NHS
The Shrewsbury and Telford Hospital
NHS Trust

Local Health Economy
Elective Care Access Policy (Large)

Version 4.2

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Approvals

Organisation	Date
Approved Planned Care Working Group	Oct 2015
Approved Planned Care Working Group	Jun 2016
Approved Planned Care Working Group	Jan 2017
Updated to IST Model Access Policy	Dec 2018
Scheduled Care Board	Jan 2019

Version History

Version	Date	Amendments
Version 1	Oct 2014	
Version 2	Jun 2016	Updated in line with RTT rule changes Oct 2015
Version 3	Jan 2017	Updated following audit by IST
Version 4	Jan 2019	Updated and changed in line with NHS Improvement Model Access Policy Guidance
Version 4.1	Jul 2019	Updated with Joint CQC VBC policies
Version 4.2	Oct 2019	Updated with Joint CQC Cons to Cons policies

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Introduction

Summary

The Shrewsbury and Telford Hospital NHS Trust (SaTH), Shropshire Clinical Commissioning Group (SCCG) and Telford & Wrekin Clinical Commissioning Group (TWCCG) are united in its commitment as a Local Health Economy (LHE) to ensure patients receive treatment in accordance with national standards and objectives. This access policy outlines the LHE's expectations and requirements in terms of managing patients along all non-emergencies, referred to as 'elective care pathways'.

Important Points

The Trust is committed to delivering high quality and timely elective care to patients.
This policy:

- Sets out the rules and principles under which the Trust manages elective access to outpatient appointments, diagnostics and elective inpatient or day case treatment.
- Gives staff clear direction on the application of the 'NHS Constitution' in relation to elective waiting times.

- Demonstrates how elective access rules should be applied consistently, fairly and equitably.

The Trust’s elective access policy was developed following consultation with staff and clinical commissioning groups (CCG’s). It will be reviewed and ratified on an annual basis, or earlier if there are changes to national elective access rules or locally agreed principles.

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

The access policy is underpinned by a comprehensive suite of detailed Standard Process Descriptions (SPD’s). All clinical and non-clinical staff must ensure they comply with both the principles stated within this policy and the specific instructions within SPD’s

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

Scope

This policy applies to the principles and procedures for the management of the different groups of patients encompassing elective pathways. These are categorised as follows:

- Patients on a Referral to Treatment (RTT) pathway awaiting treatment.
- Patients not on an RTT pathway but still under review by SaTH Clinicians.
- Patients on a cancer pathway.
- Patients who have been referred for a diagnostic investigation either by their GP or by a SaTH Clinician.

Purpose

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

This policy describes the way in which Shrewsbury and Telford Hospital NHS Trust, Shropshire CCG and Telford & Wrekin CCG will, as a Local Health Economy (LHE), collectively manage administration for patients

who are waiting for or undergoing treatment on an admitted, non-admitted or diagnostic pathway.

As set out in both Everyone Counts and the NHS Constitution, patients have the right to start Consultant led treatment within maximum waiting times. The policies and procedures comprising this policy adhere to national best practice and provide a framework to ensure that patients are treated transparently, fairly and reasonably.

Structure

The policy is structured into 4 sections as outlined below:

1) General Principles.
2) Pathway Specific Principles – following a logical chronological patient journey. Where there is a Standard Process Description (SPD) providing a detailed process to be followed at a given stage, this is referenced at the relevant point. Readers can use the link information contained in ‘Section 4 Standard Process Descriptions’ to view any supporting documentation.
3) Cancer Pathways.
4) Reference Information.

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1. General Principles

Foundation Principles

1) The Trust will give priority to clinically urgent patients and treat everyone else in turn.
2) The Trust will work to meet and better the maximum waiting times set by NHS England for all groups of patients.
3) The Trust will at all times negotiate appointment and admission dates and times with patients.
4) The Trust will work to ensure fair and equal access to services for all patients.

Roles and Responsibilities

Local Health Economy (Collectively)

The Local Health Economy is collectively responsible for the production, review and revision of this policy on at least an annual basis. Each of the three organisations will have a designated lead in this respect.

Commissioning Groups

CCGs are responsible for ensuring that GPs and all other primary care staff adhere to the principles set out in this policy.

General Practitioners

General Practitioners (GPs) and other referrers play a pivotal role in ensuring patients are fully informed during their consultation of the likely waiting times for a new outpatient consultation, and of the need to be contactable and available when referred. GPs should ensure quality referrals are submitted to the appropriate provider first time. Where a Referral Management Centre (RMC) exists this responsibility will adhered to.

Shrewsbury and Telford Hospital NHS Trust

- **Chief Executive/Chief Operating Officer/Assistant Chief Operating Officer (Scheduled Care)**
  The Chief Operating Officer (COO), on behalf of the Chief Executive, has overall responsibility for the implementation of this policy and Board level accountability for the delivery of elective access standards. The COO is responsible for ensuring the delivery of targets and monitoring compliance of elective access standards. The Assistant Chief Operating Officer for Scheduled Care will be responsible as designated by the Chief Operating Officer.
- **Clinicians**
  Clinicians have a responsibility for adhering to key internal procedures in the proactive management of

patients along their RTT journey. Key examples are the timely and accurate completion of the clinic outcome form and swift review of referrals.

- **Patient Access Team**
  The Patient Access Manager is SaTH's designated lead in respect of the review and revision of this policy on at least an annual basis in collaboration with the CCG designated leads. The Patient Access Team provides SaTH's central point of expertise, advice, training and support in respect of referral to treatment rules, standards and processes.
- **Clinical Centres**
  Centre Managers are responsible for the overall delivery of RTT standards and for ensuring that staff are competent and compliant in the application of this policy and associated Standard Process Descriptions.
- **Administration Staff (including Secretaries)**
  All administration staff must abide by the principles in this policy and the supporting Standard Process Descriptions (SPDs).
- **Chief Information Officer**
  The Chief Information Officer for Business Intelligence is responsible for the timely production of patient tracking lists (PTLs) which support the Clinical Centres in managing waiting lists and RTT standards.

- **Business Intelligence Team**
  The Business Intelligence Team is responsible for producing and maintaining regular reports to enable Centres to accurately manage elective pathways, and ensure compliance with this policy.

Patients

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

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

Staff Competency and Compliance

Competency

- As a key part of their induction programme, all new starters to the Trust will undergo mandatory

contextual elective care training applicable to their role.

- All existing staff will undergo mandatory contextual elective care training on at least an annual basis.
- All staff will carry out competency tests that are clearly documented to provide evidence that they have the required level of knowledge and ability.
- This policy, along with the supporting suite of SPDs, will form the basis of contextual training programmes.

Compliance

- Functional teams, specialties and staff will be performance managed against key performance indicators (KPIs) applicable to their role. Role specific KPIs are based on the principles in this policy and specific aspects of the Trust's Standard Process Descriptions.
- In the event of non-compliance, a resolution should initially be sought by the team, specialty or individual's line manager. The matter should then be dealt with via the Trust's disciplinary or capability procedure.

General Elective Access Principles

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

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

Individual Patient Rights

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

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

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

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

- The patient chooses to wait longer.
- Delaying the start of the treatment is in the best clinical interests of the patient (note that in both of 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.

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

Patient Eligibility

All Trusts have an obligation to identify patients who are not eligible for free NHS treatment and to assess liability for charges in accordance with Department of Health guidance /rules. The Trust's Overseas Visitor Team (OSV) will check every patient's eligibility for treatment. Therefore, at the first point of entry, patients will be asked questions that will help the Trust assess 'ordinarily resident' statuses.

Some visitors from overseas, who are not ordinarily resident, may receive free healthcare, including those who:

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

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

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

Patients Moving Between NHS and Private Care

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

original referrer's letter arrives in the hospital. The RTT pathways of patients who notify the Trust of their decision to seek private care will be closed with a clock stop applied on the date of this being disclosed by the patient.

Commissioner Approved Procedures

Since the CCGs operate within finite budgetary constraints the policy makes explicit the need for the CCGs to prioritise resources and provide interventions with the greatest proven health gain. The intention is to ensure equity and fairness in respect of access to NHS funding.

To do this, the policy provides the list of interventions 'not routinely funded' by the CCGs and the specified criteria required for the funding of certain other interventions. Please note that the policy guidance relating to these interventions should be read with reference to the principles detailed below.

Commissioners, general practitioners, service providers and clinical staff treating residents of Shropshire and Telford and Wrekin are expected to implement this policy. When interventions are undertaken on the basis of meeting criteria specified within the policy, this

should be clearly documented within the clinical notes. Failure to do so will be considered by the CCGs as lack of compliance.

The CCGs explicitly recognise that for each of the interventions listed in this policy there may be exceptional clinical circumstances in which the CCGs would consider the funding of these interventions. It is not feasible to consider every possible scenario within this document. In cases where specified criteria are not met, applications may be considered on an individual basis through an Individual Funding Request (IFR) process. The IFR policy for Shropshire is available at www.shropshireccg.nhs.uk. The IFR policy for Telford and Wrekin is available at www.telfordccg.nhs.uk.

In considering individual cases the CCG applies following definition of exceptionality:

- Where care is not routinely funded by the respective CCG, evidence must be provided to show that the patient is significantly different to the population of patients with similar clinical needs who would also not be offered the treatment.
- This should include evidence that the patient is likely to gain significantly more benefit from the treatment than would be expected for other patients not currently offered it.

Exceptional clinical circumstances are defined as referring to a patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients with the same medical condition and at the same stage of progression as the patient. In making a case, therefore, the clinician must specify how this patient is clinically different from others currently excluded from treatment - either in reference to the clinical picture, the expected benefit, or both.

If patients choose to privately fund an intervention that is not normally funded by the CCGs, they will retain their entitlement to other elements of NHS care. For example, if they privately fund a cancer drug or cancer intervention not normally funded by the CCGs they will retain their entitlement to all the other elements of cancer care that other residents of Shropshire and Telford and Wrekin receive free of charge. However when patients are privately funding an intervention, they are responsible for all the costs associated with that intervention, including Consultant costs and diagnostics. They are therefore unable to receive a mixture of privately funded and the CCG's funded care within the same appointment or intervention – in line with national guidance, they cannot 'top-up' a CCG's funded appointment or intervention by paying for an

additional intervention to be provided or monitored during the same consultation. The relevant CCG policies can be found on the respective CCG websites in the ‘commissioning’ section.

This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding clinical and cost effectiveness. All efforts will be made to work with our main service providers to jointly review and update the policy.

Unless providers are notified otherwise, implementation of the policy will continue to be monitored by the Prior Approvals process, selected audit of interventions against the criteria and by the application of procedures within the Referral Assessment Service (RAS) for Shropshire patients. For Telford and Wrekin patients, the provider should not perform any of the procedures included in the policy without explicit consent from the CCG. Referrals via TRAQS can be considered as explicit consent and referrals received via any other route require prior approval.
Implementation will be supplemented by continual monitoring of activity against the interventions. If substantial growth in activity occurs providers will be expected to investigate & confirm to the CCGs that they are complying with the policy.

Please note that where any policies refer to children or adults, unless specifically stated otherwise within that individual policy, an adult is considered to be 18 and over.

Military Veterans

In line with the 'Armed Forces Covenant' published in 2015, all veterans and war pensioners should receive priority access to NHS care for any conditions related to their service, subject to the clinical needs of all patients. Military veterans should not need to have first applied and become eligible for a war pension before receiving priority treatment.

GPs will notify the Trust of the patient's condition and its relation to military service when they refer the patient, so that the Trust can ensure it meets the current guidance for priority service over other patients with the same level of clinical need. In line with clinical policy, patients with more urgent clinical needs will continue to receive priority. The Trust will ensure that patients who are Military Veterans are highlighted in the Trust's PAS system.

Prisoners

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

The Trust will work with staff in the prison services to minimise delays through clear and regular communication channels and by offering a choice of appointment or admission date in line with reasonableness criteria. Where a significant delay is likely the patient will be referred to the Consultant to review to ensure that no harm will occur. The Consultant may at this point return the patients care to the GP if it is appropriate to do so and is in the best interests of the patient.

Vulnerable Patients

It is essential that patients, who are vulnerable, for whatever reason, have their needs identified at the point of referral.
This group of patients includes but is not limited to:

- Patients with learning difficulties, psychiatric problems or dementia.
- Patients with physical abilities or mobility problems.

- Children (under 18) for whom there is a safeguarding concern.
- Patients where English is not their first language.

Service Standards

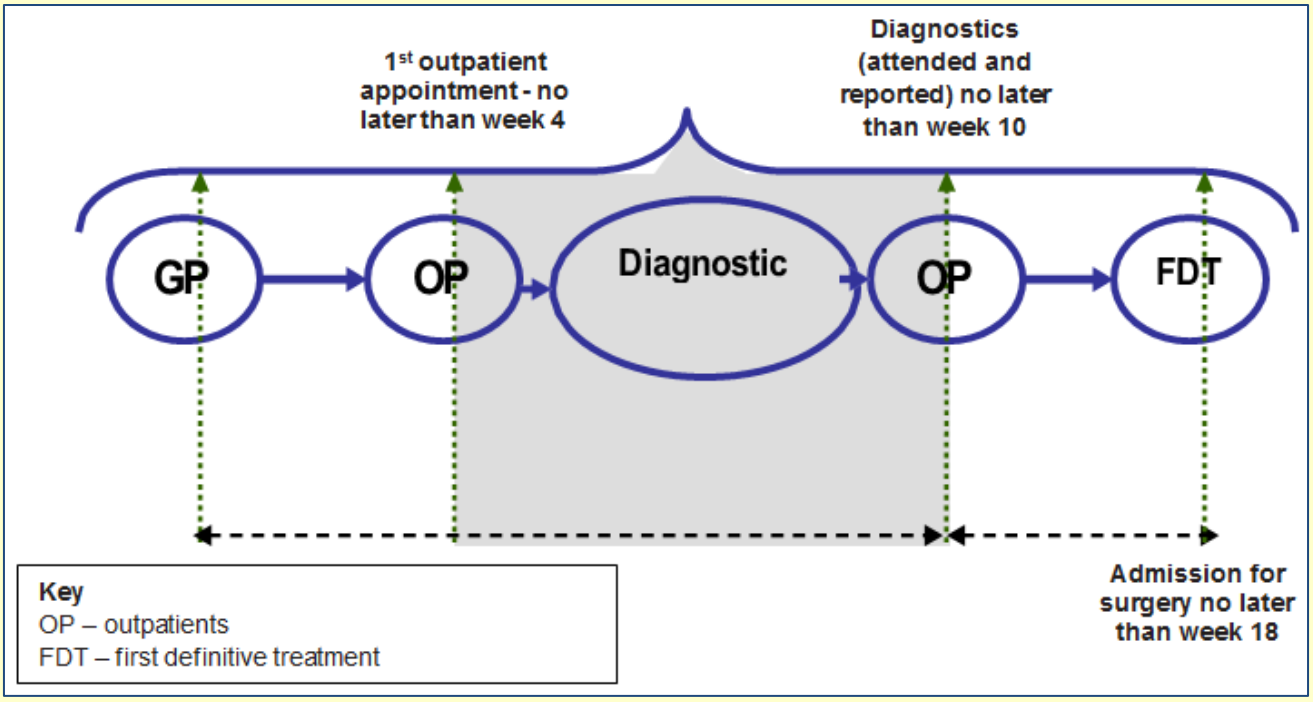
Key business processes that support access to care will have clearly defined service standards, monitored by the Trust. Compliance with each service standard will support effective and efficient service provision, and the achievement of referral to treatment standards. Key standards for implementation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

- Referral receipt and registration (within 24 hours).
- Referral vetting and triage (within 48 hours of registration).
- Addition of urgent outpatient referrals to waiting list (within 48 hours of registration).
- Addition of routine outpatient referrals to waiting list (within 5 days of registration).
- Urgent patient contacted by the Trust after addition to waiting list (within 48 hours).
- Routine patient contacted by the Trust after addition to waiting list (within 2 weeks).
- Urgent diagnostic reporting (within 24 hours).
- Routine diagnostic reporting (within 48 hours).

Pathway Milestones

To achieve treatment within 18 weeks of receipt of referral, pathways should be designed with key milestones and sufficient capacity agreed with Clinicians and commissioners.
For example, you could break down surgical pathways into the milestones shown in Figure 1.

Figure 1: Key Milestones on a Surgical Pathway



The agreement and measurement of performance against pathway specific milestones is an important aspect successful RTT sustainability. Pathway specific milestones should be agreed for each specialty (in line with robust demand and capacity analysis) in terms of the point of the pathway by which the following should occur:

- First outpatient appointment.
- Treatment decision.
- Treatment.

As a minimum, the following differentiation should be applied to all routine patients under the care of surgical and medical specialties where an admission is rarely necessary for treatment.

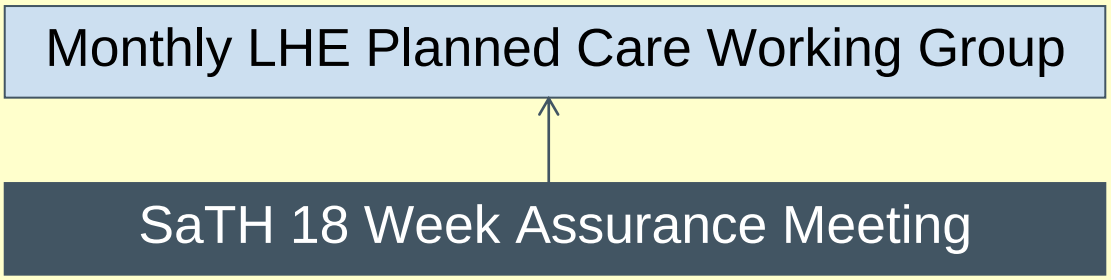
Pathway Milestone	Surgical Specialties	Medical Specialties
First Outpatient Appointment	No later than week 4	No later than week 8
Treatment Decision	No later than week 10	No later than week 14
Treatment	No later than week 18	No later than week 18

Monitoring

Centre Operational teams will regularly, and continuously, monitor levels of capacity for each pathway milestone (for both outpatient and inpatient activity) to ensure any shortfalls are addressed in advance. This will avoid poor patient experience, resource intensive administrative workarounds and, ultimately, breaches of the RTT standard.

Regular and robust demand and capacity analysis is a critical success factor in understanding individual services, forward planning and the delivery of elective care standards. Demand and capacity analysis should be undertaken on at least an annual basis, aligned to the annual planning process, by all specialties.

Elective Care Governance Structure



Information, Monitoring and Reporting

Information and monitoring reports are available on the Trust intranet via the
SQL Reporting Service:

- New RAG PTL.
- Inpatient Waiting List.
- RTT Delivery Summary Dashboard & 18 week Dashboards.
- Demand and Capacity Models.
- Data Quality Reports.
- New Active Booking List.
- Follow-up Booking List.
- On-Hold Referral Report.

- Stopped Clock Report.
- Theatre Analyser.
- OP Analyser.

Reasonableness

'Reasonableness' is a term applicable to all stages of the elective pathway. Reasonableness refers to specific criteria which should be adhered to when offering routine appointments and admission dates to patients to demonstrate that they have been given sufficient notice and a choice of dates. A reasonable offer is defined as a choice of two dates with at least three weeks' notice.

Chronological Booking

Patients will be selected for booking appointments or admission dates according to clinical priority. Patients of the same clinical priority will be appointed in RTT chronological order, i.e. the patients who have been waiting longest will be seen first. Patients will be selected using the Trust's patient tracking lists (PTLs) only.

Communication

All communications with patients and anyone else involved in the patients care pathway (e.g. general practitioner (GP) or a person acting on the patients

behalf), whether verbal or written, must be informative, clear and concise. Copies of all correspondence with the patient must be kept in the patient's Medical Records or stored electronically for auditing purposes. GPs or the relevant referrer must be kept informed of the patient's progress in writing. When clinical responsibility is being transferred back to the GP/referrer, e.g. when treatment is complete, this must be made clear in any communication.

Communication with patients

All communications with patients, whether verbal or written, must be informative, clear and concise and MUST be recorded within Pathway Validation on the PAS system.

The Trust will use the PAS system to identify patients with specific communication needs and will, where possible and when notified, may make reasonable adjustments i.e. larger font letters/voicemail and/or text reminders of appointments/utilising communication addresses for carers as requested.

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 127 days).
Diagnostics	
Applicable to diagnostics tests	99% of patients to undergo the relevant diagnostic investigation within 5 weeks and 6 days (or 41 days) from the date of decision to refer to appointment date.

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

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

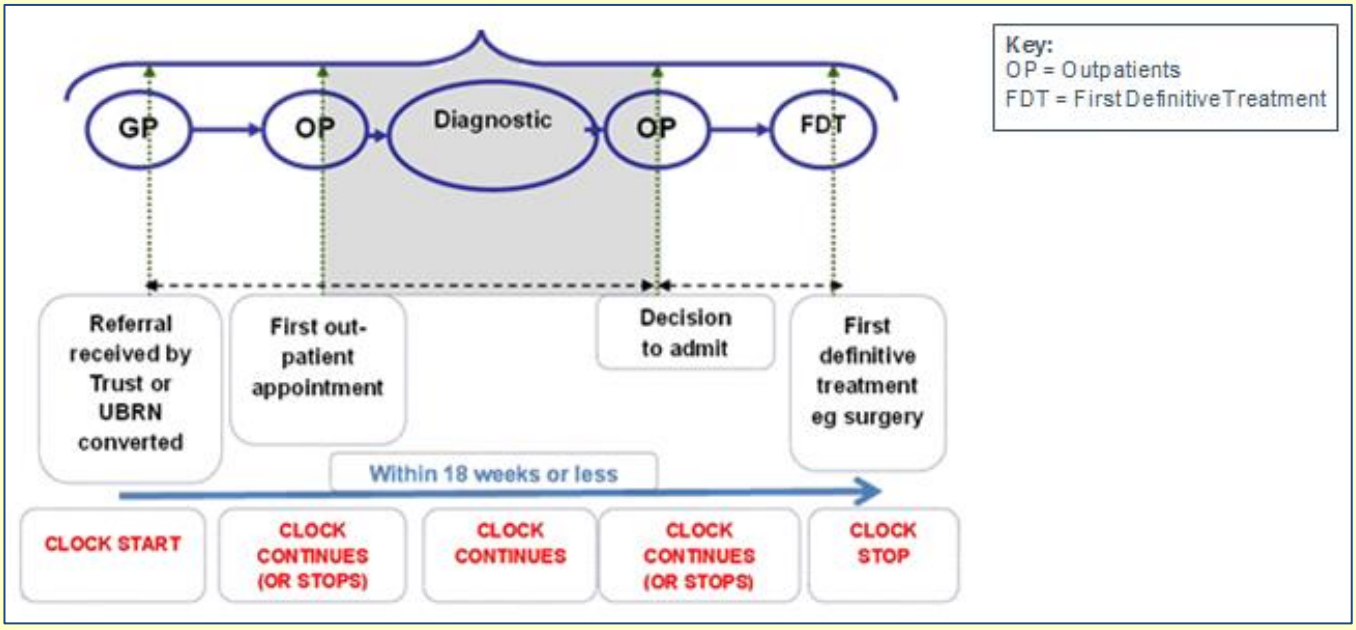
- **Clinical exceptions**: when it is in the patients best clinical interest to wait more than 18 weeks for their treatment.

- **Choice**: when patients choose to extend their pathway beyond 18 weeks by declining reasonable offers of appointments, rescheduling previously agreed appointment dates/admission offers, or specifying a future date for appointment/admission.
- **Co-operation**: when patients do not attend previously agreed appointment dates or admission offers (DNA) and this prevents the Trust from treating them within 18 weeks.

Overview of National Referral to Treatment Rules

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

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



Clock Starts

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

- A referral is received into a Consultant led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before clinical responsibility is transferred back to the referrer.
- A referral is received into an interface or referral management assessment centre which may result in an onward referral to a Consultant led service before clinical responsibility is transferred back to the referrer.
- A patient self refers into a Consultant led service for pre-agreed services agreed by providers and commissioners.

Exclusions

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

- Obstetrics and midwifery.
- Planned patients.
- Referrals to a non-Consultant led service.
- Referrals for patients from non-English commissioners.
- Genitourinary medicine (GUM) services.
- Emergency pathway non-elective follow-up clinic activity.

New Clock Starts for the Same Condition

Following active monitoring

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

Following a decision to start a substantively new treatment plan

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

For second side of a bilateral procedure

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

For a rebooked new outpatient appointment following DNA

Planned Patients

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

Clock Stops for First Definitive Treatment

An RTT clock stops when:

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

Clock Stops for Non-Treatment

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

- It is clinically appropriate to return the patient to primary care for any non-Consultant led treatment in primary care.
- A clinical decision is made not to treat.
- A patient did not attend (DNA) which results in the patient being discharged.

- A decision is made to start the patient on a period of active monitoring.
- A patient declines treatment having been offered it.

Active Monitoring

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

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

Patient Initiated Delays

Non-attendance of appointments/admissions (Did Not Attend – DNA)

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

First appointment DNAs following initial referral

The RTT clock is stopped and nullified in all cases (as long as the Trust can demonstrate the appointment was booked in line with the 'reasonableness' criteria as detailed on page 7). If the Clinician indicates another first appointment should be offered, a new RTT clock will be started on the day the new appointment is agreed with the patient. For example, if the patient DNAs their appointment on 4th July and a conversation with the patient happens on 4th July to agree another appointment for 18th July, the new clock starts on 4th July.

Subsequent (follow-up) appointment/diagnostic/admission DNAs

The RTT clock continues if the Clinician indicates that a further appointment/admission should be offered. If patients wait more than 18 weeks as a result of such

delays, the 8% tolerance is in place to account for this. The RTT clock stops if the Clinician indicates that it is in the patient's best clinical interests to be discharged back to their GP/referrer.

Cancelling, declining or delaying appointment and admission offers

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

- The requested delay is clinically acceptable (clock continues).
- The patient should be contacted to review their options – this may result in agreement to the delay (clock continues) or to begin a period of active monitoring (clock stops).

- The patients 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 patients treatment plan (active monitoring – clock stops).

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

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.

Long term illnesses

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

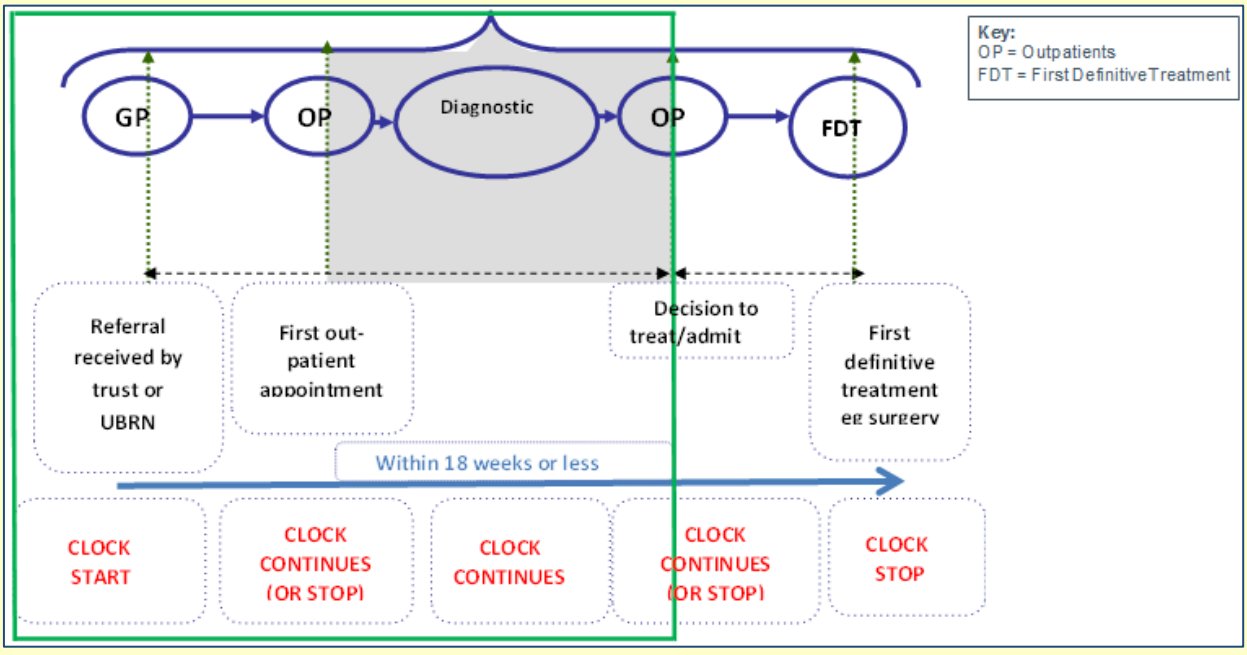
- If it is clinically appropriate for the patient to be removed from the waiting list (this will be a clock stop event via the application of active monitoring).
- If the patient should be optimised/treated within secondary care (active monitoring, clock stop) or if they should be discharged back to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

2. Pathway Specific Principles, Referral to Treatment and Diagnostic Pathways

Non-Admitted Pathways

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

Figure 3: Non-Admitted stages of the patient pathway



Receipt of Referral Letters

The NHS e-Referral Service (e-RS) must be used for referrals from English GPs and Referral Management Centres (RMCs).

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

Pre-requisites prior to referral

In line with national RTT rules, before patients are referred, the GPs and other referrers should ensure that patients are ready, willing and able to attend for any necessary outpatient appointments and/or treatment, and that they fully understand, where possible, the implications of any surgery or other treatment which may be necessary.

Methods of Referral

NHS e-Referrals (e-RS)

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

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

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

Paper referrals received from English GPs will be added to the PAS system and immediately cancelled (for audit purposes). The referral will be returned to the GP via a secure NHS.net account and the GP will be asked to refer in via the e-Referral service. The relevant CCG will be informed.

Secondary Care

It is the responsibility of the Centre management teams, in conjunction with Clinicians, to ensure that the Directory of Services (DoS) is up to date in terms of the service specific criteria, and that the clinics are mapped to the relevant services. This gives the best chance of the patient being booked into the correct clinic at the first visit and reduces the rejection rate. Centre Management teams should review and update their DoS on at least an annual basis in parallel with revision dates to the Access Policy. The Patient Access Centre will initiate and co-ordinate reviews.

Paper based referrals

All paper based referral letters should be date stamped upon receipt into the Trust and sent directly to the Central Booking Office which is based at the Royal Shrewsbury Hospital. Where referrals are received directly into the Central Booking office they will be date stamped on receipt and recorded on the Trust's PAS then forwarded to the relevant Clinician to triage.

Referral criteria/minimum data sets

1) The referrer is responsible for ensuring that the referral letter contains the essential minimum data set. This includes the patients NHS number, full patient demographics, and a preferred day, evening

or mobile telephone number that the patient would like to be contacted on, as well as sufficient clinical data to enable the appropriate appointment to be made. The letter should also state the patient's current drug regime, clinical question to be answered and significant past medical history. An incomplete referral will be returned to the originating referrer. Referrals that are deemed to be misdirected to the wrong Consultant specialist will be returned to the referrer with a letter.

2) Referrals should be addressed to a speciality rather than a named Consultant and referrals will be allocated to the Consultant with the shortest waiting time. Named referrals will be allocated to the relevant Consultant but if they do not have sufficient capacity to accept the referral then a decision will be made, in conjunction with the Consultant and the speciality operational/service manager, to allocate the referral to an appropriate alternative Consultant. Exceptions to this would be where denying access to a sub speciality opinion would compromise clinical care.

Referral Types

Below are details of referral types, other than GP, which are out of the scope of elective care.

Emergency Clinics – All Specialties	GP referral is not required
Fracture Clinics	GP referral is not required
Obstetrics	The e-RS system does not currently support GPs to make referrals to same-day outpatient appointments
Maternity	The e-RS system does not currently support GPs to make referrals to same-day outpatient appointments
Screening Services	Non-Consultant led service
Pathology services	Non-Consultant led service
Referrals made by Clinicians other than GPs (such as other primary care professionals or hospital Consultants).	Not included within e-RS
TIA Clinics	The e-RS system does not currently support GPs to make referrals to same-day outpatient appointments
Rapid Access Clinics	The e-RS system does not currently support GPs to make referrals to same-day outpatient appointments

Internal Consultant to Consultant referrals

CCGs require clinicians in secondary care to seek prior approval of any onward referral for an outpatient appointment to other secondary care clinicians in line with the guidelines set out below. The policy ensures that the GP has a continuing oversight of the care given to their patients and that patients are seen and treated in the most appropriate setting. It is recognised that the policy is likely to result in fewer hospital attendances and more patients being managed by either a community service or their GP. The process should be managed by all parties to ensure that undue delays are not put into the system which would be detrimental to patient care.

These guidelines apply in the following referrals:

- Consultant to consultant referrals within a specialty where this is for a different condition that the patient was initially referred for.
- Consultant to consultant referrals between specialties where this is for a different condition to that the patient was initially referred for.
- Consultant to consultant referrals to another hospital trust where this is a specialist tertiary centre.

The term “consultant” applies to any clinician (both referrer and receiver) within a secondary care provider

including junior doctors, nurses, midwives, AHPs and other health professionals.

Consultant to consultant referrals require authorisation by an appropriate lead consultant. Patient's expectations should be managed during this process and therefore when the referral is sent back to the GP or Community Service, it should be made clear to the patient that the GP will be best placed to make a decision re: onward referral. In coming to a decision, the consultant should be making clear to the patient whether they are being directed back to the GP for onward referral or the consultant is onward referring directly.

The vast majority of referrals should be made from Primary to Secondary Care ("GP to Consultant") for the following reasons:

- To offer patient choice for each different episode of care. Patients should be offered the opportunity for 'Choice' in relation to referral for and opinion or management of a condition.
- To provide care closer to home wherever possible by ensuring management of patients within primary care where appropriate.
- To contribute to the management of secondary care capacity by ensuring only those genuinely needing

secondary care receive it, and in a more timely way as part of 18 weeks pathway.

For these reasons, when a Consultant decides that the opinion of another Consultant/service should be sought, in the majority of cases he/she will write back to the referring GP detailing this opinion so that the patient and their GP can agree on further management. There are however circumstances in which a “Consultant to Consultant” referral is clinically appropriate. This policy describes these. No matter how well defined these circumstances are, there will always be occasional exceptions where Consultants and Commissioners will have to take a view based on individual patients and clinical circumstances. These decisions will be recorded by the provider and submitted to the commissioners via the contract route for a joint decision.

Service Condition 8.5, NHS Standard Contract 2017/18, states with regards to Consultant to Consultant referrals:

"Except as permitted under an applicable Prior Approval Scheme, the Provider shall not carry out, nor refer to another provider to carry out, any non-immediate or routine treatment or care that is unrelated to a Service User's original Referral or

presentation without the agreement of the Service User's GP."

Circumstances in which Consultant to Consultant referrals ARE appropriate

- The patient has an immediate need for investigation or treatment - confirmed or suspected cancer for instance.
- Urgent problems for which delay would be detrimental to the patients' health, and where the expectation here is that the patient would be seen within two weeks of the referral;
- The referral is part of a jointly clinically agreed pathway, in line with NICE Guidance and local improvement work as appropriate.
- Patients who remain under the original team referred to (e.g. neurology) but require simultaneous input directly associated with their current condition/treatment from another team (e.g. respiratory). Equally, when a patient needs onward referral, but the expertise/input of the initial team is still required e.g. if a patient with HIV has a hernia, the HIV team will still need to be available to the surgical team.
- Pre-operative assessments, including in other specialties such as cardiology.

- Pregnant patients who need review by other specialists as a result of their pregnancy and where a rapid opinion is required to ensure continuation of a healthy pregnancy.
- Patients referred following an emergency department attendance with a trauma related injury or an urgent condition. Or direct referral pathways agreed from Emergency Department. A tertiary referral to another Trust because the originating hospital does not provide the clinical service required.
- Referrals made under safeguarding (adult and child) guidance/legislation
- Non-cancer tertiary/specialist centre as agreed locally.
- Within a multi-disciplinary team, this should not be recorded as a new outpatient appointment but as a follow up appointment.
- Referrals within a specialty for the same condition. Cross referral within the same department with sub specialty interests for the same condition can be made exceptionally, i.e. a cardiologist requesting a diagnostic. However our expectation is that these would be exceptional and that all referrals will be previewed by a consultant at the time of booking to

ensure that patients are not inconvenienced by being booked in with the wrong sub specialist.

- Consultant referrals to the memory clinic where a high index of clinical suspicion of a diagnosis of dementia is suspected.
- Within the Paediatric service generally where there is a need for the involvement of a tertiary centre (e.g. a neurologist, surgeon etc.) or another local specialist (e.g. ophthalmologist, ENT surgeon, community paediatrician, etc.). Also within neonates follow up from an inpatient stay may include referral to other specialities within SaTH and Tertiary Centres (e.g. respiratory, cardiology, surgery).

Referral requiring redirection to another organisation (tertiary referrals)

The CCGs consider it is acceptable to make referrals into other organisation or to accept referrals from other organisations in the following circumstances

- Suspected or diagnosed cancer.
- Urgent problems for which delay would be detrimental to the patient's health (the "two week rule" as applied got GP referrals).
- Where the destination is recognised as specialist and only accepts referrals from consultants.
- Where the referral is for a very specialist opinion or treatment where the destination of the referral is "the provider of choice".

- Where onward referral is expected and planned as an essential part of the same pathway of care.
- Referral to established multi-speciality combined clinics.
- Referrals relating to chronic multi-system diseases where specialist management or intervention is required, with close collaboration (i.e. sharing of complex clinical information).
- Referrals that facilitate discharge from or prevent an acute admission.

Circumstances in which Consultant to Consultant referrals are NOT appropriate

The contract does not permit a hospital clinician to refer onwards where a patient's 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 referral or attendance at Emergency Department.

In this situation, the contract requires the hospital clinician to refer back to the patient's GP. If the GP agrees, the onward referral can then be made (either by the provider clinician or by the GP) but the GP may instead choose to manage the patient's condition him/herself or to refer into a different service.

Where a patient is transferred to the care of a Locum within the same specialty and same condition, if a first attendance has already taken place all subsequent appointments will be follow up attendances (this is consistent with RTT guidelines and will be perceived by the patient as a follow up).

Monitoring compliance with the policy

There is evidence that an increase in consultant initiated referrals is offsetting any reduction in GP initiated referrals. Commissioners therefore wish to audit a representative sample of consultant to consultant (C2C) referrals to establish whether such referrals are being made in accordance with the currently agreed policy and whether any change in clinical practice is necessary. Audit will be conducted jointly between the Trust and CCG commissioners. Audits will need to be undertaken in line with provider audit policies detailed within contracts.

The Trust will nominate two or more clinicians to work with the GPs. One GP and one Trust clinician will constitute an audit panel to review the audit sample. There will be 2 Audits carried out in a year, one in Q1, and one in Q3. The terms of reference and methodology are to be jointly agreed between both parties. It is envisaged that the audit panel will need to meet on three or more occasions to conduct the audit

and the clinicians will need to agree between themselves suitable dates for audit sessions.

In order to make best use of the clinicians' time, it is proposed that the audit sample should initially be reviewed by a manager nominated by the CCG and a manager nominated by the Trust. The managers will identify and record any C2C referrals that are clearly compliant with the C2C policy and other applicable commissioning policies. (Examples may include urgent cancer referrals, A&E consultant referrals to Fracture Clinic, or management of the condition for which the patient was initially referred). The auditors will be given access to the sample records either by the Trust providing appropriate access to their systems or by extracting the original patient notes. Information from the sample will be recorded on a data collection form. Commissioners will provide the Trust with a list of records (volume to be agreed) from SLAM reports in order achieve a confidence level of 95% with a confidence interval of 5% for the level of compliance with the C2C policy. The Trust will be required to make these records available to the auditors. The audit lead will prepare a report highlighting the auditors' conclusions and any recommendations for amendments to the policy and/ or the Trusts' management arrangements for C2C referrals. Where there is any

difference of opinion between the auditors that cannot be resolved by discussion, this will be recorded in the audit findings. Outcomes of any audits will first be presented to either the Planned Care Working Group or Contract Meeting with the provider.

Inter Provider Transfers (IPTs)

Incoming IPTs

All IPT referrals will be received electronically via the Trust's secure generic NHS.net email account into the Central Booking Office. The Trust expects an accompanying MDS (Minimum Data set) pro-forma with the IPT, detailing the patients current RTT status (the Trust will inherit any RTT wait already incurred at the referring Trust if they have not yet been treated) and if the patient has been referred for a new treatment plan for the same condition (where a new RTT clock will start upon receipt at this Trust) the patient's pathway identifier (PPID) should also be provided. If the IPT is for a diagnostic test only, the referring Trust retains responsibility for the RTT pathway.

If any of the above information is missing, the referral should be recorded on PAS and the information actively chased by the Central Booking Office.

Outgoing IPTs

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

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

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

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

e-Referral service

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

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

If a patient's appointment has been incorrectly booked on the NHS e-Referral system into the wrong service at the Trust by the referrer, the referral should be electronically re-directed in the e-Referral system to the correct service. A confirmation letter of the appointment change will be sent to the patient. The patients RTT clock will continue to tick from the original date when they converted their UBRN.

Paper based referrals

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

Patients will be selected for booking from the Trust's patient tracking list (PTL) only. A fixed appointment will be sent to the patient however, they will have the opportunity to change this.

Patients will be offered a choice of at least two dates with three weeks' notice within the agreed first appointment milestone for the specialty concerned. Appointment dates can be offered with less than three weeks' notice and, if the patient accepts, this can then be defined as 'reasonable'. Where there is insufficient capacity to offer an appointment within the required milestone, this should be escalated to the relevant service manager by the Patient Access teams.

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

Clinic Attendance and Outcomes (New and Follow-up Clinics)

Arrival of patients

Patient demographic details should be checked at every clinic attendance and amended as necessary on the Trust's PAS system. The status of overseas visitors will be checked at this time. The OSV team must be notified where it is suspected that there is an overseas visitor.

Every patient, new and follow-up, whether attended or not, will have an attendance status and outcome recorded on PAS at the end of the clinic. All clinics should have completed and recorded outcomes, or 'be cashed up' within two working days of the clinic taking place. Clinic outcomes (e.g. discharge, further appointment) and the patients updated RTT status will be recorded by Clinicians on the agreed clinic outcome form (COF) and forwarded to reception staff immediately.

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

outpatient attendance, depending on the clinical decisions made or treatment given/started during the consultation:

Patients on an open pathway

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

Patients already treated or with a decision not to treat (stopped clock)

- New clock start if a decision is made regarding a new treatment plan.
- New clock start if the patient is fit and ready for the second side of a bilateral procedure.
- Stopped RTT clock if the patient is to be reviewed following first definitive treatment.
- Stopped RTT clock if the patient is to continue under active monitoring.
- Accurate and timely recording of these RTT statuses at the end of the clinic are therefore critical to supporting the accurate reporting of RTT performance.

Booking Follow-up Appointments

Patients on an open pathway

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

Follow-up appointments should be agreed with the patient prior to leaving the clinic where practically possible. This provides the best opportunity for patient choice to be accommodated within the required timescale for achievement of the RTT standard.

Patients not on an open pathway

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

- They will be added to the Follow-up Active Booking List.
- An appointment will then be agreed with the central booking office.

Patients who do not attend (DNA)

All patient DNAs (new and follow-up) will be reviewed by the Clinician at the end of clinic in order for a clinical decision to be made regarding next steps (see 'Clock Stops for Non-Treatment' for the application of RTT rules regarding DNAs). A COF must be completed for each patient that DNAs their appointment.

Children who fail to attend first appointments

- Will usually be offered a second appointment. Should this also be missed a letter will be sent to the G.P, copied to the parents, and the Paediatric Liaison Health Visitor informing them of two DNAs and suggesting that they re-refer if the problem persists.
- If the initial referral states a problem that is likely to be short lived, or seems driven by parental anxiety, a second appointment may not be sent, but a letter should be sent to the GP and parents informing them of this, stating that we assume the problem has now resolved, and asking for a re-referral if needed.
- If the initial referral letter states a potentially serious problem, a phone call to the parents by the Clinician might be more appropriate.

- If the GP mentions Social Worker or Health Visitor concerns in the letter then a second appointment is offered, and contact with those professionals may be sensible.

Children who fail to attend follow-ups

- Will normally be offered a second appointment. If that is also missed, the Consultant will write to the GP, Paediatric Liaison Health Visitor and the family discharging them unless:
  - They've had multiple DNAs in the past, when maybe one DNA will warrant such a letter.
  - If the Consultant knows the family well, may offer a third appointment or make contact with family via phone/letter.
  - If child is at risk, the Consultant should try to make contact with family expressing concerns before contacting Social Care.
  - If the child has a chronic illness and is therefore likely to be well known, input from the Specialist nurse may be helpful, or ask GP to make contact via the repeat prescription mechanism.

Following review of the notes by the Consultant, if the practitioner considers the parents' behaviour to possibly be neglectful, action should be taken.

- Contact the parents to rearrange the appointment.
- Discuss with the Named Doctor or Named Nurse.
- Refer to the 'Trust Safeguarding Policy' and if required refer to Social Care if child thought to be at risk of significant harm.

Follow-up appointments

- Patients who require an appointment within six weeks should be fully booked as they leave the outpatient appointment where possible.
- Patients who require an outpatient follow-up appointment in more than six weeks' time will be sent a fixed appointment. However, they will have the opportunity to change this if unsuitable.
- Long term follow-up appointments will be agreed between Consultant and the patients GP around the clinical needs of the patient.
- Any patients who require a further appointment outside six months will be flagged to the Centre management team and Clinicians for further investigation with a view to establishing the appropriateness of the further follow-up appointment. However, if the speciality Clinician deems that this is not in the best clinical interests of the patients care, they can be offered a further follow -up appointment outside the six month rule.

Pathway exceptions will include Glaucoma, Rheumatology and Long Term Conditions including MS, Parkinsons, Epilepsy, Heart Failure, Long term Diabetes or Endocrine disorders.

Appointment Changes and Cancellations

Appointment changes initiated by the patient

- If the patient gives any prior notice that they cannot attend their appointment (even if this is on the day of clinic), this should be recorded as a cancellation and not DNA.
- If the patient requires a further appointment, this will be booked with the patient at the time of the cancellation.
- If the patient is on an open RTT pathway, the clock continues to tick. If there are insufficient appointment slots within the agreed pathway milestones, the issue must be escalated to the relevant centre management team. Contact with patient must be made within two working days to agree an alternative date.
- If the patient has never been seen and advises they do not wish to progress their pathway, they will be removed from the relevant waiting list and a clock stop and nullification applied. The patient will be

informed that their Consultant and GP will be informed of this.

- If as a result of the patient cancelling, a delay is incurred which is equal to or greater than a clinically unsafe period of delay (as indicated in advance by Consultants and recorded in the specialty guidance), the patients pathway should be reviewed by their Consultant. Upon clinical review, the patients Consultant should indicate one of the following:
  - Clinically safe for the patient to delay: continue progression of pathway. The RTT clock continues.
  - Clinically unsafe length of delay: Clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues.
  - Clinically unsafe length of delay: in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP.

Appointment changes initiated by the hospital

- Hospital initiated changes to appointments will be avoided as far as possible as they are poor practice and cause inconvenience to patients. In the event of a hospital initiated cancellation, the patients RTT clock continues to tick from the original referred received date.

- The patient will be contacted to arrange an alternative appointment date and time. Both an apology and a reason for cancellation will be given. The Trust will make every effort to ensure that they do not cancel patient's appointments.
- If the cancellation is within two weeks of the appointment date, the patient will be telephoned. If the cancellation is outside of the timeframe, the patient will be contacted by letter. Appointments will be made as close to the original appointment as possible. This is particularly important when patients need to re-attend for test results or to review medication.
- Patients will be contacted immediately if the need for the cancellation is identified, and offered an alternative date(s) that will allow patients on open RTT pathways to be treated within 18 weeks. Equally, this will allow patients not on open pathways to be reviewed as near to the clinically agreed timeframe as possible.
- If a patient is cancelled or rescheduled twice by the Trust, this will need to be escalated immediately to the appropriate Centre Manager to take immediate action.
- Clinicians are actively encouraged to book annual leave and study leave as early as possible.

Clinicians must provide 6 weeks' notice of a clinic has to be cancelled or reduced.

Clinic Management

Clinic templates

Clinic templates define the number of each type of patient that can be seen in a clinic based on the number and grade of Clinicians in the clinic. Centre Managers and Clinical Directors will review Consultant clinic templates as part of the annual job planning process and demand/capacity profiling. Any changes to clinic templates should be forwarded to the Central Booking Office to be processed on PAS once agreed. Access rights to the functionality on PAS to make changes to clinic templates will be restricted to Central Booking Office staff only.

Ad hoc clinic cancellation and reduction

1) Changes to Clinic templates will be clearly communicated to the Central Booking Office. A minimum of six weeks written notice of planned annual, study or professional leave must be given when a doctor or other professional requires a clinic to be cancelled or reduced.
2) Consultants, medical staff and other health professional staff must give at least six weeks'

notice of annual leave. Where this is not given, the Consultants team or alternative health professional must cover the clinic. Leave should be given as early as possible to minimise the effect on clinics. This is the responsibility of the operational/business manager for the speciality. Known annual bank holidays (Christmas, Easter….) can be planned for with significant notice.

3) Approved cancelled clinics due to leave should be taken up by other Consultants/Specialities wherever possible to ensure maximum utilisation.
4) Requests at less than 6 weeks' notice will need to be presented to the Centre Manager, signed off by the Clinical Director with a clear justification as to why the request could not be made sooner and evidence that alternative cover arrangements are in place to ensure continuation of the service.
5) The Trust is committed to offering certainty to patients as well as choice in arranging care. As such, every effort will be made to avoid cancelling patient's appointments. Every effort will be made to backfill absent Clinicians by the speciality. Cancellation will be a last resort.
6) Clinics should not be cancelled or reduced for any purpose unless there are exceptional circumstances. Ideally eight weeks, with a minimum of six weeks written notice of planned annual, study or

professional leave, must be given when a doctor or other professional requires a clinic to be cancelled or reduced. Wherever possible, patients that have been previously cancelled should not be cancelled for a second time. Such occurrences require immediate escalation to the Centre Manager to take immediate action.

7) When clinics have to be unavoidably cancelled/reduced at short notice this must be approved by the Centre Manager. Liaison with Nursing staff, Scheduling Services Manager, Central Booking Office and Clinic Preparation is essential.
8) On receipt of a request to cancel or reduce a clinic, the Booking Team will avoid cancelling the following patients:
    - Urgent Cancer or Urgent Two Week Wait Referrals.
    - RACPC & Urgent Symptomatic Breast Patients.
    - Long term follow-up flagged cancer patients.
    - Urgent appointments.
    - Those patients with a time dependent appointment.
    - Those patients cancelled previously.
9) The patients will be contacted by the Central Booking Office/Centre Administration teams to arrange a new appointment. Every effort will be

made to ensure that patients are contacted including the use of first class post and telephone calls when cancellations are being made for clinics within two weeks of the patient's appointment.

10) Centre teams must ensure that they inform the Central Booking Office of the patient's follow-up by date at the time of cancellation.

Booking rules

Booking instructions for all specialties will be given to the Central Booking Office. These will be signed off by the Centre/Business Managers and Consultants and sent to the Central Booking Office. Each Centre must produce a comprehensive version controlled set of Booking Rules which must be clear and concise. These will be reviewed on an appropriate basis and any changes required will be clearly identified.

Outpatient clinic accommodation

The Trust will ensure that outpatient clinic capacity is fully utilised. Any cancelled scheduled clinic sessions due to annual or study leave will be communicated to Centres. Clinic templates will be reviewed on an annual basis by the appropriate Operational / Business Manager and the Consultant to ensure that there is adequate capacity available to deliver the required volumes of patients to meet the Trust's business plan.

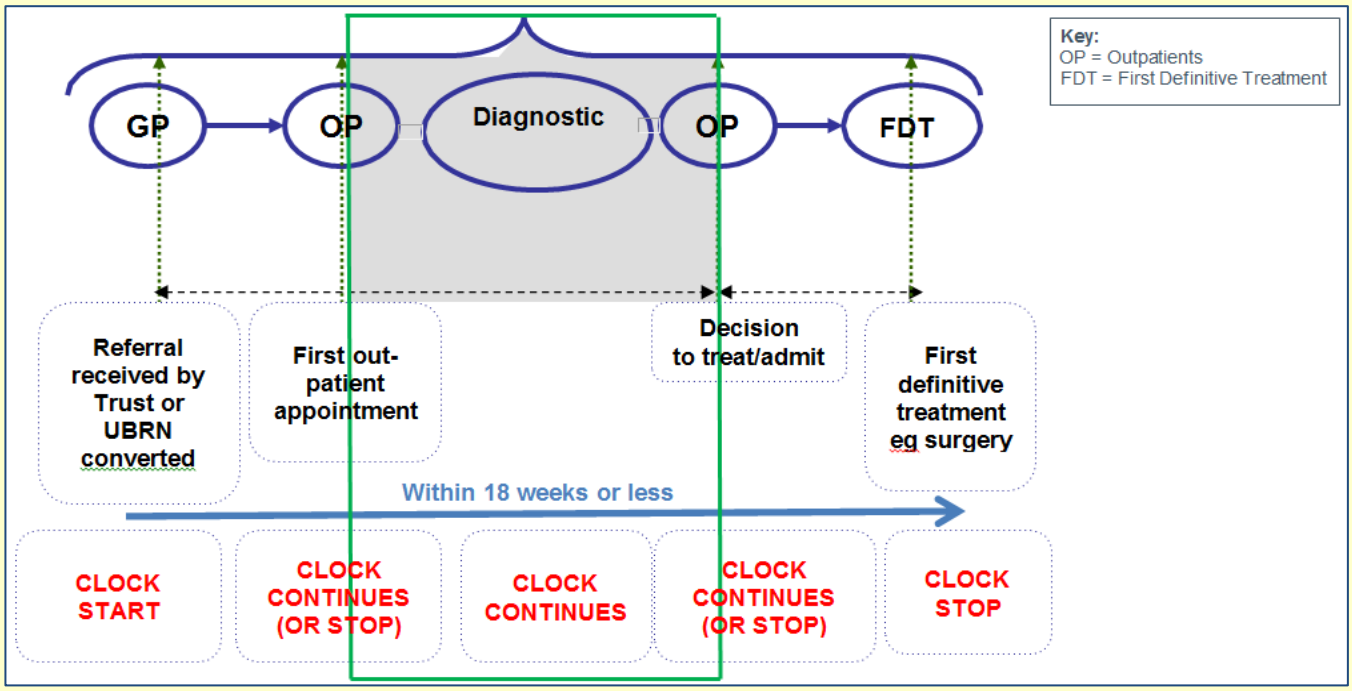
This review will need to reflect the demand fluctuations for the service and plan revision accordingly.

Diagnostics

The section within the green border on the Figure 4 diagram represents the diagnostic stage of the RTT pathway which forms part of the non-admitted pathways. It starts at the point of a decision to refer for a diagnostic test and ends on the results/report from the diagnostic procedure being available to the requester.

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

Figure 4: Diagnostic phase of the patient pathway



Patients with a Diagnostic and RTT Clock

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

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

Straight to Test Arrangements

For patients who are referred for a diagnostic test where one of the possible outcomes is review and if

appropriate treatment within a Consultant led service (without first being reviewed by their GP) an RTT clock will start on receipt of the referral. These are called straight-to-test referrals. SaTH agreed straight to test services are Gastroenterology and Cardio Respiratory.

Patients with a Diagnostic Only Clock

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

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

National Diagnostic Clock Rules, Reasonable Offers, Cancelling or Not Attending

Patients referred for a diagnostic clock rules:

- **Diagnostic clock start:** the clock starts at the point of the decision to refer for a diagnostic test by either the GP or the Consultant.

- **Diagnostic clock stop**: the clock stops at the point at which the patient undergoes the test.
- **A reasonable offer:** for diagnostic tests a reasonable offer is a date and time of three or more weeks from the time that the offer was made at any of the Trust's sites. Should a patient accept an appointment less than two weeks into the future, this becomes a reasonable offer. All offered and declined appointments will be recorded on CRIS. Some diagnostic tests will be undertaken on an admitted basis.
- **Patients who decline two reasonable appointment offers:** if a patient declines two reasonable offers, the clock for the 6 week diagnostic standard can be re-set from the first appointment offered. The clock cannot be reset if there is no evidence that the appointments offered to and declined by the patient were reasonable.
- **Patients who do not attend (DNA):** Standard Radiology DNA protocol will apply (in line with Trust policy on outpatient appointment DNAs – see section 2), when a patient does not attend for the first time. A radiology Clinician will review the diagnostic request with a view to discharging the patient providing that:
  - The delay is not contrary to their best clinical interest.

- The clinical interests of vulnerable patients (see the Safeguarding Children Policy or Safeguarding Vulnerable Adults Policy and Procedure) are protected.

If the patient is to be discharged, the following process must be adhered to:

- A copy of the request form, plus the CRIS generated DNA letter, will be sent to the referring Consultant/GP.
- The request will be cancelled on CRIS.

Adjustments to the 6 week diagnostic standard as outlined above do not affect the patients 18 week RTT waiting time. It is therefore important that staff is aware of patients who are on both a diagnostic 6 week and 18 week RTT pathway and that their care is delivered in line with both national standards.

Booking Diagnostic Appointments

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

If a patient declines, cancels or does not attend a diagnostic appointment, the diagnostic clock start can be reset to the date the patient provides notification of this. However:

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

Diagnostic Cancellations, Declines and/or DNAs for Patients on Open RTT Pathways

Where a patient has cancelled, declined and/or not attended their diagnostic appointment and a clinical decision is made to return them to the referring Consultant, the RTT clock should continue to tick. **Only the referring Consultant can make a clinical decision to stop the RTT clock, if this is deemed to be in the patient's best clinical interests, by discharging the patient or agreeing a period of active monitoring.**

Active Diagnostic Waiting List

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

Active Planned Diagnostic Waiting List

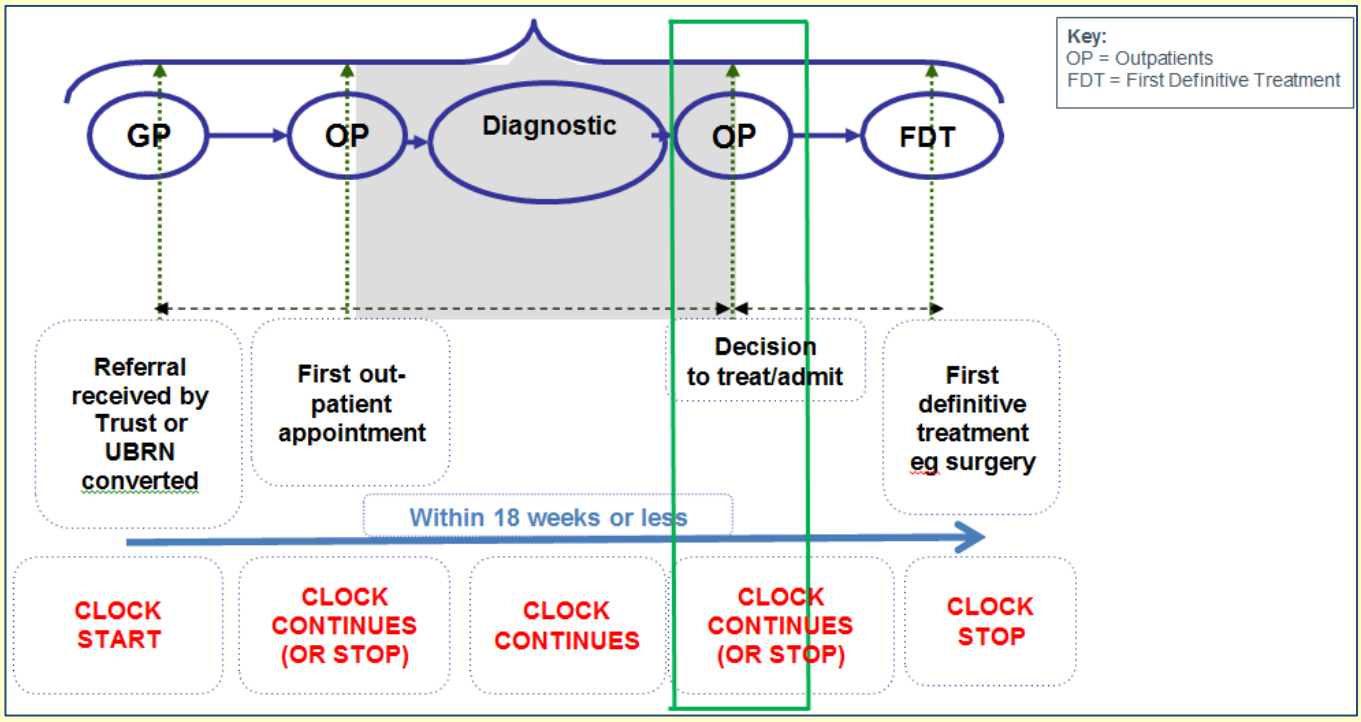
Patients who require a diagnostic test to be carried out at a specific point in time for clinical reasons are exempt from the diagnostic clock rules and will be held on a planned waiting list with a clinically determined due date identified. However, if the patients wait goes beyond the due date for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

Therapeutic Procedures

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

Pre-Operative Assessment (POA)

Figure 5: Stages in Pre-Operative Assessment



All patients with a decision to admit (DTA) requiring a general anaesthetic will attend a pre-operative clinic on the same day, where possible, to assess their fitness for surgery. The vast majority of patients can be assessed by the Trust's dedicated pre-operative nurse specialists.

Patients should be made aware in advance that they may need stay longer on the day of their appointment for attendance in POA.

For patients with complex health issues requiring a POA appointment with a Consultant, the Trust will aim to agree this date with the patient before they leave the

clinic. The Trust will aim to agree an appointment no later than seven working days from the decision to admit.

Patients who DNA their POA appointment will be contacted with a view to agreeing a further appointment. If they DNA again, they will be returned to the responsible Consultant. The RTT clock continues to tick throughout this process.

If the patient is identified as unfit for the procedure, the nature and duration of the clinical issue should be ascertained. If the clinical issue is short term and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold, UTI), the RTT clock continues. However, if the clinical issue is more serious and the patient requires optimisation and/treatment, Clinicians should indicate to administration staff if it is clinically appropriate for the patient to be removed from the waiting list, and if so whether the patient should be:

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

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

Acute Therapy Services

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

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

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

Physiotherapy

For patients on an orthopaedic pathway referred for physiotherapy as first definitive treatment the RTT clock stops when the patient begins physiotherapy.

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

Surgical Appliances

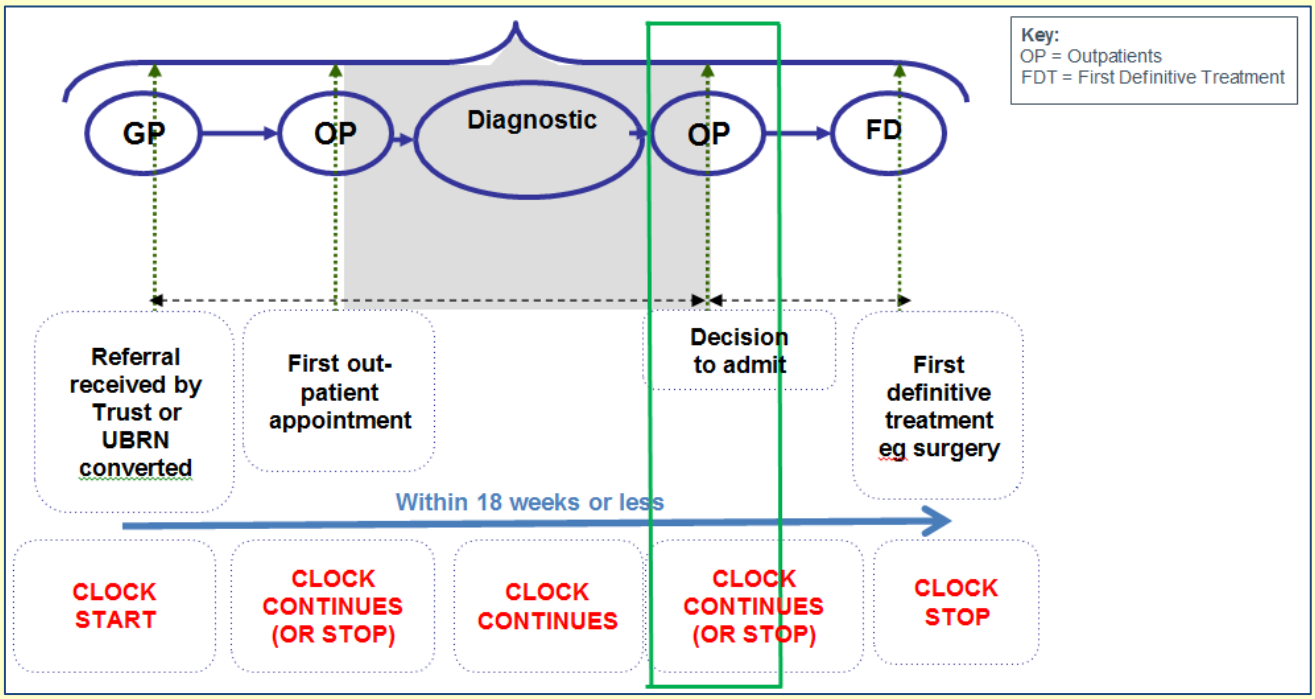
Patients on an orthopaedic pathway referred for a surgical appliance with no other form of treatment agreed. In this scenario, the fitting of the appliance constitutes first definitive treatment and therefore the RTT clock stops when this occurs. Please note that this service is not provided by SaTH but may be applicable if Clinician's refer to Robert Jones and Agnes Hunt Orthopaedic Hospital via an Inter Provider Transfer.

Dietetics

If patients are referred to the dietician and receive dietary advice with no other form of treatment, this would constitute an RTT clock stop. Equally, patients could receive dietary advice as an important step of a particular pathway (e.g. bariatric). In this pathway, the clock could continue to tick.

Non-Activity Related RTT Decisions

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



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

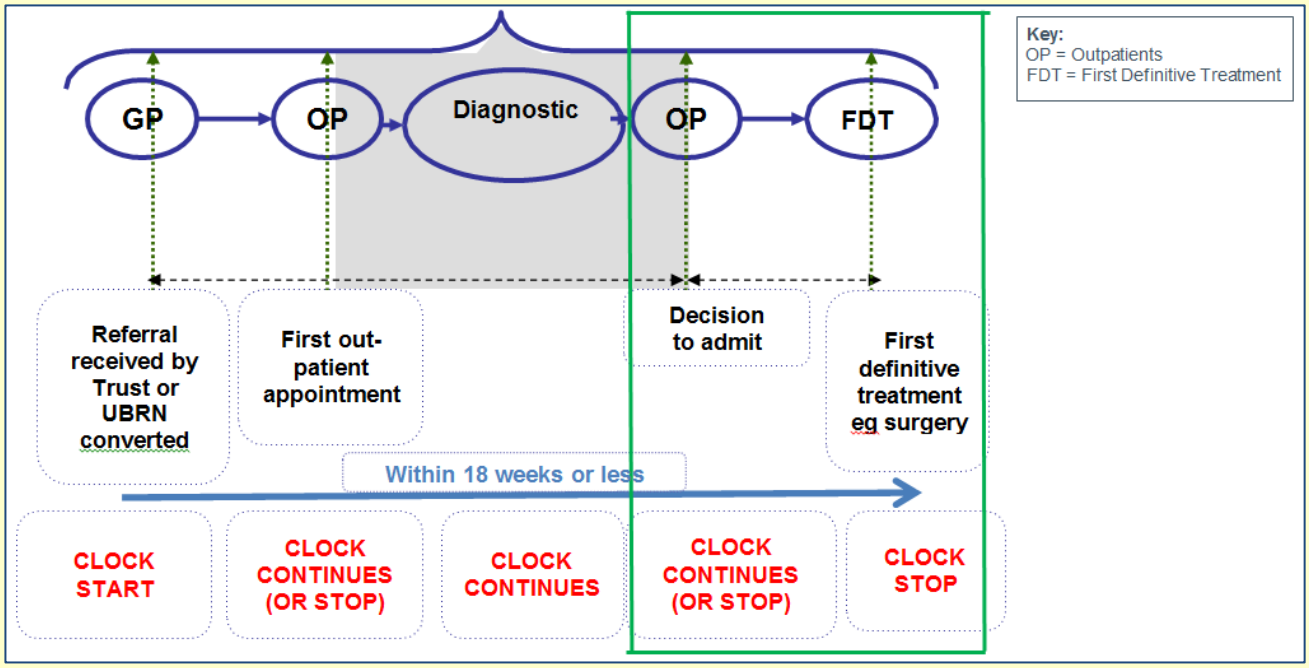
Administration staff should update PAS with the clock stop. The date recorded will be the day the decision not to treat is communicated in writing to the patient.

Admitted Pathways

The section within the green border on Figure 7 represents the admitted stage of the pathway. It starts

at the point of a decision to admit and ends upon admission for first definitive treatment.

Figure 7: Stages in the management of admitted patients



Adding Patients to the Active Inpatient or Day Case Waiting List

Ideally patients will be fit, ready and available before being added to the admitted waiting list. However, they will be added to the admitted waiting list without delay following a decision to admit, regardless of whether they have undergone pre-operative assessment (see 'Pre-operative Assessment') or whether they have declared a period of unavailability at the point of the decision to admit (see 'Patient Initiated Delays').

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

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

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

Completion of waiting list 'to come in' (TCI) forms

A waiting list TCI form will be completed at the time of the decision to admit, in full by the Clinician making the decision to admit for all patients added to the waiting list.

Waiting list TCI forms will be collected from the Outpatient clinics by a nominated member of the Patient Access Team on a daily basis. Urgent TCIs will be added to the waiting list on the site of the outpatient appointment irrespective of where the surgery takes

place. Routine TCIs will be sent directly to the Central Booking Office. All waiting list entries must be put onto PAS within 48 hours or two working days of the outpatient appointment. TCI forms will be monitored via Patient Access on a weekly basis using the Relevant SQL report and any missing will be chased with the appropriate Consultant immediately

Adding patients to the admitted waiting list

Patients must be added to the admitted waiting list within two working days of the decision to admit. When logging a patient on the waiting list module of PAS, the Booking team must ensure that:

- Patients are not already listed for the same condition.
- The entry is recorded correctly as either active or planned.
- Full treatment text and an accurate procedure code are noted.
- That the patient is not already scheduled for surgery for another procedure under a General Anaesthetic.
- Any communication with the patient should be recorded on PAS in the Pathway validation section of the system.

Patients Requiring More Than One Procedure

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

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

Patients Listed for More Than One Procedure

A patient referred for two separate conditions resulting in the requirement for two admissions for different procedures could be managed in the following ways. On completion of the first procedure the clock is stopped for that particular pathway. If the patient is unfit as a result of the first surgery to undergo the second

surgery and there is no prospect of the patient becoming fit then the patients clock can be stopped (decision not to treat) and patient should be discharged back to the care of their GP or alternatively the patient could be placed on a period of active monitoring by the Clinician until the patient becomes fit, ready and available to proceed with the second procedure.

Under no circumstances should a patient be on more than one waiting list within the Trust for general anaesthetic. Such patients must be given the opportunity to recover from one procedure under anaesthetic before opting to undergo another. If a patient requires more than one procedure at the same point in time, a clinical decision must be made which procedure is clinically more urgent. The key is that this should be a clinical decision to facilitate the most appropriate management of the patient.

Bilateral Procedures

Patients will only be put onto the admitted waiting list for one side at a time.
The RTT clock will stop when the first definitive treatment begins (i.e. when the procedure is carried out). Once the patient is fit and ready to proceed with

the second procedure, a new clock will start when the patient is listed in Sema.
If the decision to admit involves two procedures as part of the single pathway of treatment the clock stops when the first treatment begins. The subsequent procedure is undertaken based on clinical need as part of the same pathway but the clock has already stopped. This is a process for planned patients who are managed according to clinical need.

Subsequent Treatments for the Same Condition

If following active monitoring a patient is added to waiting list a new clock will start on the day Decision to Admit is made and communicated with the patient. This also applies to a patient on a previous emergency pathway. Patients who are removed from the waiting list will need to be reviewed in outpatients first before being re-instated unless based on clinical judgement this is decided against by the Consultant. The new clock start date will be either the date of the GPs request or the date of the review in outpatients.

Patients Requiring Thinking Time

Patients may wish to spend time thinking about the recommended treatment options before confirming they would like to proceed. It would not be appropriate to

stop their RTT clock where this thinking time amounts to only a few days or weeks. Patients should be asked to make contact within an agreed period with their decision.

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

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

Scheduling Patients to Come In for Admission

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

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

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

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

The TCI Letter

A letter must be generated immediately following the agreement of a TCI date. The TCI letter must contain the following core details:

- Patients name.
- NHS Number & Hospital Number.
- Date letter sent to patient.
- Date and time of admission.

- Details of necessary pre-assessment before admission.
- Where to report on arrival.
- Named contact for queries relating to admission.
- Reference to instructions for admission and/or booklet.
- Specific information about the treatment.
- General information about the patients stay in hospital and discharge.
- General information about the hospital facilities (car park etc.).

Planned Waiting Lists

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

When patients on planned lists are clinically ready for their care to begin and reach their due date for their planned procedure, they will either be admitted for the procedure or be transferred to an active waiting list and

a new RTT clock will start. For some patients (e.g. surveillance endoscopies) a diagnostic clock would also start.

Patients Declaring Periods of Unavailability While on the Waiting List

If patients contact the Trust to communicate periods of unavailability for social reasons (e.g. holidays, exams), this period should be recorded on PAS within Pathway Validation.

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 and recorded in the specialty guidance), the patients pathway will be reviewed by their Consultant.

Upon clinical review, the patients Consultant will indicate one of the following:

- Clinically safe for the patient to delay: continue progression of pathway. The RTT clock continues.
- Clinically unsafe length of delay: Clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues. In exceptional circumstances if a patient decides to delay their treatment it may be appropriate to place the patient

under active monitoring (clock stop) if the Clinician believes the delay will have a consequential impact on the patient's treatment plan.

- Clinically unsafe length of delay: in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP. The patient could also be actively monitored within the Trust.

Patients Who Decline or Cancel TCI Offers

If patients decline TCI offers or contact the Trust to cancel a previously agreed TCI, this will be recorded on the PAS within Pathway Validation. The RTT clock continues to tick. If, as a result of the patient declining or cancelling, a delay is incurred which is equal to or greater than a clinically unsafe period of delay (as indicated in advance by Consultants and recorded in the specialty guidance), the patients pathway will be reviewed by their Consultant. Upon clinical review, the patients Consultant will indicate one of the following:

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

- Clinically unsafe length of delay: in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP.
- The requested delay is clinically acceptable but the Clinician believes the delay will have a consequential impact (where the treatment may fundamentally change during the period of delay) on the patients treatment plan-active monitoring.

Patients Who Do Not Attend Admission

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

On-The-Day Cancellations

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

Hospital Cancellations of TCIs

There are various reasons why an operation may have to be cancelled which fall into three main categories – cancellation by the Trust for clinical reasons, cancellation by the Trust for non-clinical reasons and cancellation by the patient. These should be included on any subsequent electronic discharge letter or in the patient's notes. All reasons for cancellation will be added to PAS by the Central Booking Office.

Cancellation by the Trust for clinical reasons

If the operation is cancelled because the patient is unfit for surgery or the operation is no longer required the clock stops and the patient should be referred back to their GP. The exception to this is patients who develop colds, D&V prior to admission and would be expected to recover in 7-10 days, the clock continues for these patients.

Cancellation by the Trust for non-clinical reasons

The Trust will only cancel a patient's admission when it is not possible to carry out the procedure (e.g. bed capacity, unplanned leave, emergency cases). Everything must be done to try and avoid a hospital cancellation as it causes distress to the patient and an operational problem to the hospital. Should it be necessary to cancel elective admissions, priority will be

given to clinically urgent cases and long waiters. The new date also has to be within the 18 week patient target. Every effort should be made to avoid cancelling a patient's admission: Theatre lists should not be cancelled except under exceptional circumstances. Only the Assistant Chief Operating Officer for Scheduled Care or nominated Deputy can authorise cancellations.

Admitting Patients

Where a patient's admission is a procedure or operation constituting first definitive treatment as part of an RTT pathway, the admission on PAS will stop the patient's clock.

Emergency Admissions for an Elective Procedure

Where patients are admitted as an emergency for an elective procedure the patient will be removed from the waiting list and their RTT clock stopped.

Removals Other Than Treatment

Patients who state that they do not wish to receive treatment will have their waiting list entry removed and their clock stopped.

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3. Cancer Pathways

Introduction and Scope

This section describes how the Trust manages waiting times for patients with suspected and confirmed cancer, to ensure that such patients are diagnosed and treated as rapidly as possible and within the national waiting times standards. This policy is consistent with the latest version of the Department of Health's 'Cancer Waiting Times Guide' and includes national dataset requirements for both waiting times and clinical datasets.

Policies

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

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

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

Accurate data on the Trust's performance against the

national cancer waiting times is recorded in the cancer management system and reported to the National Cancer Waiting Times Database within nationally predetermined timescales.

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

Roles and Responsibilities

Chief Executive/Chief Operating Officer/Deputy Chief Operating Officer

The Chief Operating Officer (COO) on behalf of the Chief Executive has overall responsibility for the implementation of this policy and board level accountability for the Trust's adherence to this policy. The COO is responsible for ensuring the delivery and monitoring compliance of the cancer waiting times targets. The Deputy Chief Operating Officer will be responsible as designated by the Chief Operating Officer.

Cancer Performance Manager

The Cancer Performance Manager will ensure that all cancer services core team staff involved in cancer pathway tracking are aware of this policy and the importance of following the procedures. Training will be provided to the cancer services core team on this policy together with the Trust's Elective Care Access Policy. Training will also be provided to new members of the

team at induction. The Cancer Performance Manager is responsible for reviewing this policy.

Cancer Performance Management Team

The management team which incorporates the Cancer Performance Manager, Assistant Cancer Performance Manager and Cancer Performance Analyst will ensure:

- That the processes outlined in this document are implemented and adhered to, without deviation by the cancer support team, on a day-to-day basis.
- That refresher training on this policy and the Trust's Elective Care Access Policy is included within the cancer support services core team annual training programme, in order to maintain skills and knowledge.

The Cancer Performance Management Team in conjunction with the wider cancer services team has a responsibility to ensure that the patient pathway is validated prior to upload to the national cancer waiting time database, demonstrating a true and accurate waiting time for each patient.

Cancer Pathway Co-ordinators

The Cancer Pathway Coordinators will ensure the accuracy of information for all patients managed against national cancer waiting time targets on the Somerset Cancer Register (SCR), using information received from multi-disciplinary sources.

All Cancer Pathway Coordinators have a responsibility to ensure that they comply with the guidance in this operational policy.

Clinicians

Clinicians must agree a 'Consultant Upgrade' within the appropriate site specific multi-disciplinary team meeting if they suspect a diagnosis of cancer in order to effectively upgrade patients to the national 62 day target.

Centre and Operational Management Teams

The Centre and Operational management teams have a responsibility to ensure that adequate capacity is available for all patients added to all waiting lists to enable the Trust to achieve the required local and national cancer standards. The Centre and Operational management teams have a responsibility to ensure that their respective clinical teams have robust processes in place in order to enable cancer patients to be added to the waiting list in a timely and consistent manner.

Administrative Booking Clerks/Receptionists

The Administrative Booking Clerks/Receptionists have a responsibility to ensure that the data entered onto SEMA/SCR accurately reflects the information provided by the GP on referral, in order that patients can be tracked within the relevant national cancer time frame. The Administrative Booking Clerks/Receptionists have a responsibility to ensure that the data entered onto

PAS/SCR accurately reflects the information provided by the clinical teams on the clinic outcome form (COF).

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

All staff (to whom this document applies)

- Have a duty to comply fully with this policy/procedure and are responsible for ensuring they attend all relevant training offered.
- Are responsible for bringing this policy to the attention of any person not complying with it.
- Will ensure any data created, edited, used, or recorded on the Trust's IT systems in their area of responsibility is accurate and recorded in accordance with this policy and other Trust policies relating to collection, storage and use of data to maintain the highest standards of data quality and maintain patient confidentiality.

Training/Competency Requirements

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

All relevant staff will have annual refresher cancer waiting times training.

Cancer Waiting Time Standards

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

Table 1: Key cancer waiting time standards

Service standard	Operational standard
Maximum 2WW from urgent GP referral for suspected cancer to first appointments.	93%
Maximum 2WW from referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment.	93%
Maximum 31 days from decision to treat to first definitive treatment.	96%
Maximum 31 days from decision to treat/earliest clinically appropriate date (ECAD) to start of subsequent treatment(s) where the subsequent treatment is surgery.	94%
Maximum 31 days from decision to treat/ECAD to start of subsequent treatment(s) where the subsequent treatment is drug treatment.	98%

Maximum 31 days from decision to treat/ECAD to start of subsequent treatment(s) where the subsequent treatment is radiotherapy.	94%
Maximum 62 days from urgent GP referral for suspected cancer to first treatment.	85%
Maximum 62 days from urgent referral from an NHS cancer screening programme for suspected cancer to first treatment.	90%
Maximum 62 days from Consultant upgrade of urgency of a referral to first treatment.	85%
Maximum 31 days from urgent GP referral to first treatment for acute leukaemia, testicular cancer and children's cancers.	No separate standard, monitored as part of 62 days from urgent GP referral.

Clock Starts

Two week wait

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

62 day

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

- Urgent two-week wait referral for suspected cancer.
- Urgent two-week wait referral for breast symptoms (where cancer is not suspected).
- A Consultant upgrade.
- Referral from NHS cancer screening programme.
- Non-NHS referral (and subsequent Consultant upgrade).

31 day

A 31 day cancer clock will start following:

- A decision to treat (DTT) for first definitive treatment.
- A DTT for subsequent treatment.
- An ECAD following a first definitive treatment for cancer.

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

Clock Stops

62 day

A 62 day cancer clock will stop following:

- Delivery of first definitive treatment.
- Placing a patient with a confirmed cancer diagnosis onto active monitoring.

Removals from the 62 day pathway (not reported):

- Making a decision not to treat.
- A patient declining all diagnostic tests.
- Confirmation of a non-malignant diagnosis.

31 day

A 31 day cancer clock will stop following:

- Delivery of first definitive treatment.
- Placing a patient with a confirmed cancer diagnosis onto active monitoring.
- Confirmation of a non-malignant diagnosis.

In some cases where a cancer clock stops the 18-week RTT clock will continue, e.g. confirmation of a non-malignant diagnosis. For a more detailed breakdown of the cancer rules please read the latest cancer waiting times guidance or the cancer operational policy.

GP/GDP Suspected Cancer Two Week Wait Referrals

All suspected cancer referrals should be referred by the GP/GDP on the relevant cancer pro forma provided and submitted via e-referral or email using the generic nhs.net email address. Referrals from Powys GPs are not received via the e-Referral service.

Day 0 is the date the referral was received.

The first appointment can be either an outpatient appointment with a Consultant or investigation relevant to the referral, i.e. ‘straight to test’.

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

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

Any 2WW referral received by the Trust for a service that the Trust is not commissioned to deliver will be sent electronically to an appropriate local provider with a

copy for information sent electronically to the referring GP within 24 hours of receipt.

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

Downgrading Referrals from Two Week Wait

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

Two Referrals on the Same Day

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

Screening Pathways

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

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

Consultant Upgrades

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

The 62 day pathway starts (day 0) from the date the patient is upgraded. Upgrade must occur before the DTT date. Patients not upgraded at this point will be measured against the 31 day DTT to first definitive treatment.

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

Who can upgrade patients onto a 62 day pathway
The specialist team receiving the referral or reviewing the patient or diagnostic result can delegate the responsibility to upgrade the patient. This could be:

- Specialist nurse/practitioner, either by triaging the referral form/letter or at nurse led initial clinic.
- Specialist registrar either by triaging the referral form/letter or at initial clinic.
- Radiologist/histologist/other Trust Clinicians on reviewing patients and/or diagnostics.

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

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

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

If a patient requires any further treatment following their first definitive treatment for cancer (including after a

period of active monitoring) they will be monitored against a 31 day subsequent treatment clock. The clock will start following the patient agreeing a treatment plan with their Clinician. This will be the decision to treat (DTT) date.

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

Reasonableness

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

Pauses

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

- 2WW: If a patient DNAs their initial (first) outpatient appointment or attendance at diagnostic appointment, e.g. endoscopy, the clock start date can be reset to the date the patient rebooks their appointment (the date the patient agrees the new appointment not the new appointment date). This

adjustment will be made by either the 2WW booking clerk or the Cancer Performance Manager at validation.

- 62/31 day pathways: If a patient declines admission for an inpatient or day
- Case procedure, providing the offer of admission was ‘reasonable’ the clock can be paused from the date offered to the date the patient is available. This adjustment will be made by the Cancer Performance Manager at validation.

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

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

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

Patient Cancellations

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

First appointment cancellations

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

Subsequent cancellations

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

Multiple cancellations

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

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

Patient DNAs

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

First appointment

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

A waiting-time adjustment applies from receipt of referral to the date the patient makes contact to

rearrange the appointment and all details must be recorded on the cancer management system.

If a patient DNAs their first appointment for a second time they will be discharged back to the referring GP.

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

Patients who are not contactable
If the patient is not contactable at any time on their 62/31 day pathway, a record of the time and date of the call to them in the 'additional information' section on PAS should be made at the time of the call.

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

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

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

If the patient remains not contactable:

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

Patients who are unavailable

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

Diagnostics

The Trust will maintain a 2WW for all diagnostic 'straight to tests' for patients on a cancer pathway and a 14 day turnaround for all subsequent diagnostic tests on a patient's 62/31 day pathway.

Refusal of a diagnostic test

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

Managing the Transfer of Private Patients

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

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

Tertiary Referrals

Inter provider transfer (IPT) forms will be used for all outbound referrals for patients on a cancer pathway. Where possible, information will be transferred between Trusts electronically. Transfers will be completed via a named NHS contact. A minimum dataset and all relevant diagnostic test results and images will be provided when the patient is referred.

Entering Patients on the Tracking Pathway

Suspected cancers: 2WW GP/GDP referrals

On receipt of a 2WW referral from a GP/general dental practitioner, the 2WW office will record the referral (including known adjustments, referring symptoms and first appointment) onto the cancer management system within 24 working hours of receiving the referral. The 2WW booking team are responsible for confirming a patient's attendance at the first appointment and recording the outcome, checking all dates are correct and that DNAs/breach reasons are entered correctly prior to validation by the Cancer Performance Manager.

Suspected cancers: screening patients

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

Suspected cancers: Consultant upgrades

For upgrade before initial appointments the 2WW office will be responsible for entering patient details onto the cancer management system database and allocating the patient an appointment within the 2WW guidelines. For upgrades at any other point of the pathway the MDT co-ordinator will be responsible for updating the cancer management system and will begin tracking of the pathway.

Suspected/confirmed cancers (31 day patients)
Patients not referred via a 2WW/screening/Consultant upgrade referral should not be entered onto the cancer management system until they have a confirmed cancer diagnosis. The only exception is patients with suspected cancer who are being discussed at an MDT meeting.
Once a patient has been diagnosed with either a new cancer or recurrence, a record should be entered in the cancer management system, selecting the appropriate cancer status (by the Cancer Pathway co-ordinator) within 24 hours of being notified.

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

Monitoring and Auditing

It is the responsibility of the cancer information team to run a weekly programme of audits for data completeness and data anomalies. This is managed by the Cancer Performance Analyst on behalf of the Cancer Performance Manager.

Any data anomalies are highlighted to the relevant tumour site Cancer Pathway co-ordinator for investigations and correction. Response to the cancer

information team must occur within 24 working hours of the anomaly being raised in order not to delay the audit programme and to ensure accurate performance available at all times.

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

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

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

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

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4. Reference Information

Glossary Terms

Term	Definition
2WW	Two-week wait: the maximum waiting time for a patients first outpatient appointment or ‘straight to test’ appointment if they are referred as a 62 day pathway patient.
31 day pathway	The starting point for 31 day standard is the date a patient agrees a plan for their treatment or the date that an earliest clinically appropriate date (ECAD) is effected for subsequent treatments.
62 day pathway	Any patient referred by a GP with a suspected cancer on a 2WW referral pro-forma, referral from a screening service, a referral from any healthcare professional if for breast symptoms or where a routine referral has been upgraded by a hospital Clinician, must begin treatment within 62 days from receipt of referral.

Active monitoring	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures.
Active waiting list	The list of elective patients who are fit, ready and able to be seen or treated at that point in time. Applicable to any stage of the RTT pathway where patients are waiting for hospital resource reasons.
Bilateral procedures	Where a procedure is required on both the right and left sides of the body.
Breach	A pathway which ends when a patient is seen/receives their first treatment outside the 14-day first seen, 62 day referral to treatment and/or 31 day decision to treat to treatment target times.
Chronological booking	Refers to the process of booking patients for appointments, diagnostic procedures and admission in date order of their clock start date.
Consultant led service	A service where a Consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse led clinics which are under the umbrella of Consultant led services.

Day case	Patients who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.
Decision to admit	Where a clinical decision is made to admit the patient for either day case or inpatient treatment.
Direct access	Where GPs refer patients to hospital for diagnostic tests only. These patients will not be on an open RTT pathway.
Elective care	Any pre-scheduled care which doesn't come under the scope of emergency care.
First definitive treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgement in consultation with the patient.
Fixed appointments	Where an appointment or admission date is sent in the post to the patient without the opportunity to agree a date.

Full booking	Where an appointment or admission date is agreed either with the patient at the time of the decision or within 24 hours of the decision.
Incomplete pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage.
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night
Nullified	Where the RTT clock is discounted from any reporting of RTT performance.
Oncology	The branch of science that deals with tumours and cancers.
Partial booking	Where an appointment or admission date is agreed with the patient near to the time it is due.
Patient-initiated delay	Where the patient cancels, declines offers or does not attend appointments or admission. This in itself does not the stop the RTT clock. A clinical review must always take place.

Planned waiting list	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18-week RTT pathway.
Reasonable offers	A choice of two appointment or admission dates with three weeks' notice.
Straight to test	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an RTT pathway.

Acronyms

Term	Definition
ASIs	Appointment slot issues (list): a list of patients who have attempted to book their appointment through the national E-Referral Service but have been unable to due to lack of clinic slots.
Cancer Management System	A database system used to record all information related to patient cancer pathway by MDT co-ordinators, CNSs and Clinicians.
Cancer Pathway co-ordinator	Person responsible 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. Co-ordinates the MDT meeting and records the decision for progress along the cancer pathway.
Cancer PTL	Patient tracking list: a complex spread sheet 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.

CCGs	Clinical commissioning groups: commission local services and acute care.
CNS	Clinical nurse specialists: use their knowledge of cancer and treatment to co-ordinate the patients care plan and act as the patients 'keyworker'.
COF	Clinic outcome form.
COSD	Cancer outcomes and services dataset: the key dataset designed to define and deliver consistency in data recording, data submission and analysis across cancer in the NHS, including diagnostics, staging, treatment and demographic information. Data is submitted to the cancer registry and used for national reporting.
DNA	Did not attend: patients who give no prior notice of their non- attendance.
DTT	Decision to treat (date): the date on which the Clinician communicates the treatment options to the patient and the patient agrees to a treatment.
ECAD	Earliest clinically appropriate date that it is clinically appropriate for an activity to take place. ECAD is only applicable to subsequent treatments.

e-RS	(National) e-Referral Service.
GDP	General dental practitioner (GDP): typically leads a team of dental care professionals (DCPs) and treats a wide range of patients, from children to the elderly.
GP	General practitioner: a physician whose practice consists of providing on-going care covering a variety of medical problems in patients of all ages, often including referral to appropriate specialists.
IOG	Improving outcomes guidance: NICE guidance on the configuration of cancer services.
IPT	Inter-provider transfer.
MDT meeting	A multidisciplinary team meeting where individual patients care plans are discussed and agreed.
MDS	Minimum dataset: minimum information required to be able to process a referral 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.

NCWTDB	National cancer waiting time's database**:** all cancer waiting times general standards are monitored through this.
PAS	Patient administration system records the patients demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient.
PPID	Patient pathway identifier.
PTL	Patient tracking list. A tool used for monitoring, scheduling and reporting on patients on elective pathways (covering both RTT and cancer).
RACPC	Rapid access chest pain clinic.
RCA	Root cause analysis: defines steps on a patient's pathway and identifies breach reasons. In the context of this policy, this is not the same as the level of investigation involved in an RCA for, for example, a Serious Incident (SI).
RMC	Referral management centre.
RTT	Referral to treatment.
SMDT	Specialist multidisciplinary team meeting: where individual patients' care plans are discussed; takes place across multiple organisations and involves support from a centre specialising in treating a particular tumour type.

TCI	To come in (date). The date of admission for an elective surgical procedure or operation.
TIA	Transient ischaemic attack: a mini stroke caused by a temporary disruption in the blood supply to part of the brain.
TSSG	Tumour site specific group.
UBRN	Unique booking reference number.

Links to Recommended Further Reading

Click on the title of the publication to view the document.

Title	Published by	Publish date
Referral to treatment Consultant led waiting times Rules Suite.	Department of Health	Oct 2015
Recording and reporting referral to treatment (RTT) waiting times for Consultant led elective care.	NHS England	Oct 2015
Recording and reporting referral to treatment (RTT) waiting times for Consultant led elective care: frequently asked questions.	NHS England	Oct 2015
The NHS Constitution.	Department of Health	Jul 2015
Diagnostics waiting times and activity Guidance on completing the 'diagnostic waiting times & activity' monthly data collection.	NHS England	Mar 2015

Diagnostics FAQs Frequently Asked Questions on completing the 'Diagnostic Waiting Times and Activity' monthly data collection.	NHS England	Feb 2015
Equality Act 2010.	Department of Health	Jun 2015
Overseas Visitor Guidance.	Department of Health	Apr 2016
Cancer waiting times.	Department of Health	Oct 2015
Delivering cancer waiting times good practice guide.	NHS Improvement	Jul 2016
Armed Forces Covenant.	Ministry of Defence	Jul 2015
Value Based Commissioning Policies.	Shropshire CCG	Jul 2019

Shrewsbury and Telford Hospital Contact Information

The Patient Access Manager is SaTH's designated lead in respect of the review and revision of this policy on at least an annual basis in collaboration with the CCG designated leads.

The Patient Access Team provides SaTH's central point of expertise, advice, training and support in respect of referral to treatment rules, standards and processes.

The Central Booking Office is responsible for booking outpatient appointments and the scheduling of both day case and inpatient admissions.

Centre Manager for Patient Access and Outpatient Nursing Support
is based at The Princess Royal Hospital
01952 641222 ext. 5736

Patient Access Manager
is based at The Princess Royal Hospital
01952 641222 ext. 5653

PA for Patient Access
is based at The Princess Royal Hospital
01952 641222 ext. 5730

Scheduling Services Manager
is based at The Royal Shrewsbury Hospital
01743 261000 ext. 1045

Booking Support Services Manager
is based at The Royal Shrewsbury Hospital
01743 261000 ext. 1412

Central Booking Office
01952 282810 or 01743 261044
Monday to Friday 8.00am until 8.00pm and Saturday 9.00am until 12.00pm.

Cancer Performance Manager
is based at The Royal Shrewsbury Hospital
01743 261000 ext. 3447

For more information about attending our hospitals and the services we offer, please visit our website at www.sath.nhs.uk/patients-visitors or scan the QR code.