

Elective care model access policy

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Introduction

The national elective improvement team (referred to as the IST) produced this model elective access policy in response to requests from colleagues in trusts and wider health systems for guidance and support in producing their own elective access policies.

This **guidance** is framed for acute trusts, but the principles apply equally to consultant-led services in all settings, for example community trusts. It should not be simply copied and pasted, as there are elements which should be reviewed and amended to reflect local arrangements.

The trust and wider health system leads, and other key stakeholders should read the whole model policy to ensure they understand the principles contained within it and identify where local adaptation is required.

Important points

This policy focuses on patients. It aims 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. We have taken every care to avoid any contradiction with national RTT rules but if there are any ambiguities, the national rules take precedence. Please let us know via the email address below if you find any such contradictions.

Although this is a model policy, we would like to enhance it further over the coming months, so all comments and feedback are very welcome. You can contact us through:

- the elective care area on the NHS Improvement hub:
<https://improvement.nhs.uk/improvement-hub> You can post comments on the page where the policy is or on the discussion forum page.
- our email address: at nhsi.electiveist@nhs.net

We refer to trusts needing various standing operating procedures (SOPs) in place to underpin the access policy principles. We also plan to publish model SOPs for guidance.

Policy structure

The model 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

We present general policy statements in black and supporting text that outlines what trusts may wish to include [in blue](#). Blue text will not feature in sections that are self-explanatory.

When considering your own policy, remember to take into account your local arrangements and any interdependencies between sections and the management of patients.

1. General principles: referral to treatment and diagnostic pathways

Introduction and overarching principles

The introduction and overarching principles should state the trust's commitment to patients and outline what the policy covers. It may include how the policy was developed, who was involved, how it should be read, and how it is supported by standard operating procedures (SOPs). The example below contains some of the information a trust may wish to include.

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 elective access policy was developed following consultation with staff, clinical commissioning groups (CCGs), general practitioners, clinical leads and CCG lay members. It will be reviewed and ratified at least annually or earlier if there are changes to national elective access rules or locally agreed principles.

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

The access policy is underpinned by a comprehensive suite of detailed standard operating procedures (SOPs). All clinical and non-clinical staff must ensure they

comply with both the principles within this policy and the specific instructions within SOPs.

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

Purpose

This section should cover why the trust is writing the policy and what it is designed to do. Trusts should make reference to the NHS constitution and the national waiting time standards. The example below contains some of the information a trust may wish to include.

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.

Roles and responsibilities

This section should describe specific responsibilities of key staff/staff groups. Trusts will need to reflect on their own structure when writing their access policy. The roles contained below provide an example.

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) which support the divisions in managing waiting lists and RTT standards.
- Waiting list administrators, including clinic staff, secretaries and booking clerks, are responsible to general managers for compliance with all aspects of the trust's elective access policy.
- Waiting list administrators for outpatients, diagnostics and elective inpatient or day care services are responsible for the day-to-day management of their lists and are supported in this function by the general managers and divisional directors who are responsible for achieving access standards.
- General managers and divisional directors are responsible for ensuring data is accurate and services are compliant with the policy.
- Operational managers are responsible for ensuring the NHS e-referral service directory of services (DOS) is accurate and up to date.
- The 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.
- CCGs are responsible for ensuring all patients are aware of their right to treatment at an alternative provider in the event that their RTT wait goes beyond 18 weeks or if it likely to do so.
- In the event that patients' RTT waits go beyond 18 weeks, CCGs must take all reasonable steps to offer a suitable alternative provider, or if there is more than one, a range of suitable alternative providers, able to see or treat patients more quickly 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 CCGs 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.

Staff competency and compliance

This section should cover how staff will demonstrate competency and compliance with the access policy. This may include details on training, levels of competence, KPIs and capability.

Competency

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

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

General elective access principles

This section should focus on details specific to elective care cover under the NHS constitution and the maximum waiting time standards.

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.

Individual patient rights

This section should provide a summary of the patient rights from the NHS Constitution.

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

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

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

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

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

procedures at that stage.

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

Patient eligibility

This section should provide a summary of patient eligibility criteria and how the trust will check if patients are eligible or not. The example below provides some details on capturing patients at the first point of entry. Trusts will, however, want to make sure this section is reflective of their own eligibility criteria and processes.

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.

Patients moving between NHS and private care

This section should provide a summary of how the trust will manage (including clock statuses) patients who decide to transfer part or all of their treatment to a private provider.

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

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

Commissioner-approved procedures

This section should provide details on how the trust will manage procedures of limited effectiveness and reference the trust's policy/process for approval.

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

Military veterans

This section should provide a summary from the Department of Health December 2008 guidance on how the trust will manage military veterans. Trusts should ensure that the section details the process for identifying and managing patients.

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.

Prisoners

This section should detail the process for managing prisoners and how their RTT clock will be managed.

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.

Service standards

This section includes the trust's key business processes and timeframes. Trusts should detail how each process will be recorded, reported and monitored. The example below covers some of the key touch points.

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

Key standards for implementation include the following:

- referral receipt and registration (within 24 hours)
- referral vetting and triage (within 48 hours of registration)
- addition of urgent outpatient referrals to waiting list (within 48 hours of registration)
- addition of routine outpatient referrals to waiting list (within 5 days of registration)
- urgent patient contacted by the trust after addition to waiting list (within 48 hours)
- routine patient contacted by the trust after addition to waiting list (within 2 weeks)
- 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

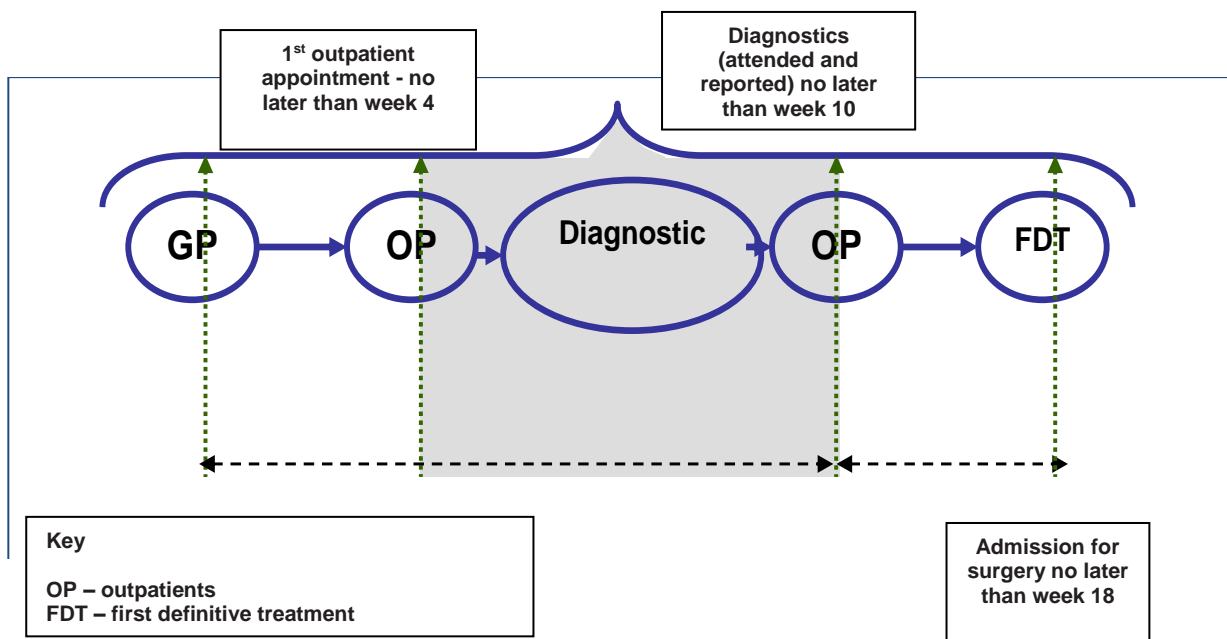
Pathway milestones

It can be helpful to provide a high-level summary of the key milestones on a patient pathway. Although some pathways will be more complex than the diagram below, it can help staff to contextualise what part of the pathway each section of the policy is addressing.

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

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

Figure 1: Key milestones on a surgical pathway

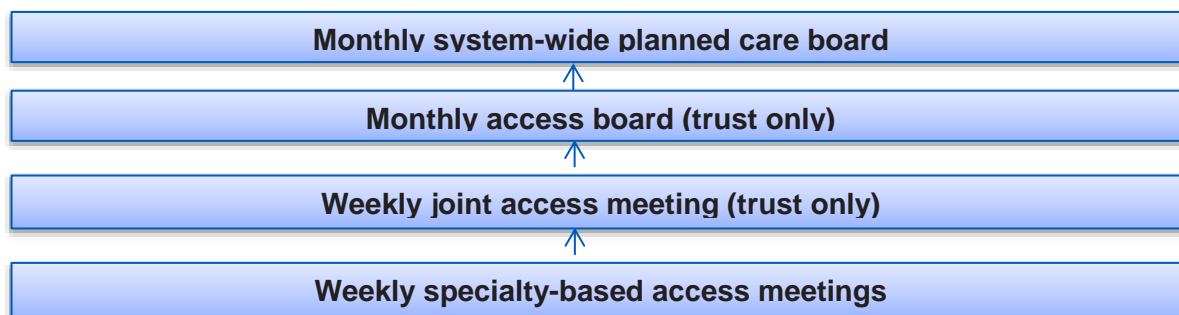


Monitoring

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.

Governance

Trusts should describe here their own elective governance structures. An example is shown below.



Reasonableness

Trusts should provide a definition of 'reasonableness' when offering routine appointments. A reasonable offer is a date at least three weeks in the future. Good practice is at least two offers three weeks in the future. The example text below adopts the 'best practice' definition.

'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.

Chronological booking

The policy should describe how patients will be prioritised and the importance of chronological booking. It is important for trusts to state their approach and ensure chronological booking is adopted.

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, ie the patients who have been waiting longest will be seen first. Patients will be selected using the trust's patient tracking lists (PTLs) only. They will **not** be selected from any paper-based systems.

Communication

This section should set expectations for how the trust will communicate with external stakeholders. It should also detail how correspondence will be stored.

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

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

National referral to treatment and diagnostic standards

Elective care standards should be detailed early in the access policy. Trusts may wish to state all targets (cancer included) or split them into more manageable sections (as below). Make sure that targets are up to date. It can also be helpful to describe the targets and explain tolerances and exceptions.

Referral to treatment	
Incomplete	92% of patients on an incomplete pathway (ie 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 which must be adhered to. The cancer standards are listed in the Section 3. Cancer pathways.

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

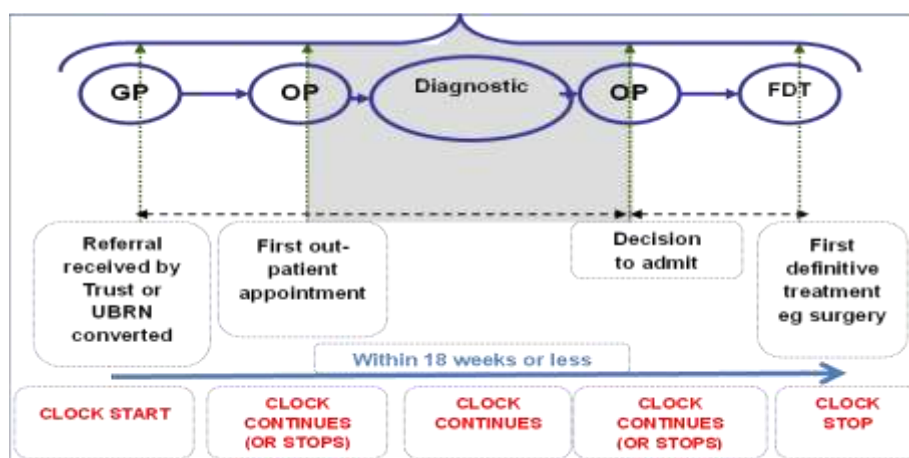
- **Clinical exceptions:** when it is in the patient's best clinical interest to wait more than 18 weeks for their treatment.
- **Choice:** when patients choose to extend their pathway beyond 18 weeks by declining reasonable offers of appointments, rescheduling previously agreed appointment dates/admission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

Overview of national referral to treatment rules

The access policy should provide a summary of the RTT rules and align with national guidance and cover clock starts, exclusions, new clock starts for the same condition, clock stops for first definitive treatment, clock stops for non-treatment, active monitoring, patient-initiated delays, instances when patients are unfit for treatment.

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

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



Key
OP – outpatients
FDT – first definitive treatment

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 which 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.

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.

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 on page 19.

Planned patients

Trusts should have a standard operating procedure (SOP) for the management of patients on planned waiting lists. The aim of this SOP is to ensure that patients are seen or admitted within the clinically indicated timeframe. This should include a process for adding them to the active waiting list if they do not receive the required test or procedure within the appropriate timeframe. It should be referenced in the access policy and should reflect any clinically acceptable nuances. For example, for a patient requiring a repeat computed tomography (CT) in six weeks, it might be acceptable for there to be a few days' flexibility in the due-by date, as long as this has been approved by the clinician and the date has been agreed with the patient. For longer-term planned waits, for example surveillance colonoscopy every two years, it may be clinically acceptable for there to be greater flexibility in the due-by date, for example up to a month or two before they are considered to be actively waiting and added to the RTT and/or diagnostic waiting list.

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

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.

Clock stops for non-treatment

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

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

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.

Patient-initiated delays

Trusts need to agree their own mechanisms for managing patient-initiated delays. It is imperative that such arrangements are founded on individual patients' best clinical interests and that they do not include blanket rules for stopping the clock.

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

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

First appointment DNAs

The RTT clock is stopped and nullified in all cases (as long as the trust can demonstrate the appointment was booked in line with reasonableness criteria). If the clinician indicates another first appointment should be offered, a new RTT clock will be started on the day the new appointment is agreed with the patient.

Subsequent (follow-up) appointment DNAs

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

Cancelling, declining or delaying appointment and admission offers

Patients can choose to postpone or amend their appointment or treatment if they wish, regardless of the resulting waiting time. Such cancellations or delays have no impact on reported RTT waiting times. However, clinicians will be informed of patient-initiated delays to ensure that no harm is likely to result from the patient waiting longer for diagnosis or 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).

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 (ie 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.

More detailed guidance on this topic can be found the relevant sections of the policy on pages 31 and 45.

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

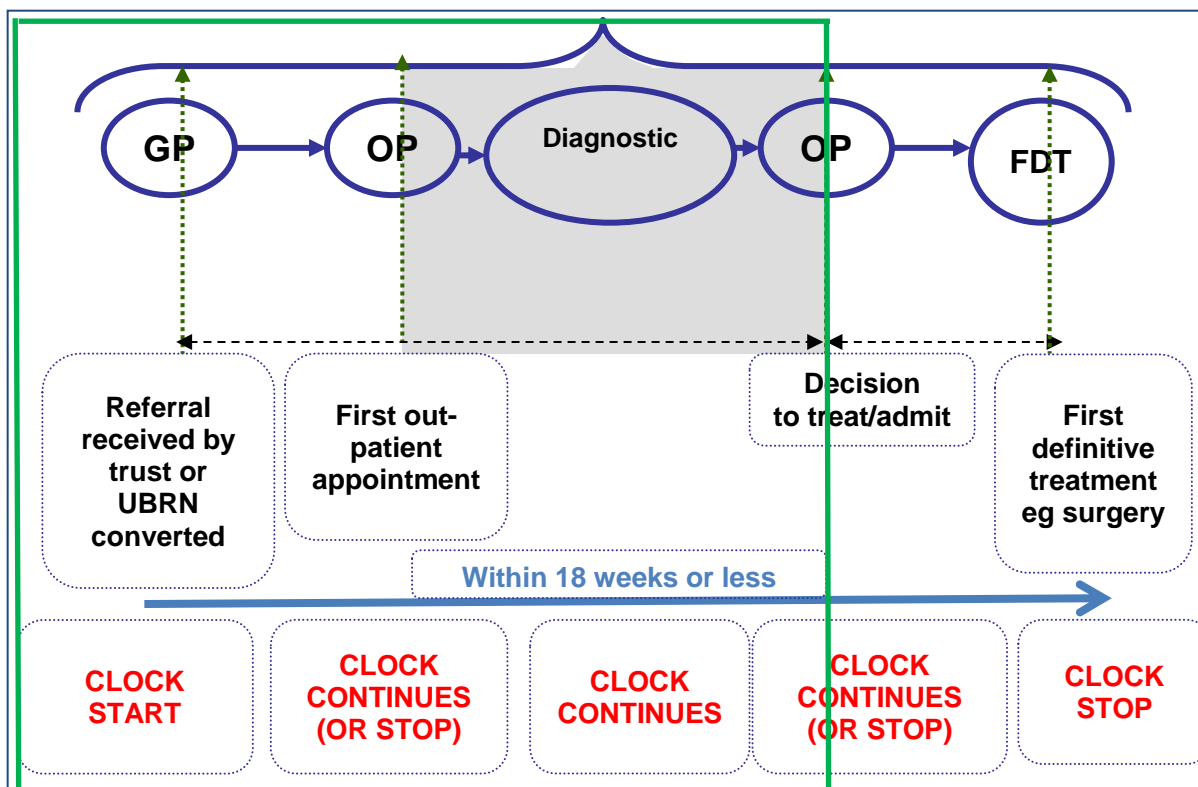
2. Pathway-specific principles referral to treatment and diagnostic pathways

Non-admitted pathways

Trusts may wish to cut sections of the patient pathway into their preferred way of managing stages of treatment. The section below breaks the pathway into the non-admitted stage.

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 (ie 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

Receipt of referral letters

An outline of the process for receiving referrals into the trust should be provided in this section. Typically, this section describes the process for the e-Referral service and paper-based referrals. A description of any referral requirement, eg to a service should be detailed in this section.

Paper-based referrals are still currently accepted, but the trust discourages this route. The NHS e-Referral Service (e-RS) is the preferred method of receiving referrals from GPs and Referral Management Centres (RMCs). 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.

Methods of receipt

This section should outline the requirement that from 1 October 2018, all referrals from GPs to consultant-led services should be made electronically through the national e-Referral Service (e-RS) and that the trust will no longer be paid for activity which results from GP referrals made other than through e-RS.

The method of receipt will include details on how referrals are reviewed and the timescale for decisions. Trusts should ensure that turnaround times are recorded and monitored. The example below is based on good practice turnaround times.

NHS e-referrals (e-RS)

All NHS e-referrals must be reviewed and accepted or rejected by clinical teams within one working day for urgent referrals or two working days for routine referrals.

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

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

Paper-based referrals

For non-GP paper-based referrals, trusts should ensure they have a documented and robust process for managing paper referrals to ensure accurate recording and handling. The example below is based on a centralised approach. The trust should provide a description of how paper referrals will be prioritised. The section below is one of a number of approaches:

All routine and urgent pooled and consultant-specific referral letters should be sent to the trust's centralised booking office.

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 centralised booking office within one working day of receipt. For patients referred by paper, the referral received date is the point that the RTT clock starts.

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

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

Referral types

Trusts should ensure they detail any unique referral types or services which may have differing processes. The section below provides some examples:

Rapid access chest pain clinic (RACPC) referrals

RACPC patients must be seen by a specialist within 14 days of the trust receiving the referral. To ensure this is achieved:

- RACPC referrals should be made via e-RS only.
- GPs should ensure that appropriate information regarding the RACPC referral is provided to the patient.

Transient ischaemic attack (TIA) clinic referrals

Most patients referred to TIA services come via an emergency route and are therefore out of scope in terms of elective care. However, where there is an elective TIA service, the principles within which it should be managed should be included in the policy.

Consultant to consultant referrals

Consultant-to-consultant referrals must follow the guidelines as agreed locally with commissioners. Some broad guidance to acceptable circumstances for consultant-to-consultant referrals is listed below:

- referrals that are part of the continuation of investigation treatment of the condition for which the patient was referred – this includes referrals to pain management where surgical intervention is not intended
- urgent referrals for new condition

- suspected cancer referral - this will be vetted and dated by the receiving consultant and upgraded if deemed necessary. Once upgraded the patient will be treated within 62 days of the date the referral was received by consultant.

Clinical assessment and triage services (CATS) and referral management centres (RMCs)

These services provide intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care. This section should detail the arrangements relating to any such services that are in place locally, including standards for receipt of referral and milestones within which referrals are referred onwards.

A referral to a CATS or an RMC starts an 18-week RTT clock from the day the referral is received in the CAT/RMC. If the patient is referred on to the trust having not received any treatment in the service, the trust inherits the 18-week RTT wait for the patient.

A minimum dataset (MDS) form must be used to transfer 18-week information about the patient to the trust.

Inter-provider transfers (IPTs)

Trusts should have agreed procedures with other trusts to which they refer a significant number of IPTs, or from which they receive such. The principles from this agreement should be included here.

Incoming IPTs

All IPT referrals will be received electronically via the trust's secure generic NHS net email account in the central booking office.

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

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 patient pathway identifier (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

Booking new outpatient appointments

This section should reiterate the requirement that from 1 October 2018, all referrals from GPs to consultant-led services should be made electronically through the national e-Referral Service (e-RS) and that the trust will no longer be paid for activity which results from GP referrals made other than through e-RS.

It describes how new outpatient appointments are booked into appointments through the e-referral service and paper-based referrals in the case of non-GP referrals. Trusts should review their e-referral functionality and paper-referral processes to ensure it reflects local practices.

E-referral service

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

If there are insufficient slots available for the selected service at the time of attempting to book (or convert their Unique Booking Reference Number UBRN), the patient will appear on the appointment slot issue (ASI) work list. The RTT clock starts from the point at which the patient attempted to book. Patients on the ASI list must be contacted within two 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 (non-GP referrals)

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

Patients will be selected for booking from the trust's patient tracking list (PTL) only.

An 'invitation to call' letter will be generated from PAS, asking patients to make contact by day seven of their RTT pathway.

Should the patient not make contact, the demographic details should be confirmed with the GP. Three attempts will then be made to contact the patient, one of which made in the evening. If still unsuccessful, a second 'invitation to call' letter will be sent to the patient and a copy sent to their GP.

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

Where there is insufficient capacity to offer an appointment within the required milestone, this should be escalated to the relevant 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, eg hospital or patient initiated.

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

This section covers procedures for clinic attendance and outcomes. It is important that the policy describes exactly how the trust will record patient statuses, cash up clinics, complete outcome forms, and update RTT statuses.

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

Clinic outcomes (eg 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 (ie 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 open pathway

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

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.

Booking follow-up appointments

This section describes how the trust will book follow-up appointments. Trusts will need to make sure that this section reflects local practices and that it is consistent with good patient follow-up management, eg recording a due date. The example below provides a process for both open and closed pathways with a partial booking system for the latter (not on an open pathway) group.

Patients on an open pathway

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

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

Patients not on an open pathway

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

- They will be added to the PBFU waiting list.
- Nearer to the time that their follow up appointment is due, they will be sent an 'invitation to book' letter.
- An appointment will then be agreed with the central booking office.
- Should the patient fail to contact the central booking office, an attempt will be made to contact the patient at three different times of days, one of which will be after 5 pm.
- If unable to make contact, a clinical review will take place to decide on the best course of action.

Did not attends

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

Appointment changes and cancellations initiated by the patient

This section covers the processes for managing appointment changes and cancellations initiated by the patient. It is important to note and implement the definition of a cancellation in the access policy (please see the first point below) in terms of recording outcomes in this eventuality. The trust should ensure that the policy does not include blanket rules, eg discharge after two cancellations and recognises that cancellations in themselves do not stop clocks. Clock stops should only be applied following a clinical review and where discharge is in the patient's best clinical interest (please see the last few bullet points for more detail). Also, please refer to the patient-initiated delay section on page 17.

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

If the patient requires a further appointment, this will be booked with the patient at the time of the cancellation.

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

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

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. This may, for example, include the expectation and process for clinical annual and study leave.

- 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 6 weeks' notice of 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 open RTT pathways to be treated within 18 weeks. Equally, this will allow patients not on open pathways to be reviewed as near to the clinically agreed timeframe as possible.

Diagnostics

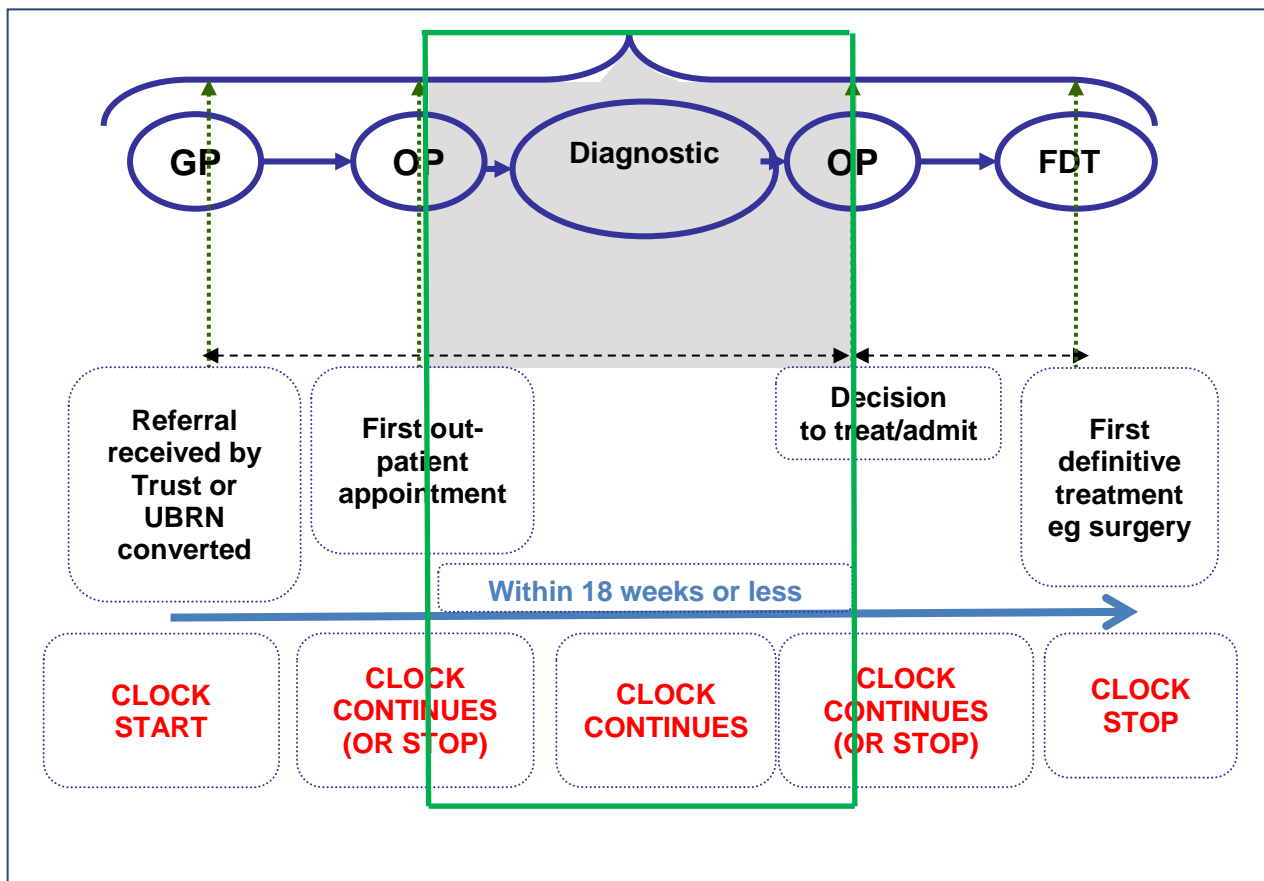
This section provides an introduction to the diagnostic phase of the patient pathway. Although a number of patients will already be known to the hospital from outpatients it is important that the trust details any other referral routes. The following sections, for example, cover patients with an RTT and diagnostic clock, straight to test and diagnostic only patients.

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, ie 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

Patients with a diagnostic and RTT clock

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

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

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.

The trust should insert here a locally agreed list of such services.

Patients with a diagnostic clock only

Patients who are referred directly for a diagnostic test (but not consultant-led treatment) by their GP, ie 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.

The trust should insert here a locally agreed list of such services.

National diagnostic clock rules

The trust should provide details on the diagnostic clock rules, including clock start, clock stop, reasonableness, DNA, cancellations, and any impact on the patient's RTT clock.

- **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.

Booking diagnostic appointments

The appointment will be booked directly with the patient at the point that the decision to refer for a test was made wherever possible (eg 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 does not attend 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.**

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

Where a patient has cancelled, declined and/or not attended 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.**

Active diagnostic waiting list

[The trust should state how diagnostic patients will be captured and monitored on a 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).

Planned diagnostic appointments

This section includes details on planned diagnostic patients, noting their exemption from diagnostic clock rules. The trust should describe how these patients are monitored on a planned waiting list and ensure that patients are transferred to an active waiting list, with a new diagnostic clock and RTT clock, if they go over their due date.

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

Therapeutic procedures

This section provides information on therapeutic procedure which would stop an RTT clock and how this is managed against waiting time rules.

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

Pre-operative assessment (POA)

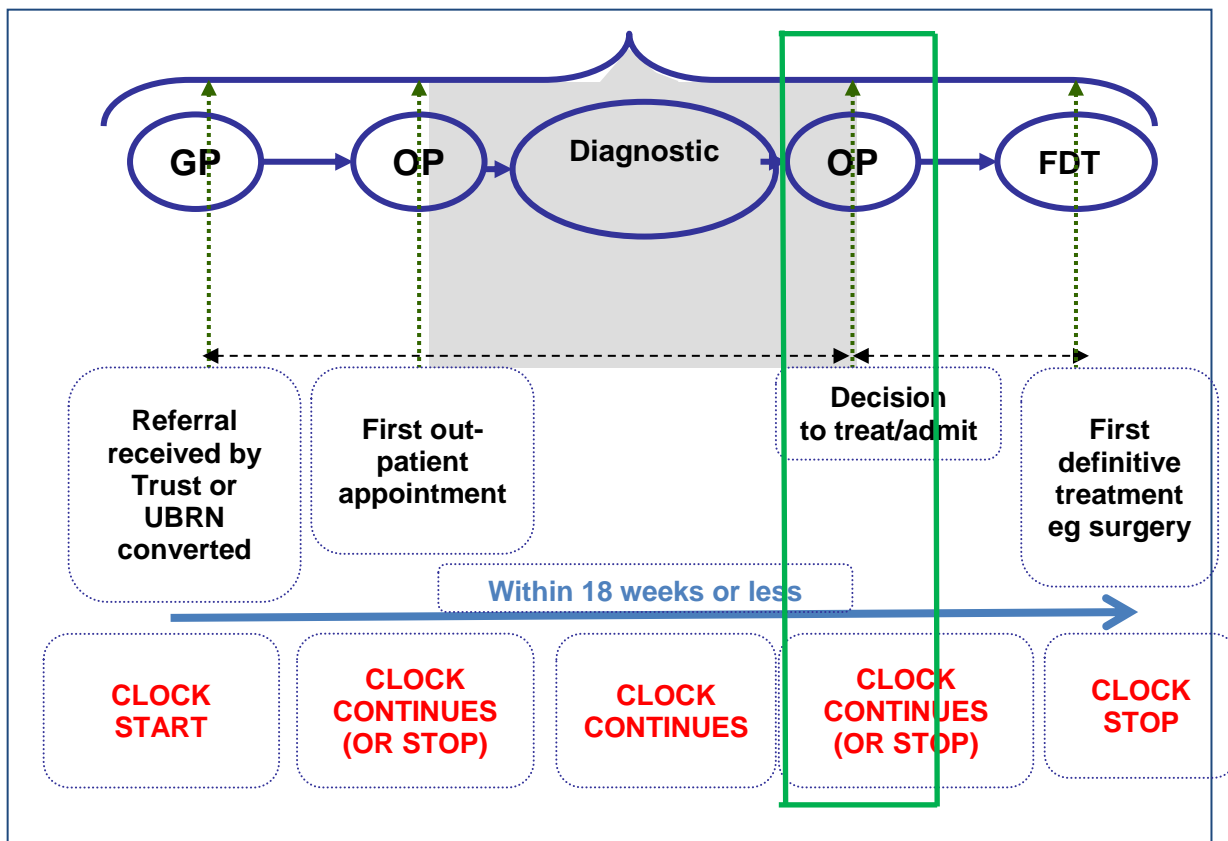
It is important for trusts to describe the process for managing pre-operative assessment in their organisation. This should include at what stage in the pathway patients can expect to be pre-operatively assessed, for example at a walk-in service on the same day as the decision to admit. If a walk-in service is not in place, trusts should strive to pre-operatively assess the patient as soon as possible following the decision to admit.

Trusts should also describe in this section the principles and RTT clock rules for the management of DNAs and the patient's fitness status.

Should patients be added to the admitted waiting list if they have not been pre-operatively assessed?

Yes – although the **ideal** patient pathway would be for the DTA, POA and addition to the waiting list all to take place on the same day, if a same day POA service is not in place, patients should still be added to the waiting list without delay following the DTA, regardless of whether the POA has taken place.

Figure 5: Stages in pre-operative assessment (POA)



Key
 OP – outpatients
 FDT – first definitive treatment

All patients with a decision to admit (DTA) requiring a general anaesthetic will require a POA. Where the patient is attending the trust at the point of the DTA (eg an outpatient appointment), then the pre-operative assessment should take place on the same day as the decision to admit to assess the fitness of the patient for surgery. The vast majority of patients can be assessed by the trust’s dedicated POA nurse specialists.

Where necessary, patients should 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 nurse consultant or anaesthetist, 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.**

If the patient is identified as unfit for the 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 (eg 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.

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:

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

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

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.

Surgical appliances

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

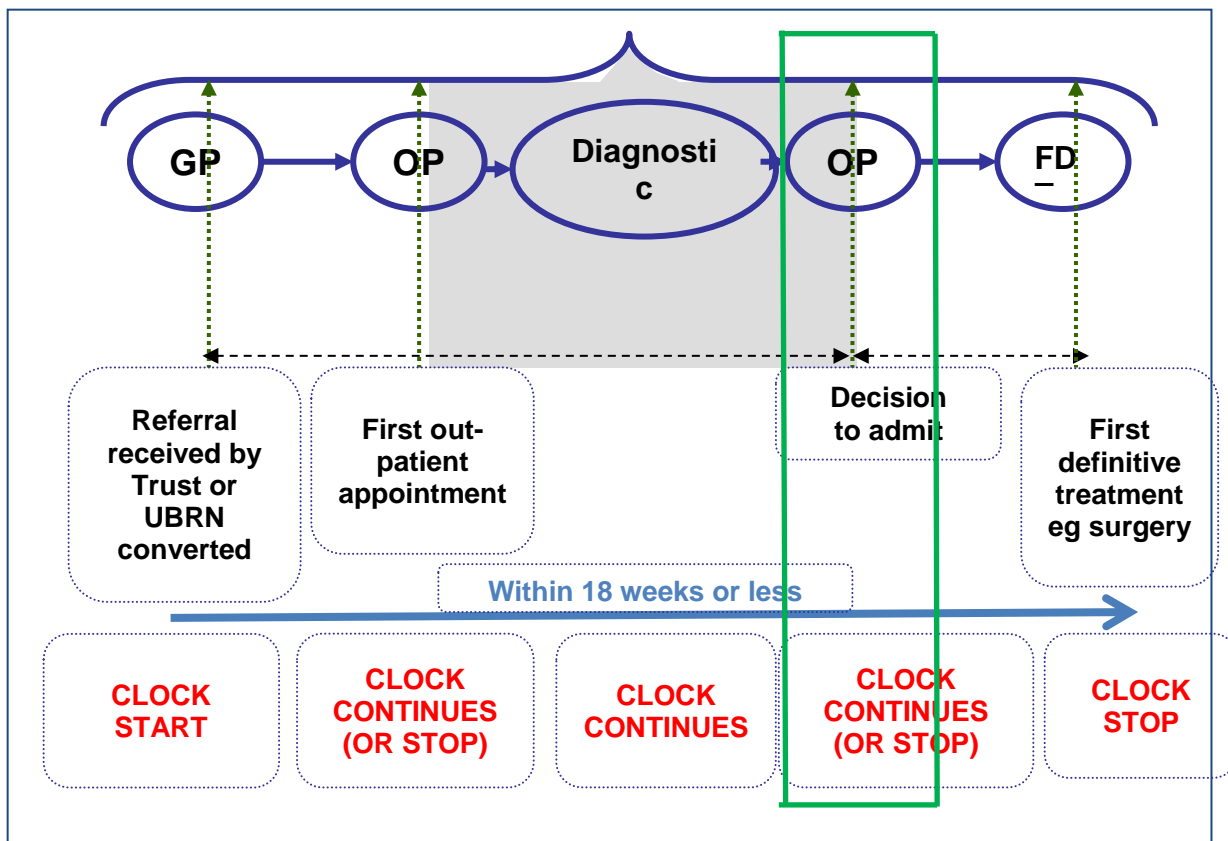
Dietetics

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 (eg bariatric). In this pathway, the clock could continue to tick.

Non-activity related RTT decisions

This section covers the process and timestamp for non-activity related RTT decisions. Trusts should review local processes to provide guidance on key non-activity related 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.

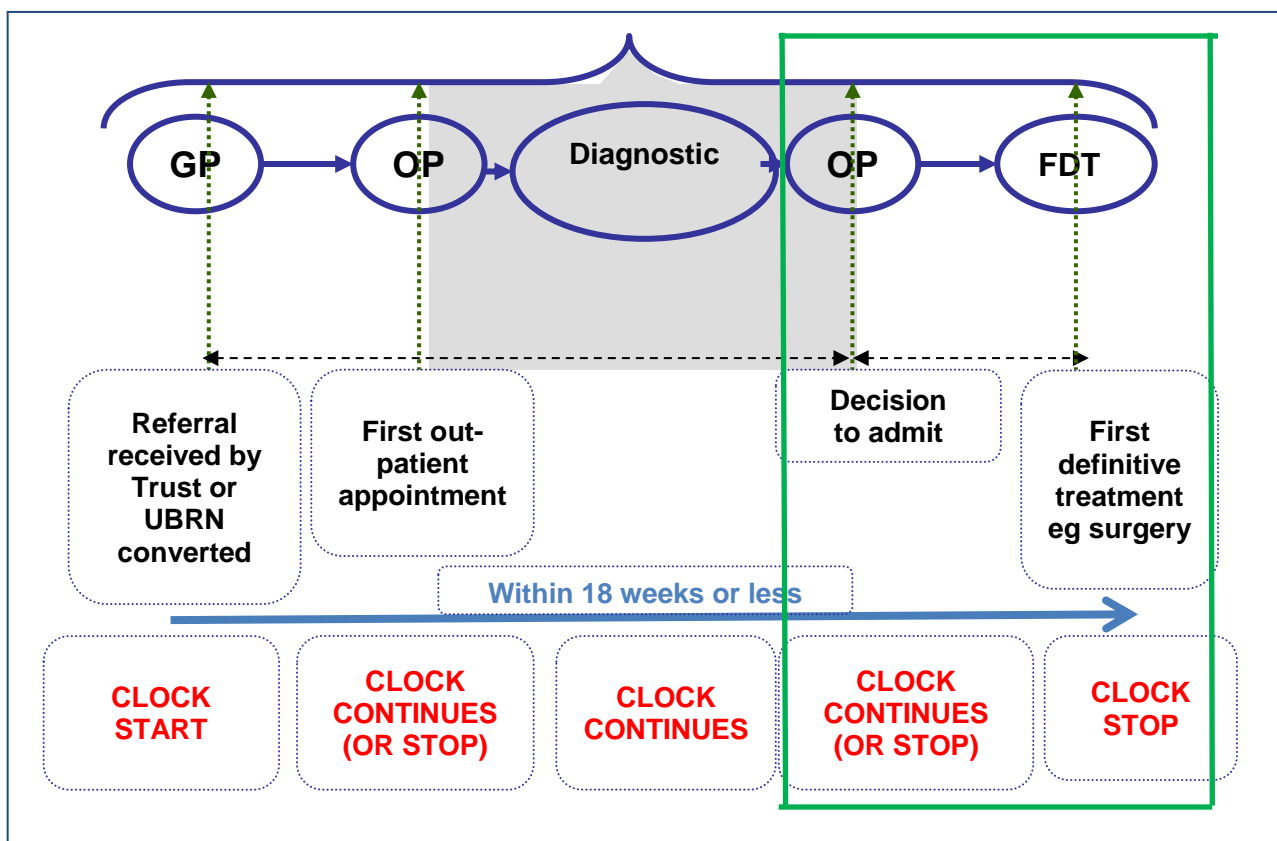
Administration staff should update PAS with the clock stop. The date recorded will be the day the decision not to treat is communicated in writing to the patient.

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

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. It is worth noting the difference between active RTT patients and planned patients (awaiting admission at a specific clinically defined time). It also helps to include clock start statuses (please see bullet points below).

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.

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.

Patients requiring thinking time

The access policy should address RTT statuses when addressing patient thinking time. The section below provides an approach which is consistent with national guidance. While it is not possible to specifically define short or long in an access policy it can be helpful for clinicians to consider whether the outcome (clock continues or stops) would make sense to the patient.

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.

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. An 'invitation to call' letter will be generated from PAS, asking patients to make contact.

If the patient does not make contact, the demographic details will be confirmed with the GP. Three attempts will then be made to contact the patient, with one being in the evening. If still unsuccessful, a second 'invitation to call' letter will be sent to the patient and a copy sent to their GP.

Patients will be offered a choice of at least two 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, eg hospital or patient initiated.

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

The access policy should cover patients declaring periods of unavailability (also covered on page 18 under patient-initiated delays). It is important that the policy is consistent with national rules and it should be noted that in the policy that the RTT clock continues throughout such periods and no blanket rules, such as 'a maximum of eight weeks' are stated or applied. While periods of unavailability (leading to patient-initiated delays) are applicable to both non-admitted and admitted stages of the pathway, they tend to be more applicable to admitted pathways.

If patients contact the trust to communicate periods of unavailability for social reasons (eg holidays, exams), this period should be recorded on PAS.

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

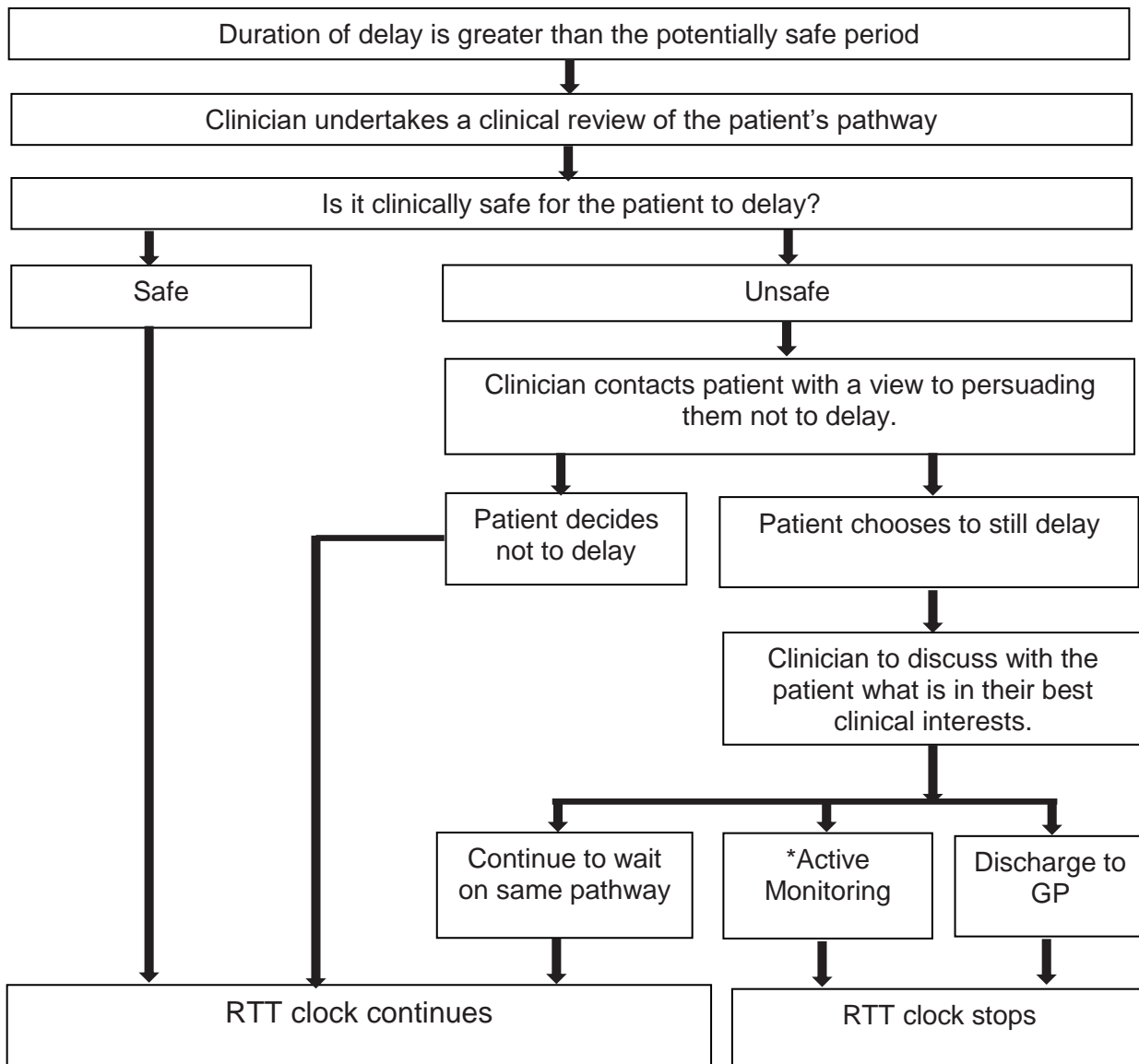
- Clinically safe for the patient to delay: continue progression of pathway. The RTT clock continues.
- Clinically unsafe length of delay: clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues. In exceptional circumstances if a patient decides to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

Patients who decline or cancel TCI offers

In this section it is appropriate to note that declined and cancelled TCIs do not stop the clock. It is important to describe that no blanket rules can be applied and only the clinician can make the decision on an individual basis to stop the clock by applying an appropriate clock stop code. This section should also convey that in reaching a decision on an individual patient basis, clinicians should strike a balance between the trust's responsibility for acting in the patient's best clinical interests and the fact that patients have a right to choose to delay. The flowchart below provides

a framework to support trusts to achieve this and to ensure that the correct RTT clock rules are applied in each scenario.

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 greater than a potentially clinically safe period of delay (as indicated in advance by consultants for each specialty), the patient’s pathway will be reviewed by their consultant. The flowchart below outlines possible outcomes.



*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.

Patients who do not attend admission

This section should describe the process for when patients DNA their admission appointment. Trusts will need to ensure that DNAs are reviewed by the patient's consultant and they are only discharged (clock stop) if it is in their best clinical interest. There should be no blanket rules, for example two DNAs lead to automatic discharge.

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.

On-the-day cancellations

This section should provide details on the 28-day target in the event of an on-the-day cancellation. It is of benefit to note the implications when the trust cannot rebook the patient within this timeframe.

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. If it is not possible to offer the patient a date within 28 days of the cancellation, the Trust will offer to fund the patient's treatment at the time and hospital of the patient's choice where appropriate.

Planned waiting lists

Access policies need to cover both active and non-active RTT patients. Consequently, a section on the management of planned waiting lists is an important part of the pathway for stakeholders and staff to understand. The section should provide 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 (eg surveillance endoscopies) a diagnostic clock would also start.

3. Cancer pathways

The cancer section has its own set of rules and principles so it is worth describing what the cancer section is about and the general principles. Trusts should note the Department of Health's [Cancer waiting times guide](#) and the national dataset requirements.

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 waiting times standards. This policy is consistent with the latest version of the Department of Health's [Cancer Waiting Times Guide](#) and Addendum to v9, and includes national dataset requirements for both waiting times and clinical datasets.

Principles

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

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

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

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

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

Roles and responsibilities

Trusts should set out here the responsibilities of key staff/staff groups, taking into account their own locally agreed (governance) structures.

Chief executive: The chief executive has 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.

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

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 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 performance and 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.

Cancer access manager: Responsible for monitoring delivery of key tasks by the MDT co-ordinators and the 2WW office team.

Deputy cancer access manager and cancer information team: Responsible for running daily audits of all 2WW referrals and highlighting:

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

2WW office team and those designated to make 2WW outpatient

appointments: Responsible for receiving 2WW and breast symptom outpatient referrals and ensuring they are managed to comply with the 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.

Training/competency requirements

Trusts will wish to specify their training/competency requirements in this section. The below is an example of what a trust might include.

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

Cancer waiting times standards

As before, it is useful to state the various targets near the start of the section. It is particularly helpful for cancer as there are a number of targets involved during the patient pathway and between services.

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

Table 1: Key cancer waiting time standards

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

Summary of the cancer rules

As with RTT, details on clock starts and clock stops should be described in this section. The trust may wish to refer to the latest cancer guidance or cancer operational policy for operational roles that are more concerned with detailed cancer management, rather than the general principles described in this document.

Clock start

2WW

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

62 day

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

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

31 day

A 31-day cancer clock will start following:

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

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

Clock stops

A 62-day cancer clock will stop following:

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

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

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

A 31-day cancer clock will stop following:

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

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

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

GP/GDP suspected cancer two-week wait referrals

This section will include the process, recording and timescales for two-week wait referrals. Trusts should review their own processes and describe the key events as shown in the example below.

All suspected cancer referrals should be referred by the GP/GDP on the relevant cancer pro forma provided and submitted via e-referral or email using the generic nhs.net email address.

Day 0 is the date the referral was received.

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

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

For 2WW referrals received by the trust without key information the 2WW team will contact the relevant GP surgery by phone within 48 hours of receipt of referral to obtain the missing information. The referral process should begin, ie outpatient appointment booked for patient while information is being obtained, to ensure there is no delay to the patient's pathway.

Any 2WW referral received by the trust for a service that the trust is not commissioned to deliver will be sent electronically to an appropriate local provider with a copy for information sent electronically to the referring GP within 24 hours of receipt.

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

Downgrading referrals from two-week wait

[A description of when a two-week wait referral can be downgraded should be included in this section. It is important to note the process for discussing the referral with the GP and that only the GP can decide to withdraw the referral.](#)

The trust cannot downgrade 2WW referrals. If the consultant believes the referral does not meet the criteria for a 2WW referral they must contact the GP to discuss. If it is decided and agreed the referral does not meet the 2WW criteria, the GP can retract it and refer on a non 2WW referral pro forma. (It is, however, only the GP who can make this decision.)

Two referrals on the same day

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

Screening pathways

[A section on the screening pathway is important to note the services involved and the instances that create a clock start.](#)

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

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

Consultant upgrades

Details on the process and clock starts for consultant upgrades should be described in the access policy. The example below will be applicable for most trusts, but it is important to check is it consistent with your local processes.

Hospital specialists have the right to ensure that patients who are not referred urgently as suspected cancer referrals or through the screening programmes, but who have symptoms or signs indicating a high suspicion of cancer, are managed on the 62-day pathway. This can be achieved by upgrading the patients onto a 62-day upgrade pathway.

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

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

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

Who can upgrade patients onto a 62-day pathway

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

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

Responsibilities

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

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

Subsequent treatments

The policy should include details on subsequent treatments and the management of earliest clinically available date.

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

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

Reasonableness

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

Waiting-time adjustments

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

Pauses

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

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

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

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

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

Patient cancellations

Due to the urgency associated with cancer patients it is important the trust provides a detailed approach to patient cancellations, DNAs and when patients are uncontactable. The policy should be consistent with national rules and act in the best interest of the patient. The text below provides an example of how the trust may approach such instances and the escalation process.

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

First appointment cancellations

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

Subsequent cancellations

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

Multiple cancellations

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

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

Patient DNAs

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

First appointment

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

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

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

Subsequent appointments

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

Patients who are uncontactable

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

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

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

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

If the patient remains uncontactable:

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

Patients who are unavailable

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

Diagnostics

A diagnostic section should specify how two-week waits are applicable for straight to test and the timescales expected for diagnostic tests and reports. The policy will need to cover the escalation for refusal and how refusal of all diagnostic tests should be handled.

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

Refusal of a diagnostic test

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

Managing the transfer of private patients

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

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

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

Entering patients on the tracking pathway

Suspected cancers: 2WW GP/GDP referrals

On receipt of a 2WW referral from a GP/general dental practitioner, the 2WW office will record the referral (including known adjustments, referring symptoms and first appointment) onto the cancer management system within 24 working hours of receiving the referral.

The 2WW co-ordinators are responsible for confirming a patient's attendance at the first appointment and recording the outcome, checking all dates are correct and that DNAs/breach reasons are entered correctly.

Suspected cancers: screening patients

The MDT co-ordinating team will be responsible for entering patients referred via the screening programme onto the cancer management system database within 24 hours of receiving notification of the referral.

Suspected cancers: consultant upgrades

For upgrade before initial appointments the 2WW office will be responsible for entering patient details onto the cancer management system database and allocating the patient an appointment within the 2WW guidelines.

For upgrades at any other point of the pathway the MDT co-ordinator will be responsible for updating the cancer management system and will begin tracking of the pathway.

Suspected/confirmed cancers (31 day patients)

Patients not referred via a 2WW/screening/consultant upgrade referral should not be entered onto the cancer management system until they have a confirmed cancer diagnosis. The only exception is patients with suspected cancer who are being discussed at an MDT meeting.

Once a patient has been diagnosed with either a new cancer or recurrence, a record should be entered in the cancer management system, selecting the appropriate cancer status (by the MDT co-ordinator) within 24 hours of being notified.

Confirmed cancers

The MDT co-ordinator is responsible for ensuring a patient with a newly diagnosed cancer has a record entered on the cancer management system, and keeping that record updated.

Monitoring and audit

Monitoring and audit are an important part of cancer management and trusts will want to detail how this process is undertaken. The text below provides an example of how a trust may outline its approach.

It is the responsibility of the cancer information team to run a weekly programme of audits for data completeness and data anomalies.

Any data anomalies are highlighted to the relevant tumour site MDT co-ordinator for investigations and correction. Response to the cancer information team must occur within 24 working hours of the anomaly being raised in order not to delay the audit programme and to ensure accurate performance available at all times.

In addition, a regular data quality programme will be established to review the following:

- comparative audit of data on the cancer management system and PAS
- comparative audit of diagnosis code on PAS, cancer management system and healthcare records
- comparative audit of cases removed from the 62-day pathway and re-entered as 31-day patients within four weeks of removal.

This will involve reviewing a random selection of healthcare records from each tumour site and will be led by the cancer information team.

The cancer information team will also capture numbers of patients 'upgraded' each month and will carry out a quarterly audit to ensure that patients are being 'upgraded' at the earliest opportunity.

Glossary

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

Terms

Term	Definition
2WW	Two-week wait: the maximum waiting time for a patient's first outpatient appointment or 'straight to test' appointment if they are referred as a 62-day pathway patient.
31-day pathway	The starting point for 31-day standard is the date a patient agrees a plan for their treatment or the date that an earliest clinically appropriate date (ECAD) is effected for subsequent treatments.
62-day pathway	Any patient referred by a GP with a suspected cancer on a 2WW referral pro-forma, referral from a screening service, a referral from any healthcare professional if for breast symptoms or where a routine referral has been upgraded by a hospital clinician, must begin treatment within 62 days from receipt of referral
Active monitoring	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures.
Active waiting list	The list of elective patients who are fit, ready and able to be seen or treated at that point in time. Applicable to any stage of the RTT pathway where patients are waiting for hospital resource reasons.
Bilateral procedures	Where a procedure is required on both the right and left sides of the body.
Breach	A pathway which ends when a patient is seen/receives their first treatment outside the 14-day first seen, 62-day referral to treatment and/or 31-day decision to treat to treatment target times.
Chronological booking	Refers to the process of booking patients for appointments, diagnostic procedures and admission in date order of their clock start date.

Consultant-led service	A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse-led clinics which come under the umbrella of consultant-led services.
Day case	Patients who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.
Decision to admit	Where a clinical decision is made to admit the patient for either day case or inpatient treatment.
Direct access	Where GPs refer patients to hospital for diagnostic tests only. These patients will not be on an open RTT pathway.
Elective care	Any pre-scheduled care which doesn't come under the scope of emergency care.
First definitive treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgement in consultation with the patient.
Fixed appointments	Where an appointment or admission date is sent in the post to the patient without the opportunity to agree a date.
Full booking	Where an appointment or admission date is agreed either with the patient at the time of the decision or within 24 hours of the decision.
Incomplete pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage.
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night
Nullified	Where the RTT clock is discounted from any reporting of RTT performance.
Oncology	The branch of science that deals with tumours and cancers.
Partial booking	Where an appointment or admission date is agreed with the patient near to the time it is due.
Patient-initiated delay	Where the patient cancels, declines offers or does not attend appointments or admission. This in itself does not stop the RTT clock. A clinical review must always take place.
Planned waiting list	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18-week RTT pathway.

Reasonable offers	A choice of two appointment or admission dates with three weeks' notice.
Straight to test	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an RTT pathway.

Acronyms

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.
CATS	Clinical assessment and treatment service
CCGs	Clinical commissioning groups: commission local services and acute care.
CNS	Clinical nurse specialists: use their knowledge of cancer and treatment to co-ordinate the patient's care plan and act as the patient's 'keyworker'.
COF	Clinic outcome form
COSD	Cancer outcomes and services dataset: the key dataset designed to define and deliver consistency in data recording, data submission and analysis across cancer in the NHS, including diagnostics, staging, treatment and demographic information. Data is submitted to the cancer registry and used for national reporting.
DNA	Did not attend: patients who give no prior notice of their non-attendance.
DTT	Decision to treat (date): the date on which the clinician communicates the treatment options to the patient and the patient agrees to a treatment.
ECAD	Earliest clinically appropriate date that it is clinically appropriate for an activity to take place. ECAD is only applicable to subsequent treatments.
E-RS	(National) E-Referral Service
FOBT	Faecal occult blood test: part of the bowel screening pathway, checks for hidden (occult) blood in the stool (faeces).
GDP	General dental practitioner (GDP): typically leads a team of dental care professionals (DCPs) and treats a wide range of patients, from children to the elderly.

GP	General practitioner: a physician whose practice consists of providing ongoing care covering a variety of medical problems in patients of all ages, often including referral to appropriate specialists.
The cancer management system	A database system used to record all information related to patient cancer pathway by MDT co-ordinators, CNSs and clinicians.
IOG	Improving outcomes guidance : NICE guidance on the configuration of cancer services.
IPT	Inter-provider transfer
MDT meeting	A multidisciplinary team meeting where individual patients care plans are discussed and agreed.
MDS	Minimum dataset: minimum information required to be able to process a referral either into the cancer pathway or for referral out to other trusts.
MDT	Multidisciplinary team: here describing a group of doctors and other health professionals with expertise in a specific cancer, who together discuss and manage an individual patient's care.
MDT co-ordinator	Person with responsibility for tracking patients, liaising with clinical and clinical assessment unit staff to ensure progress on the cancer pathway, attending the weekly patient tracking list (PTL) meeting, updating the trust database for cancer pathway patients and assisting with pathway reviews and changes. Also co-ordinates the MDT meeting and records the decision for progress along the cancer pathway.
NCWTDB	National cancer waiting times database: all cancer waiting times general standards are monitored through this.
PAS	Patient administration system records the patient's demographics (eg name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient.
PPID	Patient pathway identifier
PTL	Patient tracking list: a complex spreadsheet used to ensure that cancer waiting times standards are met by identifying all patients on 62-day pathways and tracking their progress towards the 62- or 31- day standards.
PTL	Patient tracking list. A tool used for monitoring, scheduling and reporting on patients on elective pathways (covering both RTT and cancer).
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 meeting: where individual patients' care plans are discussed and agreed; takes place across multiple organisations and involves support from a centre specialising in treating a particular tumour type.
TCI	To come in (date). The date of admission for an elective surgical procedure or operation.
TIA	Transient ischaemic attack: a mini stroke caused by a temporary disruption in the blood supply to part of the brain.
TSSG	Tumour site specific group
UBRN	Unique booking reference number

References and further reading

No	Title	Published by	Publication date	Link
	Referral to treatment consultant-led waiting times Rules Suite	Department of Health	October 2015	www.gov.uk/government/uploads/system/uploads/attachment_data/file/464956/RTT_Rules_Suite_October_2015.pdf
	Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care	NHS England	October 2015	www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting-RTT-guidance-v24-2-PDF-703K.pdf
	Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care: frequently asked questions	NHS England	October 2015	www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Accompanying-FAQs-v7.2.pdf
	The NHS Constitution	Department of Health	July 2015	www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf
	Diagnostics waiting times and activity Guidance on completing the 'diagnostic waiting times & activity' monthly data collection	NHS England	March 2015	www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/
	Diagnostics FAQs Frequently Asked Questions on	NHS England	February 2015	https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-

completing the 'Diagnostic Waiting Times and Activity' monthly data collection				activity/monthly-diagnostics-waiting-times-and-activity/
Equality Act 2010	Department of Health	June 2015		www.gov.uk/guidance/equality-act-2010-guidance
Overseas Visitor Guidance	Department of Health	April 2016		www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations
Cancer waiting times guidance Version 9	Department of Health	October 2015		https://digital.nhs.uk/cancer-waiting-times
Delivering cancer waiting times good practice guide	NHS Improvement	July 2016		https://improvement.nhs.uk/resources/delivering-cancer-waiting-times-good-practice-guide/
Armed Forces Covenant	Ministry of Defence	July 2015		www.gov.uk/government/uploads/system/uploads/attachment_data/file/49469/the_armed_forces_covenant.pdf

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