DOCUMENT CONTROL PAGE	
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Amendments	Date: April 2021 Summary of amendments: ▪ Included NMGH into list of MFT hospitals ▪ Updated Cancer waiting times guidance ▪ Included Cancer SOP's ▪ Updated outpatients' guidance to include virtual triage and PIFU models of care ▪ Added information on impact of extreme events on patient access ▪ General changes to improve readability and interpretation
Author	Originated / Modified By: Matthew Gatfield, Carmel McBride Designation: Group RTT Recovery Programme Manager and Head of Delivery – Performance
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Executive 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 and oversight framework 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 centre 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. WTWA Comment: NHS Choices no longer exists, it is now www.nhs.uk – this link will need to be updated. 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 the national e-Referral Service, 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).

There are amendments currently being made to the national standard hospital contract which may have a bearing on this policy, but at the time of review these were not finalised (March 2021).

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 7 Hospitals across 10 distinct sites:

- 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;
- Clinical Support Services.

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.:

- 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);
- 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 everyday 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, by providing information in an alternative format.

Transparency

Clinical priority must be the main determination of when patients are seen. 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 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) or under the National Evidence Based Intervention Programme;
- 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. 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 regarding patient access to elective services, including national Referral to Treatment Time (RTT) codes and definitions. Attending all training offered for administrative staff regarding 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 virtual 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 (including their ability to engage with virtual consultations including telephone and video calls);
- 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 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

Patients also have several responsibilities in relation to their care, these include:

1.to be available for treatment within specified timescales stated within this Policy;
2.to Inform the Trust with suitable notice if they are unable to attend for their appointment (this is in line with the NHS Constitution (2013);
3.arrive for their appointment at the allotted time (late arrivals may not be seen);
4.notify their Hospital of any changes to their demographic details;
5.inform their GP of any changes in their medical condition that may affect their attendance or clinical priority;
6.Where a parent/guardian/carer is supporting a patient, they should undertake to ensure that the patient fulfils their responsibilities;

7.patients who no longer wish to have surgery/treatment, for whatever reason, must advise their hospital consultant at the earliest possible time.

Patient Choice

The NHS Choice Framework sets out patients' rights and NHS pledges in relation to their ability to choose how they access healthcare. In relation to services provided by MFT the following are relevant:

- patients have a legal right to choose the organisation that they are referred to for their first outpatient appointment;
- patients have a legal right to choose the organisation that carries out specialist tests if this is their first outpatient appointment, but not if this test is part of a diagnostic process started;
- pregnant women can choose:
    - which services support their antenatal care;
    - where and with the support of whom they give birth.

Patients 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.

In relation to these patient rights, as part of the integration programme initiated in 2017, arising from the merger between legacy CMFT and UHSM & recently NMGH, several specialty services are now, or will soon become, Managed Clinical Services (MCSs). MCSs operate as single teams across a number of sites and/or hospitals.

For outpatient services, this means patients may be offered an appointment at any location within the MFT group of hospitals rather than where they have may have been seen in the past, or the location most local to them. This will vary by specialty as not all services are offered at all sites.

This approach will allow MFT to maximise the utilisation of all available capacity to care for patients and ensure waiting times are minimised. Where patients would prefer to be seen on another site (even if their wait will be longer), this will be accommodated, along with access to transport services where applicable.

MFT will ensure that the range of potential sites is clearly communicated to patients via our NHS e-Referral Directory of Service (DoS) at the point of referral, along with any additional information we can supply in order to support patients to make an informed choice.

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 ratification at the appropriate Operational Management Group, Compliance Steering Group and lead CCG. Once ratified, this policy will be available online 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; including 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 for any queries regarding application of the policy that arise which 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)

6. 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). As the guidance can be updated nationally, at periodic intervals, the advice is to either refer to the Policy or, in case of query, 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 the Department of Health's Guidance on Implementing the Overseas Visitors Charging Regulations (see the Trust's Chargeable Patients Policy for further guidance);
- charge those liable to pay in accordance with the Department of Health's Guidance on Implementing the Overseas Visitors Charging Regulations (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 the treatment is classed as emergency/non-elective. 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

7. GENERAL ELECTIVE ACCESS PRINCIPLES

7.1 Access Principles

The NHS Constitution (last updated October 2015), states 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, it is clinically appropriate that the patient waits longer, or in exceptional circumstances.

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.
Cancer	
Faster diagnosis standard	75% of patients to receive a "Yes/No" within 28 days of referral

In addition to the standards above, there are additional 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 (DNA) previously agreed appointment dates/ admission offers 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 are 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.

Extreme events

For the purposes of this Access Policy an extreme event embodies an unforeseen situation over a period of time which impacts 'normal' service. This may result in significant changes to the way clinical services are delivered.

During these periods, routine activity may be suspended with only urgent, cancer or life and limb activity continuing. Clinical administration processes may be adjusted, criteria extended or waived accordingly, this may include suspension of services at sites. Clinical safety will remain priority and may require patients being prioritised in a manner which deviates from 'referral to treatment' (RTT) order principles. Furthermore, specific cohorts of patients may be subject to enhanced measures, for example shielding. All Trusts would refer to national guidance issued.

During such times, services may be subject to changes with how they are offered. E.g. telephone appointments. These changes may impact adherence to national standards, with adjustment or suspension.

Some patients may be discharged with care plans, either prior to their appointment or during a clinical episode. In all cases discharges will be subject to clinical review and will be made in the best interests of the patient.

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	**75%**
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	**75%**
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

At least 95% of patients attending A&E should be admitted, transferred, or discharged within four hours.

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

e-Referral

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

GP referrals to consultant-led services should come through the e-Referral Service; either as a Directly Bookable Service or through a 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 a maximum of 4% e-RS referrals being Appointment Slot Issues. GP referrals to consultant-led services will only be accepted if received via the e-Referral service.

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;
- 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);

- 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;
- provision of information and communication in formats to meet the patient's accessibility requirements.

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:

- 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;
- their priority on the waiting list should be determined by the same criteria applied to other NHS patients;
- 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. If 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 because 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/Effective use of resources

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.

In addition to the procedures outlined within the GM EUR Policy, the national Evidence Based Interventions programme published a further list of interventions for consideration by systems in November 2020. In due course, these will be incorporated into the GM Policy and MFT Practice.

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.

- Referrals made via a referral assessment service (RAS) must be clinically triaged within 5 working days.
- Referrals registered within two working days of arrival into the Trust or within two working days of a GP referral being clinically triaged via e-RS.
- e-Referral Worklists to be reviewed and actioned within two working days by administrative teams.
- When referrals are received via the e-Referral ASI, patients will be contacted within 7 days to confirm receipt of referral. 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 several 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.

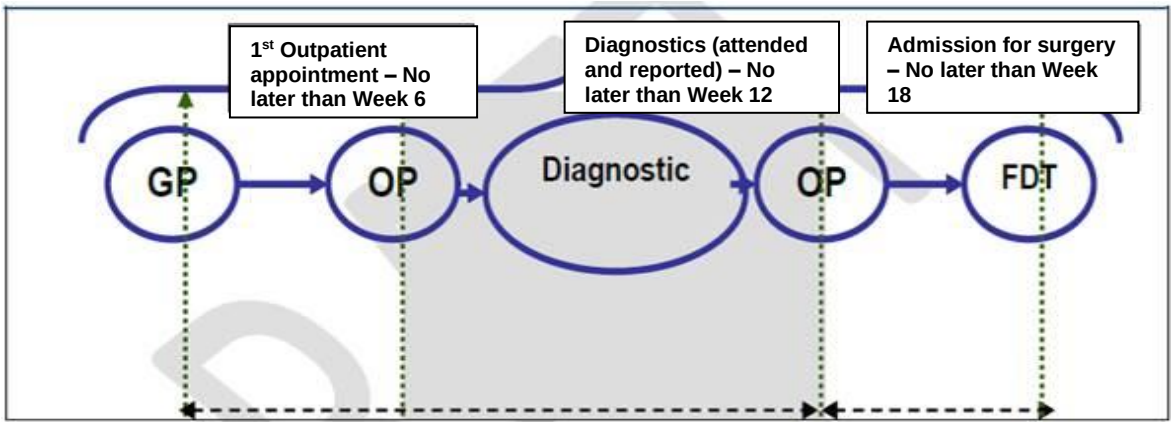

Figure 1 Patient's 18-week (RTT) pathway

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

Information for Managing 18-weeks
An RTT patient tracking list (PTL) for incomplete pathways is available via the intranet to Hospitals across all sites and to the MFT Board. It is imperative that all Trust systems are accurate to ensure the weekly NHS England RTT return and weekly Waiting List Report is correct.

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 on the Hive 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 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 for routine elective outpatients, and diagnostics is defined as a choice of 2 dates both with at least 3 weeks' notice.

Cancer pathway patients should be offered at least one date within the relevant timescale for their stage of care e.g. 1 date within 7 days of referral

7.11 Chronological Booking
Patients will be selected for appointment or admission dates according to clinical priority. For patients requiring elective admission, the consultant must have recorded their prioritisation decision in line with the current Federation of Surgical Specialty Association guidelines (see link) and this must be accurately recorded on the hospital information system.

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 appropriate trust PTL or via instruction from the Manchester Elective Surgical Hub team.

7.12 Communication
Communication 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. This must be provided 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 audit 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.

In addition, patients should be copied in all correspondence to their GP.

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

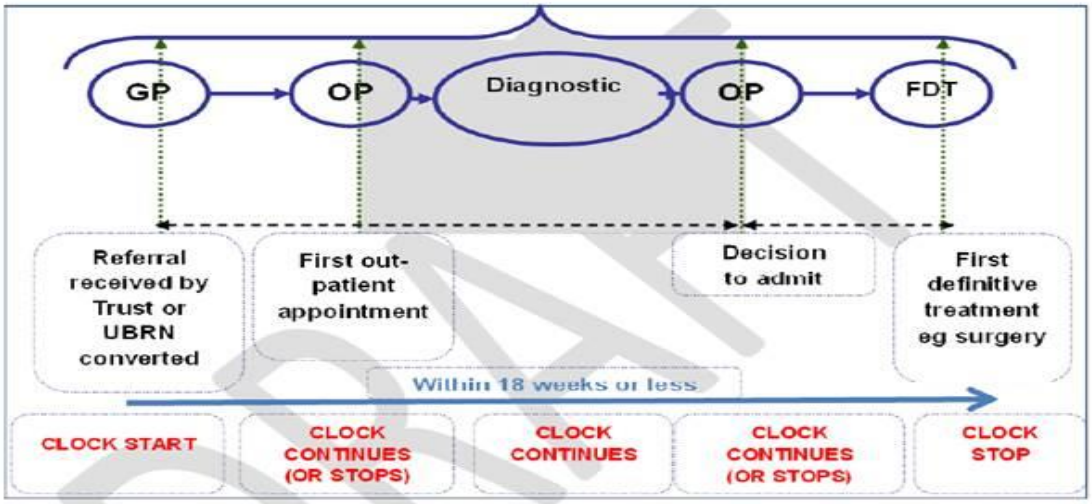

Figure 2. Diagnostic pathway

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 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 may be advice, a prescribed medication or a procedure 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.

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, or non-elective follow-up clinic activity which was started via an urgent care setting.

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

Patients referred from outside of England for treatment are not subject to management within the RTT standard but should be managed within the performance framework set by their commissioning body.

Referrals to a non-consultant-led service

Patients referred directly to an AHP service where this is intended to manage their condition or support diagnosis without the intention of onward management by a consultant led team.

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 requires a timebound investigation or treatment as part of an existing treatment plan, for example where a patient requires admission for an endoscopy as part of ongoing monitoring for their condition

Direct Access Diagnostics

Patients referred by their GP or primary care clinician directly for a test are within the scope of DMO1 guidance.

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, e.g. obstetrics, emergency care	Code must be entered for all outcome scenarios (Wythenshawe only)
90	For activity after first definitive treatment	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 (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:

Table 3 RTT Status codes

Code	Category	Note
10	Clock Start	Starts the RTT clock for new or substantively different condition at point of referral receipt and following FDT
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

8.5 RTT / 18-week Clock Continues

When the patient is continuing 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:

Table 4 RTT Status codes

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 onward referrals to another hospital outside of MFT

8.6 Clock Stops

A clock can be stopped for several reasons.

Clock Stops for Treatment

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 to delay treatment due to capacity shortfalls under any circumstances.

- the patient has declined all 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

    - 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 in the next table:

Code	Category	Note
30	Start of First Definitive Treatment	To be used regardless of whether a patient is discharged or not, e.g. a patient may have received definitive 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 first NEW outpatient appointment	This code does not apply to any other DNA scenario
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 only be used if the is to be discharged back to their referrer
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 must be performed at a set point linked to clinical criteria. Patients on the planned waiting list are not on an RTT pathway. Please see the following Action Card for further information.

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;
- 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 a planned waiting list must have an "expected admission date (EAD)" entered on PAS.

Diagnostic Planned Waiting List
Planned patients on a diagnostic waiting list will become active to RTT and DM01 (where applicable) as soon as the" expected admission date" has passed and will be subject to the 6-week target as per national guidelines. (Diagnostic Waiting Times and Activity).

Non-diagnostic Planned Waiting List
Planned patients on a non-diagnostic waiting list will become active to RTT two weeks past their EAD.

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 considered.

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, management plan or redirected internally 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 referrals are made in line with the principles outlined in the primary care responsibilities section

e-Referral Service (previously Choose and Book) is the only method for a GP to refer a patient into the Trust; subject to the provisions of NHS e-Referral Guidance.

The Provider will 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.

e-RS: Referral Assessment Services
Specialties may elect to operate a referral assessment service to allow front end triage of referrals. This may include the provision of a management plan back to the GP to support the patient to be treated and/or managed in primary care. Internally this is to be used to enable consultants to stream individual patients to the most appropriate next stage of their pathway e.g. requesting a set of specialist bloods for a patient prior to assessment to reduce the number of appointments in the patient pathway.

Clinicians are required to triage referrals through these services (in all but exceptional circumstances) within no more than 5 working days. The patients RTT clock will start from the date the referral was submitted in all circumstances.

The trust Directory of Service must indicate the range of sites that the patient may be offered an appointment or investigation at to support informed patient choice.

Patients that are accepted into the trust via this process should be notified via letter of the next stage of their pathway by letter no later than 7 days following the initial referral (this may include being added to a waiting list).

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.

Patients continue to remain under the clinical responsibility of the GP throughout the course of an advice request until the decision to refer the patient has been made by either the responsible GP or reviewing clinician The Patients RTT clock will start from the time the advice was converted to a referral by either party.

e-RS: Directly bookable Services
All directly bookable services should be supported by a process to ensure that a clinician oversees/monitors the acceptance/rejection of patients into their service where practical and administratively referrals should be reviewed and accepted within 2 working days.

All e-RS Services
In order to assure the quality of clinical decision making and administrative processing in relation to referrals and advice requests managed via e-RS all services must ensure there is regular audit undertaken. The group performance team will co-ordinate and manage this process on behalf of the group, this will be in place during 21/22.

Other Referrals (Tertiary Referrals, Email, and Fax)
The Trust will also receive referrals from other sources, for example other secondary care providers, the community or local authority. 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.

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. 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.

Considering the impact of the coronavirus pandemic during 20/21 patient waiting times will be adversely affected and therefore services will work in the spirit of the policy and offer patients the most expedient appointment possible.

Directly bookable e-Referral Services 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 or where the specialty/service is utilising a referral assessment service. Under direct booking - in circumstances where a patient calls the national e-Referral booking Service/Appointments Booking Line or their local referral management service and an appointment slot is not available in the required hospital specialty the electronic request will be sent 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 enough 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 and the patient should be informed by letter. Referrals on the ASI list do not automatically appear on PTLs and therefore must be managed closely. 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) • Patient ability to engage well with virtual consultation via telephone or video link (including access to technology) • 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	• 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

mobility status. • If the patient requires an interpreter service, for what language and how we should contact 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 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 incomplete 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.

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, usually from 16-18 years but in some cases may be older depending on the individual.

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 refer the patient to an appropriate colleague where such a service is provided by the Trust. If the referral is received via a referral assessment service, the reviewing clinician should accept the referral and request the referral is redirected internally for review by the right team. 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.

When a referral in made via the e-Referral system, when a referral is rejected by the reviewing 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:

- 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.

- the patient has an immediate need for investigation or treatment (suspected cancer for instance).

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

9.7 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 to make a decision on next steps.

70.1 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, for the same condition,

the referral should be made internally and without delay. The RTT clock will continue to tick from the original referral date.

Referral 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:

- 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.

10. MANAGING OUTPATIENT APPOINTMENTS

10.1 Types of Outpatient Appointment

Due to advancements in technology, MFT are now undertaking a wide variety of appointment types which have helped speed up access to treatments for patients these include.

Face to face in the hospital and virtual appointments (e.g. video call / telephone call) from the comfort of the patients own home, or other location.

The type of appointment offered will be based on the type clinical assessment required e.g. the appointment is part of a 'One stop' service which includes diagnostics on the same day this would be a face to face appointment in the hospital, whereas a follow up from a diagnostic appointment may be offered as a telephone assessment. We understand that not all patients are able to engage with virtual appointments and therefore services must ensure that every effort is made to offer appointments in line with individual patient needs.

For virtual appointments, in the event of a loss of connection, or technical difficulty every effort should be made to immediately re-establish contact with the patient by telephone to continue their consultation or advise when they will be contacted with a new date. If this is not possible patients should be written to immediately following the clinic advise how they rebook their appointment.

10.2 Booking Principles

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.

10.3 Failure to Attend an Outpatient Appointment

All patients who do not attend Outpatient activity (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

10.4 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

10.5 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, particularly at less than 6 weeks' notice.

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 take all possible steps to avoid 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.

10.6 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 stops for treatment.
- Clock stops 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 starts if a decision is made regarding a new treatment plan.
- New clock starts 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.

10.7 Follow-Up appointment Principles

Follow up appointments must only be arranged where it is deemed clinically necessary. Patients, who require follow up appointments, should have a booked appointment prior to leaving the clinic (where this is required in the next 6 weeks),have been added on to a waiting list or been given the relevant information on how to contact the trust to make their own follow up where they have been offered a patient initiated follow up (PIFU). Where there is no capacity to book appointments, this then needs to be escalated to the appropriate manager for discussions to take place with clinical teams. If 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.

10.8 Patient Initiated Follow Up

Patients should be empowered to decide whether they require follow up if they require it where this is clinically safe and appropriate to do so.

Patient Initiated Follow up's (PIFU) are a new initiative that gives patients the flexibility to request follow up appointments as they are needed rather than regular scheduled check-ups e.g. when experiencing a flare up of their condition. PIFUs

work well for patients who would otherwise be booked for a scheduled review, not for patients who would otherwise be discharged.

PIFU allows the patient to contact the hospital at any point within the specialty agreed period in order to request an appointment without going through their GP.

It remains the responsibility of the clinician to decide if a patient is clinically safe to be discharged to PIFU. However, patients should meet the following criteria:

- at low risk of urgent follow-up care and satisfies criteria established by the specialty
- is confident and able to take responsibility for their care for the time they will be on the PIFU pathway, e.g. they do not have rapidly progressing dementia, severe memory loss or a severe learning disability;
- understands which changes in their symptoms or indicators mean they should get in touch with the service, and how to do so;
- The patient can understand the status of their condition and is able to identify when they need to initiate the follow up;
- has the knowledge and confidence to manage their follow-up care (patient activation); if they do not, the patient may benefit from support to improve these areas in line with the personalised care approach;
- understands how to book their follow-up appointments directly with the service, and how long they will be responsible for doing this; treatment must have been completed and therefore no open RTT pathway
- exclusions: HSCs (Health Service Circular 205 – i.e. a suspected cancer referral), Cancer F/Us and early post-op F/Us.

The period for PIFU is locally agreed and only applies to the condition relating to the original referral:

- The decision for a patient to go onto a PIFU pathway is a joint decision between patient and clinician. Where this is not agreed patient will remain on the normal pathway and have access to routine follow up as required
- if the patient contacts the hospital within the PIFU period for the same condition the previous outpatient registration must be reopened, and a follow up appointment booked;
- if the patient contacts the hospital outside of this period the patient must be advised to see their GP to see if a referral to the hospital is required;
- some patients requiring lifelong treatment may never be discharged from the hospital
- if the patient contacts the hospital for symptoms which appear to be related to a different condition the Consultant should be asked to review the request and determine if the patient can be booked for a FU or not;
- patients should be given a PIFU within a 6 week's timeframe or before if stated in comments and clinically indicated

If any of the following criteria are met, the appropriateness of PIFU for the patient needs to be carefully considered:

- PIFUs are not clinically appropriate;
- the patient's health issues are particularly complex;
- there are clinical requirements to see the patient on a fixed timescale (timed follow-ups), although it is important to note that a blend of PIFU and timed follow-ups can also be offered (e.g. for cancer pathways);
- the clinician has concerns about safeguarding for the patient;
- the patient takes medicines that require regular and robust monitoring in secondary care;
- the patient is not able to contact the service easily (e.g. lack of access to a telephone/would require an interpreter);
- any patients who may be disadvantaged by being placed onto a PIFU pathway.

10.9 Validation of Outpatient Referrals with No Future Activity

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 by the hospital information system in line with the timeframe set by each hospital team.

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 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 or contact the informatics department for further information.

11. DIAGNOSTIC ELECTIVE ACCESS

This section applies to all diagnostic procedures regardless of whether they are reported under the DM01 requirements or not, to ensure that a consistent approach is taken across the organisation. There are some diagnostic tests where performance is reported on a monthly basis in line with the DM01 requirements and some that must be reported quarterly. However, all should follow the same rules for booking as detailed in this section. The 15 tests reported on as part of DM01 are below.

- 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).

For patients who require an admission for their diagnostic either as a day case or as an inpatient, the patient’s clinical urgency should be documented at listing in

accordance with guidance issue by the FSSA (see link) the administrator should ensure that this is entered accurately onto the relevant hospital information system.

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 an electronic request at the time of the decision to request. Missing information, inclusive of AIS and reasonable adjustments, 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 is received. Delays in completing the 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.

Imaging Prioritisation of Referrals
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 elective or direct access diagnostic patients is at least 3 weeks with a choice of 2 dates/times. Many patients will choose to attend at the earliest opportunity. However, not all will but it is not appropriate to stop 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 diagnostic waiting list and the referral returned to the referrer for re-Referral when declared fit, whether the referral was made internally or externally.

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 or added to the waiting list with an appropriate recall date 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 must 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, amongst others. 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 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 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 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:

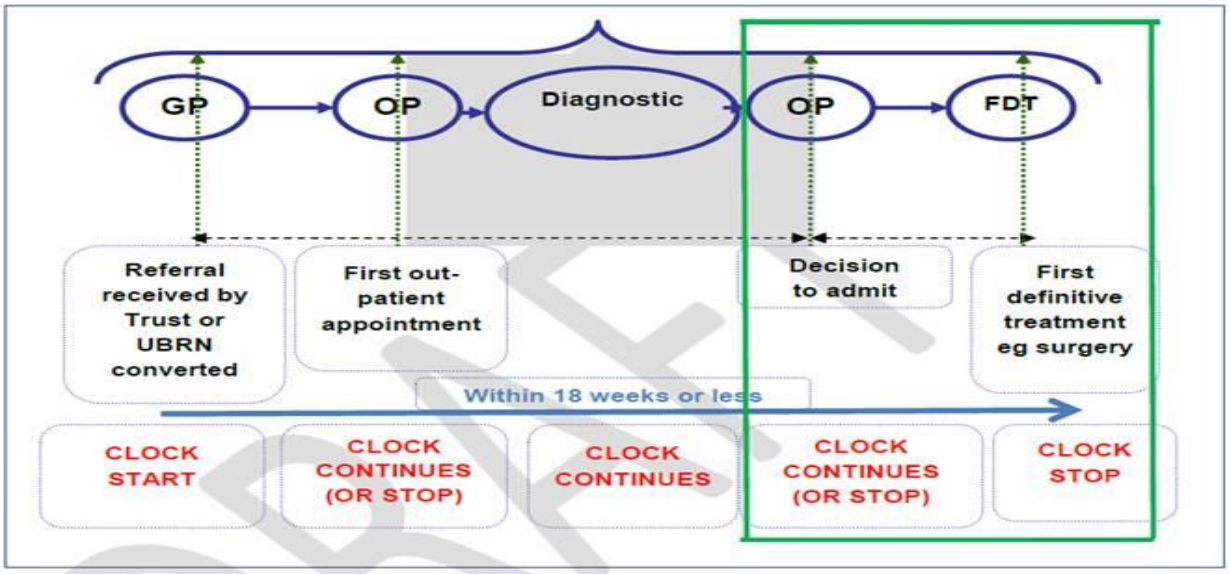

Figure 3 Admitted pathway

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 responsible consultant or a member of their designated team. At the point the patient is listed for surgery the responsible clinician must ensure that their clinical priority is recorded in line with the relevant guidance issued by the FSSA (See link). In addition consultants should also ensure it is clear if the patient is suitable for the independent sector and/or a pooled list.

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, or active optimisation lasting less than 8 weeks 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, (except for the Children's Hospital) then a replacement of equal seniority that is agreeable 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 (Apart from in exceptional situations).

For all elective admissions and day case's, hospitals and services should follow the principles set out by the Manchester Elective Surgical Hub management team to support both MFT patients and those across greater Manchester to maintain equity of access. Listing of patients will be routinely monitored via this forum for the foreseeable future.

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(P4)/Soon(P3) elective or day case procedure	6 weeks prior to admission date
Routine Replacement due to cancellation	3 weeks prior to admission date
Urgent(P1/2) 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, particularly 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.

It should be noted that, due to the requirement to undertake a Covid swab 72 hours prior to elective surgery, peri-operative timescales should ensure this is incorporated.

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 may be unfit for surgery after being listed for their procedure must be booked for a review with their treating consultant to establish to best course of action, 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 may need to be re-referred when they are fit, ready and available for treatment or they may need to be placed onto active monitoring.

Patients who have a positive Covid swab should be reviewed by the clinical team and guidance should be followed around when the patient is next suitable for listing.

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 IS provider. Exclusion criteria, anaesthetic assessments and paperwork may differ and could put patients at potential risk.

Patients Transferred to the 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. Elective patients should be provided with reasonable notice of an offer of admission (i.e. a choice of 2 dates with at least 3 weeks' notice). Patients should be prioritised in order of clinical need first and then in RTT breach date order. In order to comply with clinical need or RTT pathway requirements reasonable notice may not be possible.

Patients listed for surgery should be reviewed by the local Surgical MESH group to ensure compliance with clinical prioritisation guidance.

12.4 Adding Patients to Elective Waiting Lists

An Elective Booking Proforma must be completed for every patient accurately and in full, including the patient's clinical priority code. 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 a patient's 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 and consultants have a responsibility to discuss with their 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 and the hospital information system updated.

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. Patients whose estimated date of admission is more than 14 days in the past will automatically be added to the active waiting list.

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.

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 consider patients waiting for planned procedures and take into account 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 defined as 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. The patient should be added to the waiting list with an appropriate recall date 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 for their review to ensure this is in the best interests of the patient 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 Admission Principles

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 everyday 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. 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 patient admissions. 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 decides to cancel a patient (e.g. a theatre/appointment 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 take all practical steps to solve the potential breach.

Transfer of care to the Independent Sector for NHS Treatment
A Hospital Manager may request authorisation from the Trust to outsource patients for NHS treatment in the independent 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 (Apart from in exceptional circumstances). The following process should be followed:

- provisional list of patients identified to be reviewed by the Clinical Lead for appropriateness;
- contact made with private provider to negotiate terms of contract to include:
    - Tariff for procedure;
    - Agreement that pre-operative assessment will be completed;
    - Who will provide outpatient follow-up following the procedure;
    - Whether medical devices/prostheses are required and who will provide them;
    - Whether repatriation to the hospital will occur at a set period of time following surgery;

- final list of appropriate patients for transfer contacted by the hospital to enquire if they accept transfer for treatment;
- confirmed patients' details provided to private provider and hospital advised of admission date;
- admission date added to Hospital Information System under appropriately named 'dummy' ward, e.g. ALEX and health records provided;
- health records returned following admission with appropriate documentation from private episode of care copied and retained in Hospital records:

    - Hospital Information System updated with accurate RTT outcome of admission.

In some instances, contractual or system arrangements may dictate that the patient is onward referred to the independent sector and in these situations, we would close the patients RTT pathway as an inter-provider transfer, guidance should be sought from service managers as to the specific arrangements in place.

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 and the specific SOP's for Cancer Tracking and Step down from a pathway, these can be found in the appendices of this policy. Many of the general guidelines in the Access Policy can be applied to patients on a cancer pathway. Locally MDT's have their own processes in place to support adherence to these overarching principles.

The NHS Cancer Plan sets 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.

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;
- that 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 has been in place in national reporting from 1 April 2020. Currently the threshold for this standard is 75%

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

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- 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 V11.0

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.

Where a patient DNA's more than one appointment with reasonable notice their case should be reviewed by a clinician to decide on the best course of action for the patient, this may mean referring back to the GP but, 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.

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.
- **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:

- the date of admission for surgery will stop the clock (not the date of actual treatment);

- 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 for cancer 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/or 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. If 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

The local MFT stepdown Policy is available here and should be referred to for local guidance on this process.

For complete set of rules and guidance on this matter, please refer to the National Cancer Waiting Times Monitoring Dataset Guidance – Version 11.0

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 (if the treatment plan was not discussed).

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.

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 11.

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?
- Have they been treated by MFT or at another hospital already?

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, via their clinical notes.

All waiting lists should be subject to regular clinical and administrative validation, this is of particular importance for active waiting lists where patients may have had an extended wait for treatment, this is with the aim of ensuring that we are only tracking patients as waiting for treatments or appointments where they are still relevant and clinically required, this includes ensuring that a patients FSSA priority is still correct.

When undertaking validation of either a clinical or administrative nature there are some key principles which should be adhered to:

- no patient should be discharged from an MFT service without being informed of this in writing;
- all reasonable efforts must be made to contact a patient, including confirming their contact details with their GP;
- if a patient no longer wishes to receive treatment (and they have not received treatment elsewhere) then their consultant must be informed and should write to the GP to confirm the outcome of any review.

17. EQUALITY IMPACT ASSESSMENT

MFT Equality, Diversity & Inclusion Policy Statement:

MFT 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 Practitioner 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 updated by the Corporate Performance Team in consultation with 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 Group Management Board 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 Group Management Board and our local Clinical Commissioning Group. This policy will be made available on the Trust Intranet. When updated, the old version will be replaced, and staff informed via email. A supporting Standard Operating Procedure Manual will be available in due course 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 elective care	NHS England	October 2015	www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting-RTT-guidance-v24-2-PDF-703K.pdf
Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care: frequently asked questions	NHS England	October 2015	www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Accompanying-FAQs-v7.2.pdf
The NHS Constitution	Department of Health	July 2015	www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/

			NHS_Constitution_WEB.pdf
Diagnostics waiting times and activity Guidance on completing the 'diagnostic waiting times & activity' monthly data collection	NHS England	March 2015	www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/
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/overseas-nhs-visitors-implementing-the-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	http://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	http://northwestcsu.nhs.uk/BrickwallResource/GetResource/5f056233-96fc-46bf-bc73-0b1d67f8e7e0
The interface between Primary and Secondary care – key messages for NHS clinicians and managers.	NHS England	2016	http://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
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 affected 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
A&E	Accident and Emergency
AIS	Accessible Information Standard
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.
AWMSG	All Wales Medicine Strategy Group
BCC	Basal Cell Carcinoma
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.
CATS	Clinical assessment and treatment service
CCGs	Clinical commissioning groups: commission local services and acute care.
CMFT	Central Manchester Foundation Trust
CMS	A database system used to record all information related to patient cancer pathway by MDT co-ordinators, CNSs and clinicians.
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.
CPC	Cancer Pathway Coordinator
CWT	Cancer Waiting Times
DCPs	Dental Care Professionals
DID	Diagnostic Imaging Dataset
DNA	Did not attend: patients who give no prior

	notice of their non-attendance.
DoH	Department of Health
DOS	Directory of Service
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.
EqIA	Equality Impact Assessment
e-RS	(National) E-Referral Service
FDT	First Definitive Treatment
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.
GMP	General Medical Practitioner
GUM	Genitourinary Medicine
HSC	Health Service Circular
HTN	Hypertension
IOG	Improving outcomes guidance: NICE guidance on the configuration of cancer services.
IPT	Inter-provider transfer
LHE	Local Health Economy
MCS	Managed Clinical Service
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.
MDT meeting	A multidisciplinary team meeting where individual patients care plans are discussed and agreed.
MFT	Manchester University NHS Foundation Trust
MLMC	Manchester Local Medical Committee
NCWTDB	National cancer waiting times database: all cancer waiting times general standards are monitored through this.
NHS	National Health Service
NHSE	National Health Service England
NHSI	National Health Service Improvement
NMGH	North Manchester General Hospital
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.
PIFU	Patient Initiated Follow Up
PPID	Patient pathway identifier
PTL	Patient tracking list. A tool used for monitoring, scheduling and reporting on patients on elective pathways (covering both RTT and cancer).
RACPC	Rapid access chest pain clinic
RCA	Root cause analysis defines steps on a patient's pathway and identifies breach reasons. In the context of this policy, this is not the same as the level of investigation involved in an RCA for, for example, a Serious Incident (SI).
RMC	Referral Management Centre
RTT	Referral to Treatment
Serious Incident	SI
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.
SOP	Standard Operating Procedure
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

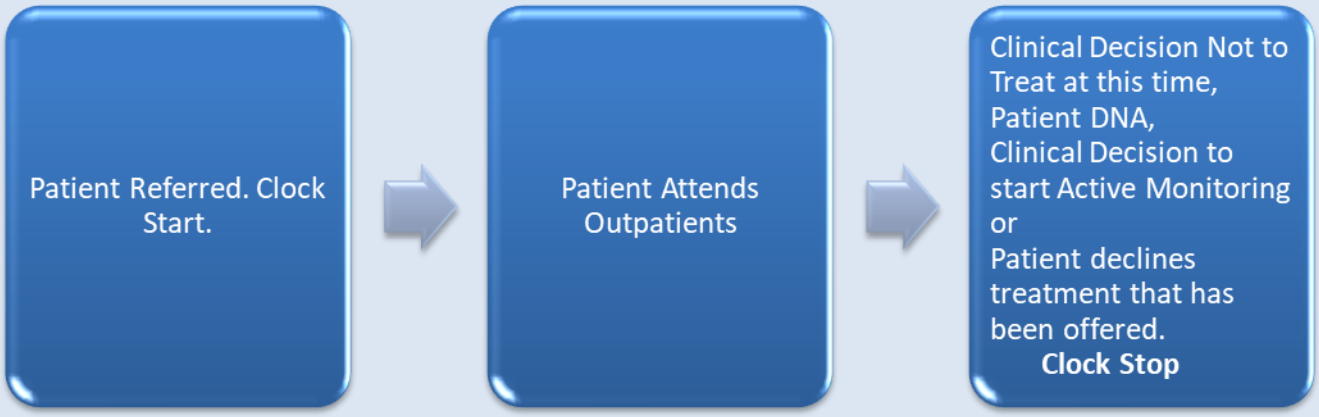
Example:

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 non-consultant-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:



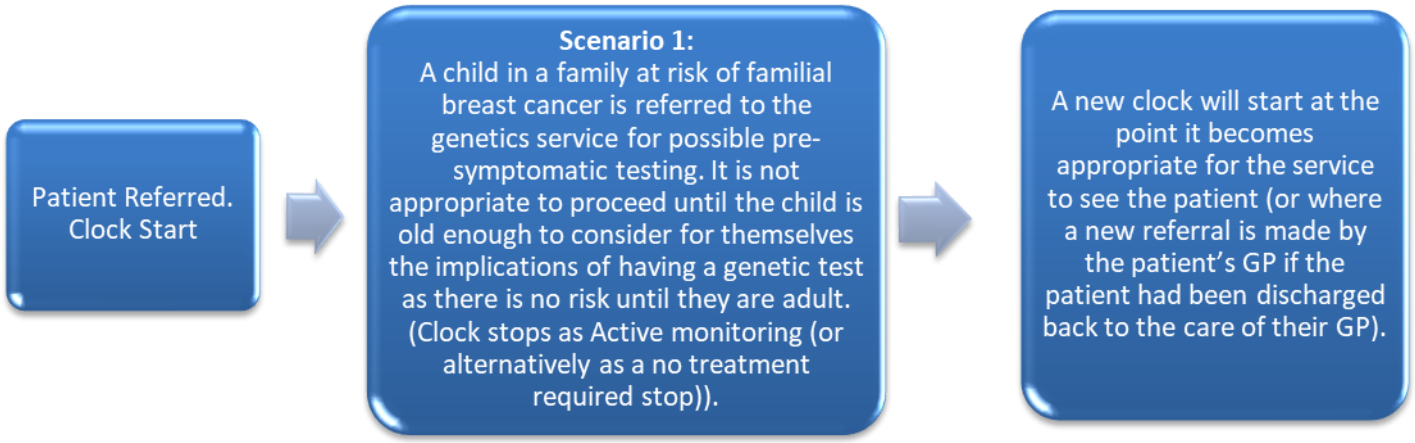
3. NEW CLOCK STARTS FOR THE SAME CONDITION

Following active monitoring (or a period of Patient Initiated Follow Up):

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 months 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 active 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)
- If they should be discharged back to the care of their GP (clock stop & discharge)

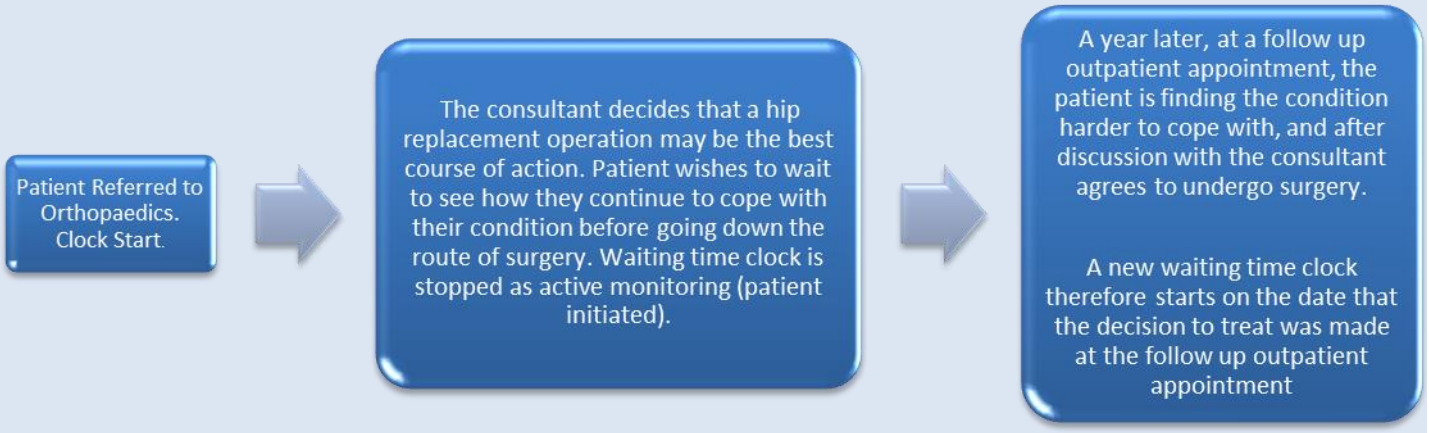
8. PATIENTS REQUIRING THINKING TIME

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, a note of this should be included in their records.

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 or rearrange more than 1 consecutive new and/or follow-up outpatient appointments (including pre-operative assessment appointments), should have their clinical record brought to the clinician's attention and a decision be made as to whether the patient should be offered further appointments and to ensure that the patient's delay is clinically acceptable. 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, within 7days. 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 a significant period e.g.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

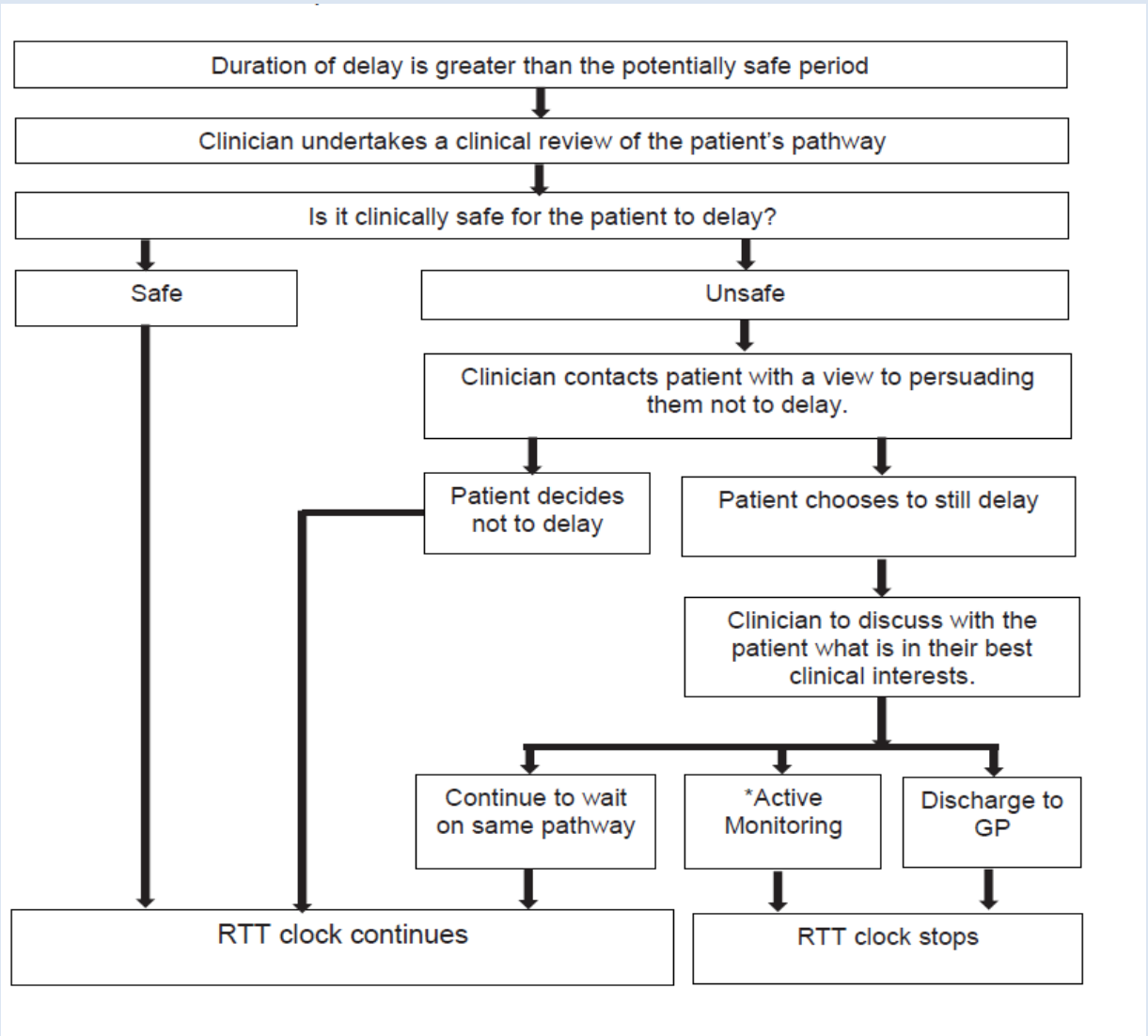
Back to Patients Who Do Not Wish to Attend Elective Admissions p52

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



12. 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

13. 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)

14. 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:

15. 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)

16. 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.

17. 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 or a period of patient initiated follow up (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 – ACTIVITY ON A PATHWAY

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

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

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 INITIATED ACTIVE MONITORING

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 – CONSULTATN INITIATED ACTIVE MONITORING

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- DNA OR CANCELLATION OF FIRST APPOINTMENT ONLY

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 CLINICIAN DECISION NOT TO TREAT
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 TREATMENT
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

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.

18. 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 with 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 exhaustive, 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.

Back to DNA of Elective Admission p51

19. Extract from the Welsh Health Specialised Services Committee Contract

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.

Back to Entitlement to NHS Treatment

24.2 Appendices – Cancer SOP's

Cancer Tracking Standard Operating Procedure

DOCUMENT CONTROL PAGE	
Title	Title: Cancer Tracking SOP Version: 1 Reference Number:
Supersedes	
Minor Amendment	Date:
Author	Originated / Modified By: Laura Elliott Designation: Head of Performance, cancer.
Ratification	Ratified by: Date of Ratification:
Application	All Staff and all patients
Circulation	Issue Date: Circulated by: Dissemination and Implementation: Via Staffnet
Review	Review Date: Responsibility of: Corporate Performance Team
Date placed on the Intranet:	Please enter your EqIA Registration Number here:

Table of contents

1 Introduction

Manchester University Hospitals Foundation Trust is committed to providing an exemplary standard of access and patient care to those with or suspected of having cancer.

This document sets out the Trust's approach to the tracking of patients on 'Suspected Cancer Pathways'. It has been developed using guidance from the Department of Health, including Cancer Waiting Times (CWT) guidance Version 11 NHS Improvement 'Delivering Cancer Waiting Times – a good practice guide', updated July 16, and other sources of best practice.

This policy should be read in conjunction with the following:

Cancer Waiting Times Guidance (v11, 2020)
ToR for PTL meetings
Trust access policy
Day 104+ clinical harm review process/RCA process
Radiology escalation policy
Somerset User Guides
Step down policy

2 Purpose

The aim of the Standard Operating Procedure (SOP) is to ensure that good practice is followed and that patients are tracked effectively and consistently across all tumour sites.

The key principals of this SOP are:

- To improve the patient experience as they move through clinical pathways, minimising unnecessary delays where possible
- To ensure bottlenecks in cancer waiting time pathways are identified and escalated to the appropriate specialty teams at an early stage
- To provide timely, consistent and accurate data recording for patients on cancer waiting time pathways
- To ensure consistent application of standards across all tumour sites

3 Roles and Responsibilities

The roles and responsibilities for the Cancer Trackers / MDT co-ordinators are summarised as follows in the Cancer Operational Policy:

- Coordinate the administrative pathway of patients with suspected/diagnosed cancer to ensure that they meet national Cancer Waiting Time (CWT) standards.
- To collect and record information as required at each stage of the patient's journey in order to meet both national and local requirements.

- Report the current position of the patient on their cancer pathway to clinicians/management during meetings so that they can make clinical/operational decisions based on this information.
- Provide detailed breach analysis reports to breach meetings for any patient with waiting times outside of the national 62-day standard.
- To collect and enter data at all stages on the suspected/confirmed cancer pathway for a given tumour groups and record this information on the Somerset Cancer Register database, ensuring, through liaison with the clinical MDT teams, that this data is accurate, timely and complete. (including COSD)
- Use the data collected to proactively track the cancer patients and escalate any potential problems/breaches of the CWT. Concisely and accurately present this information at PTL meetings clearly indicating actions necessary.
- To ensure that exceptions and alterations to the waiting times of individual patients are appropriately supported by documentation and can be audited.
- To liaise with colleagues from other Trusts to ensure that data is accurate for patients transferred to other hospitals to undergo treatment or diagnostics.
- Monitor all patient transfers in and out of the hospital

Hospital site management and administration teams are expected to engage with cancer service teams, playing an active role in PTL meetings and acting quickly to any escalations/requests from cancer services in order to expedite patient pathways.

4 Cancer Waiting Times Standards

Target	Criteria	DoH Operational Standard
2WW	Maximum two weeks from urgent GP (GMP or GDP) referral for suspected cancer to first outpatient attendance	93%
	Maximum two weeks from referral of any patient with breast symptoms (where cancer is not suspected) to first hospital assessment	93%
31 Day	Maximum 31 days from decision to treat to first definitive treatment	96%
62 Day (classic)	**Maximum 62 days from urgent GP (GMP or GDP) referral for suspected cancer to first definitive treatment**	**85%**
Subsequent	Maximum 31 days from 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	94% Surgery 98% Drug 94% Radiotherapy
Screening	Maximum 62 days from urgent referral from NHS	90%

	Cancer Screening Programme (breast, cervical and bowel) for suspected cancer to first definitive treatment	
Consultant Upgrade	Maximum 62 days from consultant upgrade of urgency of a referral to first definitive treatment	85%*
Rare Cancer	Maximum of 31 days from urgent GP referral to treatment for Children's cancer, testicular cancer and acute leukaemia	Monitored within 62-day classic
Faster Diagnosis Standard	• Maximum four weeks (28 days) from receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer, breast symptomatic referral or urgent screening referral, to point at which patient is told they have cancer, or cancer is definitely excluded.	75%

*This measure is reportable locally but not nationally at present

5 Tracking Standards

Somerset Cancer Register (SCR) is the database the Trust uses to record all relevant information about patients referred on a suspected cancer pathway and those with cancer diagnosis. From an MDT Co-ordinator / Patient Tracker perspective SCR is used to record the following:

- Referral, diagnostics, diagnosis, staging, treatment, transfer between Trusts
- All MDT meetings where the patient has been discussed and the outcomes, except for the Gynaecology MDT meeting which is recorded on the Christie Web Portal.
- COSD and SACT data, alongside data for the National Audits
- Patients progress along the suspected cancer pathway from Day 0 in the pathway through to first definitive treatment and any subsequent treatment or treatment for recurrence of the disease. The full patient pathway including all actions and activities in the pathway must be recorded in to the 'Tracking Notes' section of the Cancer Waiting Times tab.

The MDT Co-ordinator / Patient Tracker ('Tracker') should use Somerset to produce a daily PTL list for all patients on a suspected cancer pathway. This includes all patients referred in from other Trusts, and all those referred out for treatment in other organisations.

Tracking

- Ensures equality of patient access to services
- Delivers operational standards
- Ensures high quality of patient experience
- Ensures that timed pathways are delivered

All MDTC/Trackers should ensure they are fully aware of any timed pathways for their tumour groups.

5.1 Tracking standards – Generic

- All steps in the patient pathway must be documented in the tracking notes accurately, including all OPAs, diagnostics, MDTs.
- Day 38 should be populated in the tracking/visible on the PTL for all pathways that may be subject to multi centre pathway rules. This should be populated as soon as the pathway is registered on Somerset
- Day 28 should be populated in the tracking/visible on the PTL
- 24-day treatment breach date should be populated in the tracking/visible on the PTL (where it is relevant)
- The date Carped / transferred / Carp received date and any pauses in a pathway must always be visible and should never be lost in updated tracking notes. It must be clear if the patient has been sent for diagnostic or treatment DRP and CARP should be used to define.
- Any requests for expedites or escalation must be documented in the tracking notes (PTL and outside of PTL)
- All tracking notes must be clear, concise, useful and informative. Tracking notes should be legible for others in the event that they need to take over tracking. I.e. email sent to RW on 01.01.16 re review of CT, not 'email sent to chase CT'. Notice should be paid to the 500-character limit on the PTL.
- Tracking notes should not contain 'copy and paste' from letters, histology etc, items should not be duplicated. Clear updates should be visible on what has happened, future plans / what is outstanding. It should be immediately clear where the patient is up to in their pathway
- The outcomes of all OPAs and diagnostics should be sought on the day of the attendance or the following morning to ensure there are no delays in the pathway.
- Tracking should proactively pull patients through their pathway. Emails to request updates and awaiting regular updates such as external PTLs are not always sufficient. Face to face discussion, telephone calls etc will be required.
- Ensure all non-communication is captured to be discussed at PTL meetings.
- Ensure that relevant managers are contacted and included in escalation / expedites as appropriate following the escalation criteria. Escalation should take place real time where possible.
- Track ALL patients back to Day zero (62-day patients <u>at least</u> once weekly) all other targets at least weekly. Patients at risk of breach and other outcomes should be tracked in addition in-between these times.
- Tracking should focus on the national standards in time order – 28-day diagnosis, 38-day IPT/CaRP and earliest date for treatment. This should include tracking to day 24 following a late IPT.
- Where appointments are needed with visiting consultants, that are time critical, appointment slots should be requested to be put on hold
- All pathway updates obtained from CNS, CWP, Secretaries must be substantiated against the external Trusts PTL each week.
- MDTC/Trackers should proactively engage in learning all pathways and tumour sites to effectively enable cross cover during times of sickness, annual leave and to support learning and development

- All MDTC should complete the NHSI/E e- learning modules for cancer.

5.2 Tracking standards – First Attendance/Upgrade

Patients should be tracked from Day 0 in their pathway. The trackers are required to:

- Ensure all patients are appointed in a timely manner, alerting the specialty managers to any patients on Somerset with no appointment after 72 hours
- Ensure that the 'first seen date' has been populated accurately.
- Ensure that outcomes from all appointments are received and escalate for any missing letters which are not available after 48 hours
- Ensure that any cancellations or DNA (Did not attend) are re-appointed or discharged in line with the national policy. Ensure this is correctly documented within Somerset and auditable against Trust systems.
- Ensure that the next stage of the pathway following first attendance is clearly documented and that any requests for investigations are logged as suspected cancer as necessary and received in the appropriate departments within 24 hours of the appointment
- Ensure that all steps in the pathway are clearly documented in the Cancer Waiting Times tracking section of the Somerset System.
- Ensure that Upgrades from Consultant teams (email/letter) are actioned and added to Somerset within 24 hours
- Ensure the Consultant Radiologist Upgrades are captured by utilising the ICE Upgrade list. This list should be checked on a daily basis. Where the patient is already active on a relevant tumour site pathway no action is needed, other than to mark as actioned on ICE. Where there is no current pathway, the upgrade should be added to Somerset and the relevant clinical/management teams informed.

5.3 Tracking standards – Diagnostic phase

- Ensure that the requests are noted as suspected cancer and that all diagnostics are requested in line with the suspected cancer pathway. All diagnostics requested without HSC notification must be investigated immediately and the patient stepped off the pathway or the request upgraded.
- Ensure that the next stage of the pathway is effectively planned in line with the timed pathways and the Day 28 and Day 38 criteria, highlighting any delays promptly and escalating as necessary.
- Ensure that any results appointments are planned in advance to ensure there are no gaps between reports being received and moving the pathway along
- Ensure that all outstanding reports needed for MDT, follow up OPA or to meet key pathway milestones are highlighted to the service responsible as soon as possible, following the agreed escalation methods
- Ensure any delays and requests to expedite are accurately recorded in the 'tracking notes' section of SCR so that a full audit trail of all delays and actions taken to mitigate delays is evident
- Ensure that all results are flagged to the appropriate consultant as soon as they are available, and the next stage of the pathway is agreed and acted

upon. Any delays responding to the results or moving the pathway along must be escalated to the appropriate specialty manager

- Patients requiring specialist diagnostics at another trust should have them requested within 24 hours of the MDT discussion or the clinic appointment / telephone call to the patient if the patient needs to be informed of the next stage of the pathway first. Any non-compliance should be flagged to the clinician and the speciality teams. Any patient requiring an outpatient appointment to be given the next stage of the pathway should be seen within 48 hours. Longer waits are to be escalated to the specialty teams
- All specialist diagnostics should have a DRP (diagnostic referral proforma) submitted to the receiving trust to highlight to the appropriate tracking team the diagnostic required.

5.4 Tracking standards – MDT / SMDT

- Patients should be added to the appropriate MDT list as requested by the CNS, Consultant, Radiologist or histopathologist following the operational policy for that MDT.
- Any patient identified as needing discussion at MDT through the Trust PTL should be added and the clinical teams alerted.
- All MDT coordinators should be aware why each patient is listed on the PTL and be aware of any special requests for information and breach dates
- All relevant diagnostic results should be tracked and added to Somerset as appropriate
- All MDT outcomes should be entered in real time in the MDT meeting and the clinical team should check the accuracy on screen.
- All MDT outcomes should be issued to the appropriate personnel on the distribution list on the same day as the S/MDT meeting
- Where the CWP (Christie Web Portal) is in use, data items required for national returns should be duplicated in both this and the SCR system
- Any urgent additions should be facilitated by the MDT team as appropriate
- Named SMDT / MDT cover is in place and must be adhered to at all times, as named cover, not just cover is a requirement of the Quality Surveillance Team Key Indicators for all tumour sites.
- MDT meetings should be closed accurately. Information added should be sense checked. (i.e. if pathology has been discussed, the relevant treatment should be added, is a recorded treatment first or subsequent etc)
- 31-day treatments from MDT should be accurately tracked
- If the role of tracker/MDTC is split then regular discussion should take place between staff working on a tumour group, before and after MDT meetings, to ensure the relevant discussion at MDT and accurate tracking of the pathway. This should also be replicated for patients tracked on another hospital site
- Attendance recording at MDT is the responsibility of the MDTC and should be regularly reviewed by the MDT.

5.5 Tracking standards – External diagnostics

- All patients being sent for external diagnostics where care is being retained by the Trust should be sent as a DRP (Diagnostic referral proforma). DRP should be sent from Somerset
- Patients sent for DRP should be followed up to ensure the diagnostic is booked in a timely manner and the report is received quickly. Where possible advise the receiving Trusts of the MDT or next OPA date. Patients referred out as a DRP are the full responsibility of the referring Trust.
- All diagnostics should be requested by the clinician on the same day as the MDT or the OPA (as per internal diagnostics). The tracker must ensure the diagnostic is requested and highlight if there are any delays.
- Trackers need to proactively ensure all diagnostics are received back into the Trust for all patients listed or highlighted for S/MDT discussion
- Patients referred in for diagnostics should be expedited as necessary and outcomes transferred to the requesting Trust in a timely manner

5.6 Tracking standards – Transfer of Care (For Treatment)

- Patients being transferred to another Trust for treatment must be communicated using a CARP. When sending this, the tracker must ensure it is sent to the correct email account and sent from NHS net
- Trackers must ensure that the IPT is acknowledged and document the IPT accepted date in the tracking note
- Trackers are to ensure all patients Carped out appear on the next PTL report received from the Trust and that each subsequent week, the patient is on their PTL
- PTLs should be produced to include patients received from other Trusts not just 'first seen' at MFT. All IPT are to be acted upon the same day. Those returned due to a 'change of plan' must be highlighted to the referrer for on-going management. Any patient with IPT purely for treatment (pathway not commenced at MFT) must be highlighted to the clinical team with breach date information, including if required a 24-day treatment date after late referral. Booking teams and management teams should be informed to arrange urgent appointments. All Carps must be checked to ensure they appear on tracking. Any non-acceptance/re-dating of a Carp should be highlighted to the referring Trust as soon as possible
- All carps in should be receipted to the referring Trust

5.7 Tracking standards – Treatment and subsequent treatment

- Proposed and agreed treatment dates must be added accurately in the tracking notes, making it clear whether the date is agreed. Treatment dates should be added into the relevant section of Somerset. It should be checked whether a treatment has gone ahead within 48 hours of the planned date as a maximum and any alterations to plan notified to relevant teams
- When treatment dates are planned the tracker should ensure that the DTT is clear and that the treatment is in time for all applicable standards. i.e. 31 DTT as well as 62.

- The date for pre-op / pre-anaesthetic and any other assessments the patient requires before treatment should also be recorded, and the tracker must ensure that it is clear the patient has attended and passed each stage.
- All treatments from external trusts must be verified with the trust's tracking / performance teams
- All patients with clear treatment plans from SMDT which include a subsequent treatment should be monitored to ensure all subsequent treatments are captured. In the main this can be done via the specialty PTL meetings and with the CNS.
- Any enabling treatment recorded as 'active monitoring', as described in the cancer waiting times guidance, should be approved by the Cancer Performance Manager. It should be noted that specific advice has been sought from NHSE and folic acid must not be used as an enabling treatment for chemotherapy.
- All MDTC/Trackers should ensure they are fully aware of the relevant treatments acceptable under cancer waiting times guidance.

5.8 Tracking standards – Data Quality / Data Capture

- All COSD data must be inputted from the MDT meetings. Any gaps in data from the MDT meeting must be flagged to the chair of the MDT in real time or shortly afterwards to ensure missing data gaps are filled
- COSD reports should be checked for compliance levels on a monthly basis
- All audit documentation should be recorded, and data gaps also highlighted to the chair of the MDT
- All trackers are responsible for checking the data they enter. Each tracker should actively work to ensure all dates (including those from other trusts) are recorded correctly.
- The CWT check report should be updated weekly to ensure performance prediction is as accurate as possible.

5.9 Tracking standards – Breached Pathways

Further detail is provided in the RCA/Harm review SOP.

- To ensure that all pathways understood to be breached are correctly validated the tracker should check the reasons, referral source and dates, DTT, cross check letters to ensure there are no unknown pauses.
- For all 62-day pathway breaches (62-day, upgrade or screening) a full breach root cause analysis should be completed in Somerset within 72 hours of the treatment by the MDTC/Tracker. This should then be sent to divisional teams for cross checking, additions and initial review by clinicians/CNS. Once the RCA is agreed by the division this should be notified to the Cancer Performance Manager. This should be within 10 days of the treatment date
- All patients listed as -20 days to breach on the PTL with no treatment date in place before day -42 should be highlighted to divisional teams as a possible 104+ day breach. Plans should be put in place by divisions to treat prior to day 104 where possible and clinical review of those at-risk pathways should occur.

- The 104+ day clinical harm review process should be followed for relevant pathways.

At risk/Breached pathways

Patients at risk of breaching/breached should be noted as such via Somerset and have additional input into their pathways.

The criteria for adding to the list includes patients late in the pathway with no diagnosis, patients CaRPed out late, complex patients who are identified as at risk of breaching through the Cancer PTL, those listed for treatments where capacity is a known issue and those whose treatment plans change.
Each hospital site should have a process for additional review patients at risk of breaching the operational standards.

All Trackers/MDTC are responsible for:

- Ensuring pathways are tracked effectively to ensure that patients at risk are appropriately identified in the PTL process
- Micromanaging all patients at risk of breach on a daily basis to pull the patient through the pathway

8 Glossary

Reference	Meaning
CWT	Cancer Waiting Times (National standards)
MDT	Multi-disciplinary Team (meeting, local)
SMDT	Sector Multi-Disciplinary Team (meeting)
COSD	Cancer Outcomes and Services Dataset
CaRP	Communication and Referral Proforma
GP	General Practitioner
GDP	General Dental Practitioner
SCR	Somerset Cancer Registry
PTL	Patient Tracking List
IPT	Inter Provider Transfer

MDTC	MDT Co ordinator

DOCUMENT CONTROL PAGE	
Title	Title: Policy for stopping the Cancer 28-day Faster Diagnosis clock Version: 1 Reference Number:
Supersedes	Supersedes: Policy for the Upgrade('Step-up') and Downgrade ('Step-down') of Patients to and from the Fast Track, 62 Day Cancer Pathway Significant Changes:
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Author	Originated / Modified By: Cathryn Winchcombe Designation: Cancer Manager, WTWA
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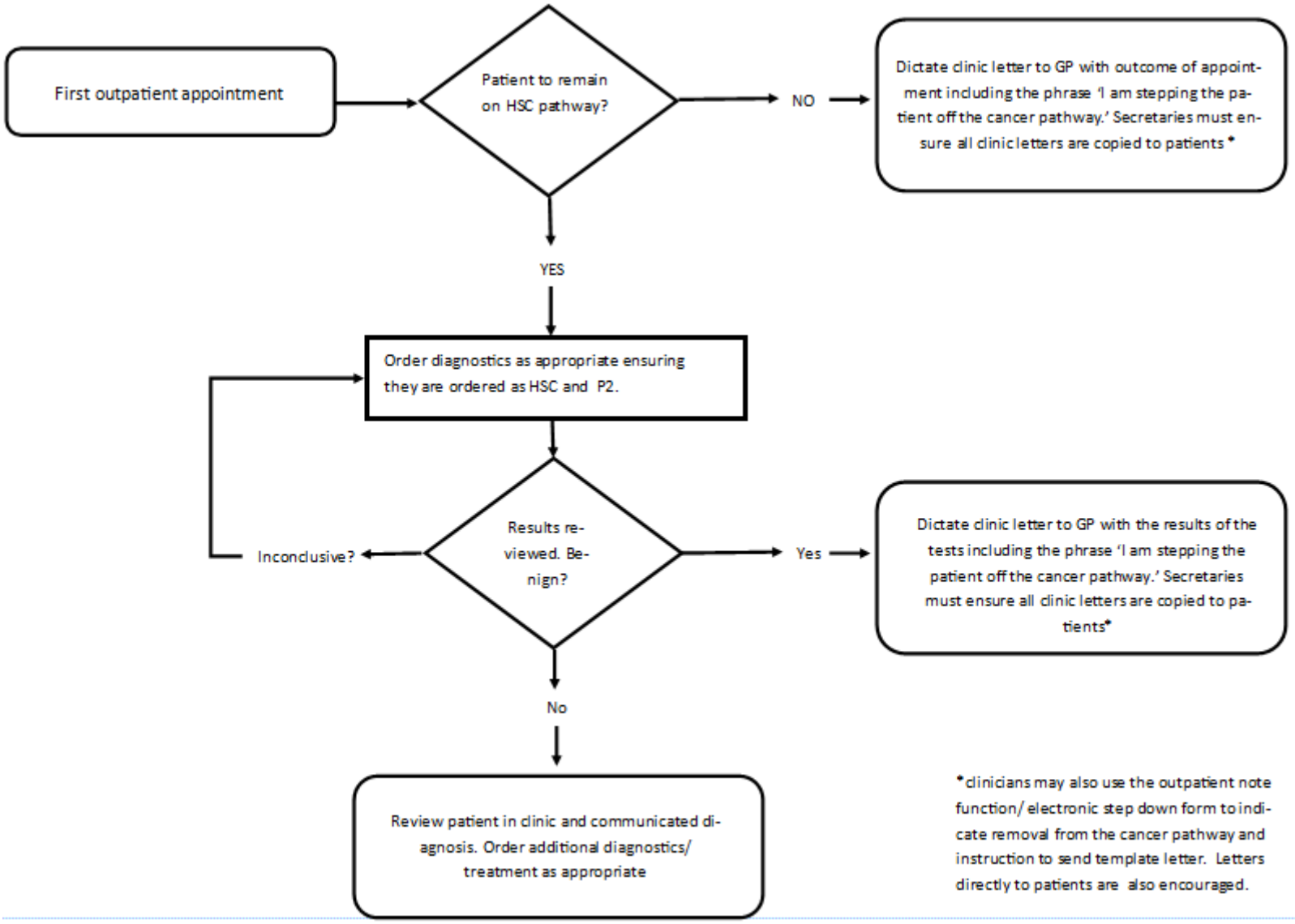
Application	Target Audience: All clinical teams responsible for the management of patients on high suspicion of cancer pathways
Circulation	Issue Date: Circulated by: Dissemination and Implementation:

Review	Review Date: Responsibility of:
Date placed on the Intranet:	Please enter your EqIA Registration Number here: 2020-214

1. Introduction

This policy has been produced support clinical and operational teams to deliver the national cancer faster diagnosis standard. Current cancer waits guidance states that there should be ‘a maximum 28 days from receipt of two week wait (GP, GDP, Optometrist, urgent referral from cancer screening process) to the patient being informed of a diagnosis or ruling out of cancer’. The 28 day faster diagnosis pathway ends only when there is communication with the patient whether that is to inform them of a diagnosis of cancer, a ruling out, or if they are going to have treatment before a clinical diagnosis of cancer can be made**.**

The below flowchart sets out the process that should be followed to effectively manage patients through the diagnostic phase of their pathway


First outpatient appointment
Patient to remain on HSC pathway?
NO
Dictate clinic letter to GP with outcome of appointment including the phrase 'I am stepping the patient off the cancer pathway.' Secretaries must ensure all clinic letters are copied to patients *
YES
Order diagnostics as appropriate ensuring they are ordered as HSC and P2.
Results reviewed. Benign?
Inconclusive?
Yes
Dictate clinic letter to GP with the results of the tests including the phrase 'I am stepping the patient off the cancer pathway.' Secretaries must ensure all clinic letters are copied to patients*
No
Review patient in clinic and communicated diagnosis. Order additional diagnostics/ treatment as appropriate
*clinicians may also use the outpatient note function/ electronic step down form to indicate removal from the cancer pathway and instruction to send template letter. Letters directly to patients are also encouraged.

2. Purpose

The purpose of this policy is to provide guidance on acceptable methods of communication to patients to ensure compliance against the faster diagnosis standard. The 28-day FDS pathway **ends only at the point of communication with the patient**, whether that is to inform them of a diagnosis of cancer, a ruling out, or if they are going to have treatment before a clinical diagnosis of cancer can be made. Patients will remain on an active 62-day clock until such point that evidence of communication with the patient is documented on the electronic patient record.

The national standard dictates that 75% of patients will have been informed of a ruling in or a ruling out of cancer within 28 days of the receipt of a two week wait referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), or receipt of a two week wait referral of any patient with breast symptoms (where cancer not suspected).

3. Roles and Responsibilities

3.1 Group and Site Cancer Clinicians

The Group and Site cancer clinicians will be accountable for ensuring clinical teams effectively implement processes to ensure the timely and systematic communication of diagnoses to patients in line with national cancer waits guidance.

3.2 Divisional Directors of Operations

Will be accountable for ensuring processes are followed in specialties to provide timely notification to patients of either the ruling in or ruling out of cancer

3.3. Clinical Directors, Consultants and authorised members of the clinical team

Will be accountable for ensuring the following:

- Any patient who is seen at first outpatient appointment and cancer can be ruled out are informed and the clinic letter clearly states that the patient has been stepped off the HSC pathway
- Any tests that are ordered on an active HSC pathway are ordered with the appropriate priority label
- Results of any tests requested on an HSC pathway are reviewed in a timely manner and patients with benign diagnoses are informed at the earliest opportunity. This can be via letter, over the telephone, in a face to face appointment or via a virtual appointment. Evidence of any discussions however must be annotated on EPR. Standard letters have been approved by Group for use in these circumstances and can be found in appendix 1 and 2. The use of these letters are not mandatory, and services are encouraged to dictate individual letters.

3.4 Cancer Services

Will be accountable for the following:

- Notifying clinicians when results are available in order to reach a decision on next steps
- Reviewing patients' records for evidence that communication of diagnosis has been made.
- Escalating issues where there is no clear decision made by the clinician on the status of a patient's diagnosis. Where no movement on pathways is highlighted for more than one week, this will be escalated to the appropriate divisional director
- Ensuring clinical and operational teams have access to all relevant information in relation to pathway details and breach dates
- Undertake a quarterly audit of the communication to patients to ensure any letters/telephone conversations are being received and understood by patients, in line with the national cancer waits guidance

4. Detail of Trust Procedural Document

Equality Impact Assessment.

Manchester University NHS Foundation Trust is committed to promoting equality and diversity in all areas of its activities. In particular the Trust aims to ensure that everyone has equal access to its services and that there are equal opportunities in its employment and procedural documents, and decision making supports the promotion of equality and diversity. An Equality Impact Assessment has been undertaken prior to developing this policy, and the issues identified were incorporated as part of the policy.

The Trust undertakes Equality Impact Assessments to ensure that its activities do not discriminate on the grounds of:

Religion or Belief	Age
Disability	Race or ethnicity
Sex or gender	Sexual orientation
Trans	Marriage or Civil Partnership

Pregnancy or Maternity

We also consider the impact on socially excluded groups and the impact on human rights.

An equality impact assessment has been completed and logged with the Equality team.

Consultation, Approval and Ratification Process

Consultation, approval, and ratification will take place via the respective Oxford Road and WTWA cancer site committees as well as oversight at the Group Cancer Committee.

The policy will be reviewed in three years unless national guidance changes, necessitating an earlier review.

Dissemination and Implementation

Dissemination

This policy will be available on the intranet

Implementation of Trust Procedural Documents

No training required to implement this policy. The document provides clear written guidelines for management of the 28 faster diagnosis pathway.

Monitoring Compliance of Policy for the ending of the Cancer 28 day Faster Diagnosis Standard

Compliance with the policy will be monitored at the weekly cancer PTL with any issues escalated to the appropriate divisional teams for action. In addition, compliance with the policy and achievement of the target will be monitored at the respective Oxford Road and WTWA cancer site committees as well as the Group Cancer Committee.

The 'Cancer Manager is responsible for monitoring compliance with the Policy for the ending of the Cancer 28 day Faster Diagnosis Standard' at Division and Corporate Level.

This will be completed on a bi-monthly basis and reported to the Oxford Road and WTWA cancer site committees, and the Group Cancer Committee.

The following will be monitored for compliance:

Cancer Services will undertake a quarterly audit of the communication to patients to ensure any letters/telephone conversations are being received and understood by patients, in line with the national cancer waits guidance

Any shortfalls identified will have an action plan put in place to address which will have timescales included for re-audit / monitoring.

Standards and Key Performance Indicators 'KPIs'

75% of patients will have been informed of a ruling in or a ruling out of cancer within 28 days of the receipt of a two week wait referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), or receipt of a two week wait referral of any patient with breast symptoms (where cancer not suspected).

References and Bibliography

NHS England, (2020), *National Cancer Waiting Times Monitoring Dataset Guidance – version 11*

Associated Trust Documents

N/A

Appendices

Appendix 1 – standard letter

Dear (INSERT NAME)

You have recently been reviewed by a member of the (INSERT SERVICE NAME*)* team on date of (INSERT DATE).

I am writing to reassure you that, following this review, all findings are benign (non-cancerous) and do not require an urgent follow up appointment.

The clinical team may require to see you in the future in which case you may be contacted at a later date by the Appointments Booking team.

Please note that all results will be forwarded to your GP.

If you have any queries/concerns, please contact (INSERT SERVICE CONTACT NUMBER)

Kind Regards

(INSERT SERVICE NAME)

Appendix 2 – standard letter with urgent follow-up

Dear (INSERT NAME)

You have recently been reviewed by a member of the (INSERT SERVICE NAME*)* team on date of (INSERT DATE).

I am writing to inform you that, following this review, all findings are benign (non-cancerous); however, the clinical team would like to discuss the results with you in the near future.

A member of the Appointments Booking team will contact you to arrange the required appointment.

If you have any queries/concerns, please contact (INSERT SERVICE CONTACT NUMBER)

Kind Regards

(INSERT SERVICE NAME)