all services are available on all sites, and some sites or clinicians would have longer waiting times unless we use what we have flexibly. The Trust therefore offers services to patients on the basis that they should be available to attend any Trust site and any suitable clinician. This helps to reduce waiting times and helps patients overall

- Incoming IPTs - from other Trusts

All IPT referrals should be received electronically via the trust's secure generic NHS net email account in the relevant referral management office.

The trust expects an accompanying minimum data set pro-forma with the IPT form, detailing the patient's current RTT status (the trust will inherit any RTT wait already incurred at the referring trust if they have not yet been treated) and if the patient has been referred for a new treatment plan for the same condition (where a new RTT clock will start upon receipt at this trust). The patient's pathway identifier (PPID) should also be provided. If the IPT is for a diagnostic test only, the referring trust retains responsibility for the RTT pathway.

If any of the above information is missing, the referral should be recorded on PAS and the information actively chased by the central booking office.

- Incoming IPTs - intra-Trust

Refer to the Sending Inter-provider Transfers SOP on the Trust intranet

- Outgoing IPTs

The trust will ensure that outgoing IPTs are processed as quickly as possible to avoid any unnecessary delays in the patient's pathway.

An accompanying MDS pro forma will be sent with the IPT, detailing the patient's current RTT status (the receiving trust will inherit any RTT wait already incurred if the patient has not yet been treated). If the patient has been referred for a new treatment plan for the same condition, a new RTT clock will start on receipt at the receiving trust. The patient's PPID will also be provided.

If the outgoing IPT is for a diagnostic test only, this trust retains responsibility for the RTT pathway.

Referrals and the accompanying MDS will be emailed securely from the specialty NHS net account to the generic central booking office NHS account. The central booking office will verify (and correct if necessary) the correct RTT status for the patient. If the patient has not yet been treated, the RTT clock will be nullified at this trust. They will then forward to the receiving trust within one working day of receipt into the generic email inbox

2.4 Booking new outpatient appointments

This section describes how patients are booked into appointments through the e- referral service and paper-based referrals.

E- referral service (e-RS)

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 attempts to convert their unique booking reference number in to an appointment. Patients on the ASI list must be contacted within 10 working days by the central booking office to agree an appointment.

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.

Paper-based referrals

For those referrals that cannot be booked via e-RS (that meet the published exclusions criteria), 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.

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

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

This section covers procedures for clinic attendance and outcomes.

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 outcome'd or 'cashed up' within one working day of the clinic taking place.

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

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:

Patients on an active pathway

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

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

2.6 Booking follow-up appointments

This section describes how the trust will book follow-up appointments.

Patients on an active 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 plans 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 with local arrangements to obtain authorisation to overbook.

Patients on an inactive pathway

Patients who have already been treated or who are under active monitoring and require a follow-up appointment should be managed via the partial booking of follow-ups (PBFU) process. Before they leave the clinic, the process will be clearly explained to the patient. If a patient is on PBFU and they have not requested to be seen or attended within 6 months they then they should be discharged and, if their condition deteriorates, they should be re-referred. In principle, open appointments should be set at 6 months in order to maximise capacity for new patient appointments.

DNAs

All 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, which could include offering a further appointment or discharging back to their GP for re-referral (see page 18 for the application of RTT rules regarding DNAs). When being reviewed by the clinician they should also consider safeguarding issues / concerns in the safeguarding adult policy. If the patient is discharged, the clinician should write to the GP and patient informing them of the decision. 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 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 a DNA.

If the patient is on an active RTT pathway, the clock continues to tick. If there are insufficient appointment slots within the agreed pathway milestones, the issue must be escalated to the relevant speciality management team.

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.

A patient who cancels their first outpatient, inpatient or any follow-up appointment may be offered a further appointment. If the patient cancels a second time, they may be referred back to the care of their GP. If as a result of the patient cancelling, a delay is incurred which is equal to or greater than a clinically unsafe period of delay (as indicated in advance by consultants for each specialty), the patient's pathway should be reviewed by their consultant. Upon clinical review, the patient's consultant should indicate one of the following:

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

Appointment changes initiated by the hospital

This section covers hospital initiated delays and processes to minimise the chance of such delays occurring.

- Hospital-initiated changes to appointments will be avoided as far as possible as they are poor practice and cause inconvenience to patients
- Clinicians are actively encouraged to book annual leave and study leave as early as possible. Clinicians must provide a minimum of 6 weeks' notice, but ideally longer, if a clinic has to be cancelled or reduced

- Patients will be contacted immediately if the need for the cancellation is identified, and offered an alternative date(s) that will allow patients on active RTT pathways to be treated within 18 weeks. Equally, this will allow patients not on active pathways to be reviewed as near to the clinically agreed timeframe as possible

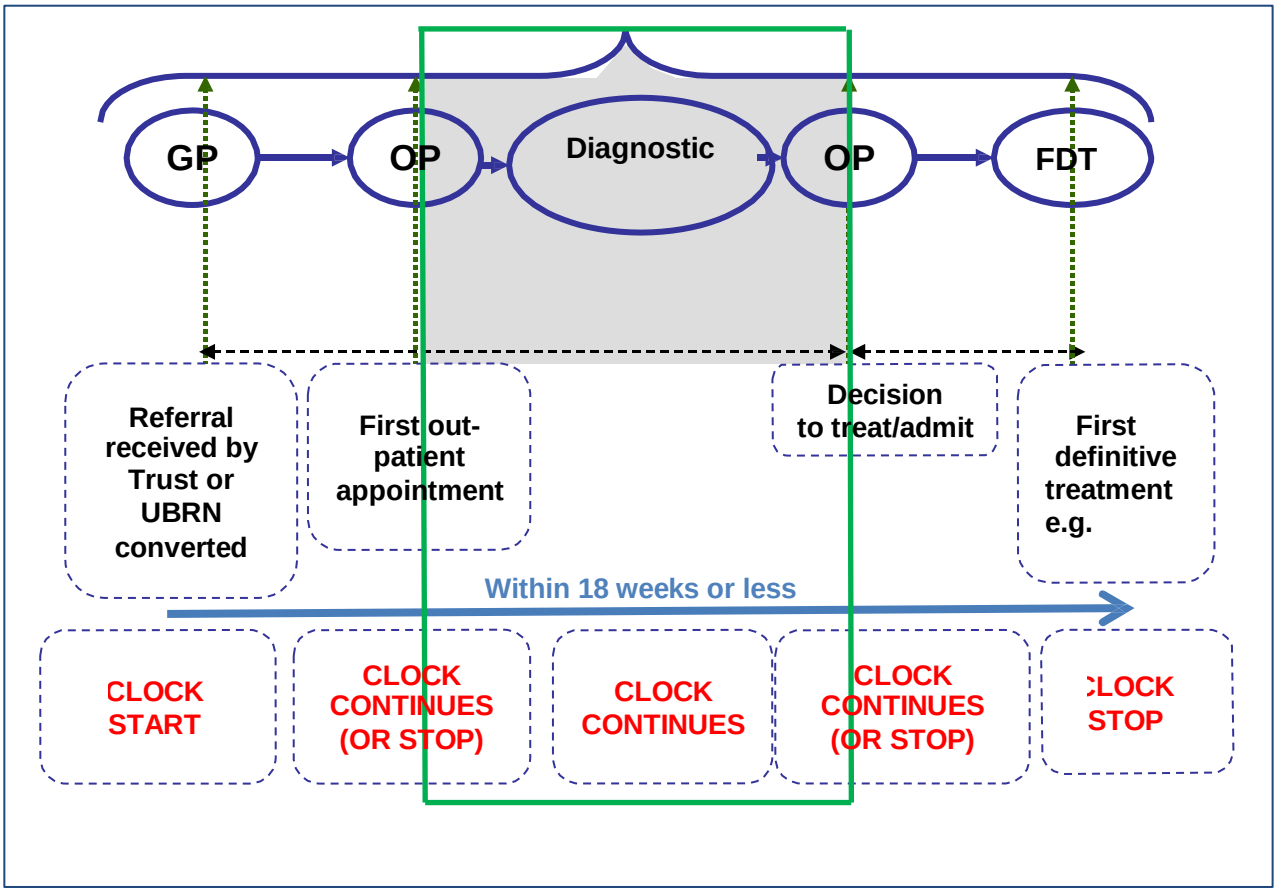
2.8 Diagnostics

This section provides an introduction to the diagnostic phase of the patient pathway.

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

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. has not made a referral to a consultant-led service at this time.

Figure 4: Diagnostic phase of the patient pathway



Key
OP – outpatients FDT – first definitive treatment

2.9 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 that starts at the point of the decision to refer for diagnostic test (often at the first outpatient consultation)

The nationally defined KPI measures how many patients are currently waiting within and over 6 weeks for a range of 15 key diagnostic tests where the prime intention is for a diagnostic procedure rather than therapeutic. The target is that 99% of patients should be waiting under 6 weeks.

2.10 Straight-to-test arrangements

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

2.11 Patients with a diagnostic clock only

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

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

2.12 National diagnostic clock rules

Diagnostic clock rules are as follows:

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

2.13 Booking diagnostic appointments

Wherever possible, diagnostic appointments will be booked directly with patients at the point that the decision to refer for a test was made (e.g. the patient should be asked to contact the diagnostic department by phone or face-to-face to make the booking before leaving the hospital).

If a patient declines, cancels or DNAs a diagnostic appointment, the diagnostic clock start can be reset to the date the patient provides notification of this. However:

- The trust must be able to demonstrate that the patient's original diagnostic appointment fulfilled the reasonableness criteria for the clock start to be reset
- Resetting the diagnostic clock start has no effect on the patient's RTT clock. This continues to tick from the original clock start date

2.14 Diagnostic cancellations, declines and/or DNAs for patients on open RTT pathways

Where a patient has cancelled, declined and/or DNAd their diagnostic appointment and a clinical decision is made to return them to the referring consultant, the RTT clock should continue to tick. Only the referring consultant can make a clinical decision to stop the RTT clock, if this is deemed to be in the patient's best clinical interests, by discharging the patient or agreeing a period of active monitoring.

2.15 Active diagnostic waiting list

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

2.16 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.

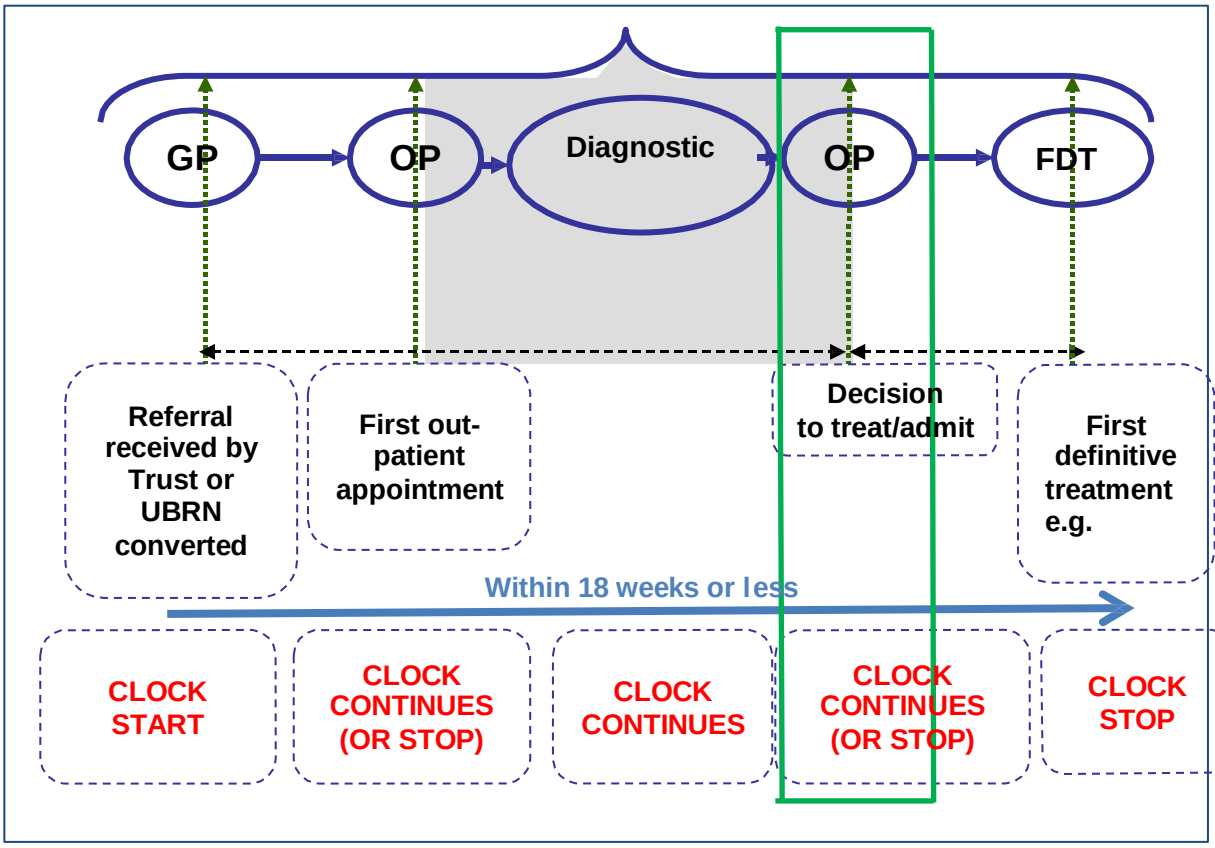
2.17 Therapeutic procedures

Where a 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.

2.18 Pre-operative assessment (POA)

Stages in the pre-operative assessment are demonstrated in Figure 5 below.

Figure 5: Stages in POA



Key

OP – outpatients
FDT – first definitive treatment

Patients with a decision to admit (DTA) requiring a general anaesthetic may attend a POA clinic on the same day as the decision to admit to assess their fitness for surgery. The vast majority of patients can be assessed by the trust's dedicated POA nurse specialists.

Where necessary, patients may be made aware in advance of their outpatient appointment that they may need stay longer on the day of their appointment for attendance in POA.

For patients with complex health issues requiring a POA appointment with a clinician, the trust will aim to agree this date with the patient before they leave the clinic. The trust will aim to agree an appointment no later than seven working days from the decision to admit. 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. The RTT clock continues to tick throughout this process.

For those patients who require a Covid 19 test before their procedure, as is currently required where having Covid 19 and undergoing an operation at the same time may lead to a worse outcome, and they refuse to undergo this test, then the Trust reserves the right to decide not to proceed with their treatment until such a time as it is deemed safe to do so without a Covid 19 test beforehand; this may not be until national requirements on the hospital are lifted or their case becomes clinically urgent enough to require emergency

treatment. This is to ensure that the trust maintains a “Covid-safe” environment for all other patients and staff.

If a patient is identified as unfit for their procedure, the nature and duration of the clinical issue should be ascertained. If the clinical issue is short-term and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold, UTI), the RTT clock continues.

However, if the clinical issue is more serious and the patient requires optimisation and/treatment, clinicians should indicate to administration staff if it is clinically appropriate for the patient to be removed from the waiting list, and if so whether the patient should be:

- optimised/treated within secondary care (active monitoring clock stop for existing pathway and potentially new clock start for optimisation treatment)
- discharged back to the care of their GP (clock stop – discharge)

When the patient becomes fit and ready to be treated for the original condition, a new RTT clock would start on the day this decision is made and communicated to the patient.

2.19 Acute therapy services

This section offers information on the management of clock start events following referral to acute therapy services. The section below provides details on typical acute therapy services.

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

- 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 active pathway and if the referral to them is intended as first definitive treatment.

2.20 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.

2.21 Surgical appliances

For 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.

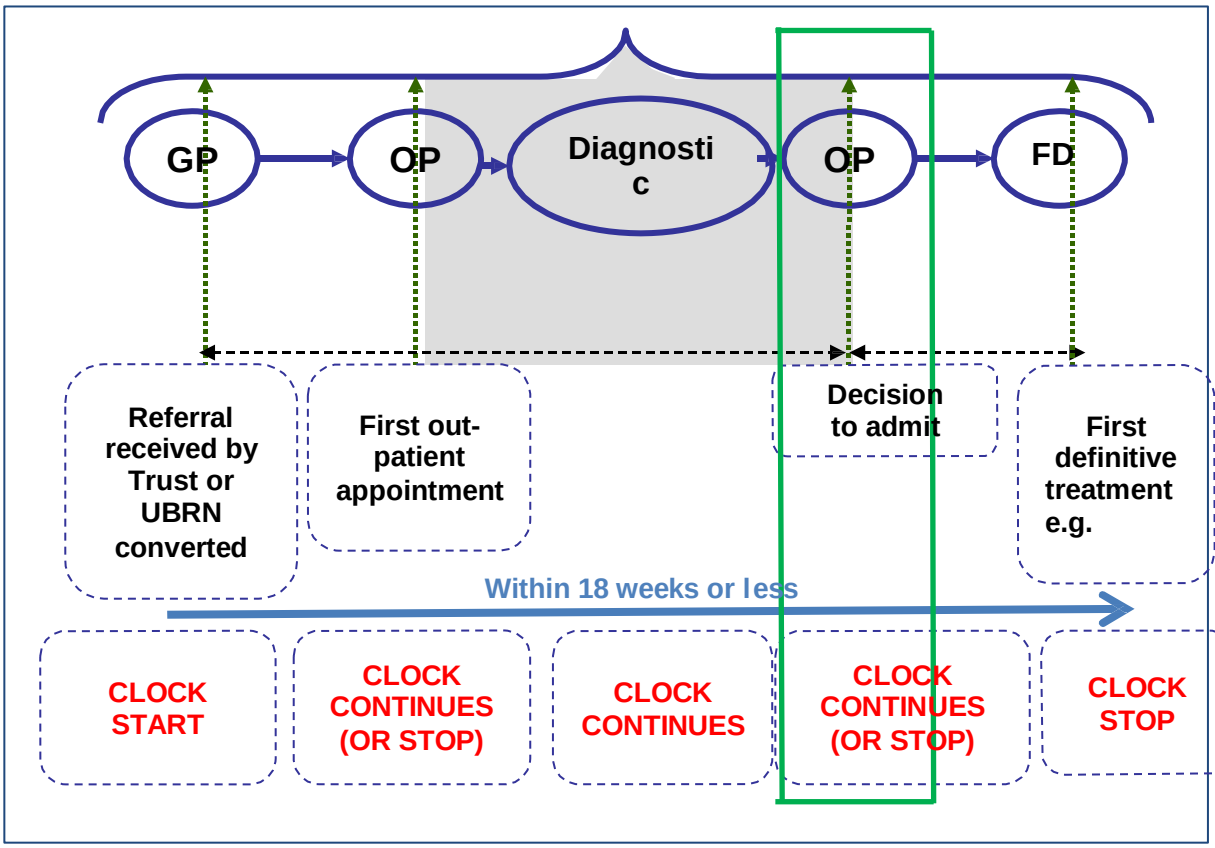
2.23 Dietetics

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. In this pathway, the clock could continue to tick.

2.24 Non-activity related RTT decisions

This section covers the process and timestamp for non-activity related RTT decisions, with an example at Figure 6 showing the stages in the management of non-activity related RTT decisions.

Figure 6: Stages in the management of non-activity related RTT decisions



Key

OP – outpatients
FDT – first definitive treatment

Where clinicians review test results in the office setting and make a clinical decision not to treat, the RTT clock will be stopped on the day this is communicated in writing to the patient.

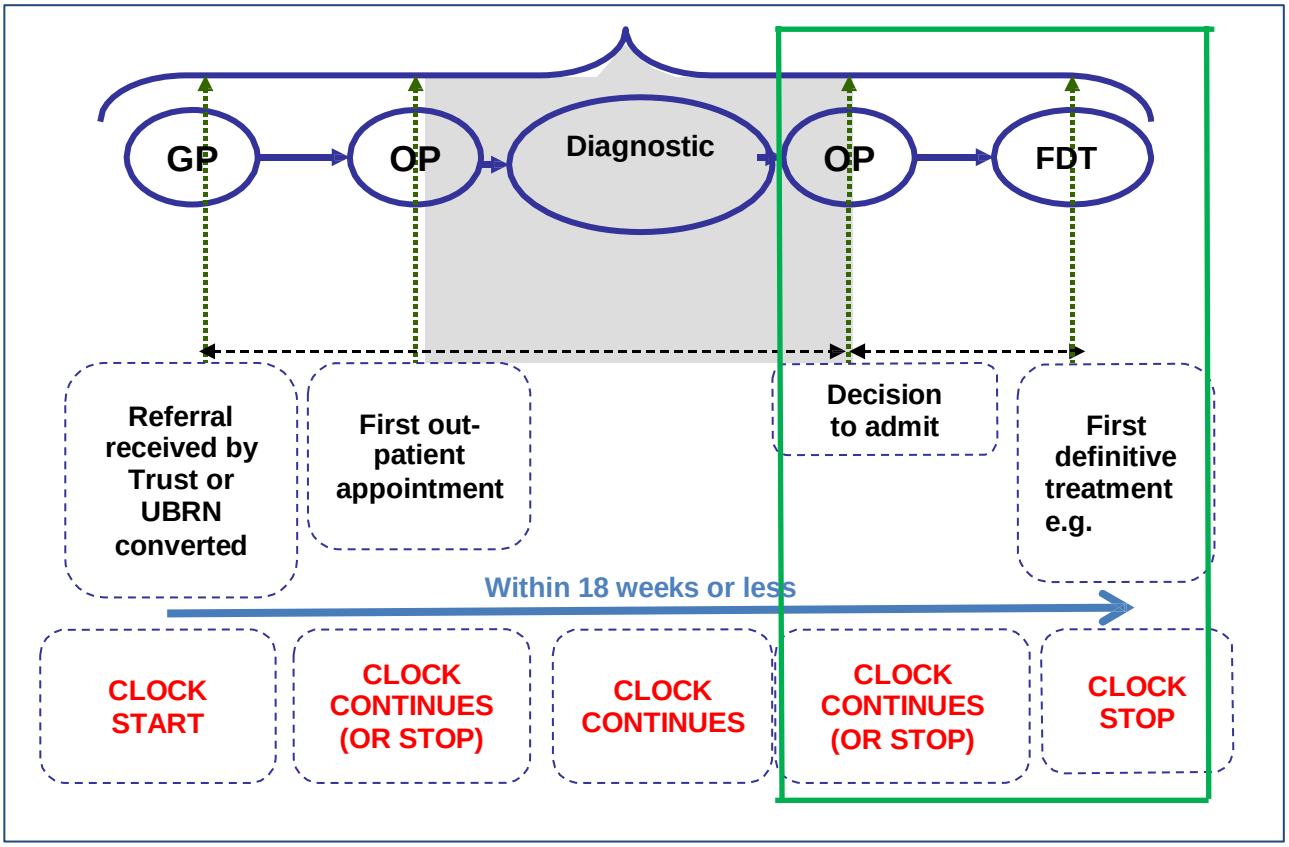
Administration staff should update PAS with the clock stop. The date recorded will be the day the decision not to treat is communicated in writing to the patient.

2.25 Admitted pathways

This section provides specific information on the management of admitted patients.

The section within the green border on Figure 7 represents the admitted stage of the pathway. It starts at the point of a decision to admit and ends upon admission for first definitive treatment.

Figure 7: Stages in the management of admitted patients



Key

OP – outpatients
FDT – first definitive treatment

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

The trust should ensure that admitted patients are captured and monitored on waiting lists. Ideally, patients will be fit, ready and available before being added to the admitted waiting list. However, they will be added to the admitted waiting list without delay following a decision to admit, regardless of whether they have undergone pre- operative assessment (see page 35 Pre-operative assessment*)* or whether they have declared a period of unavailability at the point of the decision to admit (see page 18 Patient-initiated delays).

The active inpatient or day case waiting lists/PTLs includes all patients who are awaiting elective admission. The only exceptions are planned patients, who are awaiting admission at a specific clinically defined time.

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

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

2.27 Patients requiring more than one procedure

If more than one procedure will be performed at one time by the same surgeon, the patient should be added to the waiting list with extra procedures noted. If different surgeons will work together to perform more than one procedure, the patient will be added to the waiting list of the consultant surgeon for the priority procedure with additional procedures noted. If a patient requires more than one procedure performed on separate occasions by different (or the same) surgeon(s):

- The patient will be added to the active waiting list for the primary (1st) procedure
- When the first procedure is complete and the patient is fit, ready and able to undergo the second procedure, the patient will be added (as a new waiting list entry) to the waiting list, and a new RTT clock will start

2.28 Patients requiring thinking time

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

It may be appropriate for the patient to be entered into active monitoring (and the RTT clock stopped) where they state they do not anticipate making a decision for a matter of months. This decision can only be made by a clinician and on an individual patient basis with their best clinical interests in mind.

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

2.29 Scheduling patients to come in for admission

Clinically urgent patients will be scheduled first, followed by routine patients. All patients will be identified from the trust's PTL, and subject to the clause above about clinical priorities, will be scheduled for admission in chronological order of RTT wait.

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

If there is insufficient capacity to offer dates within the required milestone, this issue will be escalated to the relevant service manager. Any admission offers declined by patients will be recorded on PAS. This is important for two reasons:

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

2.30 Management of patients on a waiting list choosing to decline offered treatment dates at current provider or an alternative provider (interim)

Patients wishing to delay treatment

In circumstances where a patient wishes to delay their treatment the following approach may be considered for both admitted and non-admitted pathways.

Following declining a 1st TCI, the patient should be recorded on the WLMDS as a 'C-code'.

- A 2nd TCI should be offered which is within 6 weeks of the 1st TCI
- TCIs offered should be reasonable (i.e. with 3 weeks-notice)
- If a 2nd TCI is declined it may be appropriate, following a clinical conversation and agreement with the patient, to consider placing a patient on hospital initiated active monitoring
- Where it is appropriate to place a patient on active monitoring, this should be for a maximum period of 12 weeks
- If a patient is placed on active monitoring the RTT clock should be stopped
- Patients placed on active monitoring should be managed through local reporting and local clinical governance arrangements.
- Throughout the agreed active monitoring period the patient should be advised of the process to follow should they wish to go ahead with treatment and be reinstated on the waiting list.
- If a patient wishes to go ahead with treatment, the provider should offer a new TCI date acting as if the patient is on the waiting list at the point which they previously left ie. They should not be returned to the beginning of the waiting list.
- TCI date offered must include date, provider and team. It is not appropriate to start a period of active monitoring and stop the clock on the basis of a patient declining earlier treatment at a provider for which the detail has not been confirmed.

Patients declining earlier treatment at an alternative provider (currently choice category)

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

In circumstances where a patient declines earlier treatment at an alternative provider the following approach may be considered:

- Following declining a 1st TCI at an alternative provider, the patient should be recorded on the WLMDS as a 'C-code'.
- A 2nd TCI should be offered which is within 6 weeks of the 1st TCI.
- TCIs offered should be reasonable (i.e., with 3 weeks-notice)
- If a 2nd TCI is declined it may be appropriate, following a clinical conversation and agreement with the patient, to consider placing a patient on active monitoring.
- If a patient is placed on active monitoring the RTT clock should be stopped.
- Patients placed on active monitoring should be managed through local reporting and local clinical governance arrangements.
- Throughout the agreed active monitoring period the patient should be advised of the process to follow should they wish to go ahead with treatment and be reinstated on the waiting list.
- Should a patient decline the subsequent offered TCIs at the existing provider, the guidance relating to cohort (a) above should be followed.
- TCI date offered must include date, provider and team. It is not appropriate to start a period of active monitoring and stop the clock on the basis of a patient declining earlier treatment at a provider for which the detail has not been confirmed.

2.31 Patients who decline or cancel TCI offers

It is appropriate to note that declined and cancelled TCIs do not stop the clock. It is important to also know that no blanket rules can be applied and only the clinician can make the decision on an individual basis. The example below (shown in the bullet points) provides an example of the impact on the patient's clock following a clinical review.

If patients decline TCI offers or contact the trust to cancel a previously agreed TCI, this will be recorded on the PAS. The RTT clock continues to tick. If, as a result of the patient declining or cancelling, a delay is incurred which is equal to or greater than a clinically unsafe period of delay (as indicated in advance by consultants for each specialty), the patient's pathway will be reviewed by their consultant. Upon clinical review, the patient's consultant will indicate one of the following:

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

*Active Monitoring – this may be applicable where the clinician ascertains that the patient no longer wishes to proceed with the originally agreed procedure or where the length of the delay incurred has a consequential impact on the original agreed procedure. In either of

these scenarios, a face to face appointment should be arranged to agree an alternative treatment plan with the patient.

2.32 Patients who DNA admission

This section describes the process for when patients DNA their admission appointment. DNAs are to be reviewed by the patient's consultant and they should only be discharged (clock stop) if it is in their best clinical interest.

Patients who do not attend for admission will have their pathway reviewed by their consultant. If the patient's consultant decides that they should be offered a further admission date, the RTT clock continues to tick. Should the patient's consultant decide that it is in their best clinical interests to be discharged back to the GP, the RTT clock is stopped.

2.33 On-the-day cancellations

This section provides details on the 28-day target in the event of an on-the- day cancellation.
Where a patient is cancelled on the day of admission or day of surgery for non- clinical reasons, they will be rebooked within 28 days of the original admission date and the patient must be given reasonable notice of the rearranged date. The patient may choose not to accept a date within 28 days.

2.34 Planned waiting lists

This section provides details on entering patients on a planned waiting list, ensuring a planned date is recorded, and the mechanism or requirement for overdue planned patients to transfer to an active waiting list (RTT clock start).

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

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

3. Cancer pathways

Introduction and scope

This section describes how the Trust manages waiting times for patients with suspected and confirmed cancer, to ensure that such patients are diagnosed and treated as rapidly as

possible and within the national Cancer Waiting Times (CWT) standards. This policy is consistent with the latest version of the *Cancer Waiting Times Guide* and includes national dataset requirements for both waiting times and clinical datasets.

3.1 Executive summary

NHS Constitution: patients' rights:

The NHS Constitution outlines what patients can expect and their rights when they are referred on a cancer diagnosis and treatment pathway. Cancer Waiting Times measure the NHS' performance against these national NHS Constitution Standards, as well as a number of other metrics. These measures are used by local and national organisations to monitor the timely delivery of services to patients.

3.2 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 To Come In (TCI) dates as defined within the policy.

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

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

3.3 Roles and responsibilities

Chief executive: Overall responsibility and accountability for delivering access standards as defined in the NHS Constitution and Operating Framework.

Chief operating officer: 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.

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.

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.

Trust cancer manager: Responsible for monitoring delivery of key tasks by the MDT Co-ordinators and for providing accurate and up-to-date information to support trust-wide monitoring of performance.

Divisional Director for Cancer: Responsible for the monitoring of performance in the delivery of the 14-day, 28-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.

Tumour group clinical leads: 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.

General 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 28-day, 62- or 31-day pathways.

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

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

Head of Information: 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.

Central booking team: Responsible for monitoring delivery of key tasks by the 2WW office (clinic bookings) team.

2WW office (clinic bookings) 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 cancer access policy and in line with their job descriptions.

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.

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.

All staff (to whom this document applies)

All staff have a duty to comply fully with this policy/procedure 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.

3.4 Cancer waiting times standards

Table 1 below outlines the key Cancer Waiting Time (CWT) standards that the trust must comply with.

Table 1: Key CWT standards

Current CWT standards:	**Operational Standard**
Maximum 28 days from:	
Receipt of two week wait referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of two week wait referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer	75%
Maximum one month (31 days) from:	
From Decision To Treat/Earliest Clinically Appropriate Data to Treatment of Cancer	96%
Maximum two months (62 days) from:	
From receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screen referral or consultant upgrade to First Definitive Treatment of cancer	85%

3.5 Clock start

The Faster Diagnosis Standard start point is the receipt of the referral by the provider who will first see the patient (recorded as the Cancer referral to treatment period start date). Receipt of referral is day zero.

Referrals received after the working day has finished should have the Cancer referral to treatment period start date set as the date that the referral was received and not the next working day.

If further information is required to manage the referral the receipt of initial referral would still be recorded as day zero. Commissioners, referrers and providers should work together

to ensure processes are in place to ensure all necessary information is sent with a referral, but it would be inappropriate to pause the clock given the patients expectations will be that a referral has been made.

Patients referred on a Faster Diagnosis Standard pathway should still be recorded in the dataset as:

Priority type code - 3 (Two Week Wait)

3.6 First seen date for urgent suspected cancer or breast symptomatic referrals

Although the Two Week Wait performance standard no longer applies, it is still necessary to record Date First Seen as one of the following:

- The patient is seen either in person or virtually for the first time by a consultant (or member of their team) following the referral receipt. This is recorded as Date first seen.
- The patient is seen at a diagnostic clinic or goes 'straight to test' in a consultant-led service (unless that test is a blood test).
- The only exception to this is where patients with suspected skin cancer are being managed through a teledermatology pathway, as detailed in section 6.10.1 of the CWT guidance.
- A virtual consultation can only count as the first seen date, where it is a consultant led clinic (including a nurse acting on behalf of the consultant), and a patient's full symptoms are considered. The patient would have to be present for this consultation.

3.7 Non-specific symptom referrals

Referrals into non-specific symptoms pathways should be recorded in the same way as urgent suspected cancer referrals as follows:

- Priority type code - 3 (Two Week Wait)
- Two week wait cancer or symptomatic breast referral type - 17 (Suspected - non-specific symptoms)

The same set of standards and principles apply to these referrals as those set out for the site specific urgent suspected cancer referrals.

3.8 Coverage of the Faster Diagnosis standard

The Faster Diagnosis Standard apply to patients referred with suspected cancer or breast symptoms from one of the following referrers:

- General Medical Practitioner (GMP)
- General Dental Practitioner (GDP)
- Optometrist
- Any other referral source as agreed locally by commissioners and providers

Local agreement is in place which allows A&E to make an urgent suspected cancer referral.

3.9 Advice & Guidance

The Advice & Guidance (A&G) function should not be used in place of a two week wait referral. For example, where a patient clearly meets NG12 criteria this should usually result in an urgent suspected cancer referral.

A&G can be used locally where agreed at a system level. This may vary by pathway depending on what is clinically appropriate and must follow engagement with referrers and providers to develop any new processes.

Prior to any implementation, systems/commissioners should undertake a local training needs analysis and carry out any training as necessary. There should also be ongoing support available to referrers and providers.

A&G can be converted into an urgent suspected cancer referral in line with the local referral and commissioning guidelines and where this happens must be classed as an urgent suspected cancer referral, not a consultant upgrade.

Where an A&G referral is converted the e-RS pathway start will capture the date on which the provider converts the referral. When making the decision on if to convert A&G directly into a referral and appointment, the clinician reviewing should take into consideration whether they have the required information, and whether the patient is likely to know there is a suspicion of cancer.

Systems or commissioners should regularly review A&G services and conduct quality assurance analysis to ensure they meet local requirements. Lessons learned should also be reviewed and findings shared across the system.

3.10 Referral policy and guidance

The following are national requirements for management of urgent suspected cancer (including non-specific symptoms) and breast symptomatic referrals:
Standardised referral forms for urgent suspected cancers should be used to ensure consistency and completeness of referral information.
If a consultant thinks the referral is inappropriate this should be discussed with the referrer. Only the referrer can downgrade or withdraw a referral. This includes where it is considered that insufficient information has been provided.
The date of receipt of initial referral or the conversion of the UBRN into a booking should always count as the start of the pathway and be recorded as cancer referral to treatment period start date. This includes scenarios where additional information is requested from the referrer and where a patient is unavailable for a period of time.
A patient should not be discharged because they are unavailable within a specific time-frame, and processes should be in place to ensure patients have the choice to book outside of a fixed time-frame.

3.11 Screening pathways

The clock start (day 0) is when a referral is received by a provider in the screening pathway

for further investigation after an initial screening test. Each individual screening programme is as follows:

- Breast - receipt of referral for breast screening assessment (i.e. not back to routine recall)
- Bowel (FOBT or FIT) - 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

3.12 First seen date for screening

The Date First Seen for the individual screening programmes are as follows:

- Breast - first attendance for breast screening assessment
- Bowel (FOBT or FIT) - first attended appointment with specialist screening practitioner (SSP) to discuss suitability for colonoscopy
- Cervical - first attended colposcopy appointment

The source of referral for outpatients should be recorded as 17 - Referral from National Screening Programme

3.13 Consultant upgrades

If a consultant upgrades a patient for the first primary cancer the 62 day period starts at the consultant upgrade date. Only those upgrades that are diagnosed with a newly diagnosed cancer and go on to treatment need to be reported.

Who can upgrade a patient?

A consultant or an authorised member of the consultant team (as defined by local policy) should upgrade a patient if cancer is suspected. The ultimate responsibility for upgrades rests with the consultant responsible for the care of the patient who may have delegated their authority by local agreement. The upgrades could come from any part of the health service, not just from consultants and teams that most commonly see cancer patients.

Can there be an upgrade from any source of referral?

Yes, except for the following as they are already on a cancer pathway:

- Urgent referrals for suspected cancer
- Referrals for breast symptoms (not suspicious of cancer)
- Urgent screening referrals
- Non-specific symptoms pathway

Why not start the 62 day pathway from the receipt of the original referral which the consultant then went on to upgrade?
At the point when the original referral is received (recorded as the referral to treatment period start date or a RTT pathway) cancer is not suspected and it might be a few weeks before a consultant (or authorised member of the consultant team) decides to upgrade the patient to the 62 day pathway. It is not appropriate to calculate a timed 62 day period from this point (i.e. retrospectively starting the clock from the original referral) as the patients

was not on the suspected cancer pathway at that point.

Circumstances where a Consultant upgrade would automatically apply

Where a patient is referred to a Cancer Multidisciplinary Team meeting on suspicion or with a confirmed cancer, the data of this request must be counted as a consultant upgrade unless:

The patient has already been upgraded on the pathway, e.g. where processes are in place to flag pathology reports of incidental findings.

- A decision to treat has already been reached for the patient.
- The patient has already received their first treatment for cancer, unless a new primary is suspected.
- The patient is on an alternative 62 day pathway - Urgent Suspected Cancer, Breast symptomatic, Urgent Screening or Non-specific symptoms pathway.

Where a patient is discussed at more than one Cancer Multidisciplinary Team meeting then, the date of request for the first meeting should be recorded.

Where a patient is referred for a Cancer Multidisciplinary Team meeting at another provider, even if for discussion only, the organisation making the referral is responsible for the consultant upgrade being made on or before the date of the inter-provider transfer.

Is an upgrade possible if a recurrence is suspected?

No, the upgrade to the 62 day standard is intended for suspected new primaries only.

3.14 Reasonable offer of appointment

A 'reasonable' offer of an appointment is defined by locally agreed access policies. Providers should refer to Elective care: model access policy issues by NHS improvement, and should make a reasonable offer for diagnosis or treatment in a cancer as has been agreed locally.

Part of being reasonable means that the patient has been consulted and listened to, considering what the patient would find reasonable.

In the cases of contention, such as treatments offered on the same day, the commissioner should decide whether the offered appointment was reasonable.

An offer will be deemed to be reasonable if 48 hours' notice is given.

3.15 Adjustments

First seen adjustment:

Although the first seen standard is being retired with this new guidance, it is important we still record this data item correctly, as doing so drive the calculation of breach allocation and other elements of the cancer pathway. An adjustment is allowed if as patient Does Not

Attend (DNAs) for the allocated appointment time and gives no notice for their initial out-patient appointment / diagnostic clinic that would have been recorded as date first seen. If the patient turns up in a condition where it is not possible to carry out the required procedure (e.g. if they have not taken a preparation they needed to take prior to the appointment), this should be recorded as DNA. If the patient arrives after the scheduled appointment time and it is not possible to fit them in (e.g. fully booked) or there is not enough time left to carry out the planned procedure/tests in the remainder of the session then this is classed as a DNA.

Under this adjustment, the clock can be reset from the receipt of the referral (recorded as the cancer referral to treatment period start date) to the date upon which either the patients makes contact to re-book their appointment or the date the appointment is re-booked should the patient not directly contact the provider to do so. This period is called the waiting time adjustment (first seen) and is effectively deducted from the total waiting time.

An adjustment is not possible if a patient cancels or reschedules an appointment or is not available to be seen for a period of time.

First seen adjustment for screening

The first seen adjustment can be applied using the same rules as first appointment for urgent suspected cancer or breast symptomatic referrals. This adjustment would then be applied to the Faster Diagnosis Standard and if applicable the 62 day Referral to Treatment Standard.

Patient choice treatment adjustment:

An adjustment for treatment can be applied if a patient declines a 'reasonable' offer of admission for treatment (for both admitted and non-admitted pathways).

For cancer patients under the 31 day or 62 day standard, the adjustment would be the time between the date of the declined appointment (the offered To Come In date) to the point when the patient could make themselves available for an alternative appointment.

Clinically urgent treatment of another condition treatment adjustment:

An adjustment can be applied if it is deemed clinically essential to treat another medical condition before treatment for cancer can be given, after a decision to treat the cancer has been made.

In such cases the adjustment would apply from the point at which it is confirmed that a patient needs treatment for the other medical condition, to the point at which after receiving treatment for this condition the patient is deemed clinically fit to commence their cancer treatment.

This would be recorded with the waiting time adjustment reason (treatment) being recorded as 'clinically urgent treatment of another condition'.

Where a patient is ordered diagnostics, or referred to another specialist to exclude another medical condition, an adjustment cannot be applied for the period in which the patient is waiting to be seen for this assessment or diagnostics. An adjustment can only be taken from the point at which another condition is diagnosed, and the patient deemed clinically unfit for their cancer treatment, prior to the other condition being treated.

This adjustment cannot be applied for where a patient is advised to make lifestyle changes for example stop smoking, lose weight or commence a period of pre-habilitation prior to their cancer treatment. In these cases, the patient clock would continue. The 62 day and 31 day threshold is set to allow for patients in this scenario who will exceed the timescales.

Urgent treatment of another condition applied to patients with COVID-19 or influenza

This adjustment should be applied as follows in relation to COVID-19 or influenza:

- Where a clinical decision is taken to offer a patient treatment now (i.e. the clinical view is that the risk of delay outweighs the COVID-19 or influenza risk), but the patient declines and requests a later date, an adjustment can be taken from the offered date to the date the patient is willing to come for treatment. In such situations, a process should be put in place to review the patient at fixed intervals to check whether their view has changed.
- Where the clinical recommendation, agreed with the patient, is to delay treatment until COVID-19/influenza risk decreases, a treatment adjustment cannot be taken.
- If a patient chooses not to access treatment due to concerns about COVID-19/influenza they should remain on the appropriate active waiting list and remain visible. In line with current cancer waiting times standards, waiting times will not be 'paused' and clocks will continue through the period that the patient chooses not to attend.
- If a patient waiting for treatment - with a decision to treat (DTT) - tests positive for COVID-19/influenza then the clinically urgent treatment adjustment guidance can be applied. In such cases the adjustment would apply from the point at which it is confirmed that a patient has tested positive, to the point at which it is deemed that it is clinically appropriate to proceed with treatment.

Egg harvesting treatment adjustment

Where a patient opts for egg harvesting prior to their cancer treatment, an adjustment can be applied from the point at which the decision is made until eggs are harvested.

An adjustment cannot be applied for the period of time taken for the patient to wait to be seen by the egg harvesting service, only from the point at which the patient is seen by the services and agrees to egg harvesting to the point where harvesting takes place.

This would be recorded under the waiting time adjustment (treatment) with the waiting time adjustment reason (treatment) being recorded as 'Egg Harvesting'.

3.16 Management of DNAs & cancellations

Patients should not be referred back to their GP after a single Did Not Attend (DNA) or

cancellation. Patients should only be referred back to their GP after multiple DNAs following a clinical decision to do so.

Patients should never be referred back to their GP after an appointment cancellation unless this has been agreed with the patient – by cancelling an appointment a patient has shown a willingness to engage with the NHS.

3.17 Private patients

A patient will be removed from the 28-day cancer pathway where:

- A patient opted for private diagnostics (patient may come back for NHS funded treatment)

This should not be applied if NHS diagnostics are sub-contracted to a private provider as the activity would still be NHS funded and an NHS provider would still be commissioned to provide the diagnostics.

Coverage of treatment standards:

- Whose cancer care is undertaken by a private provider on behalf of the NHS, i.e. directly commissioned by an English NHS commissioner;
- Whose care is sub-contracted to another provider – including a private provider – (and hence paid for) by an English NHS provider, i.e. commissioned by an English NHS commissioner but subcontracted out by the commissioned provider;
- Patients who choose initially to be seen privately but are then referred for first and/or subsequent treatments in the NHS.

Where private patients require MDT discussion this should be requested in line with the Trusts private patients MDT discussion guidelines where applicable.

3.18 Tertiary referrals

Process

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 data set and all relevant diagnostic test results and images will be provided when the patient is referred.

3.19 Best Practice Timed Pathways

Faster diagnosis is fundamental to achieving the Long-Term Plan ambitions for cancer. The NHS Cancer Programme has developed a Faster Diagnosis Framework, which sets out NHS England and Improvement's strategic approach to speed up cancer diagnosis and improve patient experience.

Further information can be found via: NHS England » Faster diagnosis

4. Glossary

4.1 Terms

Term	Definition
28 day pathway	From receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent referral of any patients with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer.
31 day pathway	From Decision To Treat/Earliest Clinically Appropriate Date to Treatment of Cancer.
62 day pathway	From receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer.
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	Where a patient: Is told they have a diagnosis of cancer, or that cancer is excluded after day 28 following receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent referral of any patients with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer. And/or Is treated more than 31 days after DTT/ECAD. And/or Is treated more than 62 days after receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer.
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 that 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.
First definitive treatment (cancer)	For Cancer Waiting Times this is the start of the treatment aimed at removing or eradicating the cancer completely or at reducing tumour bulk.
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.

4.2 Acronyms

Term	Definition
ASIs	Appointment slot issues (list): a list of patients who have attempted to book their appointment through the national E-Referral Service but have been unable to due to lack of clinic slots.
A&G	Advice & Guidance
CATS	Clinical assessment and treatment service
CNS	Clinical Nurse Specialists: Ensure the patient have access to information and advice regarding their diagnosis and treatment. Help patients to make sense of a large amount of unfamiliar information, and support patients decision making about care, treatment and follow-up arrangements.
COF	Clinic outcome form
COSD	Cancer Outcomes and Services Dataset: The national standard for reporting cancer in the NHS in England since January 2013
DNA	Did not attend: patients who give no prior notice of their non- attendance.
DTT	Decision To Treat: The date the patient agrees a treatment plan, i.e. the data that a consultation between the patient and clinician took place and a planned treatment was agreed
ECAD	Earliest Clinically Appropriate Date: The earliest date that it is clinically appropriate for the next activity that actively progresses a patient along the pathway for that treatment to take place.
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 on-going care covering a variety of medical problems in patients of all ages, often including referral to appropriate specialists.
ICB	Integrated Care Board: Replaced CCG (Clinical Commissioning Groups) in the NHS in England from 1st July 2022
Infoflex	Civica Clinical Pathways software helps NHS clinicians effectively manage patient pathways, such as cancer care pathways through integrated healthcare data
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
MDT co-ordinator	A person who provides consistent patient-centred focus throughout the pathway of care, by providing one point of contact along the administration pathway for the MultiDisciplinary Team
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 tool used for monitoring, scheduling and reporting on patients on elective pathways (covering both RTT and cancer).
RACPC	Rapid access chest pain clinic
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**
SMDT	**Specialist MultiDisciplinary Team**
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**

4.3 References and further reading

Title	Published by	Publication date	Link
Referral to treatment consultant-led waiting times Rules Suite	Departme nt of Health	October 2015	www.gov.uk/governmen t/uploads/system/upload s/attachment_data/file/4 64956/RTT_Rules_Suit e_October_2015.pdf
Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care	NHS England	October 2015	https://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	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2017/10/Accompanying-FAQs-v7.32-ASI-FAQ-update.pdf
The NHS Constitution	Departme nt of Health	July 2015	https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
Diagnostics waiting times and activity Guidance on completing the 'diagnostic waiting times & activity' monthly data collection	NHS England	March 2015	www.england.nhs.uk/sta tistics/statistical-work-areas/diagnostics- waiting-times-and-activity/monthly- diagnostics-waiting- times-and-activity/
Frequently Asked Questions on completing the 'Diagnostic Waiting Times & Activity'	NHS England	February 2015	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/08/DM01-FAQs-v-3.0.pdf

Equality Act 2010	Department of Health	June 2015	https://www.gov.uk/guidance/equality-act-2010-guidance
Overseas Visitor Guidance	Department of Health	December 2020	https://www.gov.uk/government/publications/how-the-nhs-charges-overseas-visitors-for-nhs-hospital-care/how-the-nhs-charges-overseas-visitors-for-nhs-hospital-care
Armed Forces Covenant	Ministry of Defence	July 2015	www.gov.uk/governmen t/uploads/system/uploads/attachment_data/file/4 9469/the_armed_forces_covenant.pdf
Learning disability improvement standards for NHS Trusts	NHS Improvement	June 2018	https://www.england.nhs.uk/learning-disabilities/about/resources/the-learning-disability-improvement-standards-for-nhs-trusts/
Elective recovery planning supporting guidance	NHS England and NHS Improvement	February 2022	C1466-delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care.pdf (england.nhs.uk)