Royal United Hospitals Bath
NHS Foundation Trust

Elective Patient Access Policy

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Related Policies and Guidelines	• Bed Management Policy • Escalation Policy

Contents

Amendment History

Issue	Status	Date	Reason for Change	Authorised
10	Approved	11 Nov 2009	Planned Review	Operational Governance Committee
11	Approved	May 2013	Planned review and name change from “Effective Management of Waiting Lists” to Elective Patient Access” policy	Operational Governance Committee
12	Approved	Dec 2016	Planned 3 year review	Francesca Thompson – Chief Operating Officer
13	Approved	March 18	Planned review	Francesca Thompson – Chief Operating Officer

1. Policy Introduction

This Trust is committed to delivering high quality and timely elective care to patients. This policy is based on the NHSI Elective Care Model Access Policy August 2017:

- Sets out the rules and principles under with the Trust manages elective access to outpatient appointments, diagnostic tests and elective inpatient or day case treatment.
- Gives staff clear direction on the application of the NHS constitution in relation to elective waiting times.
- Demonstrates how elective access rules should be applied consistently, fairly and equitably.

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

The access policy should be read in full by all staff involved in the elective care booking process including clinical and non-clinical staff, once they have successfully completed the relevant local induction training. It should not be used in isolation as a training tool.

The access policy is underpinned by a comprehensive suite of detailed standard operating procedures (SOPs). All clinical and non-clinical staff must ensure they comply with both the principles within this policy and the specific instructions within SOPs.

This policy reflects the requirement to comply with:

- The NHS Constitution
- The Referral to Treatment Target (RTT)
- The national Cancer waiting time standards
- Current outpatient, inpatient and diagnostic waiting time standards
- Acute Trust Performance Framework
- NHS Improvement – Referral to Treatment systems and processes - best practice

This policy applies to all individuals in the employment of the Royal United Hospitals Bath NHS Foundation Trust ("the Trust").

A patient friendly guide to the NHS Constitution is detailed on NHS Choices via this link:

http://www.nhs.uk/choiceintheNHS/Rightsandpledges/Waitingtimes/Pages/Guide%20to%20waiting%20times.aspx

Training guides and Standard Operating Procedures by role and/or specific department are found on the RUH Intranet A-Z under Outpatient Guide.

1.2 Purpose

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

The policy:

- Is designed to ensure the management of elective patient access to services is transparent, fair, equitable and managed according to clinical priorities.
- Sets out the principles and rules for managing patients through their elective care pathways
- Applies to all clinical and administrative staff and services relating to elective patient access at the Trust.

1.3 Roles and responsibilities

Although responsibility for achieving standards lies with the divisional managers and ultimately the Trust board, all staff with access to and a duty to maintain elective care information systems are accountable for their accurate upkeep. Examples as follows:

Chief Executive: The chief executive has overall responsibility and accountability for delivering access standards as defined in the NHS Constitution and Operating Framework.

Chief Operating Officer: Responsible for ensuring that there are robust systems in place for the audit and management of RTT, DMO1 and cancer access standards against the criteria set out in this policy and procedure document.

Divisional managers: Accountable for implementing, monitoring and ensuring compliance with the policy within their divisions.

Business Intelligence Unit: Responsible for the timely production of patient tracking lists (PTLs) which support the divisions in managing waiting lists and RTT standards.

Waiting list administrators: including clinic staff, secretaries and booking clerks: Responsible to Specialty managers/Divisional managers for compliance with all aspects of the Trust's elective access policy.

Waiting list administrators for outpatients, diagnostics and elective inpatient or daycase services: Responsible for the day to day management of their lists are supported in this function by their managers, specialty managers, and divisional managers who are responsible for achieving access standards.

Specialty managers and divisional managers: Responsible for ensuring the data is accurate and services are compliant with the policy.

Outpatient booking manager and specialty managers: Responsible for ensuring the NHS e-referral service directory of services (DOS) is accurate and up to date.

Business Intelligence Unit: Responsible for producing and maintaining regular reports to enable divisions to accurately manage elective pathways and ensure compliance with this policy.

General Practitioners (GPs) other Health Care Professionals and Referral Management Services: 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.

The CCGs: Responsible for ensuring there are robust communication links for feeding back information to GPs. GPs should ensure quality referrals are submitted to the appropriate provider first time via E-Referral Service.

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.

Competency

- As a key part of their local induction programme, all new starters to the trust will undergo essential training in elective care/RTT applicable to their role.

- All existing staff will undergo essential training in elective care/RTT on at least an annual basis, via e-learning package* or face to face training and updates will be communicated through Admin Handbook.
- All staff will carry out RTT competency tests on-line that are clearly documented to provide evidence that they have the required level of knowledge and ability.
- This policy, along with the supporting suite of SOPs, will form the basis of elective care/RTT training.

Compliance

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

* being developed – available Q4 2017/18

1.4 General elective access principles

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

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

1.5 Individual patient rights

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

- Choice of hospital and consultant
- 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.

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The Trust is obligated to provide RTT treatment within 18 weeks for 92% of all patients. There are certain exceptions where patients choose to wait longer however the RTT clock continues. Examples as below:

- If the patient chooses to wait longer.
- If delaying the start of treatment is in the best clinical interests of the patient

All patients are to be treated fairly and equitably in line with the protected characteristics detailed in the Equality Act 2010.

1.6 Patient eligibility

All trusts have an obligation to identify patients who are not eligible for free NHS treatment and specifically to assess liability for charges in accordance with Department of Health guidance/rules.

The Trust will check every patient's eligibility for treatment. Therefore at the first point of entry, patients will be asked questions that will help the trust assess "ordinarily resident status". Some visitors from abroad, who are not ordinarily resident, may receive free healthcare, including those who:

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

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

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

1.7 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. Where it has been agreed, for example, that a

surgical procedure is necessary the patient can be added direct to the elective waiting list if clinically appropriate. The RTT clock starts from the date the GP or original referrer's letter arrives in the hospital.

Where patients are seen privately but then transfer to the NHS, if they are transferring onto an 18 week RTT pathway, the clock would start at the point at which clinical responsibility for the patient's care transfers to the NHS.

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

1.8 Individual Funding Requests (IFR)

Individual Funding Requests apply to low priority treatments that are considered on an individual patient basis or that meet a set of clinical criteria set by the CCGs. This may differ from one CCG to another. Robust protocols and management is required to ensure that procedures are not undertaken without prior approval or adherence to clinical criteria as funding for that procedure can be withheld and that patients do not experience an unnecessary delay.

A comprehensive list of IFR procedures can be found on the relevant CCGs websites.

Procedures not normally funded

There are a number of procedures which require specific approval from CCGs before the Trust can proceed with treatment. In these instances, approval must be obtained from the CCG by the consultant or the specialty's management team before the patient can be listed for treatment. Procedure or treatments which are not normally funded fall into two categories.

- Prior approval procedures – requires Commissioner approval
- Exceptional funding – requires Commissioner approval

Identification at receipt of referral before appointment

When a procedure or treatment that needs prior approval is identified from the referral, the patient will be returned to the care of the referrer, requesting that the patient is re-referred once prior approval has been received. The letter to the referrer will be copied to the patient to inform of the need to request prior approval. The patient will be removed from the outpatient waiting list.

Identification at outpatient appointment

If it is not clear from the initial referral that the patient will require treatment or a procedure not normally funded then the patient may be seen in outpatients. If it is identified at the outpatient appointment that prior approval is required the consultant will inform the patient at the outpatient consultation stage that this is the case.

The request for funding should come from a healthcare professional directly involved in the care of the patient, usually from a consultant level clinician who will be delivering the proposed treatment (NHS England guidance).

Criteria Based Treatment

Some procedures are funded by CCGs when the patient meets certain clinical criteria. If a clinician wishes to proceed with treatment and the treatment falls into this category then the clinician must identify in the patient notes or the patient letter that they meet the criteria specified in the relevant CCGs policy. If the patient does not meet the criteria then treatment may not be given. In the latter case the patient will be removed from the waiting list.

Robust protocols and management is required to fully document the patient's clinical condition against the criteria; this will support CCGs audit of the Trust's compliance.

Exceptional funding

Exceptional funding applies to procedures that are not currently commissioned by CCGs. Funding will not be supported by the Exceptions Committee unless there is unequivocal evidence that the case is exceptional, and that the proposed intervention will be of significant clinical benefit. The commissioning of these procedures is subject to review, in the event of new research evidence and NICE guidance.

Examples of procedures that may be considered exceptional include: non-cancer related breast surgery, pinnaplasty, complementary therapies and use of botox.

1.9 Non-Contracted Activity

From 1st October 2017 the trust will no longer provide non-specialist elective procedures and planned care to patients registered with a Welsh GP. This is even where funding approval has been agreed. There are two exclusions to this:

- Specialist services – Pulmonary hypertension and Tuberous Sclerosis.

- Powys Health Board – these patients will be accepted with evidence of payment before the referral can be processed. The clock will start when this confirmation is received.

When a referral is received for a patient residing in Scotland or Northern Ireland, prior approval to treat is required before the referral can be processed. The clock will start when prior approval is received.

The Trust is not contracted to treat patients on the NHS who are from overseas, including those from the Isle of Man and Channel Islands.

1.10 Military veterans

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

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

1.11 Prisoners

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

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

1.12 Accessible Information Standard

The new Accessible Information Standard was agreed on 24th June 2015.
All organisations that provide NHS or adult social care must follow the Accessible Information Standard by law. Organisations must follow the Standard in full by 31st July 2016.

As part of the Accessible Information Standard, organisations that provide NHS or adult social care must do five things. They must:

1. Ask people if they have any information or communication needs, and find out how to meet their needs.
2. Record those needs in a set way in the electronic patient record on Millennium.
3. Highlight a person's file, so it is clear that they have information or communication needs, and clearly explain how those needs should be met.
4. Share information about a person's needs with other NHS and adult social care providers, when they have consent or permission to do so.
5. Make sure that people get information in an accessible way and communication support if they need it.

In order to capture this information the Outpatient Outcome form is completed following the initial clinician outpatient conversation – the "need" is then recorded Millennium using a SNOMED term.

1.13 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.

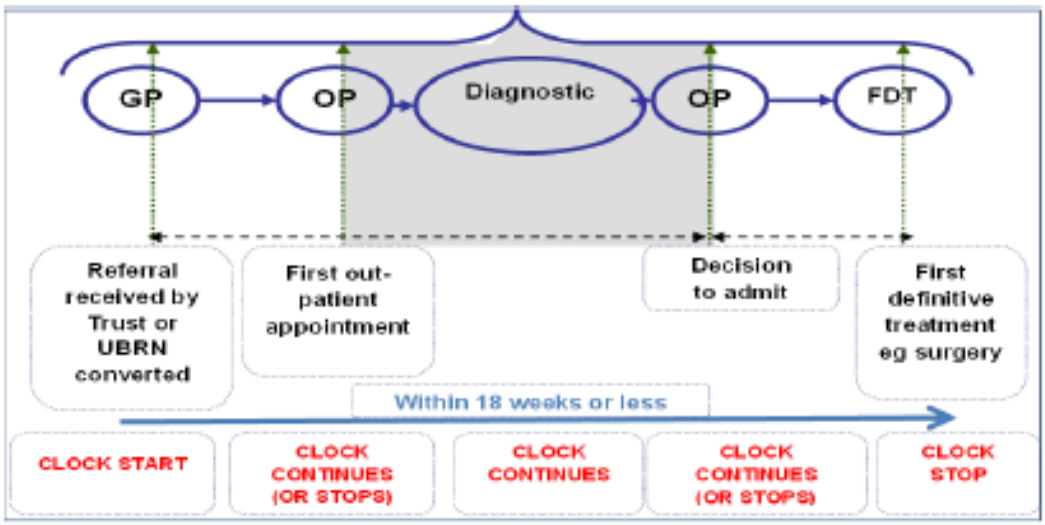
Key standards for implementation include the following:

- 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 24 hours)

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

1.14 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. This is the responsibility of the management team within the clinical specialty to agree the individual milestones and will vary by procedure and specialty.



Key

OP – outpatients
FDT – first definitive treatment

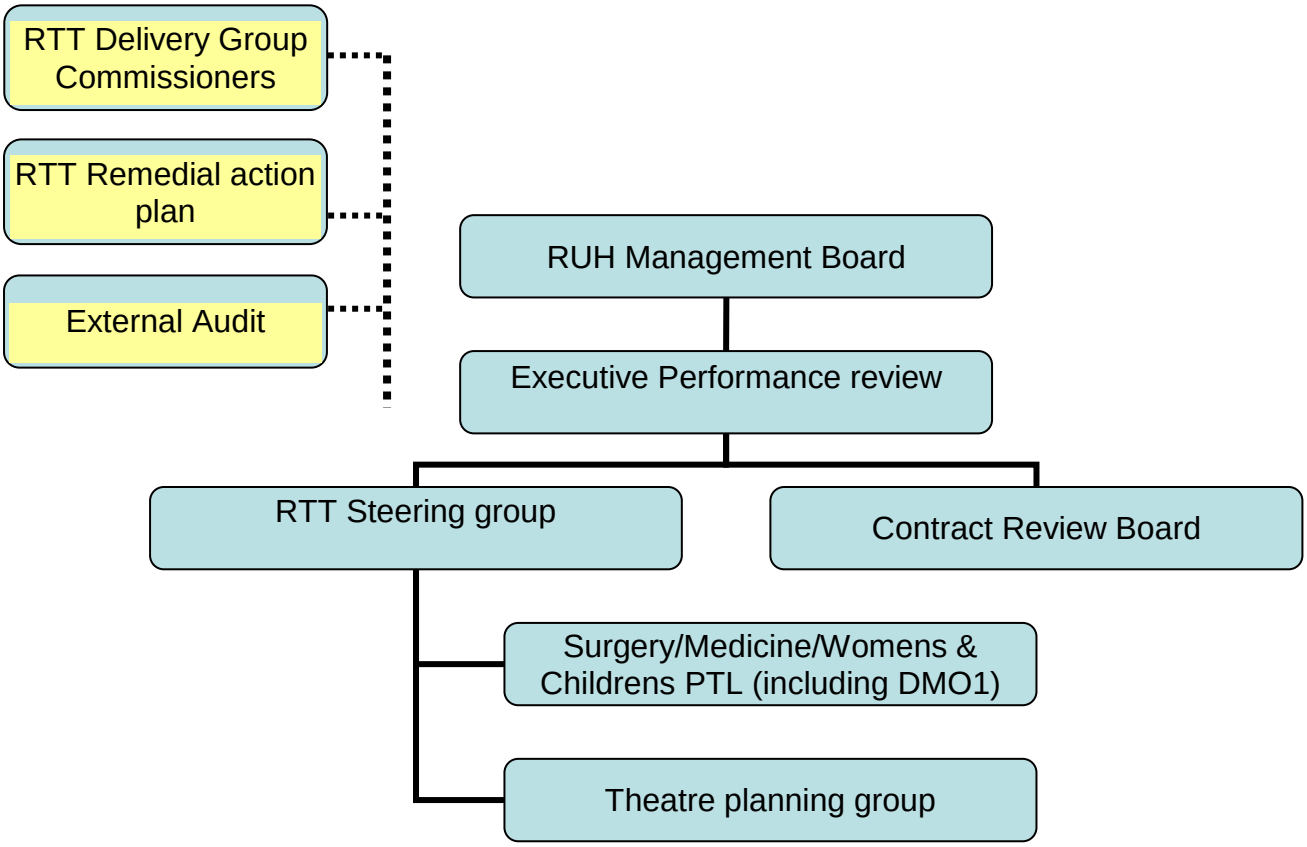
1.15 Monitoring

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

Regular daily and weekly monitoring will be undertaken to ensure adherence to this policy. Information will be collated and provided by the Business Intelligence Unit through PPM and Business objects reports. Monitoring information will be provided at a specialty or consultant level as appropriate.
Key decisions are undertaken via weekly Divisional PTL, escalated to RTT Steering Group via divisional leads.

Reporting structure is shown below.

1.16 Governance – PTL



Daily Monitoring

Daily monitoring reports are provided electronically to all relevant managers and teams.

Weekly PTL meetings

The weekly meetings will focus on areas of concern that relate to the following areas of RTT/18 weeks. All attendees are expected to highlight any concerns for the specialty areas that they represent in relation to:

- Outpatient PTL
- Inpatient PTL
- In month breach position
- Patient cancellations and 28 day rebooking position
- IFR patients
- RTT performance/forecast for month (updated)
- Diagnostics (6 week pathway)
- Elective admissions and outpatient department concerns.

Monthly monitoring

Monthly monitoring is undertaken via the RTT Steering Group escalating to Executive Performance review where this is indicated.

Exclusions from reporting

The Trust Business Intelligence Unit will maintain documentation of the logic and processes for deriving data from the Trust's patient administration system (Millennium) into the RTT waiting list, including exclusions applied to the data. Exclusions are applied in line with national rules and updating of exclusions is undertaken by the Business Intelligence Unit in agreement with the RTT Steering Group.

1.17 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 choice of dates. A reasonable offer is defined as a choice of two dates with at least three weeks' notice.

1.18 Chronological booking

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

1.19 Communication

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

GPs or the relevant referrer must be kept informed of the patient's progress in writing, which is provided electronically within the agreed contract timeline. When clinical responsibility is being transferred back to the GP/referrer, e.g. when treatment is complete, this must be made clear in any communication.

1.20 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 (0r 128 days)
Diagnostics	
Applicable to diagnostic tests	99% of patients to undergo the relevant diagnostic investigation within 5 weeks and 6 days (or 41 days) from the 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 4.

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

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

2. Overview of national referral to treatment rules

2.1 Clock starts

The RTT clock starts when any healthcare professional (or service permitted by an English NHS commissioner to make such referrals) refers to a consultant-led service. The RTT clock start date is the date the trust receives the referral. For

referrals received through NHS e-Referral, the RTT clock starts the day the patient converts their unique booking reference number (UBRN).

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.

2.2 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/surveillance patients
- Referrals to a non-consultant led service
- Referrals for patients from non-English commissioners (excludes Welsh patients – see Section 1.19)
- Genitourinary medicine (GUM) services
- Emergency pathway non-elective admission follow up appointment.

2.3 New clock starts for the same condition

Following active monitoring

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

Following a decision to start a substantively new treatment plan

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

For second side of a bilateral procedure

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

For a rebooked new outpatient appointment

See first appointment DNAs on

2.4 Planned patients

All patients added to the planned list will be given an indicative time frame by when their planned procedure/test should take place The detailed process for management of planned patients is described in the relevant standard operating procedures.

Monitoring

Monitoring of the planned list is undertaken on a weekly basis. A patient level report is provided to Specialty Managers which includes existing planned patients and all new additions over the preceding seven days; this information is validated and returned to the RTT team where correction is required.

Planned Treatments

Planned treatments include:

- Surveillance or check procedures i.e. endoscopies or cystoscopies
- Removal or screws or metalwork
- Age or growth related surgery
- Investigations or treatments that must be given in sequence
- Sequence of events that are time specific.

2.5 Clock stops for first definitive treatment

An RTT clock stops when:

- First definitive treatment starts. This could be:
  - Treatment provided by an interface service
  - Treatment provided by a consultant-led service
  - Therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant–led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions.

- A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

2.6 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.

2.7 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.

2.8 Patient initiated delays

A key component for referrals is the requirement that patients are fit, willing and able to attend appointments/procedures scheduled along their 18 week pathway. These discussions should commence prior to any referral being made. In line with national guidance, there is no contractual guidance that guides the acute provider. However, commissioners may have clinical policies which support access criteria. Where possible, such policies will be aligned.

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

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

First appointment DNAs

All patient DNAs are reviewed by Clinicians to assess the need to offer a further appointment. If the clinician indicates another first appointment should be offered, a new RTT clock will start on the day the new appointment is agreed with the patient.

Where this is not indicated the RTT clock is stopped and nullified. (as long as the Trust can demonstrate the appointment was booked in line with reasonableness criteria). The referrer and patient will be advised in writing.

Follow up appointment DNAs

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

Cancelling declining or delaying appointments and admission offers

However 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. Where necessary clinicians will review every patient's case individually to determine whether:

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

fundamentally change during the period of delay) on the patient's treatment plan – apply active monitoring (clock stops).

The general principle of acting in the patient's best clinical interest at all times is paramount. It is generally not in a patient's best interest to be left on a waiting list for an extended period, and so where long delays (i.e. of many months) are requested by patients a clinical review should be carried out, and preferably the treating clinician should speak with the patient and GP 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 this is deemed clinically appropriate.

2.9 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, UTI) the RTT clock continues.

Longer 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:

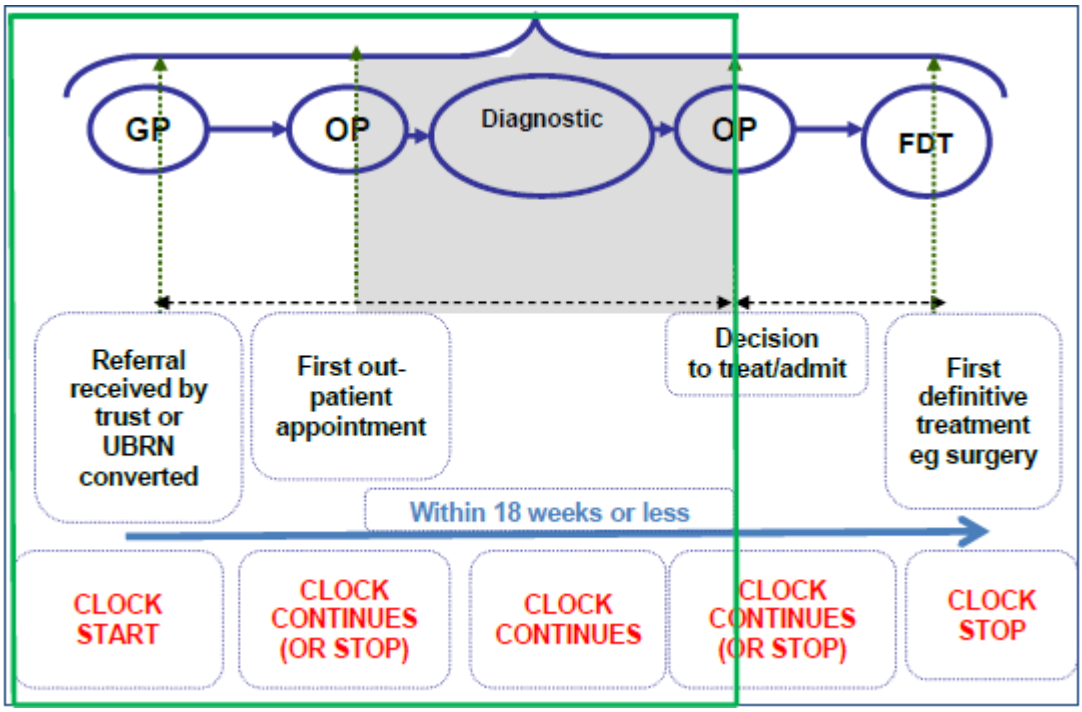
- If it is clinically appropriate for the patient to be removed from the waiting list (This will be a clock stop event via the application of active monitoring)

- 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).

3. Pathway specific principles referral to treatment and diagnostic pathways.

3.1 Non-admitted pathways

The non-admitted stages of the patient pathway comprise both outpatients and the diagnostic stages. 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.



Key

OP – outpatients
FDT – first definitive treatment

3.2 Receipt of GP referrals

The STP have agreed a paper switch off plan throughout 2017/18 which supports the contractual arrangements from October 2018 whereby Trusts can only accept referrals via the national e-Referral Service (e-RS). There will be a number of referrals that are excluded from this arrangement including GDP and NHS England commissioned services.

The e-RS Paper Switch-off Programme has been developed to support Trusts and CCGs to move to full use of e-RS for all consultant-led first outpatient appointments. The programme will help Trusts meet the conditions of the NHS Standard Contract where, from 1 October 2018, providers:

"need not accept (and will not be paid for any Activity resulting from) Referrals by GPs to Consultant-led acute outpatient Services made other than through the NHS e-Referral Service."

Where routine paper-based referrals are received these will be returned to the referring GP.

The Clinical services will ensure that the e-RS Directory of Services are maintained including links to clinical criteria referral templates. Where clinically appropriate, referrals will be made to a service rather than a name 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 interest of patients as pooling referrals promotes equity of waiting times and allows greater flexibility in booking appointments.

3.3 Methods of receipt

NHS e-referrals (e-RS)

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

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

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

Paper-based referrals (phasing out from January 2018)

All routine and urgent pooled and consultant-specific referral letters should be sent to the trust's centralised booking office. This will be replaced by electronic referral outside of e-RS in the following specialties:

Oral and Maxillo-facial Surgery (General Dental Practitioner referrals)
Specific outpatient diagnostics – see Standard Operating Procedure.

2.2 Referral types

TIA Clinics

Direct referral from Ambulatory care/A&E.

Emergency Surgery Ambulatory Care (ESAC) (outside e-RS (same day treatment)

Patients presenting with surgical conditions that do not require immediate surgery are identified via the emergency department or by GP referral to the

ESAC clinic. Following this, patients who require non-immediate surgical procedures are recorded as elective patients, and as such are on an 18 week pathway.

The RTT clock starts at the day the patient is referred to, or presents at, the ESAC clinic. The RTT rules are then applied in the same way as if the patient were to attend a routine outpatient appointment, whether going on to have admitted or non-admitted treatment, active monitoring in clinic, or added to the routine waiting list.

This outpatient will be recorded as outpatient activity, non-elective in Millennium.

Rapid Access Chest Pain Clinic (RACPC) referrals

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

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

Consultant to consultant referrals

The Consultant to Consultant & Other Non-GP Referrals policy (12 November 2010) outlines the consultant to consultant referral protocol, agreed between BANES CCG, Wiltshire CCG and the Royal United Hospital. The policy applies to referrals made between consultants providing NHS care in the private and NHS settings and to referrals between consultants providing private and NHS care. It is based on a set of underlying principles which aim to:

- Minimise delays in clinical urgent cases;
- Minimise clinical risk;
- Minimise patient inconvenience; and
- Ensure responsibility and accountability for referrals rests with GP commissioners.

Consultant to Consultant referrals directly to colleagues within the Trust should be undertaken for clinically urgent cases and for those for which the referral is directly linked to the original presenting condition.

Internal referrals – making every contact count

Where a consultant considers that a patient has a non-immediate need for treatment, and which is directly related to the condition which was the subject of the patient's original referral, the patient and the original referrer, must be

notified and the treatment must be provided, this includes onward referral to and treatment by another professional within the Trust.

Consultant to consultant referrals directly to colleagues within or outside of the Trust (Tertiary centre) must offer patient choice of clinician/provider. Such referrals are permitted when:

- Circumstances are clinically urgent, i.e. suspected cancer or likely to lead to emergency admission within 28 days.
- Tertiary referrals apply to procedures not carried out within the RUH NHS Foundation Trust.
- Consultant to consultant referrals must be triaged and action authorised by an appropriate consultant and the GP notified. The patient should not be put at any advantage or disadvantage in relation to the care they receive. Consultant to consultant referrals are entitled to care on exactly the same basis of clinical need as any other patient, that is to be treated in chronological order.

Referral Management Centre

A referral to a Referral Management Centre starts an 18 week RTT clock from the day the referral is received in the Referral Management Centre. If the patient is referred on to the trust having not received any treatment in the service, the trust inherits the 18 week RTT wait for the patient.

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

Inter-provider transfers (IPTs)

Incoming Inter-provider transfers

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

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

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

Outgoing Inter- provider transfers

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

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

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

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

2.3 Booking new outpatient appointments

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 patient's RTT clock will continue to tick from the original date when they converted their UBRN.

Paper based referrals (being phased out by October 2018)

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

A “partial booking” letter will be generated from PAS, asking patients to make contact by day seven of their RTT pathway.

Should the patient not make contact, the demographic details should be confirmed with the GP. Three attempts will then be made to contact the patient.

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 specialty manager.

Any appointment offers declined by patients should be recorded on Millennium. 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 – hospital or patient initiated.

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

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

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

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

Patients on an open pathway

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

Patients already treated or with a decision not to treat

- New clock start if a decision is made regarding a new treatment plan
- New clock start if the patient is fit and ready for the second side of a bilateral procedure
- No RTT clock if the patient is to be reviewed following first definitive treatment.
- No RTT clock if the patient is to continue under active monitoring
- Accurate and timely recording of these RTT statuses at the end of the clinic and therefore critical to supporting the accurate reporting of RTT performance.

2.5 Booking follow-up appointments

Patient Initiated Follow ups (PIFU)

PIFU appointments are offered to patients where this is clinically appropriate, this is assessed by the clinician on an individual patient basis. There is an ambition that going forward PIFU pathways will be agreed across a range of procedure types where this is clinically appropriate.

Patients on an open pathway

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

Follow up appointments should be agreed with the patient prior to leaving the clinic if the appointment is within 6 weeks. For appointments more than six weeks in advance the appointments will not be booked and will be added to the To Be Scheduled list.
Where insufficient capacity is available to book appointments within the requested time frame this will be escalated to the Specialty Manager/Clinical lead.

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 To be Scheduled list (TBS). Prior to leaving clinic the process should be clearly explained to the patient:

- They will be added to the TBS list
- Nearer to the time that their follow up appointment is due they will be sent an appointment letter.

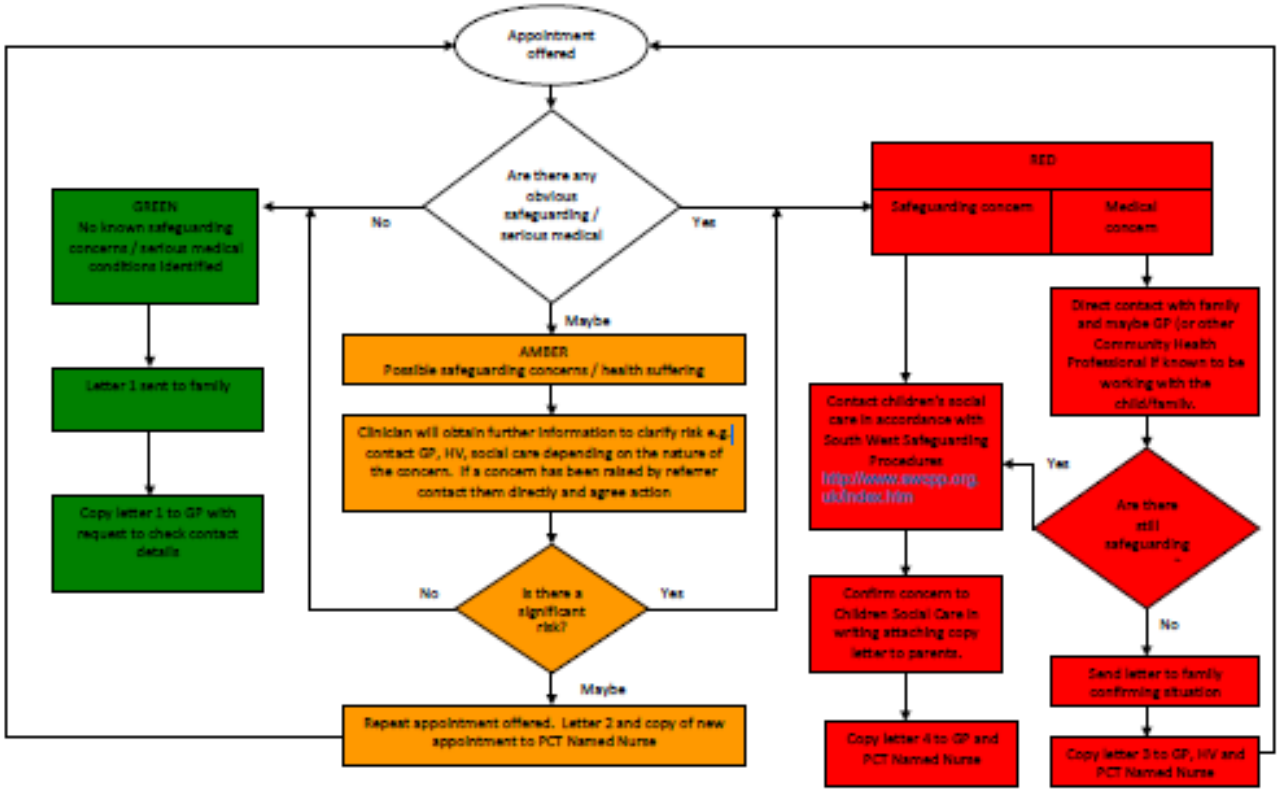
Did not attends

All did not attends (DNAs) (new and follow up) will be reviewed by the clinician at (see Section 2.8 for the application of RTT rules regarding DNAs).

Under safeguarding vulnerable adults who require additional support to ensure they are protected from harm, should be discussed with primary care to agree action that is in the best interest of the patient.

Children who fail to attend appointments require additional consideration with regard to safeguarding – the diagram below provides guidance.

DNA Algorithm – Children:



2.6 Appointment changes and cancellations initiated by the patient

If the patient gives any prior notice that they cannot attend their appointment (even if this is on the day of clinic) this should be recorded as a cancellation and not 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 specialty management team. Contact with the patient must be made within two working days to agree an alternative date.

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

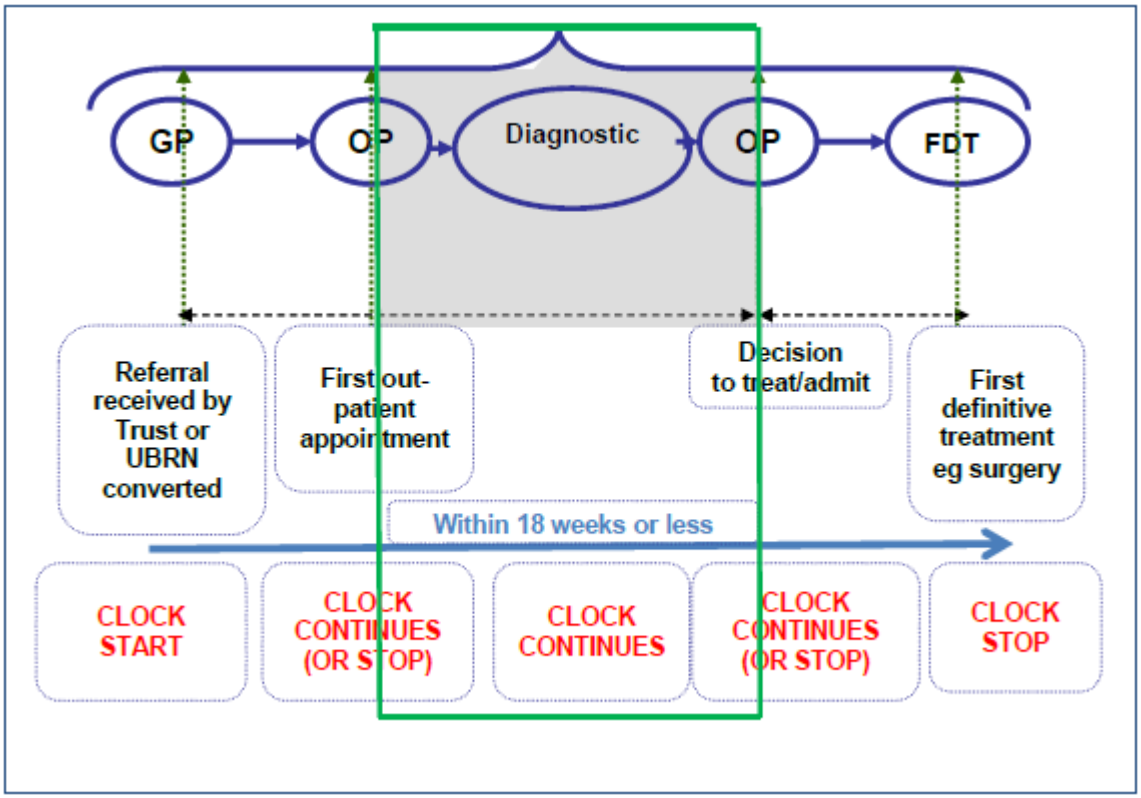
If as a result of the patient cancelling, a delay is incurred which is equal to or greater than a clinically unsafe period of delay (as indicated in advance by consultants for each specialty) the patient's pathway should be reviewed by their consultant. Upon clinical review the patient's consultant should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

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

2.7 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 the patients.
- Clinicians are actively encouraged to book annual leave and study leave as early as possible. Clinicians must provide a minimum of 6 weeks' notice of any leave that will have an impact on patient care.
- Patients will be contacted immediately if the need for the cancellation is identified and offered an alternative date/dates 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.

2.8 Diagnostics



The diagnostic stage of the RTT pathway 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/reports from the diagnostic procedure being available to the requester.

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

2.9 Patients with a diagnostic and RTT clock

The diagnostic 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).

2.10 Straight to test arrangements

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

2.11 Patients with a diagnostic clock only

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

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

Examples include:

Gastroenterology
Radiology tests
Cardiology tests
Vascular studies – DVT
Audiology Assessments
Non-obstetric Ultrasound

2.12 National 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.

2.13 Booking diagnostic appointments

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

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

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

Where a patient has cancelled, declined and/or attended their diagnostic appointment and a clinic 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. This decision should be communicated to the patient and GP in writing.**

2.15 Active diagnostic waiting list

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

2.16 Planned diagnostic appointments

Patients who require a diagnostic test to be carried out at a specific point in time for clinical reasons are exempt from the diagnostic clock rules and will be held on a planned waiting list with a clinically determined due date identified.

2.17 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. Examples include angiogram, ultrasound guided injections etc.

2.18 Pre-operative assessment (POA)

All patients with a decision to admit (DTA) requiring will attend a POA clinic – in some cases this can be done on the same day as their clinic appointment utilising the “Drop-in clinic).

However most patients will be contacted by the Elective Booking team to arrange their POA clinic appointment.

Patients who DNA their POA appointment will be contacted and a further appointment agreed. If they DNA again they will be referred back to the responsible consultant for a clinical decision to be made. **The RTT clock continues to tick throughout this process.**

A clinical decision will be made 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.

Patient unfit for > 2 weeks

- If the patient is not likely to be medically fit to proceed with elective surgery for more than two weeks following the pre-operative assessment appointment, the pre-operative assessment team, on behalf of the Trust, will confirm whether a clock stop is required. Any decision which does not require guidance from clinicians will be made within two working days.

- The Pre-operative Assessment Unit, on behalf of the Trust, will ask for guidance from the relevant clinical team for cancer and urgent patients.

- Clinicians will respond within 5 working days to this request to give guidance.

- If the reason is that the patient has a condition that itself requires active treatment or monitoring for a period of more than two weeks the patient will be removed from the waiting list and discharged back to the care of their GP or be actively monitored by their Trust clinician.

- Patients who require simple diagnostics (such as an echocardiogram) or anaesthetic assessment must have appointments within two weeks. The locally agreed process within the specialty will be followed.

- Patients who require multiple diagnostics or “other” specialist review will be removed from the waiting list.

- Patients discharged back to their GP will be re-referred to the Trust.

- Either action results in the patient's 18 week clock being stopped. RNHS E-Referrals from the GP or a subsequent decision by the clinician to attempt treatment again will initiate a new clock start and pathway.

- 18 week guidance states that "active monitoring may apply at any point on the patient's pathway" but only in exceptional circumstances after a decision to treat has been made.

- When patients are unfit for more than two weeks, the following actions are required:

    - Pre-operative assessment team send a letter to the GP and copy to the consultant detailing reason for removal from list.
    - A standard detailing how to re-refer will be sent to the GP and patient. See appendix 5.
    - Elective booking team remove the patient from the waiting list.

Patient unfit due to short term illness

If the patient is unfit due to a short term illness and this has no impact on the original clinical decision to undertake the procedure e.g cough, cold, UTI, the RTT clock continues.

2.19 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 may constitute an RTT clock stop – equally the clock could continue to tick. Information must be provided to staff in these services to know if the 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 – the fitting of the appliance constitutes first definitive treatment and the RTT clock stops at this point.

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. If patients receive dietary advice as an important step of a particular pathway (eg bariatric) the clock could continue to tick.

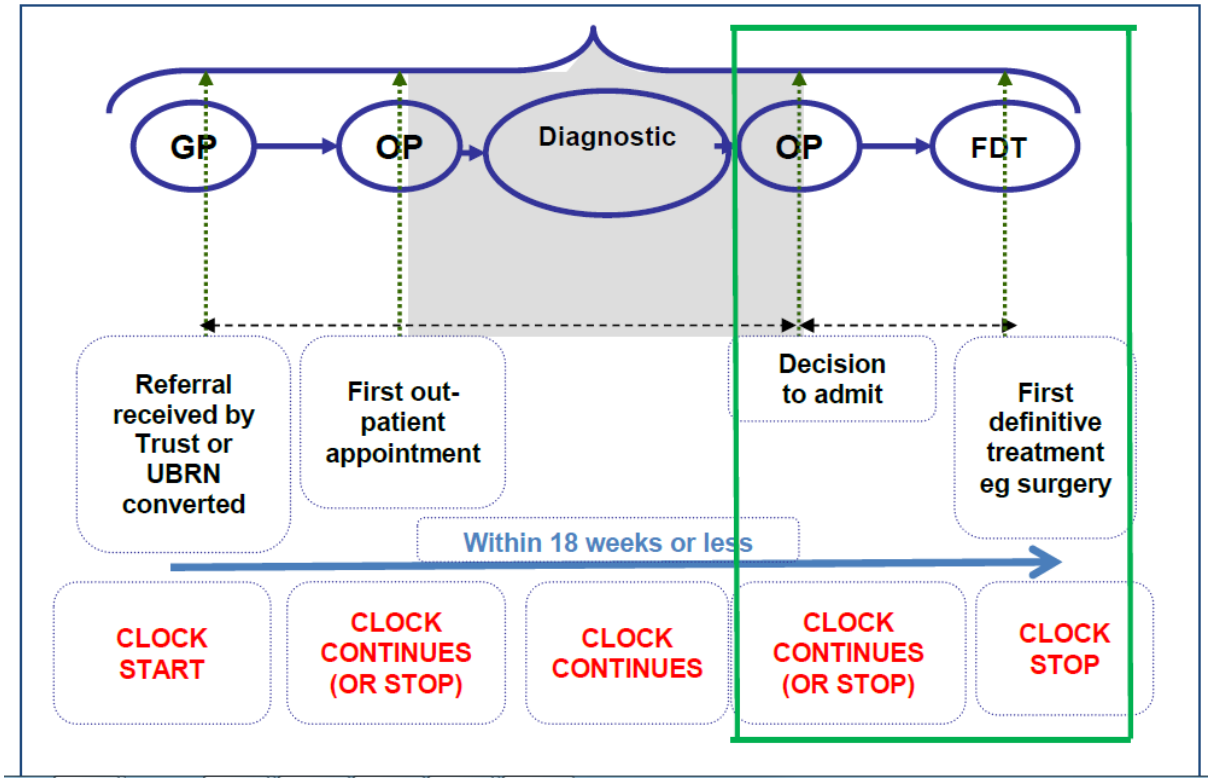
2.20 Non-activity related RTT decisions

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 notify the RTT validation team to update Millennium with the clock stop. The date recorded will be the day the decision not to treat is communicated in writing to the patient.

2.21 Admitted pathways

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



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 or whether they have declared a period of unavailability at the point of the decision to admit. **See Patient initiated delays**

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

In terms of the patient's RTT clock, adding a patient to the waiting list will either:

- Continue the RTT clock from the original date the referral was received.
- 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 previously occurred. The RTT clock will stop upon admission.

3.24 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 (first) 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.

3.25 Patients requiring thinking time

Patients who wish to spend some time thinking about the recommended treatment options are asked to make contact within a maximum of 3 weeks. If contact has not been made with the consultant's team following this period the RTT validation team will be contacted and the relevant active monitoring clock stop applied or the patient will be discharged back to the care of the GP. This will be communicated to the patient and the GP in writing.

It may be appropriate for the patient to be entered into active monitoring where they state they do not anticipate making a decision for a matter of months. This decision can only be made on an individual patient basis by the clinician 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 DTA.

3.26 Scheduling patients to come in for admission

Clinically urgent patient will be scheduled first, followed by routine patients. All patients will be identified from the trust's PTL/elective waiting list and subject to

clinical priorities will be scheduled for admission in chronological order of RTT wait. A partial booking letter will be sent asking patients to make contact.

If the patient does not make contact the demographic details should be confirmed with the GP. Three attempts will then be made to contact the patient. If still unsuccessful a second partial booking letter will be sent to the patient and a copy to their GP.

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

Any admission offers declined by patients will be declined on PAS in order to ensure

- Full and accurate record keeping
- Information can be used at a later date to understand the reasons for any delays in treatment

3.27 Patients declaring periods of unavailability while on elective waiting list

If patients contact the Trust to communicate periods of unavailability for social reasons (eg holidays/exams) this will be recorded in Millennium.

Urgent patients

Where a patient is unavailable and wants to delay treatment by up to 3 weeks the patient will remain on the waiting list and the RTT clock continues.

In exceptional circumstances where a patient who has been deemed clinically urgent is unavailable and wants to delay for **more** than 3 weeks and following clinical review of clinic letters/reports/results, and it is the best interest of the patient, the patient can be discharged back to the GP, and the 18 week clock will stop. This must be communicated to both the GP and patient and clear instructions must be provided on how to re-access the service.

Routine patients

Where a patient is unavailable and wants to delay treatment by up to 6 weeks the patient will remain on the waiting list and the 18 week pathway continues.

Where a patient is unavailable and wants to delay for **more** than 6 weeks and following clinical review of clinic letters/reports/results, and it is in the best interest of the patient as agreed in advance by consultants for each specialty,

the patient can be put on active monitoring. In some cases the patient can be discharged back to the GP, and in both cases the 18 week clock will stop. This must be communicated to both the GP and patient and clear instructions must be provided on how to re-access the service.

A standard letter detailing how to re-refer or re-access will be sent to the GP and patient.

3.28 Patients who decline or cancel TCI offers

If a patient declines TCI offers or contacts the trust to cancel a previously agreed TCI this will be recorded on Millennium. The RTT clock continues to tick. In some cases where this leads to a long delay the patient's pathway will be reviewed by their consultant. This may result in one of the following:

- Clinically safe for the patient to delay – RTT clock continues
- Clinically unsafe – clinician contacts the patient with a view to persuading the patient not to delay – 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 (e.g the treatment may fundamentally change during the period of delay) on the patient's treatment plan – active monitoring – RTT clock stop.

3.29 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. Should the patient's consultant decide that it is in their best clinical interest to be discharged back to the GP, the RTT clock is stopped.

3.30 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 rearrange date. The patient may choose not to accept a date within 28 days. If it is not possible to offer the patient at date within 28 days of the cancellation the trust will offer to fund the patient's treatment at the time and hospital of the patient's choice where appropriate.

3.31 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.

4 CANCER PATHWAYS

Introduction and Scope

This 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 standard. 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.

4.1 Principles

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

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

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

Accurate data on the trust's performance against the national cancer waiting times is recorded in the cancer management system and reported nationally.

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.

4.3 Roles and responsibilities

Chief Executive: The chief executive has overall responsibility and accountability for delivering access standards as defined in the NHS Constitution and Operating Framework.

Chief Operating Officer: Responsible for ensuring that there are robust systems in place for the audit and management of cancer access standards against the criteria set out in this cancer access policy and procedure document. . Responsible for the monitoring of performance in the delivery of 14 day, 31 day and 62 day standards alongside all screening programmes and ensuring the clinical directorate delivers the activity required to meet the cancer waiting time standards.

Tumour Group Clinical leads: Responsible for ensuring clinical pathways are designed to deliver treatment within 62 days of referral. Responsible for review the outputs of any breach route cause analysis and clinical harm review to develop actions to resolve any delay to patients.

Specialty Managers: Responsible for monitoring of performance in the delivery of the cancer standards and for ensuring the specialities deliver the activity required to meet the waiting list standards. They are also responsible for ensuring all patients are booked within 14 days by ensuring adequate capacity is available and reviewing daily and weekly reports and resolving any breaches. In addition to this, they are responsible for evaluating the impact of any process or service changes on 62 or 31 day pathways and for the completion of breach root cause analyses within their tumour sites.

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

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

Head of BIU: Responsible for administering data required for managing and reporting cancer waiting times, activity and cancer outcomes. The informatics team ensures there is a robust standard operating procedure for the external reporting of performance.

Cancer Services Manager: responsible for monitoring delivery of key tasks by the MDT co-ordinators:

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

- Patients booked past 14 days
- Patients with no appointment
- Any data entry issues
- Weekly reports showing compliance with 2ww standard in preceding week for discussion at weekly PTL meeting.

MDT co-ordinators: responsible for monitoring the cancer pathway for patients following the first attendance, ensuring it is managed in line with this policy and assisting in the pro-active management of patient pathways on Millennium and the Somerset Cancer Register including escalation of issues to the relevant clinical department, cancer nurse specialists and specialty managers.

All staff (to whom this document applies)

All staff have a duty to comply fully with this policy and are responsible for ensuring they attend all relevant training offered.

All staff are responsible for bringing this policy to the attention of any person not complying with it.

All staff will ensure any data created, edited, used or recorded on the Trust's IT systems in their area of responsibility is accurate and recorded in accordance with this policy and other trust policies relating to collection, storage and use of data to maintain the highest standards of data quality and maintain patient confidentiality.

All 2WW patient referrals diagnostics, treatment episodes and waiting lists are managed on the Trust's system. All information relating to patient activity must be recorded accurately in a timely manner.

4.4 Training and 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.

4.5 Cancer waiting times standards

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

Service standard	Operational standard
Maximum 2ww from urgent GP referral for suspected cancer to first appointments	93%
Maximum 2ww from referral or 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)	94%

where the subsequent treatment is surgery	
Maximum 31 days from decision to treat./earliest clinically appropriate date (ECAD) to start of subsequent treatment (s) where the subsequent treatment is surgery	98%
Maximum 31 days from decision to treat/ECAD to start of subsequent treatment(s) where the subsequent treatment is radiotherapy	94%
Maximum 62 days from urgent GP referral for suspected cancer to first treatment	85%
Maximum 62 days from urgent referral from an NHS cancer screening programme for suspected cancer to first treatment	90%
Maximum 62 days from consultant upgrade of urgency of a referral to first treatment	No operational standard as yet
Maximum 31 days from urgent GP referral to first treatment for acute leukaemia, testicular cancer and children's cancers	No separate standard, monitored as part of 62 days from urgent GP referral.

4.6 Summary of the cancer rules

Clock start:

2ww - a two week wait clock starts at the receipt of referral.

62 day – a 62 day cancer clock can start following the below actions:

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

31 day – a 31 day cancer clock will start following:

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

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

62 day cancer clock will stop following:

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

Removals from the 62-day pathway (not reported)

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

A 31 day cancer clock will stop following:

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

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

4.7 GP/GDP suspected cancer two week wait referrals

All suspected cancer referrals should be referred by the GP on the relevant cancer pro forma provided and submitted via e-referral.

GDP's who do not have access to e-Referral will refer as above using the ruh-tr.CancerReferrals@nhs.net email.

Day 0 is the date the referral was received by the provider.

The first appointment can be either an outpatient appointment with a consultant or (or member of their team) investigation relevant to the referral, i.e. straight to test, diagnostic clinic.

All 2WW referral will be checked for completeness by the 2WW team within 24 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 while information is being obtained to ensure there is no delay to the 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 provider will be sent electronically to the intended provider with a copy for information sent to the referring GP electronically within 24 hours of receipt.

4.8 Downgrading referrals from 2 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 he 2WW criteria, the GP can agree for the referral status to be changed to routine or urgent and booked accordingly. (It is, however, only the GP who can make this decision).

4.9 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 or receive or referral if clinically appropriate.

4.10 Screening pathways

The clock start is the receipt of 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

4.11 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 suspect new primaries only, not those who may be suspected of a recurrence.

Who can upgrade patients on 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 diagnostic.

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

If a patient requires 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 should be the same as the ECAD date for these patients.

4.12 Reasonableness

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

Waiting time adjustments

Unlike RTT it is possible to make adjustments (pauses) to patient clocks in two instances. Both of these instances are included below.

Pauses

The only two adjustments that are 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 rest to the date the patient rebooks their appointment (the date the patient **agrees** the new date not the new appointment date).
- 62/31 day pathways: if a patient declines admission for an inpatient or day case procedure providing the offer of admission was reasonable the clock can be paused from the date offered to the date the patient is available.

If the patient during a consultation or at any other point while being offered an appointment date states that they are unavailable for a set period of time (eg due to holiday or work commitments) a pause can be applied from the date that would have been offered to the patient to the date that they are available. This will apply to admitted treatment 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 Register and Millennium. The trust will ensure that TCIs offered to the patient will be recorded.

4.13 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:

4.14 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.

4.15 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
Patients can be discharged after multiple (two or more) appointment cancellations if this has been agreed with the patient. However, where a patient has cancelled multiple appointments on a 62 day GP pathway, screening pathway or breast symptomatic referral (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.

4.17 DNAs

Patients will be recorded be 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).

4.18 First appointment

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 patient contacting the hospital.

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 Register.

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

Patients who are uncontactable

If the patient is uncontactable at any time on their 62/31day pathway, a record of the time and date of the call to them should be recorded on PAS at the time of the call.

Two further attempts will be made to contact the patient by phone.

Each of these calls must be recorded in real time onPAS. 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 routes.

If the patient remains uncontactable:

- For first appointments: An appointment will be sent to the patient offering an appointment within the 2WW standard, stating the trust has attempted to offer a choice of appointment, and that the patient should contact the 2WW office to rearrange the appoint if it is convenient.
- 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 an appointment by letter
    - 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.

4.18 Diagnostics

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

Refusal of a diagnostic test

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

4.19 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.

4.20 Tertiary referrals

Process

Inter provider transfer (IPT) forms will be used for all outbound referrals for patients on a cancer pathway.

Where possible, information will be transferred between trusts electronically. Transfers will be completed via a named NHS contact.

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

4.21 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 Appointment centre will record the referral (including known adjustments, referring symptoms and

first appointment) onto the cancer management system within 24 hours of receiving the referral and a referral on the Cancer Register will be automatically generated.

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

Suspected cancers: screening patients

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

Suspected cancers: consultant upgrades

For upgrade before initial appointments the Appointments Centre will be responsible for entering patient details on the Cancer register and allocating the patient an appointment within the 2WW guidelines.

For upgrades at any 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 register 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 register, selecting the appropriate cancer status (by the MDT co-ordinator) within 24 hours of being notified.

Confirmed cancers

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

4.22 Monitoring and audit

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

Any data anomalies are highlighted to the relevant tumour site MDT co-ordinator for investigations and correction. Response to the cancer information team must occur within 24 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 register and Millennium
- Comparative audit of diagnosis code on Millennium, Cancer register and healthcare records
- Comparative audit of cases removed from the 62 day pathway and re-entered as 31 day patients within four weeks of removal.

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

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

Term	Definition
2WW	Two week wait: the maximum waiting time for a patient's first Outpatient appoint 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 (ECAD) is effected for subsequent treatments
62 day pathway	Any patient referred by a GP with a suspected cancer on a 2WW referral pro-forma, referral from a screening service, a referral from any healthcare professional if for breast symptoms or where a routine referral has been upgraded by a hospital clinician, must begin treatment within 62 days from receipt of referral
Active monitoring	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures
Active waiting list	The list of elective patients who are fit, ready and able to be seen or treated at that point in time. Applicable to any stage of the RTT pathway where patients are waiting for hospital resource reasons.
Bilateral procedures	Where a procedure is required on both the right and left sides of the body.
Breach	A pathway which ends when a patient is seen/receives their first treatment outside the 14 day first seen, 62 day referral to treatment and/or 31 day decision to treat to treatment target times
Chronological booking	Refers to the process of booking patients for appointments, diagnostic procedures and admission in date order of their clock start date.
Consultant-led service	A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse-led clinics which come under the umbrella of consultant-led services
Day case	Patients who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.
Decision to admit	Where a clinical decision is made to admit the patient for either day case or inpatient treatment.
Direct access	Where GPs refer patients to hospital for diagnostic tests only. These patients will not be on an open RTT pathway

Elective Care	Any pre-scheduled care which doesn't come under the scope of emergency care.
First definitive treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgement in consultation with the patient.
Fixed appointments	Where an appointment or admission date is sent in the post to the patient without the opportunity to agree a date.
Full booking	Where an appointment or admission date is agreed either with the patient at the time of the decision or within 24 hours of the decision.
Incomplete pathways	Patients who are waiting for treatment on an open RTT pathway either at the non-admitted or admitted stage.
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night.
Nullified	Where the RTT clock is discounted from any reporting of RTT performance.
Oncology	The branch of science that deals with tumours and cancers
Partial booking	Where an appointment or admission date is agreed with the patient near to the time it is due.
Patient-initiated delay	Where the patient cancels, declines offers or does not attend appointments or admission. This in itself does not stop the RTT clock. A clinical review must always take place.
Planned waiting list	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18 week RTT pathway.
Reasonable offers	A choice of two appointment or admission dates with three weeks' notice.
Straight to test	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an RTT pathway.

ACRONYMS

Term	Definition
ASIs	Appointment slot issues (list): a list of patient who have attempted to book their appointment through the national E-Referral Service but have been unable to due to lack of clinic slots.
CATS	Clinical assessment and treatment service.
CCGs	Clinical commissioning groups: commission local services and acute care.
Clock Stop	18 week pathway is stopped.
CNS	Clinical nurse specialists: use their knowledge of cancer and treatment to co-ordinate the patient's care plan and act as the patient's "keyworker".
COF	Clinical 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 (Choose and Book)
FOBT	Faecal occult blood test: part of the bowel screening pathway, checks for hidden (occult) blood in the stool (faeces).
GDP	General dental practitioner (GDP): typically leads a team of dental care professionals (DCPs) and treats a wide range of patients, from children to the elderly.
GP	General practitioner: a physician whose practice consists of providing ongoing care covering a variety of medical problems in patients of all ages, often including referral to appropriate specialists.
Cancer Management	A database system used to record all information related to

System	patient cancer pathway by MDT co-ordinators, CNSs and clinicians.
IOG	Improving outcomes guidance: NICE guidance on the configuration of cancer services.
IPT	Inter-provider transfer
MDT meeting	A multidisciplinary team meeting where individual patients care plans are discussed and agreed.
MDS	Minimum dataset: minimum information required to be able to process a referral either into the cancer pathway or for referral out to other trusts.
MDT	Multi-disciplinary team: here describing a group of doctors and other health professionals with expertise in a specific cancer, who together discuss and manage an individual patient's care.
MDT co-ordinator	Person with responsibility for tracking patients, liaising with clinical and clinical assessment unit staff to ensure progress on the cancer pathway, attending the weekly patient tracking list (PTL) meeting, updating the trust database for cancer pathway patients and assisting with pathway reviews and changes. Also co-ordinates the MDT meeting and records the decision for progress along the cancer pathway.
NCWTDB	National cancer waiting times database: all cancer waiting times general standards are monitored through this.
PAS	Patient administration system records the patient's demographics (eg name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient.
PIFU	Patient initiated follow up appointment
PPID	Patient pathway identifier
PTL	Patient tracking list: a complex spreadsheet used to ensure that cancer waiting times standards are met by identifying all patients on 62-day pathways and tracking their progress towards the 62- or 31- day standards
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 the same as the level of investigation involved in an RCA for, for example, a Serious Incident (SI).
RMC	Referral management centre
Referral to treatment	Referral to treatment
SMDT	Specialist multidisciplinary team meeting: where individual

	patients' care plans are discussed and agreed; takes place across multiple organisations and involves support from a centre specialising in treating a particular tumour type.
TCI	To come in (date). The date of admission for an elective surgical procedure or operation.
TIA	Transient ischaemic attack: a mini stroke caused by a temporary disruption in the blood supply to part of the brain.
TSSG	Tumour site specific group
UBRN	Unique booking reference number.