DOCUMENT CONTROL PAGE	
Title	Title: Manchester Foundation University Trust Access Policy Version: 2 Reference Number:
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Author	Originated / Modified By: Audrey Walters, Tariq Sheikh Designation: Performance Manager and Assistant Service Improvement Manager
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EXCECUTIVE SUMMARY

The length of time a patient waits for hospital treatment is an important quality issue and is a visible and public indicator of the efficiency of the services provided by the Trust. The Trust is committed to putting patients first and ensuring that national operational performance standards are met in line with the Next Steps on the NHS Term Plan.

https://www.longtermplan.nhs.uk/

The Trust is required to deliver performance against the key measures set out by our regulator, NHS Improvement (NHSI), through the accountability framework and oversight model.

The Access Policy informs patients, relatives and staff of their rights and what to expect from the Trust. It is linked to the NHS Constitution (2015) and therefore to certain legal rights. It also allows Trusts and commissioners to set out their local approach to managing and sustaining shorter waiting times, as set out in the NHS Constitution.

Part of the NHS pledge is to put patients at the center of their care which involves making sure that the patients are diagnosed and start treatment as soon as possible, at a time that is convenient for them.

The NHS Constitution (last updated October 2015), says that patients have the right to access certain services commissioned by NHS bodies within maximum waiting times. Where this is not possible, and the patient requests it, the NHS will take all reasonable steps to offer a range of suitable alternative providers, unless the patient chooses to wait longer or it is clinically appropriate that they wait longer.

In addition to these standards, the following quality indicators must be attained. The threshold, method of measurement and consequences of breach are also detailed.

- The Provider shall make specified information available to prospective NHS patients through the NHS Choices website, and shall in particular use NHS Choices to promote awareness of the services among the communities it serves, which can be found at http://www.nhschoices.nhs.uk. Also the provider must ensure the information provided is accurate and accessible in line with the Accessible Information Standard. For further information please see Accessible Information Guidance V1.1 August 2017
- Commissioners and Providers will provide information on patient's right to access services within the maximum waiting times. The NHS Constitution states that patients have the right to start treatment within 18 weeks from referral.
- The Provider shall offer clinical advice and guidance to GPs on potential referrals through E-Referral, whether this leads to a referral being made or not.
- The Provider and the Commissioners shall work together to ensure that patients are not inconvenienced by insufficient slots being made available to e-Referral. This is by means of joint robust Capacity and Demand planning monitored through the Local Health Economy (LHE) Planned care meetings.
- Ensure that there are contingency plans in place to deal with patient bookings and the receipt of referrals should the e-Referral system be temporarily unavailable.

- Have in place a system to accept referrals from The Appointments Slot Issue (ASI) worklist where patients have attempted to book an appointment but there were no slots showing on e-Referral at the time, as detailed in the Appointment Slot Issue guidance (NHS England ASI Guidance)

- Ensure that the only referrals which are rejected are those considered to be clinically inappropriate (except where local arrangements have been agreed that ensures patients' are fully informed of the choice of alternative providers).

- Provide clear feedback information in e-Referral when referrals are rejected.

- The Provider shall issue the Patient's Discharge Summary to the Patient's GP: within 24 hours of the Patient's discharge from the Provider's Premises.

Manchester Local Medical Committee (MLMC) informed the Trust of the Implementation of a new standard hospital contract which was republished on March 2019, with new requirements to reduce inappropriate bureaucratic workload shift onto GP practices.

These are in addition to the requirements that were highlighted in the 16-17 standard hospital contract. Hospital standard contract requirement found timely production and transmission of clinic letters (where clinically required) following clinic attendance, to GP practices, 7 days (from 1 April 2018).

This policy defines roles and responsibilities and establishes a consistent approach to managing patient access to the Trust.

1. INTRODUCTION AND OVERARCHING PRINCIPLES

Manchester University NHS Foundation Trust (MFT) consists of 9 Hospitals.

- Manchester Royal Infirmary
- Wythenshawe, Trafford, Withington and Altrincham (WTWA)
- Saint Mary's Hospital
- Royal Manchester Children's Hospital
- Manchester Royal Eye Hospital & University Dental Hospital
- North Manchester General Hospital will be joining MFT in due course in 2019/20

Each Hospital provides a variety of services some of which are specialist tertiary care (only available on certain sites).

Manchester University NHS Foundation Trust is committed to providing an exemplary standard of patient access as is required and expected of a modern and efficient NHS service provider. The Trust is committed to reducing waiting times, offering quick and reliable access to services and to provide patient choice. The Trust will ensure that the management of patient access to services is transparent, fair, equitable, and managed according to clinical priority.

Whilst this policy provides guidance on Access Management, each patient will be treated on the appropriate clinical pathway for their condition and this should be clearly communicated to the patient. This may require information and communication being made available in different formats or languages in order to meet the person's Accessible Information Standards (August 2017) and communication needs.

To enable the standardisation of patient management within the Trust, it is important that patient access procedures are consistent across the Hospital sites, ensuring that we meet the standards for patient care. We must all be clear about the importance of both maintaining data standards and the uses to which data will be put, from caring for patients to accounting for the services we provide.

This policy should be read in conjunction with the following local and national documents. Some documents are specific to certain hospital sites due to the recent merger of two Trusts. These will be consolidated in due course to give one standard document across the Organisation:

- NHS Constitution for England (July 2015)
- RTT Rules Suite
- RTT Frequently Asked Questions
- Choice Framework, Department of Health(November 2019)
- Consultant-led Referral to Treatment Rules Suite, (October 2015)
- Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care
- Everyone Counts: Planning for Patients 2014/15 to 2018/19, (NHS England)
- National Cancer Waiting Times Monitoring Dataset Guidance (2019/2020

- Manchester Clinical Commissioning Groups Effective Use of Resources Treatment Policies (updated October 2019) – V6.3
- Diagnostic Imaging Dataset information
- Diagnostic FAQs: Frequently Asked Questions on completing the, Diagnostic Waiting Times & Activity' monthly data collection (updated February 2015)
- Code of Conduct for Private Practice: Recommended Standards of Practice for NHS Consultants (January 2004)
- NHS Manchester CCG's Outpatient Follow-up Appointment Framework
- NHS Manchester CCG's Consultant to Consultant Framework V4.0 (Jan 16)
- Accessible Information Standard (August 2017)

2. PURPOSE

The aim of this policy is to ensure that national guidance and good practice is followed to ensure that patients are treated promptly, efficiently and consistently.

General Principles:

Equality and Diversity and Human Rights

The Trust aims to create a culture of care based on positive attitudes towards welcoming the diversity of patients, their families, carers and service users and meeting diverse needs. The Trust is an organisation that continually improves by embedding inclusion principles and standards into every day practice and placing them at the heart of policy and planning.

Communication

Communication with patients will be informative, clear, concise and will be adapted as appropriate to meet the patient's information and communication requirements for example, providing information in an alternative format.

Transparency

Clinical priority must be the main determination of when patients are seen as outpatients or admitted as inpatients. Patients of the same clinical priority will be seen in chronological order from date referral received. The management of patients on non-admitted or admitted pathways will be equitable and transparent. Patients on a planned pathway (whose clock may have stopped for non-treatment reasons), and have a continued need for treatment, must be treated equitably and not disadvantaged in terms of their waiting time.

Data Quality

Data quality and accuracy is the responsibility of everyone in the Trust. This includes all clinical staff, service management and administration. Data capture, processing and reporting must accurately reflect working practice and must be of a standard so as not to adversely affect patient care. (For example, the incorrect procedure code has been entered and this leads to an unnecessary hospital admission).

3. ROLES AND RESPONSIBILITIES

Accountability for achieving the key performance indicators for all access targets lies with the Trust Board for MFT. However, the Executive Board in each hospital site are responsible for complying with this Policy and ensuring delivery of all access targets in line with key performance indicators.

The **MFT Group Chief Executive and MFT Trust Board through the MFT Group Chief Operating Officer**

Is responsible for ensuring that this policy is implemented effectively, the MFT Chief Operating Officer is also responsible to ensure that this document is reviewed annually or as recommended by the NHS England Intensive Support Team (IST) and the Trust Governance Board.

The **MFT Chief Operating** Officer and delegated officials (e.g. Site Executives)

Has responsibility for reporting Waiting List Performance and through the Hospital Performance reviews will monitor compliance against this policy. In addition the **MFT Chief Operating Officer** has responsibility for ensuring recommendations of internal audit are implemented once the final report is presented to the Audit Committee.

Managed Clinical Services and Clinical Standard Groups

Have responsibility for ensuring the clinical pathways and standards set are aligned to the delivery of key access targets.

Clinical Leads and Hospital Directors

Have responsibility within their Hospital for all access target performance including the maintenance of accurate waiting lists and the training of staff that are responsible for managing patient's access, to ensure compliance with this policy. The Clinical Leads and Hospital Directors will hold to account responsible staff through the monitoring processes at performance reviews.

Consultants and Clinical Teams

Consultants and their clinical teams are responsible for working within the guidelines outlined, complying with the Performance Thresholds and Standard Operating Guidance in the Policy. In particular, they are responsible for:

- Explaining the patients' responsibilities in terms of being available within 18 weeks and that patients may be discharged following clinical review where they DNA or rearrange multiple attendances etc. to ensure that clinical resources are utilised effectively across the Trust;
- Providing a detailed understanding of any potential treatment, and sufficient notice of direct patient care activity, to minimise the impact on the patient experience and

allow sufficient time for provision to be made for aftercare and other patient responsibilities.

- Complete outcome forms for all attendances and admissions; ensuring that decisions made in an administrative setting are captured and that they support operational and other teams in a timely fashion to ensure that changes to pathways are accurate;
- Ensuring that treatment options offered to patients are locally commissioned and that where applicable there is confirmation of funding for procedures covered in the Manchester Clinical Commissioning Groups Effective Use of Resources Treatment Policies V3.2 (updated August 2016)
- Communicating all relevant information regarding treatment plans and diagnoses to the patient and their GP to support them in delivering high quality ongoing care in a format that meets the patients' communication preferences and needs in line with Accessible Information Standard 2017 (AIS)

Clinical Leads and Operational Managers

Are responsible for complying with the Policy and performance thresholds by effectively managing waiting times therefore, proactively managing inpatient, outpatient and diagnostic waiting lists is essential. In particular, they must ensure compliance with notice periods defined for cancellation of direct clinical activity and that processes are in place to manage this effectively; ensuring that patient care and Trust performance are not adversely affected as a result of planned leave from the hospital.

Standard Operational Polices (SOPs) must be consistent with the policy and that systems are in place to support effective waiting list management. Included in this is the responsibility that all staff must complete the correct training and be competent to allow them to undertake delegated roles and apply the principles within this policy.

Individual staff members, including clinicians

Have responsibility for ensuring that documentation and use of Hospital Information Systems are in line with this policy. It is the responsibility of all members of operational staff to understand key principles in regards to patient access to elective services, including national Referral to Treatment Time (RTT) codes and definitions. Attending all training offered for administrative staff in regards to reporting and managing waiting lists is mandatory.

General Practitioner and practice staff

GP's and their staff are at the heart of patient care coordination between the various elements of the health and social care system. They are well placed to ensure that patients and services have accurate and up to date guidance and that patients are referred in line with locally agreed guidance.

GP's have key responsibilities in relation to their patients accessing secondary and specialist services in a timely and appropriate way, these include ensuring that:

- Referrals are made in a timely fashion from the practice following assessment to ensure that patients referred on an active pathway do not wait longer than is clinically necessary;
- Patients are aware of when their "clock" starts from so that the appropriate expectation is set at the start of their pathway;
- All new GP referrals are made via the national e-Referral Service (e-RS);
- Referrals and other correspondence include all relevant clinical and social history, investigation results and related clinical correspondence so that reviewing consultants and their teams have the appropriate information to inform patient management and referral triage (where this is in place);
- Demographic information, including address, contact telephone numbers and contact preferences are discussed and confirmed with patients prior to referral;
- Patients are only referred when they are ready fit and available for their first assessment and potential subsequent treatment;
- Patients are not referred to a named consultant unless there is a clear clinical need to do so e.g. past treatment from them or provision of a tertiary service that the patient's condition requires them to access;
- Patients understand potential treatment pathways and that if surgery is likely that this is made clear to them in advance and the outcome of this discussion is included in the referral to support consultant care planning and triage;
- Referrals are made in line with locally agreed referral guidance and/or referral criteria displayed via the Directory of Services (DoS) on e-RS;
- Where appropriate to do so patients are referred to community or interface services first and the outcome of past attendances in these services is included in any new referral to secondary care;
- Patients understand that their referral may be subject to clinical review and that a management plan may be provided to their GP where such an agreement exists with the CCG. Therefore an attendance at hospital may not be the end result of a referral;
- Referrals contain information regarding reasonable adjustments, including Accessible Information Standard Requirements, which patients will require to access secondary and specialist services.

Patients / Choice

Patients have a legal right to choose where they go for their first outpatient appointment. They can change provider if they have had to wait longer than the maximum waiting times (18) weeks or 2 weeks to see a specialist for suspected cancer) and can choose who carries out a specialist test suggested by their GP. Full guidance can be found in the Choice Framework (updated November 2019) including exceptions to these legal rights and further information where appropriate, is included within this Policy.

Patients also have a responsibility for being available for treatment within the timescales available to them within this Policy. Patients must inform the Trust in a reasonable timescale if they are unable to attend in line with the NHS Constitution (2013). The patient must arrive for their appointment at the time allocated, as late arrivals may not be seen. They must ensure that the appropriate Hospital Site has been notified of any change to their demographic details and should make every effort to attend all appointments provided for them. Patients must inform their GP of any changes in their medical condition that may affect their attendance or clinical priority. Where a

parent/guardian/carer is supporting the patient, they should undertake to ensure that the patient fulfils their responsibilities. Patients that no longer wish to have surgery/treatment, for whatever reason, must advise their hospital consultant at the earliest possible time.

4. GOVERNANCE

- There is a recognised process whereby policies are developed and/or reviewed. This is done in a collaborative way with a group of stakeholders - both internal and external to the organisation - prior to being tabled for comment and sign off at the appropriate Operational Management Group, Compliance Steering Group and lead CCG;
- Once ratified, this policy will be available on-line for staff via the MFT intranet and access to the general public, patients and visitors via the MFT website (Click Here);
- This policy will be reviewed annually.

5. STAFF COMPETENCY AND COMPLIANCE

5.1 Competency: RTT Training and Other Operational Guidance

Referral to Treatment training is available to all Trust staff; this consists of E-Learning modules via the Trust Learning Hub (https://learninghub.mft.nhs.uk/course/view.php?id=1729). All staff must undertake a RTT Awareness Level One module. Employees with a responsibility for entering RTT information will undergo further training as part of their local induction which includes the Elective Care E-learning Modules provided on the Learning Hub. New starters must not enter access waiting time data (e.g. RTT outcome codes) unless they have been appropriately trained and have had core elective care management competencies signed off by their line manager.

Care Professionals with Outcome Form Responsibilities
All Care Professionals have a responsibility for completing RTT outcome forms in an outpatient or inpatient setting where appropriate. Each Hospital Site's Medical Director is responsible for ensuring Care Professionals receive appropriate training for this and this includes relevant modules from the Trust e-learning package as well as face to face training and presentations at engagement events, for example the new consultant programme and ACE days.

Temporary Staff
All temporary employees from NHS Professionals or various agencies must undergo RTT training as appropriate to their role. This may also include e-learning packages.

Refresher Training
All employees will undergo refresher training once a year following the annual review of the policy and re-launch.

Each hospital has a named RTT lead whose role it is to be a point of escalation for operational staff, if any queries regarding application of the policy arise that are not able to be remedied by immediate line managers or operational leads. It is the responsibility of the RTT/Performance Lead at all sites to ensure that staff are made aware of the training and guidance materials available, including the e-learning modules.

5.2 Compliance

Compliance will be through the following method:

- Audit – local audits will be carried out to monitor the correctness of RTT outcome recording and the accuracy of dates. E-learning monitoring – compliance and coverage will be monitored through Hospital Performance Reviews and the relevant RTT Programme leads;
- Data Quality reporting;
- RTT Outcome coverage;
- Timeliness of adding activity (admissions, transfers, discharges, referrals);
- Demographic coverage and accuracy;
- Timeliness of correspondence (Discharge letters and Clinic letters).

5.3 Entitlement to NHS Treatment

Every effort must be made to ensure the patient is entitled to NHS treatment.
The Trust has a legal obligation to establish whether a person is an overseas visitor to whom charges apply or whether they are exempt from charges. The National Health Service provides healthcare for people who live in the United Kingdom. People who do not normally live in this country are not automatically entitled to use the NHS free of charge – regardless of their nationality, whether they hold a British Passport or have lived and paid National Insurance contributions and taxes in this country.
It should be noted, however, that all patients, regardless of whether they are eligible for NHS treatment or not, are currently entitled to receive emergency treatment in an A&E setting without charge. The patient will become chargeable at the point of admission and for any follow up outpatient appointments required as a result of the attendance.

There are also a small number of other services (and individuals) that are exempt from charges these can be found in the Department of Health Overseas Visitors Regulations (see the Trust's Chargeable Patients Policy for further guidance). Guidance can be updated nationally at periodic intervals and so either refer to the Policy or, in case of query, to the Contracts office.

All NHS Trusts have a *legal obligation* to:

- Ensure that patients who are not ordinarily resident in the UK are identified;
- Assess liability for charges in accordance with Department of Health Overseas Visitors Regulations (see the Trust's Chargeable Patients Policy for further guidance);
- Charge those liable to pay in accordance with Department of Health Overseas Visitors Regulations (again, see the Trust's Chargeable Patients Policy for further guidance);
- The Equality Act 2010 prohibits discrimination against a person on any ground such as race, colour, language or religion. The way to avoid accusations of discrimination is to ensure that services are provided flexibly to meet the needs of all individuals. The Trust also takes into consideration their responsibilities under the Human Rights Act 1998 when providing services;
- UK cross border patients, i.e. patients from Scotland and Northern Ireland can normally be treated as part of the NHS but would require the Contracts Office to obtain prior approval for their treatment, i.e. they should not be treated until this has been

sought unless their treatment is classed as an emergency. For patients from Wales we do have a contract for their patients to be treated, however, where this is high cost in-patient treatment the Contracts Office should be contacted to clarify whether approval needs to be obtained prior to treatment. Click here for an extract from the Welsh Health Specialised Services Committee contract.

6. GENERAL ELECTIVE ACCESS PRINCIPLES

7.1 Access Principles

The NHS Constitution (last updated October 2015), says that patients have the right to access certain services commissioned by NHS bodies within maximum waiting times. Where this is not possible and the patient requests it, the NHS will take all reasonable steps to offer a range of suitable alternative providers, unless the patient chooses to wait longer or it is clinically appropriate that you wait longer.

Referral to Treatment	
Incomplete	92% of patients on an incomplete pathway (i.e. still waiting for treatment) to be waiting no more than 18 weeks (or 126 days)
Diagnostics	
Applicable to diagnostic tests	99% of patients to undergo the relevant diagnostic investigation within 5 weeks and 6 days (or 41 days) from the 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 cancer section on page 53.

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

- Clinical exceptions – situations when it is in the patients 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, or specifying a future date for appointment/admission;
- Co-operation – when patients do not attend previously agreed appointment dates/ admission offers (DNA) and where this prevents the Trust from treating them within 18 weeks and the clinician feels that it would be detrimental to the patients' health for them to be removed from the waiting list.

Cancelled Operations

All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice.

Cancer

Cancer Waiting Times measure the NHS' performance against these national NHS Constitution Standards, as well as a number of other metrics. These measures are used by local and national organisations to monitor the timely delivery of services to patients.

Current Cancer Waiting Times (CWT) Standards:

MAXIMUM 2 WEEKS FROM	OPERATIONAL STANDARDS
Receipt of urgent GP (GMP,GDP or Optometrist) referral for suspected cancer to first outpatient attendance	**93%**
Receipt of referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment	**93%**
MAXIMUM 28 DAYS FROM	**April 2020**
Receipt of two week wait GP (GMP, GDP or Optometrist) referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of two week wait referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer	
MAXIMUM ONE MONTH (31 DAYS) FROM:	
Decision to treat to first definitive treatment Decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is:	**96%**
	Surgery 94%
	Drug Treatment 98%
	Radiotherapy 94%
MAXIMUM TWO MONTHS (62 DAYS) FROM:	
Urgent GP (GMP,GDP or Optometrist) referral for suspected cancer to first treatment (62 day classic)	**85%**
Urgent referral from a NHS Cancer Screening Programme (breast, cervical or bowel) for suspected cancer to first treatment	**90%**
NO SEPARATE OPERATIONAL STANDARDS SET:	
Consultant upgrade of urgency of a referral to first treatment	
Maximum one month (31 days) from urgent GP (GMP,GDP or Optometrist) referral to first treatment for rare cancers: acute leukaemia, testicular cancer and children's cancers	

Back to Starting the Clock and Inclusion of Faster Diagnosis Standard p55

Accident and Emergency

- 95% of patients should be treated, admitted or transferred within 4 Hours of their arrival to the Accident and Emergency Department;

- 100% of patients must be admitted to a ward within 12 hours of a bed being requested.

e-Referral

In some specialities, GPs will be able to use the Advice and Guidance function on e-RS in order to contact a clinician for advice on a patient's management. This could negate the need for a referral to the Trust.

GP referrals to consultant led services should all come through the e-Referral Service, either as a Directly Bookable Service or through an e-Referral Service Referral Assessment Service, where MFT as the provider receives the referral, triages it and then either:

- books an appointment;
- rejects the referral, with relevant guidance, back to the GP.

All GP referrals to MFT services should be referred via e-RS. The Appointment Slot Issues worklist will form part of performance monitoring working towards best practice of 4% e-RS referrals being Appointment Slot Issues. GP referrals to consultant led services will only be accepted if booked via e-Referral.

7.2 Individual Patient Rights

- The patient has the right to make their choice of hospital;

- To commence their treatment for routine conditions following a referral into a consultant led service with a maximum waiting time of 18 weeks to treatment;

- To be seen by a cancer specialist within a maximum of 2 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 treatment is in the best clinical interest of the patient (note that in both these scenarios the patients 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;

- We are committed to delivering equality of opportunity for all staff and services users. Our aim is to ensure that everyone can use our services and we have a workplace that is free from discrimination and harassment;
- Patients should be fully informed about what to expect when accessing the acute services in one of our Hospitals. The information should take account of patient's requirements including, but not limited to: reasonable adjustments, provision of information in languages other than English, and provision of information and communication in formats to meet the patient's accessibility requirements. For further information see the Trust Outpatient Standards Policy.

7.3 Patients moving between NHS and Private Care

Referral of Private Patients to NHS Care

In line with the Greater Manchester Effective Use of Resources: Operational Policy Version: 3.0 (24 Nov 2017) patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient. In such circumstances their care should be transferred to NHS pathways. When this happens, consultants should help to ensure that the following principles apply:

1. Patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. The 18 week clock start date will start on the date the Trust receive the referral from private care;
2. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients;
3. Should a patient be admitted to an NHS hospital as a private inpatient, but subsequently decide to change to NHS status before having received treatment, there should be an assessment to determine the patient's priority for NHS care.

If a request is made for the continuation of a course of treatment that has been initiated privately for a treatment that is not normally commissioned, e.g. alternative therapies the request will be managed as a new request for that treatment. In the event that funding is approved this will start from the date of approval (retrospective funding will not be approved).

Referral of NHS Patients to Private Care

Where a patient chooses to be treated privately rather than receiving NHS care, the consultant must refer the patient back to the care of their GP detailing all relevant clinical information to ensure there is no delay in the patient's on-going care. The RTT clock will stop from the date of communication from the patient to the Trust stating that they do not wish to be treated by the NHS. This must be clearly documented in the patient's health records for audit purposes or the date of the communication with the GP will be the RTT clock stop. This does not apply to NHS patients who are being treated in the private sector as a result of capacity shortfalls at the Trust.

Patients Requesting Private and NHS Care Simultaneously

The patient cannot request NHS and private care simultaneously. This is particularly important where the NHS element of the care is for medications only.

7.4 Commissioner Approval Procedures

Patients should not be referred for treatment that is not routinely funded as determined by the Manchester Clinical Commissioning Groups Effective Use of Resources Treatment Policies (https://manchesterccg.nhs.uk/publications/our-policies/effective-use-resources/).Commissioner approval should be **sought prior to referral** and, therefore, an approval reference should be detailed on the referral. Where this approval reference is not detailed, and the referral letter does not detail the reasons for consultation in terms of meeting exception criteria, the referral will be returned as incomplete. If approval has not been sought, the referral will be sent back to the GP.

If the patient's consultation identifies that they meet the exception criteria for a low priority procedure then the 18 week clock will continue to tick during the process of approving funding. The responsibility for the application for funding in this scenario lies with the secondary care clinician.

7.5 Military Veterans

Military Veterans receive their healthcare from the NHS and should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical needs. Where this is the case, they should be seen in an outpatient setting within 4 weeks.

Where the individual's condition is classified as routine they should be treated in accordance with their clinical priority for treatment and in chronological order as per Patient Access principles, so as not to disadvantage clinically urgent patients who are not military veterans. Reference: The Armed Forces Covenant - https://www.gov.uk/government/publications/the-armed-forces-covenant. Last updated July 2015.

7.6 Prisoners

All elective standards and rules are applicable to prisoners. Delays to treatment incurred as a result of difficulties in prison staff being unable to escort patients to appointments or for treatment do not affect the recorded waiting time for the patient but may result in safeguarding referral. The Trust will work with staff within the prison service to minimise delays through clear and regular communication channels and by offering a choice of appointment or admission date in line with reasonable criteria.

7.7 MFT Service Standards

Where possible, the Trust will aim to work to the standards set out below:

- Referral registered within two working day of arrival into the Trust;
- Referral vetting and triage within two working days of registration. e-Referral Worklists to be reviewed and actioned within two working days;
- When referrals are received via the e-Referral ASI, patients will be contacted within 7 days to confirm receipt of referral. An appointment should be booked within 6 weeks. Where capacity does not allow this, the issue will be escalated to the management team for resolution. Appointments for Internal and Tertiary referrals will be made within 5 working days of receipt;
- Clinic appointments will not be cancelled at less than 4 weeks' notice except in exceptional circumstances;
- We will offer choice on where and how we deliver patient care whenever possible;
- If a suspected cancer referral is received for a non-commissioned service within the Trust it should be referred on to the correct provider within one working day, ideally immediately and this will be communicated to the GP. Similarly, a non-cancer referral received for a non-commissioned service should be referred on to the correct provider within 2 working days and this will be communicated to the GP;
- If, on clinical review of a referral, it is felt that the patient would be best served by another team outside the Trust then this will also be referred on within one working day of that decision and the GP informed.

7.8 Pathway Milestones

The Trust recognises that there will be a number of different pathways in various specialties. Hospitals will work with Managed Clinical Services and Clinical Standards Groups to develop clear pathways for staff to understand the patient's journey. An example is shown in Figure 1.

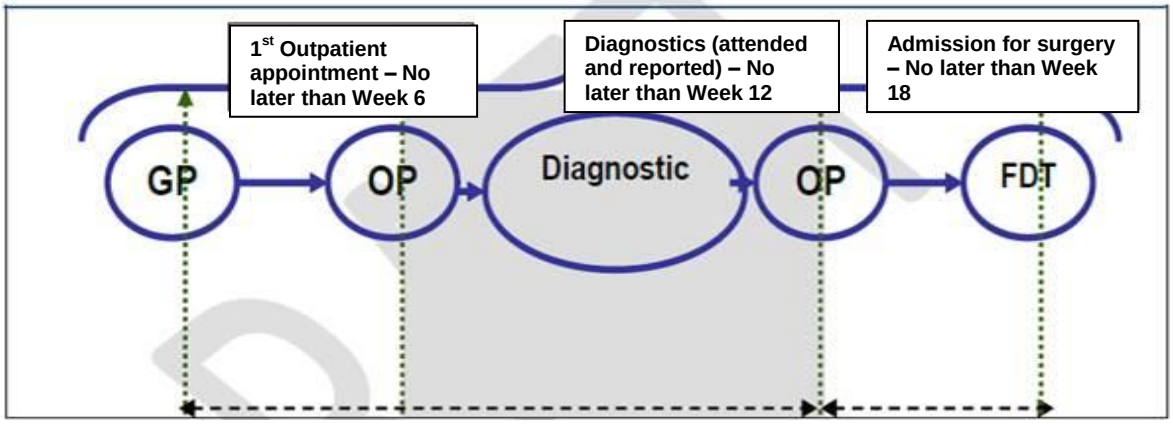


Figure 1 Patient's 18 week (RTT) pathway

The development of standardised clinical pathways is an ongoing process across MFT following the merger; clinical services are continuing to be redesigned as part of the work of the clinical standards groups.

7.9 Monitoring

Performance Information

- **Information for Managing 18 Weeks**
  A RTT patient tracking list (PTL) for admitted patients is available via the intranet to Hospitals across all sites and to the MFT Board. It is imperative that all Trust systems are accurate at all times to ensure the weekly NHS England RTT return and weekly Waiting List report is correct. A single MFT Hospital Information System will be implemented in due course.

- **Information for Managing Cancer Access Targets**
  The Cancer PTL is available to Hospitals across all sites and to the MFT Board within the Somerset Cancer Register, which is available via the MFT intranet. For further information please contact the Corporate Performance Team.

- I**nformation to NHS Improvement**
  Data returns will be submitted to NHS Improvement to meet the statutory requirements.

Other Reports

Hospitals will also be provided with access to the following reports via the Trust's Corporate Information Page and Information Reporting Suite (this list is not exhaustive):

- Patients added to an Elective Inpatient Waiting List, including conversion rates by GP, specialty and consultant (distributed to GPs);
- Patients on an Elective Planned Waiting List including those who have exceeded due dates and have moved to an Active RTT pathway;
- Cancer waiting times report;
- Outpatient Dashboard including slot utilisation, session utilisation, DNA rates and clinic cancellation performance;
- Elective Diagnostic waiting lists.

Audit

Compliance with this Policy will be measured by performance reports as detailed in this document. In addition to these, audits will be undertaken to ensure appropriate RTT recording on the Trust IT systems and the use of outcome forms.

7.10 Reasonable Notice Definition

A reasonable offer is defined as a choice of 2 dates both with at least 3 weeks' notice. Throughout this Access Policy this is clearly demonstrated so patients are not disadvantaged.

7.11 Chronological Booking

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

selected using the Trust PTL lists only, patients will not be selected from any paper based systems.

7.12 Communication

All communications with patients and anyone else involved in the patients care pathway, e.g. GP or person acting on the patient's behalf, whether verbal or written, must be informative clear and concise. The communications must be accessible in formats and language to meet patient needs in line with the Accessible Information Standard. This covers outcome letters as well as appointment letters. Copies of all correspondence with the patient will be kept in the patient's clinical notes or stored electronically for auditing purpose.

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, for example when treatment is complete, this must be made clear in any communication.

8. National Referral to Treatment and Diagnostic Standards

Referral to Treatment	
Incomplete	92% of patients on an incomplete pathway (i.e. still waiting for treatment) to be waiting no more than 18 weeks (or 126 days)
Diagnostics	
Applicable to diagnostic tests	99% of patients to undergo the relevant diagnostic investigation within 5 weeks and 6 days (or 41 days) from the decision to refer to appointment date.

Table 1 Referral to Treatment incomplete and diagnostic performance standards

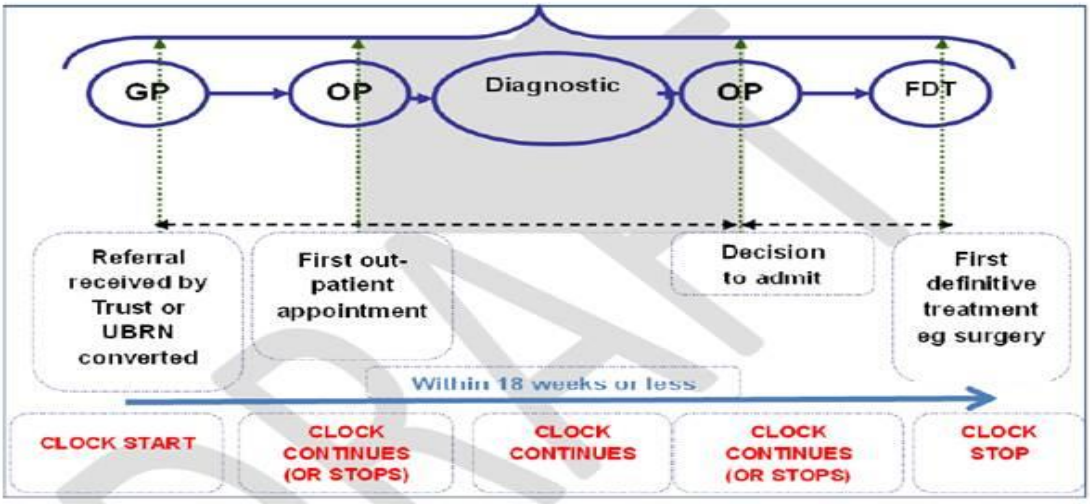


Figure 2 Diagnostic pathway

8.1 Introduction to the 18 Week RTT Rules Suite

Consultant-led services are subject to an 18 week Referral to Treatment target commonly referred to as an RTT pathway. Performance against this standard is measured and externally reported by the number of patients on an 'active pathway' or 'incomplete pathway'. 92% of patients must not be waiting longer than 18 weeks at any one time. The 18-week pathway commences with a 'clock start' date and closes with a 'clock stop' date usually at the point of First Definitive Treatment or where treatment may not be required, declined or has been postponed during a period of active monitoring.

A patient's First Definitive Treatment is defined as '*an intervention intended to manage a patient's disease, condition or injury and avoid further intervention'*. This may occur following a consultation, receipt of results from a diagnostic test or following surgery, e.g. if that surgery was not intended to manage the patient's disease, condition or injury. All patients must be managed according to their clinical urgency first and foremost, and within the operating standard thereafter.

A patient's first definitive treatment may not require admission to hospital, e.g. their treatment is advice, prescribed or given in an outpatient setting. When a decision is made to admit a patient for treatment, the patient will be added to a waiting list and classed as being on the admitted pathway. Admitted pathway means that the patient requires admission to hospital as either a day case or an inpatient to receive their first definitive treatment. Patient's whose admission later results in no treatment will, therefore, move back from an admitted pathway to a non-admitted pathway for the purposes of reporting the Trust's performance internally.

8.2 Exclusions to RTT Monitoring

There are a range of services that are not subject to the referral to treatment 18 week target. Referrals for these services do not start an RTT clock:

- **Obstetrics**

Obstetrics patients are excluded from RTT monitoring as per the national rules. Patients will be seen as is required clinically. If, however, an obstetrics patient is referred to another specialty for an unrelated condition then this will be treated in line with RTT targets.

- **A&E (Emergency Admission)**

An emergency pathway, non-elective follow-up clinic activity.

- **Access to Genito-Urinary Medicine (GUM) Services**

Choosing Health: making healthier choices easier' (Department of Health 2004), included a number of commitments, including improved access to GUM clinics, and efficient and convenient screening services. For these services, therefore, the patient must be offered an appointment which allows them to be seen within 2 working days of contacting the

service. GUM Services are **not applicable to the 18 week RTT pathway** as they are not NHS commissioned.

- **Non-English Commissioners**

- **Referrals to a non-consultant led service**

This does not include services where a nurse or other AHP is part of a multidisciplinary team providing services under the supervision or delegated responsibility of a consultant.

- **Planned patients**

When a patient is referred to a Consultant-led service and subsequently treated, each attendance thereafter must capture that the RTT clock is no longer applicable. When a patient is seen during a period of active monitoring, each attendance must capture that the RTT clock is not currently applicable.

The relevant national status codes for these scenarios are:

Code	Category	Notes
92	Patient not yet referred to treatment, undergoing direct access diagnostic test/procedure.	To be used by Diagnostic Services Only
98	Activity not applicable to 18 weeks, eg obstetrics, emergency care	Code must be entered for all outcome scenarios
90	For activity after first definitive treatment (or other clock stop reason other than active monitoring)	N/A for New Patients

Table 2 National codes

8.3 Clock Starts

A waiting time clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to:

(a) A consultant-led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treatment before responsibility is transferred back to the referring health professional or general practitioner (GP);

The date of receipt into the Trust is the clock start date for these categories of referral. In the case of an E-Referral, the clock start is recorded as the date that the patient converts their Unique Booking Reference Number (UBRN). If a patient is booked into a secondary-care-based Clinical Assessment Service the clock starts on the date the GP provided the patient with the telephone appointment – not the date of the telephone appointment.

(b) An interface, referral management or access service, which may result in an onward referral to a consultant-led service before responsibility is transferred back to the referring health professional or general practitioner (GP).

The clock start date is NOT always the date of receipt for these referrals. In general, if this service has only assessed the patient then the clock start will commence on the date that the referring service received the referral from the patient's GP/GDP (General Dental Practitioner). If the interface service provided a first definitive treatment that was subsequently determined to be unsuccessful, or if the patient is referred on following active monitoring, then the clock start date will be when the Trust receives that referral. The interface, referral management or access service must provide details of the clock start date when referring the patients to the Trust by using the MDS (minimum data set) date stamp or IPT proforma as appropriate.

Consultant-to-Consultant Referrals (same condition)
If the referral is from one consultant-led service to another for the same condition (e.g. clinician refers to a colleague who may sub specialise in the management of a specific condition) the clock start is the date the initial referral was received by the Trust. Consultant-to-consultant referrals for the same condition do not start new RTT clocks.

Consultant-to-Consultant Referrals (different condition)
(E.g. cardiology problem identified at assessment following orthopaedic referral)
These types of referrals are not permitted by Commissioners unless this is clinically urgent, e.g. a patient is discovered to have cancer in an unrelated area to the original referral.

Consultant-to-Consultant Referrals (from an emergency setting to an elective setting)
When a clinician in an emergency setting makes an outpatient referral to a specialty requesting that the patient is reviewed on an elective basis, the clock starts on the date that the consultant decides to refer and not the date when the referral is received. These referrals should only be made where clinically urgent.

In cases where a patient has been initially admitted on a non-elective pathway (an emergency setting) and it is identified that they require further treatment as an elective patient (e.g. patient admitted with acute cholecystitis who is listed for cholecystectomy), the start of the RTT clock is the date that a decision to list was made. It is imperative that the date of decision to list is clearly noted in the health records.

Where a decision to list cannot be made during the non-elective episode (e.g. the team caring for the patient need to refer to another specialty for further advice or to carry out the procedure), the RTT clock will start on the date of referral to the other consultant-led team. Again, this must be clearly noted in the health records. Please see exception criteria for consultant to consultant referrals described in this Policy.

A Consultant-led Service
Regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner;

An Interface or Referral Management or Assessment Service which may result in an onward referral to a consultant-led service before responsibility is transferred back to the referring health professional or general practitioner.

Self-Referrals
A waiting time clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional permitted to do so.

8.4 Clock Starts Following a Previous Clock Stop

Upon completion of a consultant-led referral to treatment period, a new waiting time clock only starts:

(a) When a patient becomes fit and ready for the second of a consultant-led bilateral procedure.

It is imperative that the date the patient becomes fit and ready is clearly noted in the health records.

(b) Upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan;

The clock should start at the point the decision to treat is made and this must be clearly noted in the health records. The decision about whether treatment is substantively new or different from the patient's agreed care plan is a clinical one that must be made locally by a care professional in consultation with the patient.

(c) Upon the patient being re-referred to a consultant-led, interface, or referral management/assessment service as a new referral;

When a patient has been discharged back to the care of the referring healthcare professional, any new referral, even if this is for the same condition that has worsened or an original treatment plan hasn't worked, must start a new clock in line with the guidelines previously mentioned.

(d) When a decision to treat is made following a period active monitoring;

The clock should start from the date the decision to treat is made and this should be clearly noted in the health records.

(e) When a patient rebooks their appointment following a FIRST appointment DNA that stopped and nullified their earlier clock.

The section on patients who do not attend their appointment provides further detail on this aspect (Section 10.2).

The nationally recognised RTT Status Codes for clock starts are shown below:

Code	Category	Note
10	Clock Start	Code is automatically assigned to new pathways when a referral is added to Hospital Information System.
11	End of Active Monitoring	First activity at the start of a new RTT period following a period of active monitoring
12	Consultant Referral	New RTT period for a separate condition following a consultant-to-consultant referral

Table 3 RTT Status codes

8.5 RTT / 18 Week Clock Continues

When the patient is continuing on a pathway and does not meet the criteria for a clock stop (see next section), their RTT position must be recorded accurately and in a timely manner. For example, they may require further investigations to be carried out or they may be added to a waiting list. Their continuing care prior to a treatment decision being made may possibly be carried out at a different hospital and this should also be recorded accurately and in a timely manner.

The relevant nationally recognised RTT status codes for scenarios where the clock continues are:

Code	Category	Note
20	Subsequent activity prior to treatment	E.g. diagnostic investigation required, further outpatient appointment required, patient added to the inpatient waiting list
21	Transfer to another healthcare provider for diagnostic tests	This is NOT to be used for patients who have been transferred for first definitive treatment

Table 4 RTT Status codes

8.6 Clock Stops

Clock Stops for Treatment

A clock stops when:

a) 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

b) 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 patient is to commence active monitoring. Active monitoring (watchful waiting) caters for periods of care without (new) clinical intervention, e.g. 3 monthly routine check-ups for diabetic patients. This is where it is clinically appropriate to monitor the patient in secondary care without clinical intervention or further diagnostic procedures, or where a patient wishes to continue to be reviewed as an outpatient, or have an open appointment, without progressing to more invasive treatment. Active monitoring can be initiated by either the patient or the clinician, e.g. if they wish to see how they cope with their symptoms without treatment. Active monitoring can apply at any point in the patient's pathway prior to first definitive treatment only.

    - Active monitoring should not be applied for short periods of time (e.g. a couple of days) and it should not be applied where a patient needs to have a particular diagnostic test/appointment or other intervention but wants to delay the appointment, e.g. because they have a holiday booked. It cannot be used as a means to delay treatment due to capacity shortfalls under any circumstances.

- The patient has declined treatment having been offered it;
- A clinical decision has been made not to treat;
- A patient did not attend (DNA) their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient;
- A patient did not attend (DNA) any other appointment and was subsequently discharged back to the care of their GP, provided that:

    - The provider can demonstrate that the appointment was clearly communicated to the patient;

    - The patient has undergone a clinical review and discharging the patient was not contrary to their best clinical interests;

    - Discharging the patient was carried out according to local, publicly available/published policies on DNAs provided the provider can

demonstrate that the appointment was clearly communicated to the patient and that the patient's accessible information and/or communication requirements were met;

- These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g. children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders. The provider can demonstrate that the appointment was clearly communicated to the patient in a manner that met their accessible information and/or communication requirements.

The nationally recognised RTT Status Codes for clock stops are shown below:

Code	Category	Note
30	Start of First Definitive Treatment	To be used regardless of whether a patient is discharged or not, eg a patient may have received treatment but is still under the care of the consultant
31	Start of active monitoring – initiated by patient	Active monitoring can only ever commence prior to first definitive treatment
32	Start of active monitoring – initiated by care professional	
33	Patient did not attend **very first NEW** outpatient appointment	This code does not apply to any other DNA scenario and is only used if the patient is discharged back to their referrer.
34	Decision not to treat by clinician or any subsequent DNA's after the first appointment	This code should be used for a DNA if the patient is discharged to their referrer.
35	Patient declined offered treatment	This code should not be used if the patient is still considering the treatment options.
36	Patient died before treatment	

Table 5 RTT Status codes

8.7 Patient Initiated Delays

Where a patient decides to delay or defer their treatment - which they are entitled to do – it is important that this is balanced with the clinical risk of the patient's care being deferred and the patient's responsibility to be ready and available for treatment as previously outlined in this policy. Action Card

8.8 Planned Waiting Lists

Patients on a planned waiting list are waiting to be admitted as part of planned sequence of treatments or investigations, e.g. check cystoscopy, OR where the procedure has to be performed at a set point linked to a clinical criteria, e.g. where a child needs to be 4 years old before a procedure can be performed OR where the date of admission is determined by the needs of the treatment, e.g. a child needs to be 4 years old/certain size before a procedure can be performed. Patients on the planned waiting list are not on an RTT pathway. Action Card

The planned list may include:

- Patients who require periodic review as an inpatient/day-case in order for an on-going condition to be monitored (e.g. surveillance gastroscopy, colonoscopy, cystoscopy etc.);
- A situation where the Orthopaedic surgeon may request that metalwork inserted to support the healing of a fracture is only to be removed after a certain period of time;
- Patients undergoing a series of treatments (e.g. a patient may attend for a course of pain-relieving injections on a 3-monthly basis).

The planned waiting list must not be used to hold patients:

- who wish to defer surgery;
- who are unable to have surgery due to underlying medical conditions;
- due to service capacity issues.

Capacity for Planned Waiting List Patients

All patients on the planned list must have an 'expected date of admission' which should not be exceeded. When a patient on a planned list, who has not had their First Definitive Treatment, does not have the procedure within two weeks of the planned date they will be managed in accordance with RTT rules and an RTT clock will start. If the patient has already received their First Definitive Treatment, and the planned treatment is not substantially new or different, they will remain on a closed pathway.

Planned patients on a diagnostic waiting list will become active as soon as the 'expected date of admission' has passed and will be subject to the 6 week target as per national guidelines. (Diagnostic Waiting Times and Activity).

In planning capacity, Directorate Managers must take into account patients waiting for planned procedures and take into consideration that they may require a series of treatments throughout the year. Where a series of treatments/investigations are required only the next treatment/investigation planned will be added to the waiting list. Therefore, when planning capacity requirements the additional requirements over the next 12 months must be taken into account.

8.9 Transplant Waiting Lists

When a decision is made to add a patient to a transplant waiting list and this has been communicated to the patient, then the RTT status will be updated and the 18 week clock will stop from the date of this decision. Click here for further information (Action Card).

8.10 Bilateral Procedures

Bilateral procedures are defined as surgical operations performed on both the right and left side of a patient's body. Where this procedure is necessary in two operative sessions, the 18 week clock will be stopped following the first operation/treatment. At the point the patient becomes fit and ready for the second stage of the treatment, a new 18 week clock will start and this must be clearly recorded in the medical records. Click here for further information (Action Card).

9. Non-admitted Stages of the Patient Pathway

9.1 Referral Guidance

The Trust will work with Clinical Commissioning Groups (CCGs) in developing booking and choice systems in line with NHS targets, as the preferred method of referral. Where appropriate, explicit referral guidelines will be agreed between services and those who make referrals. If a consultant/service deems that a referral is not suitable, it will be returned / rejected to the referrer with an explanation or changed to a more appropriate service for the needs of the patient.

Referrers should be encouraged to use 'open' rather than 'named' referrals which can be allocated to an appropriate Consultant with the shortest waiting time through the e-Referral electronic booking system, where applicable. Referrers should ensure that the patient's demographic details are up to date; particularly their contact telephone numbers, including a mobile number where applicable, and all relevant information is included in the referral letter (e.g. medical history, current medications).

e-Referrals (previously Choose and Book) is the preferred method of referring a patient into the Trust. The NHS contract is working towards a fully established e-Referral system with effect from 1 October 2018, subject to the provisions of NHS e-Referral Guidance:

The Provider need not accept (and will not be paid for any first outpatient attendance resulting from) referrals by GPs to Consultant-led acute outpatient Services made other than through the NHS e-Referral Service;

The Provider must implement a process through which the non-acceptance of a referral under this Service Condition 6.2A will, in every case, be communicated without delay to the Service User's GP, so that the GP can take appropriate action; and each Commissioner must ensure that GPs within its area are made aware of this process.

e-RS Advice and Guidance
The Advice and Guidance function on e-RS allows the referrer to contact a clinician for advice in managing a patient's care, which could negate the need for a referral.

MFT commenced with returning all routine paper referrals to GPs from 1 April 2018. This was done via an NHS.net account back to General Practice. The returned referral informs the GP to re-direct the referral through the e-RS system. Patients continue to remain under the clinical responsibility of the GP, during this time. From 1 July 2018 MFT commenced with returning clinically urgent referrals to have them redirected through e-RS.

Other Referrals (Tertiary Referrals, Email, and Fax)
The Trust will also receive referrals from other Trusts and Referral Centres. The referrals will be registered on the Hospital Information System within 48 hours of receipt. Where we have booking centres there will be clear processes in place to ensure accurate recording and handling of referral letters.

Clinical Prioritisation of Referrals
All referrals received through the e-Referral system will be reviewed by the appropriate consultant within 2 **working days** of the appointment being made and/or the referral being received on the ASI worklist. The consultant must:

- accept the referral, if appropriate to do so;
- reject the referral or;
- change the service as necessary.

Failure to do this will result in patients being turned away from the Outpatients Department as they have unknowingly been referred incorrectly.

Clinical review of all referrals, including e-Referrals, is essential to ensure the patient is seen in clinical priority, in the appropriate clinic by the appropriate consultant. The aim is for triage to be undertaken in an optimum time to ensure compliance against national wait time standards and so that internal targets for appointment bookings can be complied with.

Registration of New Referrals When a Referral Already Exists
If a patient is already under the care of a hospital and another referral is received for a different condition this will be classed as a new referral. If a referral is received for the same condition (e.g. request for another appointment or an appointment to be brought forward) and the patient has previously been discharged from the service, the referral will be classed as new. If the patient is still under the care of the service and has been seen recently or has an appointment in the future, then the letter will not be registered as a new referral and, instead, will be passed on to the relevant Consultant for action.

NOTE: referrals received between hospital sites in MFT should be recorded as internal referrals not as tertiary referrals as would previously have been the case.

New Patient Waiting Times
The Trust will endeavour to provide a first new outpatient appointment within 6 weeks of referral for routine clinical matters and within 3 weeks for urgent clinical matters. MFT does not recognise a 'soon' category for outpatient referrals. Military Veterans will be seen

within 4 weeks of referral for routine clinical matters. Where possible, no new patient should wait more than 10 weeks for their first appointment and urgent new patients should wait no more than 5 weeks.

e-Referral System and Outpatient Capacity (New Patients)
All outpatient new capacity for GP demand **MUST** be shown on the e-Referral Service unless the Director of Operations authorises in line with national exclusions. Under direct booking - in circumstances where a patient calls the national e-Referral booking Service/Appointments Booking Line and an appointment slot is not available in the required hospital specialty - the national e-Referral Telephone Appointments Line (TAL) will forward the referral request details (UBRN) by email to the Trust. The patient pathway starts from the date the TAL sends the electronic request to the Trust on the Appointment Slot Issues (ASI) Worklist.

It is the Trust's responsibility to ensure capacity is available to meet demand. Therefore, all hospital appointment services must be notified of the choice of appointment availability for patients on the ASI Report within ten working days of receipt to ensure sufficient time is given to arrange capacity and contact the patient. Where a full booking service is operational, the booking teams will liaise directly with the patient to arrange their appointment providing reasonable notice. The booking teams will ensure that the patient can be involved in arranging their appointment by providing, where required, interpretation and translation services and the patient's accessible information and/or communication requirements are met. If capacity cannot be provided by services, the referral must be removed from the e-Referral system at this point and registered on the Hospital Information System. Referrals on the ASI list do not appear on PTLs. Daily ASI reports must be actioned by Hospital Management teams.

Closing Referrals Opened in Error
If a referral is opened in error, the user closing the referral must always enter 'Clerical/ Admin Error' as the reason for closure and enter the date on the appropriate Hospital Information System.

Closing Referrals when the Patient Requests Self-Discharge
If a patient contacts the Trust and suggests that they no longer require any further appointments, e.g. they self-discharge, the named Consultant responsible for their care **MUST** be notified with a copy of their referral letter or last correspondence. The referral should not be closed on the Trust Information System, until confirmation is received from the Consultant that no further appointments are required. A letter should be sent to the GP to confirm that the patient has been discharged at their own request either by the Consultant if a bespoke response is required or by the Contact / Booking Centre or relevant team if a standard response is required.

Closing Referrals when a Patient is Discharged
The relevant referral MUST be closed on Hospital Information System when the patient is discharged by the Care Professional. This should be carried out at the point of discharge by the relevant member of staff, e.g. receptionist, ward clerk, medical secretarial team. If the Care Professional has not dictated a letter to the referrer regarding this decision, e.g. if the patient has DNA'd, then a letter must be sent to the referrer so they are aware.

9.2 Rapid Access Local Services

Where possible all patients referred by their GP to a Rapid Access Service should be seen within two weeks. This indicator only applies to those patients whose referral was received by the clinic within 24 working hours of the GP deciding to refer, e.g. the date on the referral letter.

9.3 Patients with No Current Address (e.g. homeless)

It is imperative that our homeless patients have access to services and, as such, a means of communicating with them should be established prior to them leaving the organisation. A nominated GP practice should be agreed for correspondence or contact if no other means of contact is available, e.g. relative or friend.

Please refer to section 4.4 – Step 3 of the Homelessness Reduction Policy (p7) via this link, for more thorough guidelines: Homelessness Reduction Policy v1 March 2019.

9.4 Referral Letter Minimum Dataset

The Trust expects the following information to be made available by the referrer:

Patient details:	**GP information:**
• Patients name • Patients NHS number • Patients date of birth • Patients address • Patients telephone number (Mobile & Home) • Email address • Patients gender • Serving military personnel; family of serving personnel/veterans if applicable • Overseas visitor status • Vulnerable • Adult/Disability • If the patient requires transport and that they meet the eligibility criteria for this, including their mobility status. • If the patient requires an interpreter service, for what language and how we should make contact with them. • If the patient has accessible and communication needs that requires the hospital to make contact/communicate with them in a particular way, e.g. partially sighted person requiring an appointment letter with larger font or require a longer time slot or a British Sign	• Dated letter • Specialty referred to • GP/Dentist name or Medical Officer (for service personnel) • GP/Dentist or Medical Officer address • GP/Dentist or Medical Officer telephone number • GP email address (NHS.net only) • GP practice code • Priority • All relevant clinical history • Clear reason for referral

Language interpreter in line with the Accessible Information Standard. • If the patient requires any reasonable adjustments relating to accessible information and communication in line with the Accessible Information Standard. • If the patient requests to see a consultant of a particular gender, e.g. for religious reasons.	

Suspected Cancer referrals should be sent into the Trust on the agreed Two Week Wait referral template. This would include the minimum dataset as described above. However if a suspected cancer referral was received in a different format or with the minimum dataset not complete the appointment would still be booked in the usual Trust timescales described without delay.

Patient Choice of Consultant
Under the NHS Constitution (2013) and 2015/16 Choice Framework patients have the right to express a preference as to which consultant they wish to be referred to and to have that preference met where practical. The Trust may be able to offer patients an earlier date with another consultant and should advise the patient of this. Patients may only be transferred to another clinician if they have explicitly agreed to this. If the patient declines the offer to transfer then this must not affect their waiting time.

Some patients may state that they prefer to be seen / treated by a doctor of a particular gender. The Trust will comply with the patient's wish if this is possible. Referrers are asked to ensure that this request is included in the referral letter and our Hospitals will ensure that the Directory of Service provides this information if applicable. If the service does not employ a doctor of the required gender within the requested specialty, the Trust reserves the right to, after discussion and agreement with the patient (which allows the patient an opportunity to change their mind), return the referral letter to the GP or refer to another Trust.

Chaperone
Patients have the right to request a chaperone; please refer to the Trust's Chaperone Policy for comprehensive details: MFT Chaperone Policy.

9.5 Managing Onward Referrals

Consultant-to-Consultant Referrals (from an emergency setting to an elective setting)
When a clinician in an emergency setting makes an outpatient referral to a specialty requesting that the patient is reviewed on an elective basis, the clock starts on the date that the consultant decides to refer and not the date when the referral is received. These referrals should only be made where referral back to the GP or GDP would cause unnecessary delays in care that would affect the patient's wellbeing.

In cases where a patient has been initially admitted on a non-elective pathway (an emergency setting) and it is identified that they require further treatment as an elective patient (e.g. patient admitted with acute cholecystitis who is listed for cholecystectomy), the start of the RTT clock is the date that a decision to list was made. It is imperative that the date of decision to list is clearly noted in the health records.

Where a decision to list cannot be made during the non-elective episode (e.g. the team caring for the patient need to refer to another specialty for further advice or to carry out the procedure), the RTT clock will start on the date of referral to the other consultant-led team. Again, this must be clearly noted in the health records. Please see exception criteria for consultant to consultant referrals described in this Policy.

Children Transferring to Adult Services (Transitional Patients)

For those patients who are transferring from Paediatric Services to Adult services, the referring clinician must provide a Minimum Data Set (MDS) which clearly identifies the pathway status of whether the patient is on an active or previously treated pathway. Depending on the speciality and referral criteria, the age range for when patients transition varies from 16-18 years.

Misdirected Referrals

If a referral has been made and the speciality of the Consultant does not match the needs of the patient, the Consultant should cross-refer the patient to an appropriate colleague where such a service is provided by the Trust. In this instance the 18 week clock is still open and continuing. If the referral is for a service not provided by the Trust then the referral letter will be returned to the referrer with a note advising that the patient needs to be referred elsewhere. In this instance the 18 week clock will stop and the pathway closed if the referral was from a GP. However, if the original referral was from another Trust/provider then the clock would continue to tick. With the e-Referral system, where a referral is rejected by the clinician, the referrer is responsible for seeking alternative care provision and communicating this to the patient.

Where a patient has been referred to one specialty within the Trust however, the patient presents as an emergency to A&E, the clinician can make an onward outpatient referral to any service without the need for a referral back to the GP, where:

1. Consultant-to-Consultant Internal Referrals are accepted when it relates to the original condition/pathway for which the patient was originally referred or for urgent conditions. Consultant-to-Consultant referrals that are accepted should be sent by the Consultant to the Outpatients / New Patients Appointment Team, via methods: electronic, fax or hand delivered, to be processed;

2. The patient has an immediate need for investigation or treatment (suspected cancer for instance);

3. By contrast, the contract does not allow clinicians to refer onwards where a patient condition is non-urgent and where the condition for which the referral would be made is not directly related to the condition which caused the original GP or emergency

presentation. In this situation the clinician should refer back to the patients GP. For further details click on the link: www.england.nhs.uk/interface July 2017.

9.6 Transfer of Care Following a Consultant Leaving the Trust

Where patients are transferred from one consultant to another because Consultant (A) leaves the Trust and patients are transferred to Consultant (B) the RTT clock will continue. Patients **MUST NOT** stay registered on a Hospital Information System with a Consultant who is no longer employed by the Trust.

Tertiary Referrals

A tertiary referral received by the Trust **MUST** include the 18 week national mandatory Inter Provider Transfer Administrative Minimum Data Set (IPT MDS) which includes the date the original Trust received the referral. Where systems currently allow consultants referring patients to other providers are required to ensure that an MDS box is stamped and completed on the referral letter or is recorded electronically. If the IPT MDS form or MDS box not received/completed, contact should be made with the referrer to request this information. This should be provided within 3 working days and if this information is not provided the Hospital Director/Manager informed.

9.7 Internal Referrals (Consultant to Consultant Referrals)

Every effort will be made to ensure that patients are seen in the correct clinic at the outset of the RTT pathway, however if following the initial consultation, a decision is made that the patient should be seen by another specialist, the RTT clock will continue to tick from the original referral date.

Referrals for a different, unrelated condition to the original referral (excluding urgent referrals, suspected cancer referrals and other agreed exclusions) must be referred back to the GP to support patient choice. Consultant-to-Consultant referrals should only be made if they meet the exception criteria agreed by Commissioners in the 'Central, South and North Manchester CCG's Consultant to Consultant Framework V4.0 (Jan 2016).

- Clinical urgency;
- Suspected Cancer;
- Diagnostic investigation as part of the original referral;
- Sub-specialty referrals;
- As a result of an acute GP referral;
- Pre-op assessment unless the patient requires optimisation of a long term condition which could be undertaken in Primary Care;
- Pregnancy related;
- Military Veterans;
- Adult or Child Safeguarding concerns;
- Immunosuppressed patients.

The 18 week clock starts from the **date of clinic or date the decision was made** and all attempts **MUST** therefore be made to ensure referrals are made in a timely manner and not delayed by administrative processes. To comply with referral to appointment targets, the Appointments Office must receive the referral **within 3 working days.**

10. Managing Outpatient Appointments

10.1 Booking Appointments

The Trust aims to create a culture of care based on positive attitudes towards welcoming the diversity of patients, their families, carers and service users and meeting diverse needs.

For all types of appointments the Trust will give priority to clinically urgent patients. Routine patients of the same clinical priority will be seen in chronological order from date referral received. If, when allocating appointments for routine patients a military person or veteran is made known these patients should be given priority for service-related conditions.

Communication with patients will be informative, clear, and concise and meet patient's accessible information and communication needs in line with the Accessible Information Standard. A summary will be recorded in the Trust's Information Systems. Appointments will be confirmed in writing, including alternative languages and formats e.g. braille, text and email. Some patients may have agreed an appointment before leaving clinic. Prior to all appointments a text-reminder system is in place, therefore it is essential that patient's contact numbers are kept up to date.

10.2 Failure to Attend an Outpatient Appointment

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. Paediatric and vulnerable patient DNAs should be managed with reference to the Trust Safeguarding policy. DNA Action Card

10.3 Patient Initiated Outpatient Cancellations

The 18-week clock continues if a patient chooses to alter their appointment. It is, therefore, important that multiple cancellations are monitored, particularly as this is likely to result in a delay in their care.

See Patient Initiated Delays Action Card

10.4 Hospital Cancellations

Hospital-initiated cancellations are to be avoided wherever possible. Compliance with partial booking rules, waiting times for new patients, leave notice periods and appropriate demand and capacity planning for services should minimise the requirement for our Hospitals to cancel patients booked into clinics.

Where this is unavoidable (e.g. sickness), hospital initiated cancellation procedures should be followed to ensure any subsequent delays do not result in harm to the patient.

If a clinician takes a decision to cancel a patient (e.g. a slot needed for an urgent patient); they must liaise with their secretary or hospital management team to advise whether the new appointment for this patient is safe and suitable.

If the patient to be cancelled is identified as a long waiter or potential breach, the clinician should liaise with the relevant hospital manager to solve the potential breach.

Repeated and consistent hospital initiated cancellations would indicate a need for clinic templates to be reviewed, consultant leave notice period and clinic capacity issues. In these instances, the situation should be escalated to the hospital management team for the appropriate service, so they can set aside specific capacity for this purpose to minimise the impact on patient care and poor patient experience.

Where Partial Booking is operational we will aim to have a minimum of 8 weeks' notice for the cancellation of clinics. For other booking types a minimum of six weeks' notice is required.

Clinic cancellation with less than six weeks' notice can only be authorised by the Hospital Manager and Clinical Lead for the relevant specialty.

It is the responsibility of the relevant clinician to arrange suitable clinical cover if a short notice clinic cancellation is necessary and has been approved, as above

A patient should not be cancelled on more than two consecutive occasions.

10.5 Outpatient Attendance and Outcome Status Completion

Every patient, new or Follow-up, whether attended or not, will have an attendance status and outcome recorded on a Hospital Information System at the end of the clinic. Clinics will be fully outcomed within one working day of the clinic taking place to account for clinics held off-site with no reception function only.

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

When they attend the clinic, patients may be on an open pathway (i.e. waiting for treatment with an RTT clock running) or they may already have had a clock stop due to receiving treatment or a decision not to treat being agreed. It is possible for patients to be assigned any one of the following RTT statuses at the end of their outpatient attendance, depending on the clinical decisions made or treatment given/started during the consultation:

Patients on an 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.

10.6 Partial Booking Follow-Up Appointment

Follow up appointments must only be arranged where it is deemed clinically necessary. This is in line with the Follow-up Framework for North, Central and South Manchester CCGs, patients and discharge protocols where these are available. Patients, who require follow up appointments, should have a booked appointment prior to leaving the clinic or have been added on to a waiting list. Where there is no capacity to book appointments, this then needs to be escalated to the appropriate manager in order for discussions to take place with clinical teams. If an a follow up is required six weeks or over, then the patient should be added to a waiting list, ensuring the appointment due by date is entered as indicated by the clinician on the clinic outcome form.

Any tests or investigations required on arrival at the appointment must be indicated on the clinic outcome form and detailed on the Hospital Information System. If the patient is a cancer surveillance patient or requires an appointment in an exact timeframe for clinical reasons, this must be indicated on the outcome form and clearly indicated on Hospital Information System. The patient's GP must be informed of the timeframe for subsequent follow-up.

Each hospital Operational Manager is responsible for managing the follow-up outpatient waiting list in conjunction with the clinicians, ensuring that all patients are booked an appropriate follow-up in the agreed timescale and with reasonable notice.

10.7 Follow Up Appointment following Discharge

There may be occasions where a patient has been discharged however the patient has been informed that they can contact the hospital if they have any further concerns regarding their condition. Where this takes place, the following should apply:

- The clinician should make it clear to the patient that they are being discharged and may require a new referral from their GP if the problem reoccurs;
- If the patient contacts the hospital within 3 months of the discharge, if agreed by the clinician, the previous outpatient registration must be reopened and a follow up appointment booked;

- If greater than 3 months the patient will be advised to see their GP to see if a referral to the hospital is required.
- There may be occasions where patients with long term conditions could be asked to contact the hospital if they become symptomatic within a 12 month period. In this instance the patient should be booked a follow up appointment, using the original outpatient registration.
- Some patients requiring lifelong treatment may never be discharged from the hospital.

10.8 Validation of Outpatient Referrals with No Future Activity

In an effort to keep our Waiting Lists accurate and up to date, there is a report on The Hive which shows Outpatient Registrations on PAS where there has been no activity recorded for a 12 month period. These patients will be auto-discharged once 12 months is exceeded, following clinical validation.

Auto-discharge will not take place in specialities where conditions are likely to be ongoing/long term. There is to be clinical validation in these specialities to ensure there is no future activity planned or waiting list recorded and also to ensure the patients' accessible information and communication needs were met.

We will not discharge where:

- The Referral Date is within the time frame determined by individual Hospitals;
- OR the latest appointment is within 12 months;
- OR the Consultant and Specialty combination has specifically been requested to be excluded;
- OR there is an active Outpatient Waiting List entry on the referral;
- OR the specialty on the referral is no longer linked to the consultant;
- OR the patient has an active Inpatient Waiting List episode for the same Consultant;
- OR the patient had an Inpatient episode (Waiting List, To Come In Date, Admission) for the same consultant (within 12 months);
- OR the patient has an active referral for the same consultant.

Please see relevant MFT Standard Operating Procedure.

11 Diagnostic Elective Access

This section applies to **all diagnostic procedures regardless of whether they are reported under the DM01 requirements** to ensure that a consistent approach is taken across the organisation. There are a number of diagnostic tests that have to report their performance on a monthly basis in line with the DM01 requirements and some that have to report quarterly. However, all should follow the same rules for booking as detailed in this section. The 15 tests reported on are as follows:

- Imaging - Magnetic Resonance Imaging;
- Imaging - Computed Tomography;

- Imaging - Non-obstetric ultrasound;
- Imaging - Barium Enema;
- Imaging - DEXA Scan;
- Physiological Measurement - Audiology - Audiology Assessments;
- Physiological Measurement - Cardiology – echocardiography;
- Physiological Measurement - Cardiology – electrophysiology;
- Physiological Measurement - Neurophysiology - peripheral neurophysiology;
- Physiological Measurement - Respiratory physiology - sleep studies;
- Physiological Measurement - Urodynamics - pressures & flows;
- Endoscopy – Colonoscopy;
- Endoscopy - Flexi sigmoidoscopy;
- Endoscopy – Cystoscopy;
- Endoscopy – Gastroscopy.

11.1 Introduction to Diagnostic Access

The Diagnostic Imaging Dataset (DID) is a monthly data collection covering data on diagnostic imaging tests on NHS patients in England. It includes estimates of GP usage of direct access to key diagnostics tests for cancer, for example, chest imaging and non-obstetric ultrasound.
The DID was introduced to monitor progress on *Improving Outcomes: A Strategy for Cancer (IOSC)*. This strategy, published 12th January 2011, set out how the Government, NHS and public can help prevent cancer, improve the quality and efficiency of cancer services and move towards achieving outcomes that rival the best. To achieve that ambition, it will be essential to prevent more cancers developing in the first place and to ensure they are diagnosed while the cancer is at an earlier stage, to increase the scope for successful treatment. Within that, GPs need easy access to the right diagnostic tests to help them to diagnose or exclude cancer earlier.

A target of 6 weeks was introduced from the point of referral to the point the test is carried out and to support this, the DID reports on imaging activity, referral source and timeliness. For further information and more detailed guidance, please see the 'Diagnostic FAQs: Frequently Asked Questions on completing the 'Diagnostic Waiting Times & Activity' monthly data collection (updated February 2015).

11.2 Direct Access Diagnostic Services

Referrals to these services are not subject to an 18 week RTT target but do have to comply with the 6 week diagnostic target as detailed above.

11.3 Managing Diagnostic Referrals

When it is identified that a patient requires a diagnostic investigation, the clinician should fully complete the electronic request at the time of the decision to request. Missing information, inclusive of AIS and reasonable adjustments, on the request card or electronic request will delay the process, so careful attention should be taken in this regard. Consideration should be given to Imaging Protocols and appropriateness of requests in relation to IRMER regulations or clinical requirements, e.g. no metal foreign bodies present

if requesting a MRI scan. Requests made in respect of cancer patients should be marked as such to ensure appropriate appointments are allocated. Failure to do this will result in a longer wait – the Trust's internal target for patients on a cancer pathway requiring a diagnostic investigation is 2 weeks.

Clock Starts
For internal referrals the clock starts on the date the referral is made – NOT the date the referral card is received. Delays in completing the request card or electronic request can result in delays that will make it impossible for the receiver to deliver the wait time within the agreed target. For external referrals the clock starts on the date the referral is received by the Trust.

Clock Pause
The clock cannot be paused for diagnostics under any circumstances. Diagnostic clocks can be adjusted following a DNA or Patient Cancellation.

Clock Stop
The clock stops at the point the diagnostic investigation has taken place.

Delays in Receipt of Referral
Where there has been a delay of 14 days or more the referrer will be contacted to discuss whether the referral is still required. If it is not required, then the patient should be contacted and informed at the same time as the test is cancelled. If it is still required, the original date of request is used and, therefore, the wait time will be consistent with the 6 week rule.

Imaging Prioritisation of Referrals
All paper request cards will be logged on to the Trust System upon receipt within **two working days**. Electronic requests via ICE will be received immediately. The referral will then be triaged according to the Department's Standard Operating Procedures. A patient's appointment will be arranged within 5 working days of triage and appointments will be confirmed in writing.

Reasonable Notice
The minimum reasonable notice for diagnostic patients is 3 weeks with a choice of 2 dates/times where the patient can be contacted. Many patients will choose to attend at the earliest opportunity. However, not all will but it is not appropriate to pause the clock for patients who cannot commit at short notice.

Patients are sent questionnaires in advance of being booked for Heart Scans/MR scan suitability. Responses are not chased by the department and if the patient does not reply within the timescale (2 weeks) then the scan is not booked and the referral is sent back to the referrer.

If the patient is unable to undergo the procedure because they are unfit to do so they will be removed from the waiting list and the referral returned to the referrer for re-Referral when declared fit.

Patient Cancellation/Alteration of a Diagnostic Appointment

See Patient Initiated Delays Action Card

Patients Who DNA a Diagnostic Appointment

See DNA Action Card

Patients who are waiting for More Than One Diagnostic Test
Patients waiting for two separate diagnostic tests/procedures concurrently should have two independent waiting times clocks – one for each test/procedure. For example, patient presenting with breathlessness could have a heart or a lung condition and therefore there might be the need to have cardiology and respiratory tests concurrently.

Alternatively, if a patient needs test X initially and once this test has been carried out, a further test (test Y) is required – in this scenario the patient would have one waiting time clock running for test X. Once test X is complete, a new clock is started to measure the waiting time for test Y.

11.4 Planned Diagnostic Investigations

Surveillance tests that are **planned for a specific date,** or need to be repeated at a specific frequency, are not included in the DM01 monthly return for the time that these patients are on planned list. These patients should be booked in for an appointment at the clinically appropriate time and they should not have to wait a further period after this time has elapsed.

For example, a patient due to have a re-test in six months' time should be booked in around six months later. The patient should not get to six months and have to wait again for non-clinical reasons.

When patients on planned lists are clinically ready for their test to commence and reach the date for their planned appointment, they should either receive that appointment or be transferred to an active waiting list and a waiting time clock should start (and be reported in the relevant waiting time return). **The key principle is that where patients' tests can be carried out immediately, then they should receive the test or be added to an active waiting list, there will be no waiting time tolerance.**

Surveillance or follow-up tests/procedures that are **not planned for a specific date**, but that will be undertaken on an ad hoc basis or at an undecided time in the future, are not categorised as planned waits and, therefore, these patients should be placed on an active waiting list once the decision to test/referral for a test has been made and waits reported in the DM01 return.

11.5 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 within 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 commences 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 (e.g. bariatric), in this pathway, the clock could continue to tick.

12. Management of Elective Waiting Lists – Admitted Pathways

Stages in the management of admitted patients:

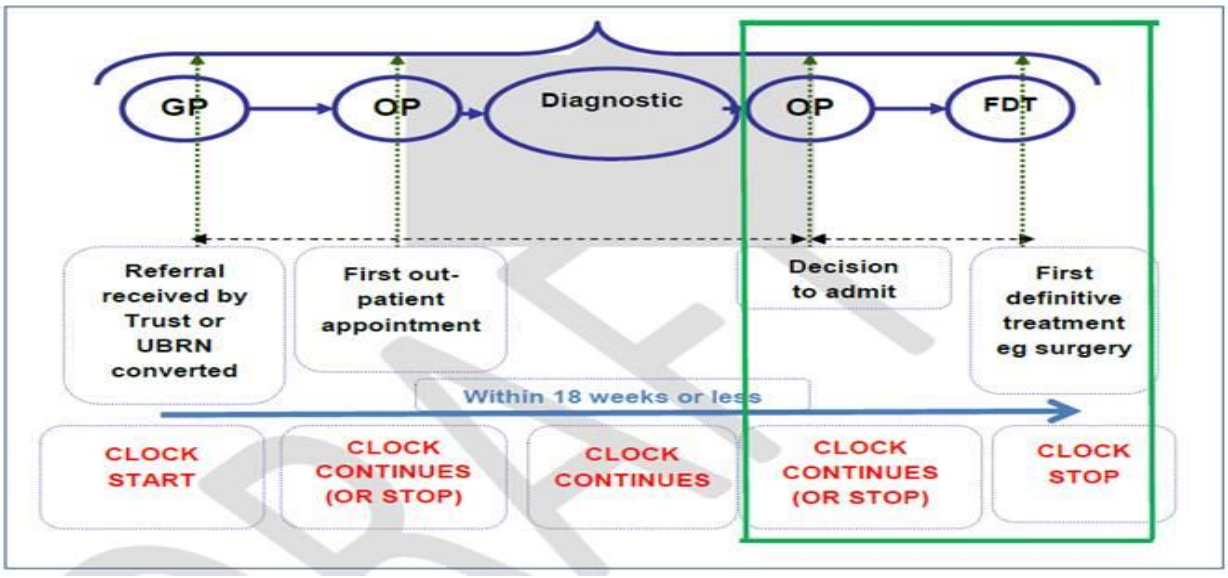


Figure 3 Admitted pathway

12.1 National Definition: Admitted Pathways

An admitted pathway is a list of patients, for whom a decision to admit has been made, currently awaiting admission regardless of whether a date to admit has been given. A patient can be on more than one elective admission list.
It is also possible for a patient to be entered on an elective admission list more than once, either for a different condition or for the same condition, where two or more admissions are required. For example, a patient would have two elective admission list entries on a list where the intention was to perform two or more operations requiring two or more admissions, such as repair of inguinal hernia and operation on varicose veins. Only one elective admission list entry should be made in the event of the intention to perform two or more procedures during one admission.

12.2 Booking Principles

The decision to add patients to the waiting list must be made by the consultant or designate.

Additions to the Hospital Information System must be completed in a timely manner and the date of adding to the list must equal the decision date.

If a patient becomes medically unfit, either once they have been added or during the course of being added to the waiting list, the following should happen**:**

- If it is a short term minor ailment requiring no active optimisation, the RTT clock continues;
- If a serious co-morbidity is found requiring longer term optimisation, the patient should be removed from the waiting list and actively monitored by the Trust or discharged back to GP until fit. All clinical management will be agreed with the patient.

A patient should only be placed on an active waiting list for surgery in the following circumstances:

- There is a sound clinical indication for surgery;
- The patient is clinically ***ready, fit and available*** to undergo surgery;
- There is a real expectation of performing the operation within a reasonable time in relation, to the patient's clinical priority;
- When patients have accepted the advice of the healthcare profession responsible for their care;
- The consultant surgeon has been informed, has agreed to the date, and will be present;
- The consultant anaesthetist who is regularly allocated to the session will be present. If he/she is not available, (with the exception of the Children's Hospital) then a replacement of equal seniority that is agreeable to anaesthetise children less than 2 years old must be identified;

- The Theatre Manager must be contacted when the date of the operation has been agreed, to ensure that staff with appropriate competencies will be available on the proposed date;
- Where possible children should be listed together on dedicated paediatric lists, or in groups at the beginning of mixed adult/paediatric lists.

Unless **all** the above criteria are met, the patient should not be listed for surgery. It is the responsibility of the admitting consultant surgeon to ensure that the requirements are met.

All patients must be admitted on the day of their operation, unless the pre-assessment team/clinician clearly identifies a clinical need to dictate otherwise.

Where it is not possible to offer treatment of patients within the maximum waiting times, the Trust will work in partnership with the Local CCG's to operate a transfer process to ensure patient rights under the NHS Constitution are met.

12.3 Pre-Operative / Anaesthetic Assessment Service

All patients requiring elective surgery as an inpatient or day-case must undergo pre-operative anaesthetic assessment. Where services are not currently participating in an 'on the day pre-op' service, patients are being pre-operatively assessed after an admission date has been provided. This significantly increases the risk of cancellations and the need to replace the admission with another patient at very short notice. Therefore, timely and appropriate scheduling of pre-operative assessment appointments is critical and the following standards must be adhered to:

Category of Patient	Minimum Timescale
Routine elective or day case procedure	6 weeks prior to admission date
Routine Replacement due to cancellation	3 weeks prior to admission date
Urgent elective or day case procedure	1 week prior to admission date but no less than 72 hours prior unless risk assessed and recorded in the patient's health records following discussion with the pre-operative assessment lead nurse

Table 6 Pre-op assessment standards

These timescales will allow for onward referral for CPEX testing or review by a Consultant Anaesthetist, and for further investigations to be completed or optimisation of the patient's condition prior to surgery. These timescales also allow for the reiteration of the need to stop certain medication prior to operation. Where these timescales cannot be complied with, the Clinical Lead for Anaesthetics must approve any short notice bookings **BEFORE** they are added to ensure the patient's results, particular MRSA screening, can be processed prior to the admission. Pre-operative anaesthetic assessment must not be completed without all the relevant clinical information available in the patient's health records and/or booking proforma.

The Pre-Operative Assessment Service aims to see patients on the day of decision to treat, but for some patients it will be clinically appropriate to offer a telephone assessment or an appointment at a later date.

If a patient DNAs their pre-assessment appointment and reasonable notice was given, the patient will be clinically reviewed and a decision made whether to remove the patient from the waiting list. Throughout this time the RTT clock continues to tick.

Patient Deemed Unfit for Surgery AFTER listing
Patients who are deemed unfit for surgery after being listed for their procedure must be referred back to their GP, unless their condition can be optimised within a reasonable clinical timeframe that does not affect the existing condition requiring treatment (e.g. approximately 8 weeks). For example, a patient may need to recover from an infection with an anticipated timescale of 4 weeks before their condition is optimised or they may need to alter their medication (HTN) for a short period of time. The Consultant must be informed of any anticipated delays in treatment and will be expected to write to the GP and patient to inform them of any decision to discharge the patient if their condition cannot be optimised within a reasonable timescale. The patient must be re-referred when they are fit, ready and available for treatment.

Patients Transferred to the Private Sector for Treatment
Pre-operative assessment for patients transferred to the Private Sector for treatment either completely or on behalf of Trust must be completed by the provider. Exclusion criteria, anaesthetic assessments and paperwork may differ and could put patients at potential risk.

Patients Transferred to Trust from Other Organisations for Admitted Treatment
Patients referred to Trust from other organisations for admitted treatment **MUST** have all relevant clinical documentation sent and filed in the patient's health records prior to listing.

Admission Dates
All patients must be admitted on the day of their operation, unless the Pre-Operative Assessment Team or Clinician clearly identifies a clinical need to dictate otherwise.

This must clearly be recorded on the Hospital Information System. Patients should be provided with reasonable notice of an offer of admission (e.g. a choice of 2 dates with at least 3 weeks' notice). Patients should be prioritised in order of clinical need first and foremost and then in RTT breach date order. In order to comply with clinical need or RTT pathway requirements reasonable notice may not be possible.

12.4 Adding Patients to Elective Waiting Lists

An Elective Booking Proforma must be completed for every patient accurately and in full. Failure to do so could result in patient harm due to the possibility of inappropriate listing, failure to notify of the need to stop or change medication prior to surgery or failure to undergo relevant investigations at pre-operative assessment.

Where a clinician requests an opinion to seek advice regarding the patient's fitness for surgery, the patient should **not be added to the waiting list**. Where it is clear that their fitness for surgery requires considerable medical input by another specialty or their GP

that is anticipated to take longer than 8 weeks, the patient should be discharged to the clinician responsible for assessing and optimising their fitness. The patient should be referred back at a later date when and if they are fit for surgery.

Clinicians must not place a patient on a waiting list to reserve a place against the possibility that treatment may be necessary in the future. If the clinician requests an opinion, a Consultant-to-Consultant referral can be made for an opinion after the patient is added to the waiting list where it is believed that the patient is clinically ready and fit for the procedure **ONLY** and where this referral does not result in an excessive delay prior to treatment.

Patients must only be added to waiting lists when they are 'ready, fit and available' to attend. GPs have a responsibility to discuss with patients the importance of being available to accept the next available appointment/TCI.

Patients should be added to the waiting list on Hospital Information System within **2 working days** of the decision being made to treat or from the decision that they are fit, should the patient be subject to 'on the day' pre-operative assessment services.

The Trust will ensure that a patient waiting to access elective care is recorded accurately on the Hospital Information System. Paper based systems will not be used.

The Trust will monitor the RTT pathway by using PTLs measuring the length of wait from referrals to new outpatient appointment, diagnostic test and elective admission.

Waiting lists are derived in line with national guidance regarding 18 week RTT, diagnostics and Cancer Wait Times.

12.5 Use of Planned Waiting Lists

Patients should only be added to a planned list where clinically they need to wait a period of time for their treatment / test. A good example is, patients undergoing surveillance.

Patients on planned lists should have a TCI arranged at the stipulated clinically appropriate time and expected admission dates should be recorded on the Hospital Information System.

Patients on a planned list will not be classified as being on an 18 week RTT pathway.

If a patient's expected admission date has passed, the patient's records should be reviewed by the clinician. Should the clinician agree that it is clinically appropriate to add a tolerance to the expected admission date, this must be recorded in the patient's clinical record.

If the clinician feels that no tolerance is accepted then the patient should be transferred to the Active Elective Waiting List and a RTT pathway commenced.

See Planned Waiting List Action Card

Children and Planned Procedures

On some occasions a child may require surgery that they cannot have until they reach an optimum age, this procedure should be classed as 'planned' although in most instances it would be more appropriate (if a period of 12 months or more is necessary before treatment) to request the GP to re-refer the child at a later date. If the patient is added to the planned waiting list, the RTT clock should reflect this period of active monitoring.

Capacity for Planned Waiting List Patients

All patients on the planned list must have an 'expected date of admission' which should not be exceeded. When a patient on a planned list does not have the procedure within two weeks of the planned date they will be managed in accordance with RTT rules and an RTT clock will start. In planning capacity, Hospital Managers must take into account patients waiting for planned procedures and take into consideration that they may require a series of treatments throughout the year. Where a series of treatments/investigations are required only the next treatment/investigation planned will be added to the waiting list. Therefore, when planning capacity requirements the additional requirements over the next 12 months must be taken into account.

Transplant Waiting Lists

When a decision is made to add a patient to a transplant waiting list, the RTT status will be updated and the 18 week clock will stop from the date of this decision. Click here to get further details (Action Card).

Bilateral Procedures

Bilateral procedures are defined as surgical operations performed on both the right and left side of a patient's body. Where this procedure is necessary in two operative sessions, the 18 week clock will be stopped following the first operation/treatment. At the point the patient becomes fit and ready for the second stage of the treatment, a new 18 week clock will start and this must be clearly recorded in the medical records. Click here for further details (Action Card)

12.6 Reasonable Notice:

Reasonable notice for non-cancer patients is at least 2 elective admission offers with at least 3 weeks' notice from the time of the offer being made. Many patients on a cancer pathway will be offered admissions much sooner and any offer for an appointment / admission between the start and end point of the 31 or 62 day period can be made. Click here for further details (Action Card).

12.7 Cannot Attend Elective Admission:

Patients can decline or alter their elective admission on one occasion. In the event the patient wishes to alter their TCI for a second time, the patients records will be reviewed by the clinician who will make a judgment on the appropriate course of action and what is in the patients best clinical interests i.e. returning the patient to the care of their GP, remaining on the Trust's waiting list to be given another TCI date or see again as a follow up.

Patient Cancellation BEFORE Admission Date Agreed

If a patient is uncertain about going ahead with treatment, the relevant clinician will be notified and if a period of active monitoring is appropriate (initiated by the patient), the Consultant must write to the GP to notify them of this decision. An appointment to review the patient should be made at this stage to ensure they are kept under review and 'visible' to the organisation. It may, however, be appropriate to discharge the patient and refer them back to their GP, where their ongoing care will continue to be managed within Primary Care. If, and when, the patient feels ready for treatment they can ask their GP to re-refer them. Referral back to the GP in this scenario must be dictated to the GP and would stop the RTT clock; a

new RTT clock would start when the Trust receives a new referral. The waiting list entry must be removed in both instances.

Patient Cancellation AFTER Admission Date Agreed
If a patient no longer requires their operation and wishes to cancel their surgery date and hence their 18 week RTT pathway, the waiting list entry is updated and closed on the Hospital Information System and the 18 week clock stopped. This request should be highlighted to the relevant clinician and a letter sent to the referrer.
Patient Alteration AFTER Admission Date Agreed
If a patient wishes to alter their admission date the 18 week clock continues. These are patients who have agreed a date of admission but subsequently cancel (prior to the admission date). In this instance the patient should be offered a further 2 offers of admission with reasonable notice (2 dates with at least 3 weeks' notice). If the patient declines two or more offers provided with reasonable notice then this decision must be recorded – **please note that patient pauses are not reportable but must be documented for audit purposes**. The RTT clock is not paused at all and will continue until such time that treatment is received. Please document the date of the earliest offer provided with reasonable notice given as part of the rescheduling process to the date from which the patient is available.

NOTE: In order to comply with clinical need or RTT pathway requirements, reasonable notice of further admission dates may not be possible.

12.8 DNA of Elective Admission

See DNA Action Card

13. Managing Elective Admissions

13.1 Booking Admissions

The Trust aims to create a culture of care based on positive attitudes towards welcoming the diversity of patients, their families, carers and service users and meeting diverse needs. The Trust is an organisation that continually improves by embedding inclusion principles and standards into every day practice and placing them at the heart of policy and planning.

For all types of admission the Trust will give priority to clinically urgent patients. All other routine patients, of the same clinical priority, will be seen in chronological order from date referral received. If, when allocating TCIs for routine patients, a military person or veteran is made known these patients should be given priority for service-related conditions.

Communication with patients will be informative, clear and concise, and will be adapted as appropriate to meet the patient's information and communication requirements for example providing information in an alternative format. Where a patient has failed to respond to a request to confirm a TCI **or** has DNA'd, the Trust will attempt to contact the patient at a time outside that of normal working hours and ensure that they have the latest information regarding the patients address and contact number. This may include checking with the GP or cross referencing on the National Spine.

Where the Trust is unable to contact a patient (following a DNA or previous cancellation by a patient) the clinician responsible will review their referral and/or clinical records to determine the best course of action which is in the patients best clinical interest i.e. remain on the waiting list with an appointment sent via the mail system or return to the care of their GP. Where a patient is discharged back to the care of the GP a letter will be dictated and typed to be sent to both the patient and the GP.

13.2 Hospital Cancellations

Hospital-initiated cancellations are to be avoided wherever possible. Compliance with partial booking rules, waiting times for new patients, leave notice periods and appropriate demand and capacity planning for services should minimise the requirement for the Hospitals to cancel patients booked into clinics. Where this is unavoidable (e.g. sickness), the hospital Initiated Cancellation Procedure (refer to the Corporate Standard Operating Procedure Guide) which should be followed.

If a clinician makes a decision to cancel a patient (e.g. a slot needed for an urgent patient), they must liaise with their Admin Manager or Hospital Management team to advise whether the new admission for this patient is safe and suitable. If the patient to be cancelled is identified as a long-waiter (or will become one within 6 weeks) the clinician must work with the relevant Hospital Manager to solve the potential breach.

Transfer of care to the Private Sector for NHS Treatment
A Hospital Manager may request authorisation from the Trust to transfer patients for NHS treatment in the private sector to ensure they are treated within 18 weeks. This is in line with a patient's right to access treatment within the maximum waiting times set within the NHS Constitution as the NHS must provide a range of alternative providers if this is not possible. The following process should be followed:

1. Provisional list of patients identified to be reviewed by the Clinical Lead for appropriateness;
2. Contact made with private provider to negotiate terms of contract to include:
    a. Tariff for procedure;
    b. Agreement that pre-operative assessment will be completed;
    c. Who will provide outpatient follow-up following the procedure;
    d. Whether medical devices/prostheses are required and who will provide them;
    e. Whether repatriation to the hospital will occur at a set period of time following surgery;
3. Final list of appropriate patients for transfer contacted by the hospital to enquire if they accept transfer for treatment;
4. Confirmed patients details provided to private provider and hospital advised of admission date;
5. Admission date added to Hospital Information System under appropriately named 'dummy' ward, eg ALEX and health records provided;
6. Health records returned following admission with appropriate documentation from private episode of care copied and retained in Hospital records;
7. Hospital Information System updated with accurate RTT outcome of admission.

13.3 Patients Who Do Not Wish to Attend an Elective Admission

See Patient Initiated Delays Action Card

14. Cancelled Operations

14.1 NHS Standard (28 Day Rule)

The Trust aims to mitigate all short notice patient cancellations. The national definition of short notice is, “Patients operations cancelled on the day of admission or after admission for non-clinical reasons”. However, where a short notice cancellation occurs the NHS Patient Constitution states that:

- If the operation is cancelled, then the patient must be given a firm date for admission that is within 28 days of the cancelled date. If this is not done, then patients are entitled to have their operations performed at a provider and on a date of their choice, funded by the original provider. Where possible, patients should be offered a further date of admission within 21 days.

Other local standards agreed with commissioners, as follows:

- Volume;
- No urgent operation should be cancelled for a second or subsequent time.

14.2 Managing Cancellations

Before cancellation
Any potential cancellation (on the day of admission or after admission, for non-clinical reasons) must be escalated explicitly via the local ‘Patient Cancellation Escalation Policy’.

Preoperative assessment
Preoperative assessment must ensure that everything that needs to be done before the patient’s operation has been done (kit ordered, bloods taken, post-op arrangements discussed, etc.).

Re-dating patients
A new and appropriate date must be agreed with the patient when they are cancelled.
For patients who have been admitted, it should be agreed with them before they leave the hospital. For patients who are cancelled on the day of admission and before they come into the hospital, it must be agreed with them at the time that they are cancelled (in the same telephone call).

If a patient is cancelled on the day of surgery, however, is offered to have their surgery within 24 hours of the original cancellation, this will be classed as a postponement.

Where a reportable cancelled operation occurs more than once, an incident form needs to be completed.

15 Cancer Access

15.1 Introduction to Cancer Standards

All staff should refer to this section of the Policy for patients on a suspected or confirmed cancer pathway in the first instance. However, this section of the Trust's Access Policy should be read in conjunction with the remainder of the Policy. Many of the general guidelines in the Access Policy can be applied to patients on a cancer pathway.

The NHS Cancer Plan (2000) and the NHS Plan (2000) set out a vision of a service for patients on a suspected cancer pathway, and those on a routine pathway, designed around the patient with a ten-year programme of investment and reform to transform the system and put it at the forefront of best-practice internationally.
The NHS Cancer Plan set out that patients referred with suspected cancer should wait no longer than 14 days for first outpatient assessment or first diagnostic test. It also stated that from decision-to-refer to first treatment should be no longer than 62 days unless referred with a rare cancer such as testicular or leukaemia, or a child. In these instances, a 31 day referral to treatment target applies.

The NHS Cancer Plan also states that patients not referred via the two-week rule system, but subsequently found to have a diagnosis of cancer, should wait no longer than 31 days from a decision-to-treat to first treatment.

The Cancer Reform Strategy (Dec 2008) extended access and treatment for a cancer pathway to include:

- All patients referred with breast symptoms to be seen within 14 days (excluding referrals for reconstruction and family history);
- Patients from National Screening Programmes to be upgraded to a 62-day pathway if cancer suspected or confirmed;
- Consultant upgrade of routine patients to a 62-day pathway;
- All subsequent treatments for primary, recurrent and metastatic cancers within 31 days of decision-to-treat or the earliest clinically appropriate date.

This policy outlines the access expectations of the patient journey from the point of referral to the start of treatment under the cancer waiting times rules. It sets out the principles that will apply at the different stages of the journey to ensure that the rules and guidelines for cancer pathways are applied fairly and consistently, and in ways that deliver the intended benefits for NHS patients and NHS organisations. Locally, where possible, the Trust will strive to offer first appointments within 7 days.

More recently, the 'Achieving World Class Cancer Outcomes: Taking the Strategy Forward' (May 2016) stated that the focus should be on fewer people getting preventable cancers, more people surviving for longer after a diagnosis with 57% of patients surviving ten years or more, more people having a positive experience of care and support, and more people having a better long-term quality of life.

Patients excluded from monitoring under the cancer standards
Any patient:

- with a non-invasive cancer;
- with a carcinoma in situ (with the exception of breast which is included);
- with Basal cell carcinoma (BCC);
- who dies prior to treatment commencing;
- who receives diagnostic services and treatment privately. However, where a patient chooses to be seen initially by a specialist privately but is then referred for treatment under the NHS, the patient should be included under the existing and/or expanded 31-day standard;
- who is first seen under the two-week standard, then chooses to have diagnostic tests privately before returning to the NHS for cancer treatment, only the two-week standard and 31 day standard apply. The patient is excluded from the 62 day standard as the diagnostic phase of the period has been carried out by the private sector.

15.2 Faster Diagnosis Standard

The Faster Diagnosis Standard, a new operational standard that aims to provide patients with timely diagnosis or all clear and improved patient experience.

The Faster Diagnosis Standard will be shadow monitored from 1 April 2019, and with national reporting from 1 April 2020. Currently the threshold for this standard has not been set nationally.

Starting the Clock and Inclusion of Faster Diagnosis Standard

The faster diagnosis standard inclusion and clock start dates are the same as detailed in first seen section of this guidance as follows:

- Urgent Referral for Suspected Cancer

    1. Inclusion – Two Week Wait Standard;
    2. Clock Start – see Section 15.3

- Breast Symptomatic Referral

    1. Inclusion – see Section 15.3;
    2. Clock Start – see Section 15.3

- Urgent Screening Referrals

See Clock Starts for National Screening Programmes;

For a more comprehensive summary please refer to the National Cancer Waiting Times Monitoring Dataset Guidance v10.0.

15.3 Cancer Waiting Times Clock Rules

Clock Starts

A two-week wait (2WW) clock starts when any healthcare professional, or service permitted by the commissioner to make such referrals, refer a patient with suspected cancer and when the provider receives such a referral. If the patient goes 'straight-to-test' following a 2WW referral the receipt of the referral is the clock start and the date of the test is the 'date first seen' under the 2WW rule.

A 31 day pathway commences for two reasons:

- When a decision to treat has been made – the clock starts from the point at which the decision to treat is made and agreed with the patient;

- When a second and/or subsequent treatment is determined – the clock starts from either the point of decision to treat OR the earliest clinically appropriate date (ECAD) to deliver that treatment.

The date of decision to treat should be clearly recorded in the patient's medical records. Patients will be advised of the need for treatment/ surgery, but the decision-to-treat date will not be confirmed until the clinician is in receipt of all relevant diagnostic test/investigation results to support the treatment/management plan. The 31 day Cancer Waiting Time clock will commence at this point. The patient will be informed of this and the confirmation of the agreed plan at the relevant times. The original 62 day clock will remain unchanged.

A 62 day pathway commences on receipt of a 2WW referral OR upgrade of a routine referral following suspicion of a cancer diagnosis OR following triage of certain direct access diagnostic tests. All GPs must check patients are available before referral, and consider deferring if not.

If a provider receives a referral and the patient is unable to attend any appointment within 3 weeks, their referral will be sent for a clinical review to ensure there is no clinical detriment to the patient. The patient will be encouraged to accept an earlier appointment, however they should be informed that their referral will be clinically reviewed. The reviewing clinician should decide whether a further date can be offered or if there should be further discussion with the patient and/or their GP.

Exceptionally, where it is deemed to be in the patients' best clinical interest the GP may opt to retract the original referral and refer again, at a later date. If the referral is not retracted and the patient refuses to accept an earlier date, then the appointment should still be booked and the clock continues from the original referral date.

Patients who have DNA'd two first attendance appointments, with reasonable notice, could be referred back to the GP, only when this is deemed to be in their best clinical interest. Such decisions should be made by the responsible clinician on an individual patient basis.

A provider will need to demonstrate that they have made every reasonable effort to communicate the appointments before discharging the patient.

Patients who cancel 2 or more first attendance appointments should only be referred back to their GP where the patient has been informed this will occur and when this is deemed to be in their best clinical interest, i.e. if this is likely to speed up their pathway. Such decisions should be made by the responsible clinician on an individual patient basis.

Exceptions
Patients with a suspected rare cancer (leukaemia, testicular) or for children referred with suspected cancer are subject to a 31 day wait from the date of receipt of referral to treatment.

Clock Starts for Patients Referred Directly from a National Screening Programme

- **Breast Screening –** the clock start date is this receipt of a referral for further assessment;
- **Bowel Screening –** the clock start date is receipt of referral for an appointment with a screening nurse to discuss colonoscopy;
- **Bowel Scope (FOBT or FIT) –** receipt of referral for an appointment to discuss suitability for colonoscopy with a Specialist Screening Practitioner (SSP);
- **Cervical Screening** – the clock start date is receipt of referral for colposcopy.

Clock Stops for Treatment and Non-Treatment
The definitions for Cancer Access Pathways are the same as 18 week Pathways (Section 2.0) except for:

1. The date of admission for surgery will stop the clock (not the date of actual treatment);

2. This can only be used where a patient declines all diagnostics appointments and is therefore discharged back to the GPs care or exceptionally when agreed with the patient followed up routinely in secondary care. (CWT 3.5.2)

Reasonable offer of diagnostics or treatment is defined as not less than 24 hours' notice.

Exceptionally, where patients repeatedly delay their diagnosis and treatment, and the responsible clinician believes it to be in the patients' best clinical interest, then they may be discharged back to the care of their GP, and taken off the 62 day pathway. This also applies when patients explicitly refuse all offers of diagnosis and treatment.

Patients should only be discharged in such circumstances where the delays are likely to be detrimental to their prognosis, and when all attempts to discuss this directly with the patient have failed (e.g. discussion with the treating clinician) and where there is an expectation that the further involvement of the GP would reduce the delays on re-Referral. If the patient agrees at a later stage to have the test(s) and is subsequently diagnosed with cancer, they will be monitored as a 31 day cancer pathway once a decision to treat has been agreed.

Patient Alteration of 2WW Appointment (either Outpatient or Diagnostic)
If the patient chooses a date outside the 2 week deadline they will remain within the 2 week wait cohort and the 62 day cohort if cancer is confirmed. No clock stops are allowed as the operational standards take into account an element of patient choice.

Patient Fails to Attend 2WW Appointment (DNA)
When a patient does not attend (DNA) their first appointment following the initial 2 week wait referral, they will not returned to their GP, but instead the clock will be reset from receipt of referral to the date upon which the patient rebooks their appointment. The reset will only occur if the Trust can demonstrate that the appointment was clearly communicated to the patient and that the patient's accessible information and/or communication requirements were met.

Hospital Initiated Cancellations for Outpatients or Diagnostic Tests
In the event that the Trust cancels a patient's appointment, the cancer waiting time clock will continue. In the event that a repeat diagnostic test is required the cancer waiting time clock will continue. In all cases it is the Trust's responsibility to re-book the patient and treat within the maximum referral treatment times. This can include, and only with the prior agreement of the patient, a decision to transfer the care to another provider if the cancer pathway cannot be delivered in the required timeframe.

Step-Down from a Cancer Pathway
For complete set of rules and guidance on this matter, please refer to the National Cancer Waiting Times Monitoring Dataset Guidance – Version 10.0

15.4 Cancer Access Referral Guidance

A tumour-specific 2WW referral proforma must be used to refer patients with suspected cancer. The decision to refer for a suspicion of cancer must be discussed openly with the patient by the GP. Failure to do this may result in the patient being contacted for a suspected cancer appointment when they were unaware this was the case. All symptomatic breast referrals will be subject to the 2 week wait rule (excludes reconstruction and family history referrals).

Upgrading Non-2WW Referrals
A consultant can upgrade a patient from a routine to urgent referral. Patients can be upgraded by the consultant or another member of the team:

- When triaging or reviewing the referral;
- After the first diagnostic test; or
- Following an MDT discussion.

Once upgraded, the patient will be managed on a 62 day pathway (date of upgrade request to first treatment is within 62 days). The clock start date is the date the referral is upgraded not the date it is received. Patient and GP should be informed of the upgrade.

Downgrading Referrals
A 2WW referral can only be downgraded prior to first appointment in secondary care after discussion and agreement with the referring GP/GDP. The referring GP/GDP alone has the ability to downgrade such referrals.

For referrals where it is felt further information is necessary there should be no pause or resetting of the pathway start date. Information should be requested from the GP but the

default position should be to book and see the patient in the safest manner within the required timescales.

Patient Choice
If the referral is urgent or a suspected cancer and a doctor of the required gender is not available (due to leave or absence), MFT will comply with the patient's wishes and agree a suitable appointment date/time, but this may not be within the required standards for urgent or suspected cancer referrals.

Referrals from National Screening Programmes
The 62-day standard is applied to referrals received from the three national screening programmes, e.g. breast, bowel and cervical. If anyone is suspected of having cancer on these programmes they are automatically monitored against the 62 day standard until cancer has been ruled out or treatment for cancer commenced.

Referrals from Private Practice to the NHS for Treatment
Where a patient wishes to transfer to an elective NHS pathway for treatment, following a private consultation, a 31 day cancer pathway will commence once a decision to treat has been agreed, or at receipt of referral if decision-to-treat date was in the private consultation period.

Definition of Reasonable Notice
The definition of reasonable notice for patients on a cancer pathway is any offered appointment between the start and end point of 31 and 62 day standards (CWT 2.4.6) Local Policy applies) however, consideration will be given to the individual patient circumstances when arranging appointments with them.
In cases of contention, such as treatments offered on the same day, the commissioner should decide whether the offered appointment was reasonable.

15.5 Definition/Guidance for Patient Cancellations/Alterations

Inpatient Cancellation/Alteration(s)
Where a patient wishes to change the date of an inpatient or day-case admission they should be appointed a date of their choice and the decision details recorded. No adjustment is permissible at this point.

If the patient is not willing to accept **any** dates (i.e. declining cancer treatment) they will be removed from the elective waiting list, the 62 day cancer pathway monitoring will stop and the referring clinician will be informed in writing.

The listing clinician will be advised by the waiting list team of any patient who cancels and re-books their inpatient or day-case admission more than twice so that clinical review can take place if necessary.

Active monitoring will not be used as a substitute for thinking time or in circumstances where palliative care is the most appropriate treatment. Where active monitoring is applied, a new 31-day/2nd or subsequent cancer-waiting-times clock should commence once the patient is ready to commence active treatment. Patients or clinicians can initiate active monitoring. For

full guidance on the use of active monitoring please see the latest national cancer waiting times guidance.

15.6 Transfers for Care/Treatment

Transfers to Independent Providers
Where a patient is referred from an NHS Provider to an independent-sector organisation as part of their NHS cancer pathway, the clock will continue and the NHS Provider will be responsible for the monitoring and reporting of performance for the patient's cancer pathway. The admission date at the independent provider is taken as the start of treatment and will stop the clock.

Inter-Provider Transfers
The minimum core Inter-Provider Transfer dataset should accompany the transfer of patients between providers. The Trust will comply with the agreed timescales for inter-provider transfers as stated in CWT Version 10.

15.7 Breach of Cancer Targets

62 day pathways (including GP, Upgrade, Symptomatic and screening)
Where a patient is treated beyond day 62 of their pathway, the Cancer Pathway Coordinator (CPC) will produce a Root Cause Analysis (RCA) to identify any delays and bottlenecks in the pathway. The pathway will be validated by the relevant hospital site team or teams and be reviewed via hospital site process. It should then be forwarded to the relevant Cancer manager for further review . Actions to address the bottlenecks and delays will be developed by the relevant team responsible for that element of the pathway.

Patients who are treated beyond day 104 of their 62 day pathway
Patients who are beyond day 104 of their pathway will be identified via the weekly PTL report. Such patients will require a clinical harm review of their pathway which will be discussed at the relevant Hospital and departmental cancer meetings. This should be reviewed again at treatment.

Where patients receive a confirmed diagnosis of cancer and are treated beyond day 104 of the pathway, a full clinical review will be undertaken in addition to the steps outlined above. The RCA and supporting information will be reviewed by the Lead Cancer Clinician to decide if the patient has suffered any harm as a result of the delays and whether an SUI is required, at which point the Trust existing policy for management of SUI will be enacted.

16 Validation

Validation is the process of checking to see that the patients who are due to have outpatient or inpatient appointments still require them. For example:

- Have they moved away?
- Has their condition improved so they no longer require the appointment?

This can be undertaken in two ways:

- Administratively - by sending letters to or telephoning the patients;
- Clinically - where the patient's clinical condition is reviewed, through a review of their clinical notes.

17 Equality Impact Assessment

MFT Equality, Diversity & Inclusion Policy Statement:

Manchester University NHS Foundation Trust is strongly committed to ensuring our services and employment practices are fair, accessible, and inclusive for the diverse communities we serve and the workforce we employ. This is reflected and reinforced in our 'vision and values'.

Patients/Visitors/Carers

Everyone has the right to be treated fairly and with dignity and respect. You will not be discriminated against on any grounds including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation.

This policy has been equality impact assessed by the authors using the Trust's Equality Impact Assessment (EqIA) framework and scored at 20. This score fell into the low priority category - no significant issues in relation to equality, diversity, gender, colour, race or religion are identified as raising a concern.

This policy has been externally equality assured by the Equality & Diversity Practioner and assured as being relevant to equality and diversity. This is because the policy affects all patient, service users, carers and has implication particularly for meeting accessible information and communication needs in line with the Equality Act 2010 and the Accessible Information Standard. The policy has been gone through and requirements have been integrated throughout.

18 Consultation, Approval and Ratification Process

This document has been produced by the Data Quality and Training Manager (Corporate Services, Performance Manager (Corporate Services) and the Outpatient Hospital Manager (Wythenshawe Hospital), with consultation from key colleagues across the Trust and approval from the Director of Performance. Formal ratification is initially from the Performance & Delivery Group and ultimately by the Operational & Transformation Oversight Group and our local Clinical Commissioning Group.

The policy will be reviewed as required when patient access standards change or are introduced. This will be as a minimum once a year and will follow the consultation/approval process detailed above.

19 Dissemination and Implementation

The policy will be circulated to members of the Performance & Delivery Group and ultimately by the Operational Management Group and our local Clinical Commissioning Group. This policy will be made available on the Trust Intranet and the Central Intelligence share point site. When updated the old version will be replaced and staff informed via email. A supporting Standard Operating Procedure Manual will be available to staff to support implementation and ongoing training.

20 Monitoring Compliance of Procedural Documents

To support this Access Policy we have developed specific Standard Operating Procedures to be used by Trust staff to ensure the rules are followed correctly and information/data is recorded and reported accurately and timely.

Having a policy is only the first step to ensure standardisation of patient access and data collection. The Trust must be sure that, through routine audit, documented processing and training, all patient activity is collected and recorded consistently. The Data Quality Team will monitor the quality of the data recorded under this policy to ensure the data standards and procedures are adhered to. Monitoring reports will be produced and areas of poor performance will be highlighted and addressed. An audit programme in line with the Information Governance Toolkit will be carried out each year. This will include the audit of system data against the patient case notes.

As the Trust develops new services, additional activity will need to be recorded. It is vital that any activity recorded meets the national definitions and reflects the resources required to deliver the care.

It is important to keep this document up to date in order to reflect the changing environment that we now work in and it will therefore be reviewed at least once a year. All changes/additions will be notified to staff.

The latest version of this policy will be available on the Trust's Intranet.

21 References and Further Reading

Title	Published by	Publication date	Link
Referral to treatment consultant-led waiting times Rules Suite	Department of Health	October 2015	www.gov.uk/government/uploads/system/uploads/attachment_data/file/464956/RTT_Rules_Suite_October_2015.pdf
Recording and reporting referral to treatment (RTT) waiting times for consultant-led	NHS England	October 2015	www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting-

elective care			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/
Accessible Information: Implementation Guidance v1.1	NHS England	August 2017	www.england.nhs.uk/accessibleinfo
Diagnostics FAQs Frequently Asked Questions on completing the 'Diagnostic Waiting Times and Activity' monthly data collection Equality Act 2010	NHS England	February 2015	www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/
Equality Act 2010	Department of Health	June 2015	www.gov.uk/guidance/equality-act-2010-guidance
Overseas Visitor Guidance	Department of Health	April 2016	www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations

Cancer waiting times guidance Version 10	Department of Health	16th January 2019	https://digital.nhs.uk/cancer-waiting-times
Armed Forces Covenant	Ministry of Defence	July 2015	www.gov.uk/government/uploads/system/uploads/attachment_data/file/49469/the_armed_forces_covenant.pdf
'2015/2016 Choice Framework' (Department of Health)	Department of Health	2015	https://www.gov.uk/government/publications/nhs-choice-framework-2015-to-2016
NHS England Long Term Plan	NHS England	7th January 2019	https://www.longtermplan.nhs.uk/
Greater Manchester Effective Use of Resources: Operational Policy Version: 6.3	Greater Manchester Shared Services	October 2019	https://www.mhcc.nhs.uk/publications/
The interface between Primary and Secondary care – key messages for NHS clinicians and managers.	NHS England	2016	www.england.nhs.uk/interface
NHS Standard Contract 2019/20	NHS England	March 2019	https://www.england.nhs.uk/nhs-standard-contract/19-20/
RTT Training Guides (Induction and Intermediate)	MFT	2019	RTT Training Suite on e-Learning
Equality, Diversity and Inclusion	MFT	2019	RTT Training Suite on e-Learning
Chargeable Patients Policy	MFT	2018	http://staffnet.cmft.nhs.uk/policies/finance/on7-2459-15-10-2018-10-57-37.pdf
Outpatient Standards	MFT	2017	Link not stated as could change
Preventing and Managing Missed Appointments for Children and Young People	MFT	2016	Link not stated as could change

22. Associated Trust Documents
Accessible Information Standard Policy
Data Quality Policy
Diversity Matters: Equality, Diversity and Inclusion Strategy 2019 - 2023
Information Governance Policy
Chaperone Policy
Children and Young People Missed Appointment Policy
Chargeable Patients Policy
Data Protection Policy
Homelessness Reduction Policy
Outpatient Operating Standards
Health Records Management Policy

23. Glossary and Acronyms

23.1 Glossary

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 or patient decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures.
Active waiting list	The list of elective patients who are fit, ready and able to be seen or treated at that point in time. Applicable to any stage of the RTT pathway where patients are waiting for hospital resource reasons.
Bilateral procedures	Where a procedure is required on both the right

	and left sides of the body.
Breach	A pathway which ends when a patient is seen/receives their first treatment outside the 14-day first seen, 62-day referral to treatment and/or 31-day decision to treat to treatment target times.
Chronological booking	Refers to the process of booking patients for appointments, diagnostic procedures and admission in date order of their clock start date.
Consultant-led service	A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse-led clinics which come under the umbrella of consultant-led services.
Day case	Patients who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.
Decision to admit	Where a clinical decision is made to admit the patient for either day case or inpatient treatment.
Direct access	Where GPs refer patients to hospital for diagnostic tests only. These patients will not be on an open RTT pathway.
Elective care	Any pre-scheduled care which doesn't come under the scope of emergency care.
First definitive treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgement in consultation with the patient.
Fixed appointments	Where an appointment or admission date is sent in the post to the patient without the opportunity to agree a date.
Full booking	Where an appointment or admission date is agreed either with the patient at the time of the decision or within 24 hours of the decision.
Incomplete pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage.
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night
Nullified	Where the RTT clock is discounted from any reporting of RTT performance.
Oncology	The branch of science that deals with tumours and cancers.
Partial booking	Where an appointment or admission date is agreed with the patient near to the time it is due.

Patient-initiated delay	Where the patient cancels, declines offers or does not attend appointments or admission. This in itself does not the stop the RTT clock. A clinical review must always take place.
Planned waiting list	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18-week RTT pathway.
Reasonable offers	A choice of two appointment or admission dates with three weeks' notice.
Straight to test	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an RTT pathway.

23.2 Acronyms

Term	Definition
ASIs	Appointment slot issues (list): a list of patients who have attempted to book their appointment through the national E-Referral Service but have been unable to due to lack of clinic slots.
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.
CMS	A database system used to record all information related to patient cancer pathway by MDT co-ordinators, CNSs and clinicians.
IOG	Improving outcomes guidance: NICE guidance on the configuration of cancer services.
IPT	Inter-provider transfer
MDT meeting	A multidisciplinary team meeting where individual patients care plans are discussed and agreed.
MDS	Minimum dataset: minimum information required to be able to process a referral either into the cancer pathway or for referral out to other Trusts.
MDT	Multidisciplinary team: here describing a group of doctors and other health professionals with expertise in a specific cancer, who together discuss and manage an individual patient's care.

MDT Co-ordinator	Person with responsibility for tracking patients, liaising with clinical and clinical assessment unit staff to ensure progress on the cancer pathway, attending the weekly patient tracking list (PTL) meeting, updating the Trust database for cancer pathway patients and assisting with pathway reviews and changes. Also co-ordinates the MDT meeting and records the decision for progress along the cancer pathway.
NCWTDB	National cancer waiting times database: all cancer waiting times general standards are monitored through this.
PAS	Patient administration system records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient. Currently used on our Central site.
PPID	Patient pathway identifier
Cancer 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

24. Appendices

24.1 Appendices – Action Cards

1. CLOCK STOP FOR FIRST DEFINITIVE TREATMENT

The first CLINICAL INTERVENTION intended to manage a PATIENT's disease, condition or injury and avoid further CLINICAL INTERVENTIONS.
What constitutes First Definitive Treatment is a matter of clinical judgement in consultation with others, where appropriate, including the PATIENT.

The clock stops at the point the treatment commences or a decision not to treat is communicated with the patient and if appropriate, the GP. For example, Decision to Treat:

- Minor procedure
- Surgical Procedure
- Medication - only where this is given as treatment (Not when this is given to keep symptoms at bay until treatment commences).
- Advice - this needs to be relevant to the condition the patient was referred with.
- First appointment attended with allied health professionals which are considered the treatment. For example physiotherapy.

Example:

2. CLOCK STOP 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 nonconsultant-led treatment in primary care
- Clinical decision is made not to treat
- Patient DNAs which resulted in the patient being discharged
- Clinical decision is made to start a period of active monitoring;
- Patient declines treatment having been offered it.

Example:

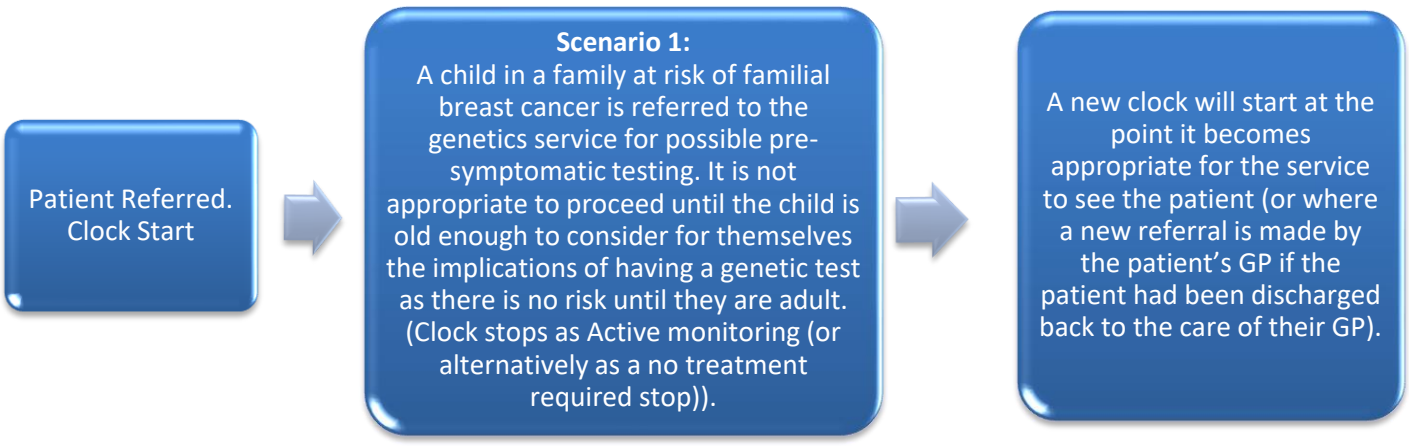
3. NEW CLOCK STARTS FOR THE SAME CONDITION

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 week's from that date.



4. NEW CLOCK STARTS FOR BILATERAL PROCEDURES

A procedure that is performed on both sides of the body, at matching anatomical sites (for example, removal of cataracts from both eyes)
The initial waiting time clock will stop at first definitive treatment for the first procedure.
Once the patient is fit and ready for the second procedure, a new RTT Period should start.

The clock should start when it is clinically appropriate for the patient to undergo that procedure, and the patient says they are available, not from the date that the provider has the capacity to admit/treat them.

Example:

Click here to go back to Bilateral Procedures (p30)
Click here to go back to Bilateral Procedures (p50)

5. PLANNED PATIENTS

Planned care means an appointment /procedure or series of appointments/ procedures as part of an agreed programme of care which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Planned activity is also sometimes called Surveillance, re-do or follow-up.

Patients on planned waiting lists are outside the scope of RTT measurement.
Patients should only be placed on a planned list when they are due to have a planned procedure or operation that is to take place in a specific time, such as a repeat colonoscopy, or where they are receiving repeated therapeutic procedures, such as radiotherapy.

It should also be remembered that many patients require structured follow-up to detect the need for further treatment at appropriate follow-up intervals for individual clinical conditions. Examples may be patients with diabetic eye disease, or other eye conditions, who need eye examination to detect progression requiring urgent treatment to prevent blindness, or patients with long term conditions who require planned monitoring including those on disease-modifying drugs (such as for rheumatoid arthritis) where both potential side-effects of the drugs and response to treatment must be assessed.

Patients who are on an RTT pathway should not be placed on a planned list if they are unfit for a procedure or operation. Instead, their clock should keep running unless a clinical decision is made to discharge or start active monitoring.

The planned list may include:

- Patients who require periodic review as an inpatient/day-case in order for an on-going condition to be monitored (e.g. surveillance gastroscopy, colonoscopy, cystoscopy etc.);
- A situation where the Orthopaedic surgeon may request that metalwork inserted to support the healing of a fracture is only to be removed after a certain period of time;
- Patients undergoing a series of treatments (e.g. a patient may attend for a course of pain-relieving injections on a 3-monthly basis).

The planned waiting list must not be used to hold patients:

- who wish to defer surgery;
- who are unable to have surgery due to underlying medical conditions;
- due to service capacity issues.

Back to Planned Waiting Lists p29
Back to Use of Planned Waiting Lists p48

6. RTT CLOCK START FOR PATIENTS TRANSFERRING FROM A PLANNED LIST

Patients on planned lists should be booked in for an appointment at the clinically appropriate time and they should not have to wait a further period after this time has elapsed. For example, a patient due to have a re-test in six months' time should be booked in around six months later and they should not get to six months and then have to wait again for non-clinical reasons. This is not an acceptable use of a planned list.

Should a patient on a planned list reach the date for their planned appointment (e.g. 6 month follow up) or planned admission date without having the appointment booked, a new RTT clock must start and the patient must be added to an active waiting list.

Should it be deemed clinically unsuitable for a patient to commence treatment, the clinician can delay the expected admission date, they must confirm the new expected admission date. The patient remains on the planned waiting list.

The key principle is that where patients' treatment can be started immediately, then they should start treatment or be added to an active waiting list.

This principle applies equally to review or surveillance appointments with a consultant-led service that may lead to consultant-led treatment.

7. ACTIVE MONITORING

When the most clinically appropriate option is for the patient to be monitored actively over a period of time, rather than to undergo any further tests, treatments or other clinical interventions at that time.

Active monitoring is NOT to be used to stop a clock when the patient decides to defer treatment or further tests as they are not available for a period of time.

- When active monitoring commences – the RTT clock stops;
- When a decision is made to stop active monitoring and to commence a pathway to treatment, a new RTT period starts from ZERO.

Patients Who Are Unfit for Surgery:
If the patient is identified as unfit for the procedure, the nature and duration of the clinical issue should be ascertained.

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

Longer Term Illnesses:
If the nature of the clinical issue is more serious for which 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. 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).

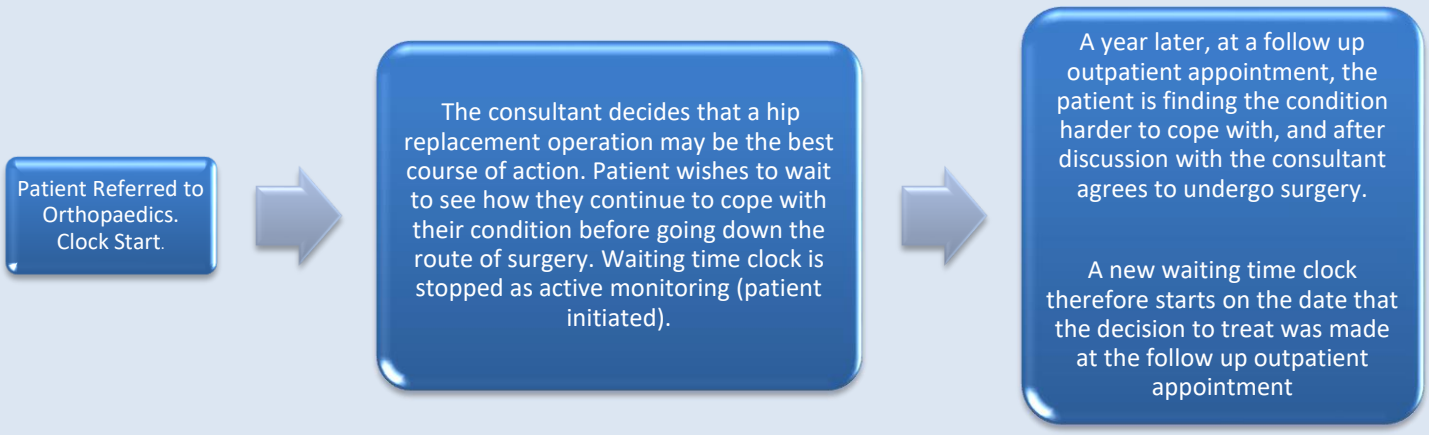
8. PATIENTS REQUIRING THINKING TIME

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

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

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

Example:



9 PATIENT INITIATED DELAYS

Cancelling, declining OR delaying Appointment Offers

Patients can choose to postpone or amend their appointment 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 the appointment. Where necessary, clinicians will review each and every patient's case on an individual basis to determine whether:

- The requested delay is clinically acceptable (clock continues);
- The patient should be contacted to review their options – this may result in agreement to the delay (clock continues) or to commence a period of active monitoring (clock stops);
- The patient's best clinical interest would be served by discharging them to the care of their GP (clock stops);

Patients should not be discharged to their GP, or otherwise removed from the waiting list, unless it is for clinical reasons.

Patients who cancel two or more consecutive new and/or follow-up outpatient appointments (including pre-operative assessment appointments), will not be routinely offered a further appointment, as long as the relevant service has discharged it's legal duty in compliance to the Accessible Information Standard. The patient's clinical record should be brought to the clinician's attention and a decision be made as to whether the patient should be discharged back to the care of their GP, within 7 working days. If a decision is made to discharge the patient back to the care of their GP, the consultant must write to the patient and the GP notifying them of this decision for safety and RTT audit purposes. The referral should be closed and a RTT outcome entered.

Patients normally choose to alter their appointment for short periods e.g. when away on holiday for 2–3 weeks. If a patient requests to defer their appointment for 8 weeks or more the patients records should be reviewed by the clinician who will make a decision on what is the appropriate clinical action i.e. refer the patient back to the GP to be re-referred when they are able to attend the reasonable notice offers or keep the patient on the waiting list and be offered a further appointment if the clinician feels it is in their best clinical interests.

Patients can, however, choose to delay their treatment whether they are on the non-admitted or admitted stage of the pathway and the RTT clock will continue unless the patient is referred back to their GP.

All offers of appointments should be recorded on the Hospital Information System, to be able to demonstrate that the patient chose to delay their treatment.

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.

Back to Patient Initiated Outpatient Cancellations p37

10. Cancelling, Declining OR Delaying Treatment Offers

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

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

Patients who decide that they no longer wish to attend any admission offers will be brought to the attention of the consultant. Where a patient is insistent they no longer wish to be seen they will be discharged back to their GP and the referral closed. A letter will be sent to the patient and copied to their GP.

Pauses to a Patient's Pathway

- *These are no longer applicable in RTT pathways*; however**,** as detailed above, the patient must be fit, ready and able to be admitted if they are added to the waiting list. Pauses to an RTT pathway **are not reportable** but must be documented on Hospital Information System **for audit purposes only**.

- **Example –** A patient who has declined two admission offers and has been provided with reasonable notice of 4th June and 7th June states that they are not available until 15th July. The next available date for admission that MFT can provide is 18th July. In this instance, the pause should be **documented/recorded** from 4th June (the first offer date provided with reasonable notice) and the 15th July (the date from which the patient is available for treatment).

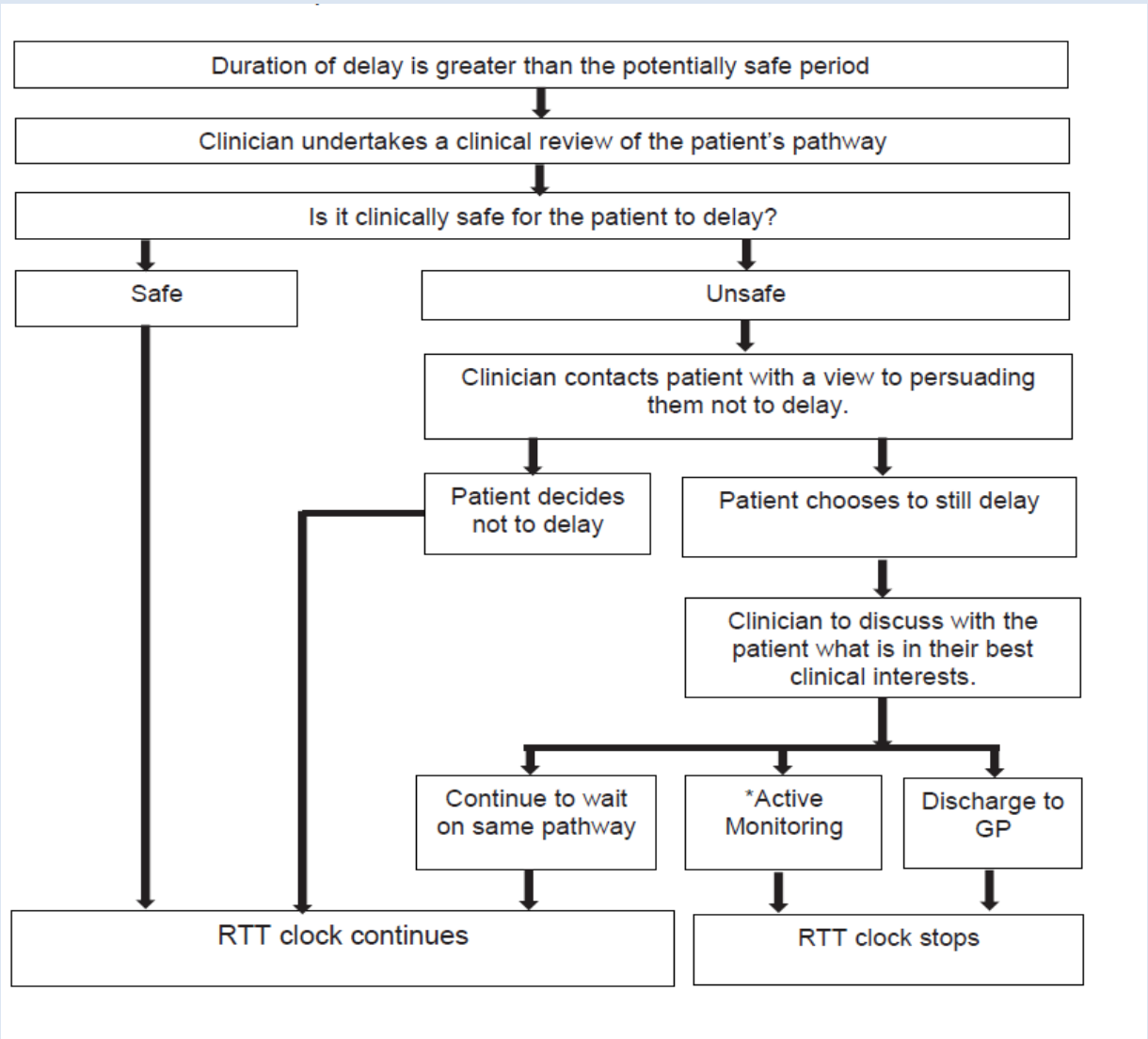
- If the patient subsequently cancels their admission date for the 18th July, then the **documented/recorded** pause period can be extended to the date which the patient informs they are available again for admission

Back to Patients Who Do Not Wish to Attend Elective Admissions p52
Back to Patient Initiated Delays p29 or Patient Initiated Delays p38

11. Cancelling, Declining OR Delaying Diagnostic Offers

If a patient chooses to alter a diagnostic appointment, the patient will be offered another appointment within three weeks of the original appointment. If a second date is offered and is then also cancelled, the patient will be clinically reviewed to determine if another appointment will be offered. Each time a patient cancels a reasonable appointment the clock is reset to the date of the cancelled appointment.
Back to Patient Cancellation/Alteration of Diagnostic Appointment p43

The flow chart below outlines possible outcomes, taken from NHSi Model Access Policy



13. PATIENTS DECLARING PERIODS OF UNAVAILABILITY WHILST ON THE INPATIENT/DAYCASE WAITING LIST

Should patients contact the Trust to communicate periods of unavailability for social reasons (e.g. 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 specialty), the patient's pathway will be reviewed by their consultant. Upon clinical review, the patient's consultant will indicate one of the following:

- Clinically safe for the patient to delay - continue progression of pathway. The RTT clock continues;
- Clinically unsafe length of delay – clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues. 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 or;
- 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.

14. REASONABLE NOTICE

'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.
Admission/outpatient dates can be offered with less than three weeks' notice, if the patient accepts an offer, this can then be defined as 'reasonable'.
If an appointment is not reasonable, then any potential waiting time adjustments cannot be applied when patients cancel or DNA.

Reasonable Offer

A Reasonable Offer is an APPOINTMENT OFFER or OFFER OF ADMISSION;

A Reasonable Offer is where the REASONABLE OFFER INDICATOR is National Code '*Reasonable Offer*';

An offer is reasonable where:

- the offer of an Out-Patient Appointment or an OFFER OF ADMISSION is for a time and date three or more weeks from the time that the offer was made;

or

- the PATIENT accepts the offer

or

- the offer is for the first Genitourinary Consultant Clinic Attendance in a Sexual Health and HIV Episode

or

- the offer is for any APPOINTMENT for treatment in a Cancer Treatment Period;

or

- the offer of an APPOINTMENT for a non-outpatient CARE CONTACT provided by a Community Health Service complies with local, publicly available/published policies for access to that SERVICE. These local policies should be clearly defined and specifically protect the clinical interests of vulnerable PATIENTS (e.g. children) and must have been agreed with clinicians, commissioners, PATIENTS and other stakeholders.

Click here to go back to Reasonable Notice (p50)

15. DECISION NOT TO TREAT

Clinical decision made not to treat at this time or no further contact is required.

- 34 – Consultant decision not to treat OR patient DNA'd and discharged.
- 35 – Patient declined treatment and discharged.

Example:

17. TRANSPLANT PATIENTS

When a decision is made to add a patient to a transplant waiting list and this has been communicated to the patient, then the RTT status will be updated and the 18 week clock will stop from the date of this decision.

- This applies to matched transplants (for example, kidney, liver) where the clock should stop at the point of adding the patient to a transplant list (after completion of work-up where relevant), and informing the patient and referring clinician of this. Once matched tissue becomes available, a new clock starts and is stopped at the point at which the patient is treated.

- For unmatched transplants (for example, many corneal grafts) the 18-week clock should stop when the transplant surgery takes place.

- For live kidney donor recipients who are not intending to go on the national waiting list for a deceased donor, the clock stops when they are considered fit for receipt of a live donor kidney (not the date of surgery).

The following advice applies for living organ donors:

Clock Starts
Happen when a person puts themselves forward to start formal work-up for donation, (for example, blood taken for blood group). This would follow provision of education, information and so on which all precede the clock start.

Clock Stops
a) Donor work-up completed, Human Tissue Authority assessment done, transplant operation has taken place.
b) Donor work-up completed but recipient seriously unwell or not yet ready. Donor clock would then stop as active monitoring. When the recipient is subsequently considered well enough to proceed, a new clock should start.
c) Donor work-up completed but recipient not suitable for transplantation. Donor clock would then stop as 'discharged'. Clocks shouldn't stop necessarily for co-morbidities where patient is waiting for opinion from other consultant (for example, cardiac) for suitability of operation and so on.
d) Donor deemed not suitable for donation following work-up. Donor clock would then stop as discharged.
e) Patient doesn't now want to donate (discharge).
f) Patient wants to delay/take stock/think about it (active monitoring).
g) Work-up completed but another family member is a more suitable donor. Clock would stop as either discharged, or active monitoring if there is a chance the other donor won't go through.

Click here to go back to Transplant Waiting List (p30)
Click here to go back to Transplant Waiting List (p50)

18. NATIONAL RTT OUTCOME CODES

Code	Description
10	1st Activity of subsequent different treatment
11	End of Active monitoring – First activity star of a new RTT period following active monitoring
12	Consultant Ref – 1st Activity – New RTT period ref direct to consultant for **separate condition**
20	Diagnostic, Follow up appointment, add to waiting List
21	Transfers to another Hospital
30	Start Treatment
31	Start Active monitoring – By Patient
32	Start Active monitoring – By Care Provider
33	DNA 1st appointment
34	Decision not to treat – DNA after 1st appointment
35	Patient Declined treatment
36	Patient Died
90	Any activity after treatment
91	Active monitoring
92	Patient not yet referred – Direct access diagnostic
98	Not applicable – Obstetrics, Dietetics etc.

19. WHAT THE CODES REALLY MEAN AND HOW TO APPLY WHEN VALIDATING.

RTT STATUS CODE 10 - NEW REFERRAL

Subsequent/Different Treatment i.e. course of Physiotherapy didn't work – Now needs surgery;
Bilateral Procedure – 1st is 10 then when patient is fit 2nd treatment is 10;
Special Funding Referrals – DOES NOT STOP THE CLOCK;
Clinician decides to offer another appointment clock starts on the date appointment is booked
Specifically agreed diagnostic.

RTT STATUS CODE 11 – END OF ACTIVE MONITORING

Patient has been on Active monitoring and now wants surgery / treatment (31);
Consultant decides a patient needs treatment after a period of active monitoring (32).

RTT STATUS CODE 12 - CONSULTANT REF – 1ST ACTIVITY

Referred by one consultant to another 1st Activity New pathway separate condition;

Most commissioners expect this type of referral to go back to GP.

RTT STATUS CODE 20

First Out-patient appointment
Diagnostic test
Subsequent outpatient appointments
Referred to colleague in same hospital – Same condition - Internal referral
Discuss MDT
Add to waiting List
Decision to rebook i.e. cancelled / DNA
Transfer from other hospital diagnostic
Further test required
Patient cancels appointment in advance
Trust cancels surgery (new TCI date must be 28 days or within 18 weeks)

RTT STATUS CODE 21

Transfer to another Hospital for treatment **not for a diagnostic or advice**
Accepted at Hospital code 20 if no IPT (inter patient transfer) form the trust must back date 8 weeks.

RTT STATUS CODE 30

First Definitive Treatment – An intervention intended to manage a patient's disease, condition or injury and avoid further intervention.
First Definitive treatment is a clinical judgement in consultation with the patient and includes:

Advise Medication or surgery;
Examples - If the above criteria has be adhered to;
Physiotherapy;
Occupational Therapy;
Podiatry;
Fitting a medical device (e.g. Hearing Aid – Not when measured);
Whilst doing diagnostic treatment is made i.e. Polyp removed;
Transplant List;
Medication – Often 1st Definitive treatment will be a medical or surgical intervention. However it may also be judged to be other elements of patients care, for example start counselling or prescription drugs to manage patients disease, condition / injury.

RTT STATUS CODE 31

Patient along with consultant decide they will wait and see;
Patient returns/ decides to have surgery clock would start again (RTT Code 11).

RTT STATUS CODE 32

Patient to stop Smoking;
Patient to Lose Weight;
Clinician wants to wait and see if condition improves / declines;
Transplant List – Initiated by Care Professional.

To stop the clock the clinician would need to advise that they are going to start a period of active monitoring when a decision is made (and agreed with patient) that it is clinically appropriate to start a period of monitoring possibly whilst the patient receives symptomatic support, but without any specific or significant clinical intervention at this stage. Active monitoring may be initiated by either a care professional or a patient. During active monitoring the patient will remain under the care of a consultant although the GP will be updated with progress of their patient.

RTT STATUS CODE 33

Patient DNA 1st appointment in their pathway;
Patient cancels 1st appointment no longer requires treatment;
Patients who cancel and Rebook on next occasion back to GP;
Partial booking non responders.

RTT STATUS CODE 34

Decisions not to treat;
Subsequent DNA's i.e. diagnostic Tests, Pre-op or TCI Date;
Patients test results show no further treatment – this can be communicated to patient via telephone or letter;
Letter to GP with results recommend the GP to initiate treatment.

ALL PATIENTS MUST BE REFERRED BACK TO GP IF A 34 IS ENTERED – IF YOU ARENT RETURNING THE PATIENT TO THE GP – **DO NOT USE 34**

RTT STATUS CODE 35

Patient declined offer of treatment;
Patient DNA's diagnostic test referred back to GP.

DO NOT USE 35, unless the patient is being discharged to their GP

RTT STATUS CODE 36
Patient Died Before Treatment

RTT STATUS CODE 90
After treatment;
DNA rebooked after treatment;
Patient is discharged back to GP - After treatment;

PLANNED PROCEDURES:

6 month surveillance check – Endoscopy;
Rheumatology – Injections following First Definite Treatment (FDT);
Urology – Lithotripsy following FDT;
Pain Management injections following FDT;
Neurology injection following FDT;
Oral Teeth Extractions following FDT – example below:

Patient needs 4 teeth removed however it's not in the patient's best interest to take all 4 at once the RTT clock stops after 1st removal. When patient is fit enough to have the other 3 removed code 90 would be used. The 3 teeth not removed in the initial operation would go on a planned waiting list.

RTT STATUS CODE 91

Patient is returning during a period of active monitoring (31/32), for regular check-ups. For example, patient is asked to lose weight before surgery until the correct weight is achieved. All appointments should be recorded under 91 and then 11 when at the target weight.

NATIONAL CODES RTT STATUS CODE 92

GP decided to refer patient to hospital for direct access DIAGNOSTIC ONLY

After diagnostic – GP can refer in. RTT clock starts.

20. Process for Managing Did Not Attends (DNAs)

Non-Admitted DNAs
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. Paediatric and vulnerable patient DNAs should be managed with reference to the Trust Safeguarding policy.

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.

Patients must not be brought back repeatedly to clinic if they DNA unless there is a clinical reason for doing so, as long as the relevant service has discharged it's legal duty in compliance to the Accessible Information Standard.

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.

There are some groups of patients who may automatically be given a second outpatient appointment if they DNA – these include patients identified as vulnerable adults, Obstetric patients, patients referred on a 2WW, Children and Young People. Please see 'Preventing and Managing Missed Hospital and Community Health Appointments for Children and Young People'. The clinician will be responsible for determining that no safeguarding issues are affected before returning the referral back to the GP. Any referral returned to the GP can be re-referred when the carer / child is available to be seen. This list is not exclusive and the decision should be clinically-led.

Where the Trust has offered an appointment with reasonable notice and the patient then DNAs, following a clinical review the patient may be discharged back to their GP and the RTT clock will be stopped. If the patient then contacts the hospital regarding their missed appointment the patient will be redirected back to their GP to request a new referral. Upon receipt of a new referral a new clock will start.

Back to Failure to Attend Outpatient Appointment p38

Diagnostic DNAs
If a patient fails to attend a diagnostic appointment, the referrer will be informed and a clinical decision made as to whether re-Referral is required, e.g. the patient may be a vulnerable adult. No clock pauses can be applied in this situation.

Each time a patient DNAs a reasonable appointment the clock is reset to the date of the cancelled appointment. Back to Patients Who DNA a Diagnostic Appointment p43

Admitted DNAs

All patients who do not attend their elective admission, will have their records reviewed by the clinician who will make a judgment on the appropriate course of action and what is in the patients best clinical interest i.e. to be discharged to the GP/referrer or remain on the waiting list to be offered a further TCI date. If a further admission date is not offered then the referrer/GP and the patient must be informed in writing of this decision and the RTT pathway clock will stop. The patient must be removed from the waiting list and the GP/referrer informed that re-Referral will be required for any future consultation. If a further admission date is offered to the patient then the RTT pathway clock will continue.

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21. Extract from the Welsh Health Specialised Services Committee Contract

1. Funding authorisation must be obtained **prior** to treatment for:

- activity, not eligible in accordance with the clinical policy criteria for that treatment;
- drugs, devices and packages of care not yet recommended by NICE or the All Wales Medicine Strategy Group (AWMSG);
- drugs, devices and packages of care outside the baseline agreement;
- WHSSC should be notified of any drugs, devices and packages of care that are high cost and above £50,000 and not prior approved;
- HSS (Highly Specialist Services) procedures where the Provider is not a designated centre.

It is also a requirement to notify of adults admitted to Critical Care and request approval for (Non-Transplant) Cardiac referrals.

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