Patient Access Policy

Version: 1.4

Document Properties	
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Name of Originator/Author:	Sioned Davies, Head of Operations for Cancer and Outpatient Services
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Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
V1.0	16.03.2023	Helen Nowakowska	Completed	Access policy redesign and refresh due to: • Process changes following the implementation of Cerner ePR+ • Clearer guidance around application and management of RTT pathways • Changes in national guidance following the Covid-19 pandemic
V1.1	20.03.2023	Helen Nowakowska	Completed	Change made to 4.21.2
V1.2	31.03.23	Helen Nowakowska	Completed	New section added (4.12.5)
V1.3	22.07.2024	Georgia Fennell	Completed	Change made to 4.16.6
V1.4	20.12.24	Sioned Davies	Pending approval	Annual review

Record of Changes			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
		Change of order of sections	Sections to match order of pathway milestones
		Changed each reference from DNA to Missed Appointments	There is a National drive to change the language used around missed appointments – moving from 'Did Not Attend (DNA)' to 'Missed Appointment'
		Removed section 4.22 from previous policy	Covid 19 specific guidance no longer applicable.
3.0	7	Added some detail to the descriptions	In line with new National access policy guidance issued Feb 25.
4.1	10	Amended National elective care standards	Aligned to the revised national standards
5.2.6	15	Amended Active Monitoring section (section 4.6.3 in previous version)	Align with national guidance and provide clarity on circumstances when active monitoring may or may not apply.
5.4	19	Amendment to include Children and Young People.	Ensure all vulnerable groups included and additional information included as required in the commissioning standards
5.6.1.9	28	Added section on Multiple RTT periods on the same pathway.	In line with new National access policy guidance issued Feb 25.
5.6.1.10	28	Added section on Multiple RTT pathways	In line with new National access policy guidance issued Feb 25.
5.9.1	49	Appointment reminder service	Updated in line with the new patient engagement portal
5.10 (4.8 in previous version)	50	Cancelling, declining or delaying appointment and admission offers	Section removed
6.0	51	Cancer waiting time standards	Aligned to new National cancer waiting time standards.
9.0	67	Updated References	New guidance published
Appendix A	69	Updated Related Policy Links	Changes to hyperlinks
Appendix F	76	Appendix F – updated clinic outcome form	New clinic outcome form in use

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1.0 SCOPE

This policy sets out the overall expectations of COCH for the management of referrals and admissions into and within the organisation and defines the principles upon which the policy is based.

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, and equitable and managed according to clinical priorities and meets the requirements of the NHS Operating Framework and the commitments made to patients in the NHS Constitution (see below).

The NHS Constitution states that patients can expect to start their consultant led treatment within a maximum of 18 weeks of referral for a non-urgent condition. Patients with more urgent conditions, such as cancer or heart disease, will be seen and treated more quickly. Patients can be referred to their health provider of choice and this should be discussed with the referrer at point of referral. Patients also can switch to a different provider if they wish after initial referral.

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.

2.0 INTRODUCTION

The trust is committed to delivering high quality and timely elective care to patients.
This overarching policy is intended to be used by all individuals working in the Countess of Chester Hospital NHS Foundation Trust (COCH) services.

This policy:

- Sets out the rules and key principles for managing patients through their elective care pathways.
- Ensures processes in the management of patients waiting for treatment are clear, transparent to patients and partner organisations and must be open to inspection, monitoring and audit.
- Gives 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 COCH Patient Access Policy was developed following consultation with staff, clinical leads, integrated care board (ICB) and general practitioners. It will be reviewed and ratified at least annually or earlier if there are changes to national elective access rules or locally agreed principles.

The COCH Patient Access Policy should be read in full by all applicable staff in conjunction with the appropriate RTT training delivered by the Trusts' Patient Pathway team, and the online Elective Care E-Learning modules available via ESR.

All clinical and non-clinical staff must ensure they comply with all the principles within this policy.

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

3.0 DUTIES & RESPONSIBILITIES	
Chief Executive	The Chief Executive is ultimately accountable for the delivery of the national elective access targets.
Chief Operating Officer	The Chief Operating Officer has delegated responsibility for ensuring that robust systems and processes are in place to support the achievement of the access targets and that there is accurate reporting both internally and externally.
Chief Information Officer	Has responsibility for timely production of patient

	tracking lists (PTLs) that support divisions to manage waiting lists and RTT standards. Ensuring effective systems in place to enable the Divisions to collect data accurately and is responsible for the reporting of information and support the accurate monitoring and reporting of waiting list and performance against access targets.
Head of Operations for Outpatient Services	Head of Operations for Outpatient Services will be responsible for ensuring the policy is reviewed annually and remains up to date with appropriate national guidance and performance standards
Information Team	The Information team is responsible for the reporting of information and support the accurate monitoring and reporting of waiting and performance against access targets.
Divisional Triumvirates	Divisional Triumvirates have accountability within their divisions for all access target performance including the maintenance of accurate waiting lists and the training of staff that are responsible for managing patient's access, to ensure compliance with this policy. The Associate Medical Directors, Divisional Directors and Divisional Directors of Nursing will hold to account responsible staff through the monitoring processes at performance reviews.
Divisional Managers	Divisional Managers have responsibility for ensuring patients are provided with reasonable notice and appropriate choice and for ensuring that their practices are consistent with the policy and that the systems are in place to support effective waiting list management. Included in this is the responsibility that all staff has access to training that allows them to undertake delegated roles and apply the principles within this policy. Responsible for ensuring the NHS e-referral service Directory of Service (DoS) is accurate and up to date, and are supported by divisional directors in achieving access standards.
Head of Health Records and Reception Services	In collaboration with the Operational teams, the Patient Services manager will ensure that the NHS e-referral service directory of services (DOS) is accurate and up to date and are reviewed annually.
Administration Staff	Administration staff are responsible for the day to day management of patients pathways and standardising the application of and compliance with all aspects of the policy, ensuring compliance with Trust processes, procedures and administration tools. Administration staff are supported in this function by

	operational management teams and divisional directors who are responsible for achieving access standards.
Clinicians	Clinicians are responsible for ensuring that their practices and documentation is consistent with the policy and that the systems are in place to support effective waiting list management and a focus on clinic outcoming.
ICB	ICB are responsible for ensuring all patients are aware of their right to treatment at an alternative provider in the event that their RTT wait goes beyond 18 weeks or if it likely to do so. ICB must take all reasonable steps to offer a suitable alternative provider, or if there is more than one, a range of suitable alternative providers, able to see or treat patients more quickly than the provider to which they were referred. A suitable alternative provider is one that can provide clinically appropriate treatment and is commissioned by a clinical commissioning group or NHS England. The ICB are responsible for ensuring there are robust communication links for feeding back information to GPs. GPs should ensure quality referrals are submitted to the appropriate provider first time.
General Practitioners (GPs)	General practitioners (GPs) and other referrers play a pivotal role in ensuring patients are fully informed during their consultation of the likely waiting times for a new outpatient consultation and of the need to be contactable and available when referred. GPs should explain to patients that if they are subsequently unable to attend their appointment, they should contact the hospital to re-arrange it. GPs should ensure quality referrals are submitted to the appropriate provider first time.
Patients	The NHS Constitution recommends the following actions patients can take to help in the management of their condition: • Patients can make a significant contribution to their own, and their families, good health and wellbeing, and should take personal responsibility for it. • Patients should be registered with a GP practice as this is the main point of access to NHS care as commissioned by NHS bodies. • Patients should provide accurate information about their health, condition and status.

	• Patients should keep appointments or cancel within a reasonable timeframe.

4.0 STANDARDS AND GOVERNANCE

4.1 National Elective Care Standards

Area	Standard	Target
Elective care	18 weeks from day receipt of referral to treatment commencing In order to achieve the national standard the national priorities for 25/26 state that Trusts should: • Improve the % of patients waiting <18 weeks for treatment to 65% and for first appointment to 72% • Reduce the proportion of people waiting >52 weeks for treatment to less than 1% of the total waiting list	92% of patients on an incomplete pathway
Cancer	Maximum 62 days from receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade **to First Definitive Treatment** of cancer	75% by March 2026
	Maximum wait of 28 days from receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent referral of any patient with breast symptoms, (where cancer not suspected), to the date the patient is informed of a	80% by March 2026

	diagnosis or ruling out of cancer.	
	Maximum 31 days From Decision To Treat/Earliest Clinically Appropriate Date to treatment of cancer.	96%
Diagnostics	Patients to undergo relevant diagnostic test within 5 weeks and 6 days from the date of decision to refer to the appointment date	99%
Rapid Access Chest Pain Clinic	Patients referred on a Rapid Access Chest Pain proforma to be seen within 2 weeks (or 24 days) from receipt of referral to first hospital assessment.	93%

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.
- Clinical exception: it is clinically appropriate for the patient's condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage
- 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 (Missed Appointments) and this prevents the trust from treating them within 18

4.2 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 Suspected cancer (USC) diagnostic reporting (1 working day)
- Urgent diagnostic reporting (within 5 working days)
- Routine diagnostic reporting (within 10 working days)

4.3 Governance

Compliance against the policy will be monitored and reported through the following governance structure:

5.0 DETAILS OF POLICY

5.1 Objectives

- This policy sets out the way in which COCH will manage patients who are waiting for treatment on admitted, non-admitted, diagnostic or cancer pathways. This includes the management of all COCH patients, irrespective of the site where they receive care.
- Every process in the management of patients who are waiting for treatment must be clear and transparent to the patients and to partner organisations and must be open to inspection, monitoring and audit.
- COCH will give priority to clinically urgent patients and treat everyone else in turn subject to the exceptions described.
- COCH will work to meet and improve on the maximum waiting times set by NHS England for all groups of patients.
- COCH will aim to negotiate appointment and admission dates and times with patients.
- In accordance with a training needs analysis, staff involved in the implementation of this policy (clinical, clerical and managerial) will undertake training provided by COCH with regular updates – verbally and via e-learning package. Policy adherence will form part of staff goals and objectives.

- COCH will ensure that management information on all waiting lists and activity is recorded on the appropriate COCH system. This must be on Cerner EPR+ or other approved reporting systems authorised by the Chief Information Officer e.g., Radiology ICE.

The accuracy of published data is of paramount concern to the Trust. In support of data accuracy all transactions made in the Cerner EPR+ and any other systems will be performed by staff according to this policy.

All Trust employees have an important role in managing waiting lists effectively. Treating patients and delivering high quality, efficient and responsive services ensuring prompt communications with patients is a core responsibility of the hospital and the wider local health community. Trust staff will promote a safe, clean and personal service.

5.2 RTT National Rules

5.2.1 General Rules

Once a referral to treatment (RTT) waiting time clock has started it continues to tick until:

- The patient starts first definitive treatment or
- A clinical decision is made that stops the clock

5.2.2 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 (UBRN) by either booking an appointment within the e-RS or by deferring the referral to provider when an appointment is not available to book at the time.

- If a patient is referred into a Referral Assessment Service (RAS), the clock start date is the date the referral letter is attached to e-Rs as this is when the Trust is first notified of the referral.
- A referral is received into a consultant-led service, regardless of setting, with the intention that the patient will be assessed and if appropriate, treated before clinical responsibility is transferred back to the referrer.
- A referral is received into an interface or referral management assessment centre which may result in an onward referral to a consultant-led service

before clinical responsibility is transferred back to the referrer.

- A patient self-refers into a consultant-led service for pre-agreed services agreed by providers and commissioners.

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

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

Example

Mr. A is referred to an orthopaedic consultant and books an appointment through the e-referral system **[RTT clock start].** After consultation, it's agreed he would benefit from surgeries on both knees. He is admitted for the left knee procedure **[RTT clock stop]**. After recovery, Mr. A contacts the hospital to schedule surgery for his right knee **[new RTT clock start]**, which is completed a few weeks later **[RTT clock stop].**

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

Example

Mr. B was referred to an orthopaedic consultant for frozen shoulder **[RTT clock start].** Physiotherapy was recommended as the initial definitive treatment **[RTT clock stop].** However, when physiotherapy didn't relieve his symptoms, it was decided at a follow-up that surgery would be necessary **[new RTT clock start].** This new RTT clock ensures that Mr. B will receive his surgical treatment within a maximum of 18 weeks from the decision to operate **[RTT clock stop upon admission for surgery].**

- Upon a patient being re-referred into a consultant led interface, or referrals management or assessment services as a new referral.

When a decision to treat is made following a period of active monitoring.

Example

A child in a family at risk of familial breast cancer is referred to the genetics service for pre-symptomatic testing. The referral cannot proceed until the child is old enough to understand the implications of genetic testing, as there is no risk until they reach adulthood **[RTT clock stop: active monitoring or treatment not required].** A new RTT clock will start when it is appropriate for the service to see the patient or if a new referral is made by the patient's GP after discharge.

- When a patient rebooks their appointment following a first missed appointments that stopped and nullified their earlier clock.

Example

Mr. D was referred by his GP to a consultant rheumatologist but was unable to attend his appointment due to unforeseen circumstances **[RTT clock nullified].** The consultant expressed concern that not seeing Mr. D could lead to significant detrimental consequences, so he should be offered another appointment. The hospital contacted Mr. D, and a further appointment was arranged **[new RTT clock starts on the date of rebooking the appointment].**

5.2.3 Clock Start Exclusions

A referral to most consultant-led services starts an RTT clock but the following services and types of patients are excluded from RTT (this list is not exhaustive. If in doubt, refer to the National RTT Guidance):

- Obstetrics and midwifery
- Planned patients (including ward discharge review appointments)
- Referrals to a non-consultant led service
- Referrals for patients from non-English commissioners
- Genitourinary medicine (GUM) services
- Emergency pathway non-elective follow-up clinic activity e.g. A&E, Fracture Clinic, SAU Ward discharges, Ward discharge Same Specialty, Urology Hot Clinic.

5.2.4 Clock Stops

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

Example

Mrs. P attended the clinic with painful hips. After an X-ray, the consultant informed her that no surgical options were available, and physiotherapy would be the most effective treatment. As the clinic has its own physiotherapists, Mrs. P was able to begin physiotherapy on the same day **[RTT clock stop: treatment started].**

5.2.5 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

Example

Mr. E attended the Orthopaedic clinic, and after an MRI scan, the consultant determined that physiotherapy would be the most appropriate treatment. The consultant then wrote to the GP, requesting a referral to the Community Physiotherapist **[RTT clock stop].**

- A clinical decision is made not to treat

Example

Mr. G was seen in the Cardiology clinic and advised to undergo a CT angiogram, with the consultant explaining that he would write with the results and, if all was satisfactory, discharge Mr. G to his GP **[RTT clock continues].** Following the CT angiogram, the consultant was satisfied with the results, and no intervention was needed, so a letter was sent to Mr. G and his GP confirming discharge **[RTT clock stop].**

- A patient missed their appointment which results in the patient being discharged

- A patient declines treatment having been offered it

Example

Miss H was advised by the doctor that a colonoscopy with hemorrhoid banding would help relieve her discomfort. However, Miss H expressed concerns and decided not to proceed with the procedure, opting instead to discontinue follow-up with the consultant team **[RTT clock stop].**

- A decision is made to start the patient on a period of active monitoring either consultant initiated, or patient initiated. Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made. 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. 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.

Example

Miss B was anxious about having surgery for her hearing loss and requested a period to see if her symptoms would improve. The consultant agreed to reassess her in the outpatient clinic in approximately 3 months **[RTT clock stop].**

Example

Mr. G informed the hospital of his wife's passing and shared that he was not ready to come in for his planned procedure. The consultant sent condolences and agreed that Mr. G should reach out when he feels prepared to proceed. At that point, an outpatient appointment will be scheduled to reassess his symptoms and determine the next steps for treatment **[RTT clock stop].**

5.2.6 Active Monitoring

Active monitoring is where a decision is made that the patient does not require any form of treatment at that time but should be monitored in secondary care for a specified period of time, rather than being discharged. This can be either hospital or patient initiated.

When a decision to begin a period of active monitoring is made and communicated with the patient, the RTT clock stops. Active monitoring should not be considered prior to a patient having their 1st appointment but may apply at any point in the patient's pathway thereafter and is designed to ensure that national measurement of patients' waiting times reflects the realities of clinical decision-making.

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. Active monitoring should not exceed a period of 12 weeks without a clinical review. Active monitoring should only be extended beyond this period for a clinical reason.

Hospital initiated

Reasons why a patient may be placed into a period of hospital-initiated active monitoring which would stop their RTT waiting clock include:

- when the most clinically appropriate option is for the patient to be actively monitored over a period of time, rather than to undergo any further tests, treatments or other clinical interventions at that time
- If the patient has a long-term illness (see section 5.6.5.4) requiring either (a) optimisation and/or treatment for it or (b) a period of recovery before proceeding, they should be considered for active monitoring.
- When a patient wishes to delay their pathway at either COCH or an alternative provider (e.g. teacher wishes to wait for treatment in school holidays or patient is going on an extended holiday and wishes to wait until their return) and either declines

two reasonable offers* of treatment dates or advises they are unavailable to attend a date of treatment within the minimum time period that a reasonable offer could be made –a period of active monitoring should commence. This must not exceed 12-weeks and a clinical review must take place within this time period. If the patient is still not willing to attend for treatment the patient should be discharged.

Patient Initiated

Active monitoring can also be considered for patient-initiated actions:

- If the patient chooses to defer treatment. The patient may wish to defer for a specified period of time to see how they cope with their symptoms, this must not exceed 12 weeks and a clinical review must take place. If the patient is still not willing to attend for treatment the patient is discharged. If a patient declines treatment they should be discharged.
- The patient advises they require 'thinking time' to enable a decision to be made for a time period longer than 3 weeks (see section 5.7.1.4).
- The patient has a period of thinking time no longer than 3 weeks and remains undecided after this period following a discussion with their consultant (see section 5.7.1.4).

* A reasonable offer is defined as 'an offer of 2 dates with 3 weeks' notice from the date the offer is made (see section 6.1.10).

When patients make a decision to delay their treatment there should be clinical oversight, and steps should be taken to ensure that the patient fully understands the clinical implications of the delay. Once the patient wishes to go ahead with treatment, the provider should offer a new offer for treatment date, acting as if the patient is on the waiting list at the point that they previously left.

Example

Mr C is seen by the cardiologist and given a diagnosis of coronary heart disease. Mr C and the consultant discuss the need for surgery to carry out coronary artery bypass grafting.

Mr C is offered a treatment date at his provider which he declines. He is then offered an alternative treatment date. Mr C, who works as a teacher, decides he wants to decline the treatment date and would rather delay his treatment for at least another 2 months until the summer holidays start so that the procedure does not impact his work. Following a clinical meeting with his cardiologist, Mr C is put on a period of active monitoring and his clock stops.

Ahead of the school summer holidays, Mr C decides that he is now happy to go ahead with his treatment and to be reinstated on the waiting list. A new clock starts and stops once his procedure takes place.

Example

Mr D is seen by the cardiologist and given a diagnosis of an aortic aneurysm. Mr D and the consultant discuss the possibility of surgery, but it is agreed that at this stage it is too small for surgery.

The patient is therefore put on a period of active monitoring. During this time regular ultrasound tests will be carried out to measure the size of the aneurysm, and lifestyle changes (weight, exercise) are addressed to minimise the risk of rupture to the patient (which would then result in emergency surgery).

5.3 Commissioner Approved Procedures

Patients referred for specific treatments where there is limited evidence of clinical effectiveness (in line with evidence-based interventions) or which might be considered cosmetic can only be accepted with the prior approval of the relevant Integrated Care Board.

There are a number of procedures not normally purchased/funded by Commissioner or which require specific approval from the Commissioner before the Trust can proceed with treatment. Please refer to Procedures of Low Clinical Priority (NHS Cheshire and Merseyside's Cheshire Commissioning Policy) and Procedure of Limited Clinical Value (Wales). It is the responsibility of the clinicians to vet their referrals and reject any that does not comply with the policy.

The RTT clock will continue to tick whilst the funding request is being processed. It is the dual responsibility between the Trust and primary care to ensure this is adhered to. If it is possible to determine what treatment will be required by the patient, the referring GP should address the approval issue with the Commissioner, prior to the referral of the patient to the Trust and this approval must accompany the referral letter.

5.4 Special Patient Groups

5.4.1 Safeguarding Children, Young People and Vulnerable Adults

It is essential that all staff recognise and acknowledge their responsibility to ensure the safety and welfare of children, young people and adults at risk.

Patients must be provided with communications in the appropriate format to access services and the Mental Capacity Act (2005) adhered to. When a patient lacks capacity about their treatment decisions, the practitioner should discuss this with the patient's GP, discussions and assessments should be evidenced by a capacity assessment and a best interest discussion held with their next of kin / family or friends or in their absence an independent advocate.

The Trust has a legal obligation under the Equality Act (2010) to make reasonable adjustments to facilitate the care of people with disabilities. Staff should work in collaboration with the patient, their carer and the team caring for the person when managing their care.

When safeguarding issues are identified Trust procedures must be followed and a consultation can be had with a member of the safeguarding team. Refer to the Trusts Safeguarding Vulnerable Adult Policy & Local Guidance Referral Pathway and Paediatric missed appointments / Was Not Brought Guideline policy.

If the patient is already subject of a concern, discussion with Social Care may be necessary if the person has care and support needs and/or there are safeguarding concerns.

If an adult does not attend an appointment as expected, the practitioner should first check that the address is correct on records used to issue the appointment. The patient/patient's carer should be contacted. If telephone number is unavailable, contact the patient's General Practitioner (to ascertain if there has been a change in contact number).

Failure to attend two appointments must instigate the need for services to establish why the person has not attended. When the safeguarding team is notified that a patient has a learning disability and/or Autism a flag will be in place on electronic patient records. In relation to safeguarding concerns known to the team ,a flag will also be placed on electronic patient records.

Practitioners should discuss any safeguarding concerns with the safeguarding team. This could include carers, who have the responsibility to ensure their client attends, not bringing the patient with care and support needs to an appointment. If there are safeguarding concerns, trust safeguarding policies and pathways to be followed. A referral to Adult Social Care may be necessary if the person has care and support needs and there are safeguarding concerns. (See Safeguarding Adults Policy).

If the person is identified as having a mental impairment which makes them unable to make choices, or if the practitioner has concerns, they cannot make a choice effectively, then the practitioner should discuss concerns with the G.P. Relevant mental capacity assessments to ascertain whether the patient has capacity to refuse to attend or allow access may need to be completed. For adults who do lack mental capacity to consent for care and treatment, support can be accessed via the Patient Information and Consent policy and Mental Capacity Act 2005.

Consideration must be given to the adult's level of understanding i.e., any learning disability, literacy, language, and/or communication difficulty. Communication should always be in a way that is appropriate to the patient's needs. Under the Equality Act 2010, reasonable adjustments must be completed with people who have a disability.

If there are concerns for the patient's safety, the case must be followed up as a matter of urgency. Advice can be sought from their line manager/supervisor or the Safeguarding and Complex Care team on 01244 363608

Non-attendance and action taken should be documented in case notes.

5.4.2 Armed Forces

In line with the Armed Forces Covenant, published in 2015, all armed forces personnel 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.

5.4.3 Referrals from Wales

All aspects of the Trust's Patient Access Policy will be applied to Welsh resident patients, with the exceptions as identified in Appendix B.

Patients who reside in Wales and are registered with a GP in Wales are wholly the responsibility of the Welsh LHB and therefore Welsh rules apply.

However, where a patient lives in Wales but is registered with an English GP the LHB remains legally responsible for their care, but the English CCG will be responsible for commissioning this care. As this care is CCG commissioned, English RTT rules will therefore apply to these patients.

It is therefore extremely important to note that, ordinarily, it is the GP location which determines which rules apply, and not the patients address.

5.4.3 Community Home Visit

The home visiting criteria is difficult to establish and for this reason, each case must be judged in isolation and on the individual needs of the patient by the triaging clinician.

5.4.4 Overseas Visitors

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

Patients who are identified as overseas visitors must be referred to the Overseas Patients Team for clarification of status regarding entitlement to NHS treatment before/during registration takes place (see Overseas Visitors SOP in Appendix A).

5.4.5 Private Patients

Patients can choose to move between NHS and private status at any point during their treatment without prejudice. Where it has been agreed, for example, that a surgical procedure is necessary the patient can be added directly to an NHS elective waiting list (OP, Diagnostic, Pre-op or IP) if clinically appropriate. Alternatively, at any point a patient can request transfer of care to a privately funded provider of their choice.

Once referred, the patient will be registered on Cerner EPR+ and added to the most appropriate waiting list at day 0. The WL added to will be defined by the receiving clinician that will be responsible for the delivery of the NHS funded elements of that patient's care. The Private Practice Code of Conduct (2004) states that a patient can move over to NHS funded care at the same point in their pathway as that of where they would be had their care remained privately funded without prejudice. Therefore, if a patient is referred in for diagnostic testing or surgery they will be added directly onto the respective WL (OP, Diagnostic, Pre- op or IP) unless the responsible clinician feels a further clinical review in OPD is indicated.

Should a private patient be admitted for privately funded treatment into an NHS hospital, and decide at that point that they would like to transfer to NHS funded care prior to the procedure taking place, a clinical review will be undertaken whereby the priority of the patient will be determined by the same criteria applied to other NHS patients; and the RTT

clock will start on the date the referral is received into COCH requesting the transfer to NHS funded services. The clock still stops on the date the patient either receives treatment, or the date the patient is transferred back to privately funded care if requested.

5.4.6 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.

5.5 Management of Patient Pathways

Patients have the right to start Consultant-led treatment within 18 weeks from referral. All patients will be managed according to their clinical urgency, and within the 18 week Referral to Treatment (RTT) standard.

The following section will explain the key milestones (stages) of treatment of the patient. The milestones of treatment can be divided into two main parts: Non-Admitted Pathway and Admitted Pathway.

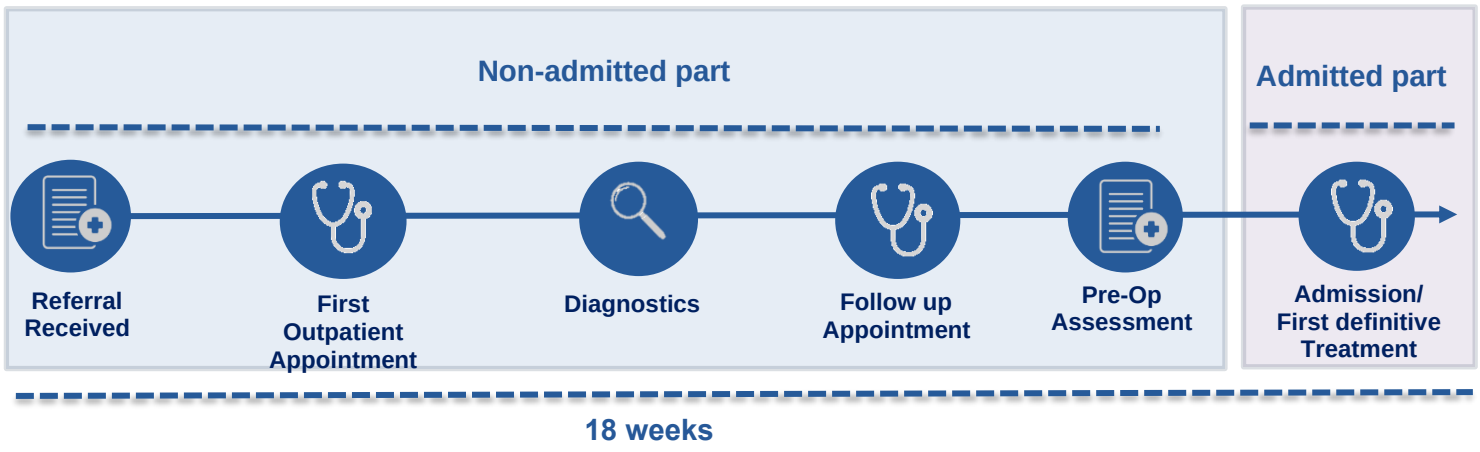
The **Non-Admitted Pathway** is also known as the Outpatient Pathway. The non admitted patient pathway includes the following milestones: Referrals, First Outpatient Appointment, Diagnostics, Follow up Appointment and Pre-Operative assessment. The pathway starts from the clock start date i.e. the date the referral is received or UBRN converted and ends when a clock stop happens at the first Outpatient or Follow up appointment.

The pathway commences from the clock start date (i.e., the date the referral is received or UBRN converted) and ends when either a clock stop happens in outpatients (this could be the first, second or a further appointment), a decision not to treat is made whereby still active, the pathway will convert to an admitted pathway.

The **Admitted Pathway** is also known at the Inpatient Pathway. This pathway means that the patient requires admission to hospital, as either day case or an inpatient, to receive definitive treatment.

The admitted stage of the patient pathway starts from when the decision to admit (DTA) has been made. Admission can be for a diagnostic (such as endoscopy) where the clock would not usually stop on admission, or a treatment, where the clock would usually stop on admission.

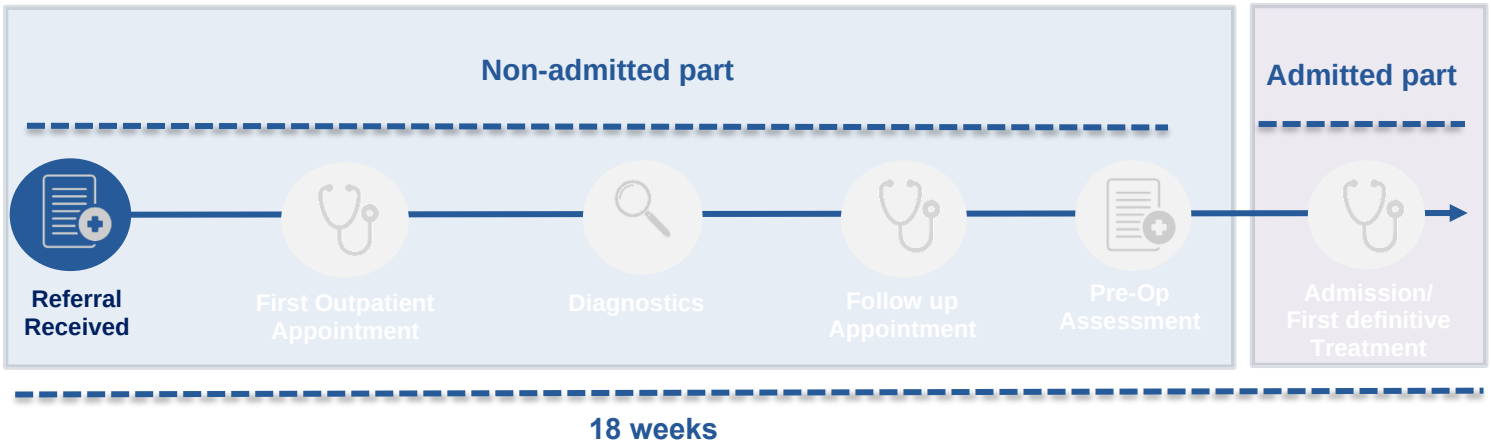
Figure 1: Pathway Milestones



5.6 Non-admitted Pathways

5.6.1 Referrals

Figure 2: Referral Milestone



5.6.1.1 Receipt of referral letters

The NHS e-Referral Service (e-RS) is the method of receiving referrals from GPs and Referral Management Centres (RMCs). Referrals from Welsh GPs should be made through the Medisec ACJ system.

Where clinically appropriate, referrals will be made to a service rather than a named clinician. Services have agreed clinical criteria to support triage and vetting, and patients will then be allocated to the most appropriate clinician, taking into account waiting times. Referring to services is in the best interests of the patients as pooling referrals promotes equality of waiting times and allows greater flexibility when booking appointments.

5.6.1.2 Rejected Referrals

Where a referral is clinically inappropriate, the consultant may not accept the referral. If this is the case, the referral will be rejected on e-RS and returned to the referrer with advice on possible alternative action to be taken. The RTT clock will be stopped as a decision not to treat (Code 34).

5.6.1.3 Redirection

On review of the referral into e-RS, should the clinician feel that the patient would be more appropriately suited to an alternative specialty, the referral must be redirected into the appropriate specialty and not rejected.

5.6.1.4 Appointment Slot Issues (ASI's)

For Directly Bookable appointments in e-RS, where capacity is not available, requests for new appointments are added to an Appointment Slot Issue (ASI) work list. The Appointments Hotline team must regularly review their ASI work list and liaise with the Operational teams to provide additional capacity for the patients who need to be booked into an appointment.

Prior to booking the appointment, the referrals are removed from the ASI work list and registered on the Cerner EPR+ system. On booking an ASI, the Appointments Clerk is responsible for ensuring the RTT clock start date reflects the date the UBRN was converted by the patient.

For Referral Assessment Service appointments and Directly Bookable appointments, polling ranges will be flexed and extended by the Appointments Hotline team according to the needs of the specialty.

5.6.1.5 Paper-based referrals

All routine, urgent pooled and consultant–specific referrals should be sent to the Trust's centralised booking office: Appointments Hotline. Any paper-based referrals from English GPs will not be accepted. The GP practice will be contacted and asked to send the referral via the NHS e-Referral Service. Any suspected cancer 2 week wait referrals will be checked for receipt on e-RS within 24 hours. If not reviewed within 24 hours they will be processed to prevent further delay and added to the paper referral log spread sheet to reconcile with contracting arrangements.

If a paper referral is received for one of those services, the referral should be addressed to the specialty rather than a named consultant. The referrer is responsible for ensuring that the referral letter contains the essential minimum data set (MDS):

- Patient NHS Number
- Full Name of Patient
- Patient Date of Birth
- Patient Gender
- Ethnicity
- War Veterans and Families
- Patient Full Address including Postcode
- Patient Up-to-date Contact Telephone Number
- Relevant Medical History
- Specific clinical question and/or diagnostic examination required
- Sufficient clinical data to enable the appropriate appointment to be made must be included. The letter should also state the patient's current drug regime, clinical questions to be answered and significant past medical history

- Diagnosis (Provisional, Differential or Definitive)
- Full Referrer Contact Details

In the case of cancer two week waits, if a referral is received which does not contain the information needed to process it, then the referring GP should be contacted immediately, thereby minimising the delay to the patient. This does not constitute a reason for making a pause to the pathway and patients should not be referred back to their GP to stop a pathway.

It is the responsibility of the staff who receives paper referrals (Appointments Hotline and Medical Secretaries) to ensure that this process is adhered to. Referrals that are not approved due to lack of clinical information can also be rejected. (See Paper-Based Referrals SOP in Appendix A).

The small number of paper referrals sent through the Trust's mail system must be opened and stamped on the day of receipt.

5.6.1.6 Referral types

- Routine
- Urgent
- Two Week Wait
- Rapid access chest pain clinic (RACPC) referrals
- Consultant to consultant referrals

Consultant to consultant referrals are only permitted when:

- They are part of the continuation of investigation or treatment of the condition for which the patient was referred – this includes referrals to pain management where surgical intervention is not intended. The RTT clock will continue.
- The referral is clinical urgent for new condition. A new RTT clock will start on the date the referral was received.
- The referral is as a result of the identification of a suspected cancer - this will be vetted and dated by the receiving consultant and upgraded if deemed necessary. Once upgraded the patient will be treated within 62 days.

In all other instances of incidental finding that are not urgent and require investigation, the clinician will write to the GP and advise that a referral for this issue is indicated.

5.6.1.7 Inter-provider transfers (IPTs) Incoming IPTs

The Trust expects an accompanying Minimum Data Set (MDS) pro-forma with the IPT details, 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.

The Appointments Hotline Team will record all tertiary referrals with a clock start date of 01/01/1900, enabling the RTT pathway to be recorded as a 'no clock start'.

The Appointments Hotline Team will review the referral letter and will:

- Update the correct clock start date if there is a completed IPT form attached to the referral letter.
- For referrals that do not include the IPT for, they will request missing IPT forms from the referring provider.
- The Appointments Hotline Team will monitor the IPT Email inbox, updating the RTT clock start when the IPT form is received.
- Should the IPT form not be received within 14 days the Senior Manager for RTT will review the referral letter. If it is clear that the referral is a new clock start, then the RTT start date will be amended. If it is unclear as to the correct clock start date pathway will remain with a clock start date of 01/01/1900 and will be submitted as a No Clock Start pathway within the RTT Return submission.

All actions will be updated on the 'No Clock Start Tracker' for audit purposes.

Please refer to IPT Form (Appendix E).

5.6.1.8 Outgoing IPTs

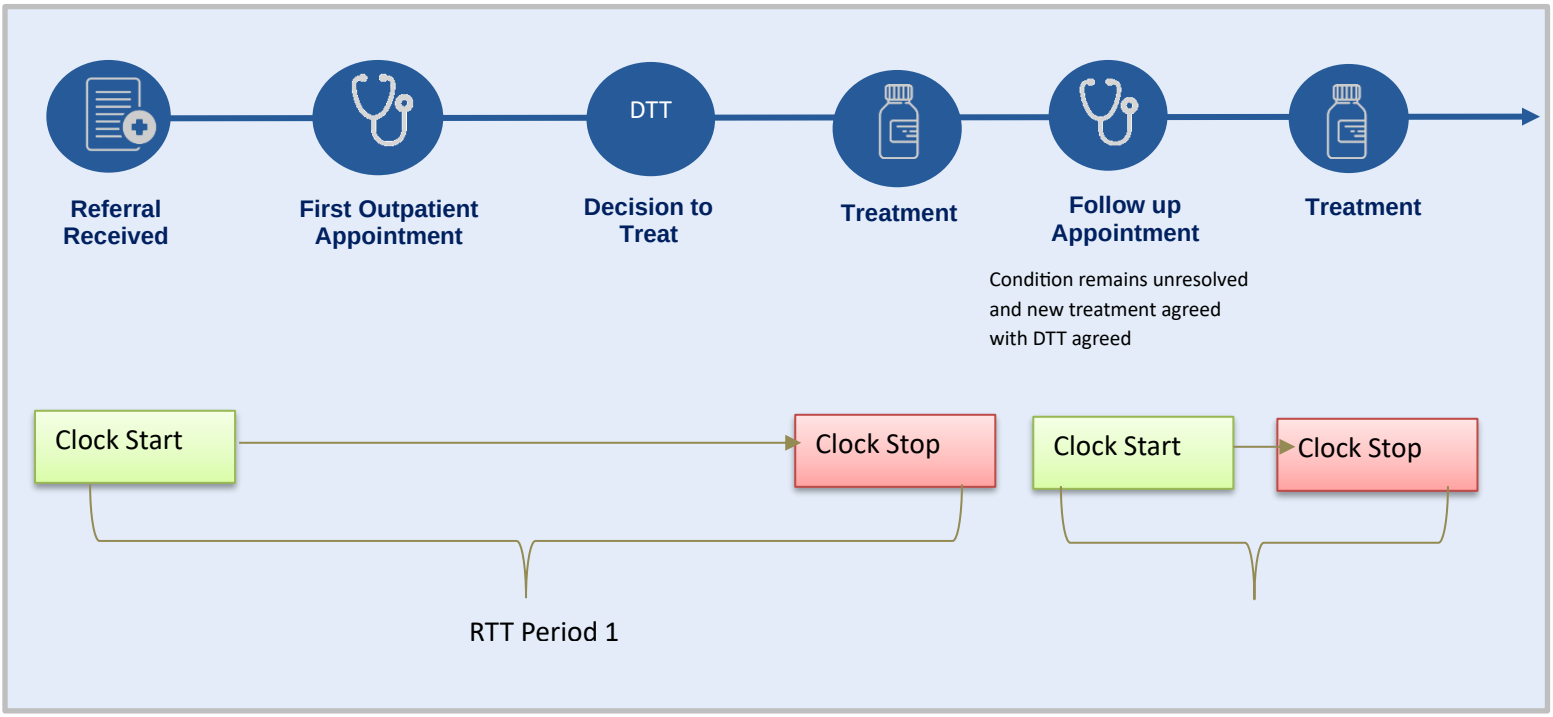
The Trust will ensure that outgoing IPTs are processed as quickly as possible to avoid any unnecessary delays in the patient's pathway.

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

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

5.6.1.9 Multiple RTT periods on the same pathway

A patient can have multiple RTT periods along the patient pathway for the same original referral. This is where a patient is treated for a condition and then has further treatment for the same underlying condition (for example, chronic or recurrent). The patient pathway will continue beyond the point the first definitive treatment starts, to include further treatment for the same condition. The RTT clocks for these treatments are sequential, not concurrent, as new treatment decisions and plans are made. There may also be periods of active monitoring between these decisions.



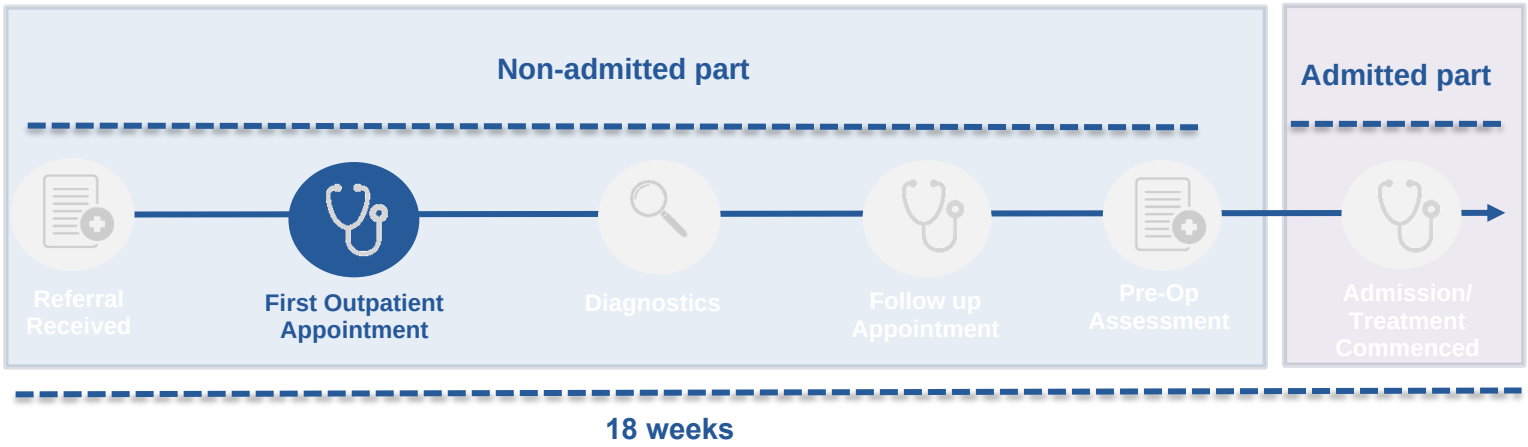
5.6.1.10 Multiple RTT pathways

Where a patient has more than one referral for unrelated clinical reasons, each referral will have its own patient pathway and RTT clock. It is important to understand any impact the management of one condition has on that for another – for example, where treatment for one condition affects the planning of another treatment or where a patient needs a period of recovery before they can be treated for another condition.

Clinical and operational teams should co-ordinate care pathways as appropriate for patients on multiple pathways. It may be appropriate to agree a period of active monitoring for one pathway while the patient undergoes and recovers from treatment on another pathway that is considered to be the clinical priority.

5.6.2 First Outpatient Appointment

Figure 3: First Outpatient Appointment Milestone



5.6.2.1 e-referral service

The Trust operates through Referral Assessment Services (RAS) and Directly Bookable services on the e-Referral Service.

5.6.2.2 RAS referrals

Patients who have been referred via a RAS (Referral Assessment Service) on e-RS should be logged on Cerner ePR+ and then triaged within 48 hours. The outcome of the triage is recorded for Appointments Hotline Team to arrange the appropriate appointment.

5.6.2.3 Directly Bookable

A directly bookable service is where direct booking is available, and the patient will leave their surgery or their referrer with either:

- An appointment, booked with their chosen provider on a date and at a time that is convenient to them
- The information necessary to enable them to make their choice of provider and to book either via the Internet or through the telephone appointments line (TAL)

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.

Regardless of the referral method, the Trust must be able to demonstrate that reasonableness criteria has been met when booking all outpatient appointments (see 4.2.10).

5.6.2.4 Paper-based referrals / RAS list

Appointments will be booked in order of clinical priority (urgent before routine) and then in chronological order of referral received date. Patients will be selected for booking from the trust's patient tracking list (PTL) only.

Patients will be offered a date for their appointment with at least three weeks' notice and within the agreed first appointment timeframe 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 timeframe, this should be escalated to the relevant service manager. (See Escalation SOP in Appendix A).

For referrals received by COCH in paper format, appointment offers declined by patients should be recorded on Cerner EPR+. This is important for two reasons: full and accurate record keeping is good practice, and the information can be used at a later date to understand the reasons for any delays in the patient's treatment, e.g., hospital or patient initiated.

5.6.2.5 Patients who are uncontactable

Where a patient waiting for a routine appointment cannot be reached by the initial phone call, three further attempts on different days at different times (ideally one out of hours after 5pm) should be made to contact the patient. If the patient still cannot be reached a letter should be sent giving the patient three weeks to make contact to book their appointment. If the patient does not make contact within those three weeks they will be returned to their referrer.

For guidance on uncontactable fast-track patients, please see section 6.1.16 of the policy.

5.6.2.6 Outpatient Clinic Types

COCH are dedicated to transforming elective care to support our patients. We offer several different types of outpatient appointments. The type of appointment offered is dependent on multiple factors and suitability of patient group and will always be determined by the responsible clinician.

Standard outpatient appointment

The patient will attend the one of COCH's hospital sites / clinics and will be seen face to face with the responsible clinician or a member of their team.

Telephone appointment

The patient will be contacted by telephone by the responsible clinician or a member of their team at an agreed date and time.

Video appointment

The patient will be contacted by telephone by the responsible clinician or a member of their team at an agreed date and time.

Virtual clinic appointment

The clinician or a member of their team will undertake a full clinical review of referral letter and clinical notes, requesting further information where required. The clinician will provide a clinical management plan which is communicated to the GP and patient informing them of the next steps, which could include, attending another type of OP clinic, sent directly to test, advising the GP of appropriate medical management etc.

5.6.2.7 First Outpatient Appointment Cancellations

Patient-Initiated Cancellation

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 a missed appointment.

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 timeframe, the issue must be escalated to the relevant speciality management team. Every effort to contact the patient will be made within 2 working days to agree an alternative date.

If the referral is a first new and the patient has never been seen and advises they no longer want an appointment, they will be removed from the relevant waiting list and the RTT clock will stop. A letter will be sent to the patient and referrer. For paediatric patients, the referral must be sent to the responsible clinician for a clinical review prior to the patient being discharged.

If a delay is incurred because of the patient cancelling, the patient's pathway should be reviewed by their consultant. Upon clinical review, the patient's consultant should indicate one of the following:

- The requested delay is clinically acceptable, and the consultant believed the treatment plan will remain the same regardless of the delay (clock continues).
- The requested delay is clinically acceptable, but the clinician feels that the treatment may change or needs further review by the time the patient is ready to proceed with treatment. (clock stops, active monitoring).

- The patient's best clinical interest would be served by discharging them to the care of their GP (clock stops, decision not to treat)

All patients must be informed at the time of their first cancellation that should they cancel the rescheduled outpatient appointment again, it is highly likely they will be discharged.

Should a patient contact the trust on a second consecutive occasion to cancel their OPA NEW, the Appointments Hotline team will email the referral details to the relevant Medical Secretarial team for the responsible consultant to review.

Following clinical review, the responsible clinician will communicate whether the patient needs to be rebooked for a further new appointment or discharged.

Should the Clinician advise that the patient is to be re-booked for a further appointment, the Clinician will email the Medical Secretarial team who will notify Appointments Hotline. Appointments Hotline will contact the patient to rebook their appointment. This will retain their existing RTT clock start date.

If the clinician deems it is within the patient's best clinical interest to discharge them to the care of their GP, they will email the Medical Secretarial team who will notify Appointments Hotline. Appointments Hotline will discharge the patient on Cerner EPR+ and generate a letter will be sent to both the patient and the GP. This would stop the RTT clock.

Hospital-Initiated Appointment Changes or Cancellations

This section covers hospital-initiated delays and processes to minimise the chance of such delays occurring.

Hospital-initiated changes to appointments will be avoided as far as possible as they are poor practice and cause inconvenience to patients. Clinicians are actively encouraged to book annual leave and study leave as early as possible. Clinicians must provide 6 weeks' notice of a clinic has to be cancelled or reduced. Requests for cancellations less than 6 weeks' notice will not be processed without written agreement by the Divisional Director and Divisional Medical Director (unless unforeseen circumstances i.e., sickness).

All cancellation requests will be made on the appropriate Trust proforma and must indicate the reason for the cancellation and the instructions in regard to rebooking the affected patients, taking into consideration, clinical priority, current waiting time and previous cancellations.

Patients will be contacted immediately if the need for the cancellation is identified and offered an alternative date(s) that will allow patients on open RTT pathways to be treated within 18 weeks. Equally, this will allow patients not on open pathways to be reviewed as near to the TBS date as possible.

For all cancelled appointments with less than 2 weeks' notice of the appointment it is the responsibility of the operational service team to contact the patient to inform them of the cancellation. This includes sickness and emergency cancellations. For any cancellations with more than 2 weeks' notice, the patient will be informed in writing by the Outpatient Team (or operational service team if they provide a non-centralised OPD).

5.6.2.8 Missed Appointment and Was Not Brought – General (See also section 5.4.1)

Children

Further information for the management of children who fail to attend appointments can be found within the following policy:

- Child Was Not Brought (WNB) Policy

Vulnerable Adults

If a vulnerable adult does not attend an appointment as expected, the responsible clinician will first check that the address is correct on Cerner EPR+. The responsible clinician will contact the patient/patient's carer. If telephone number is unavailable, the clinician will contact the patient's GP to ascertain if the contact details held are correct.

Should a vulnerable adult fail to attend two appointments, the responsible clinician will attempt to establish why the person has not attended. Clinicians will discuss any safeguarding concerns with the Trust's Safeguarding and Complex Care team. If there are safeguarding concerns, Trust safeguarding policies and pathways are to be followed:

- Safeguarding Adults Policy
- Mental Capacity Act 2005

5.6.2.9 First Outpatient Appointment – Missed Appointment

Where a patient fails to attend the first appointment after the initial referral that started their waiting time clock, their clock will be nullified (i.e., it is as if the referral never existed).

The Receptionist will ensure that the Clinician reviews the patient record and completes the 'Missed Appointment' field on the Evolve Clinic Outcome Form with the appropriate clinical decision as to whether the patient needs to be rebooked or discharged back to the care of the GP.

Should the Clinician advise that the patient is to be re-booked for a further appointment, a new RTT clock period will start on the day that the appointment is booked. For example, if the patient misses an appointment on 4th July and a conversation with the patient happens on 7th July to agree another appointment for 18th July, the new clock starts on 7th July.

If the clinician requests for the patient to be discharged, the patient will be discharged back to the care of the GP and a letter would be generated to both the GP and the patient.

Discharging patients following a first missed appointment is a clinically led decision. In all cases, the consultant will review the clinical information and if it is recommended to return the patient to the care of the GP then this is done for the patient's best clinical interests.

Telephone and Video Appointments

Missed appointments for telephone and video appointments are managed in the same way as face to face appointments as the patient still receives a letter confirming their appointment time slot.

For telephone appointments, the Clinician should attempt to call the patient twice and if there is no answer from the patient, the Clinician should then complete the 'Missed appointment' field on the Clinic Outcome Form with the appropriate clinical decision as to whether the patient needs to be rebooked or discharged.

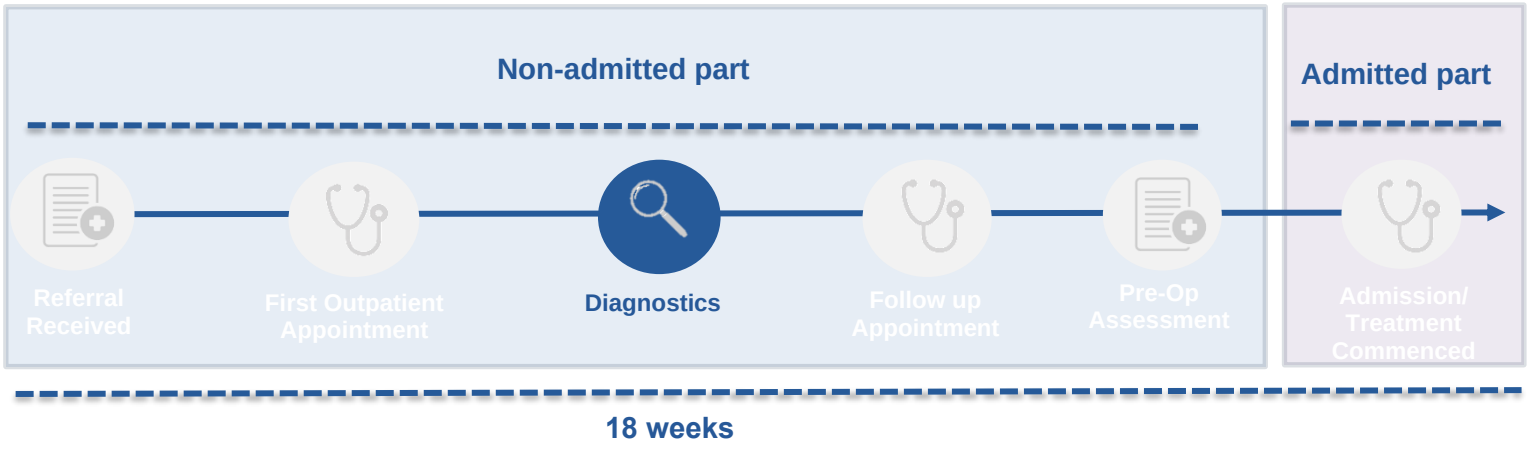
For video appointments, if the patient is not present on the Trust's video software system, the Clinician should attempt to call the patient on their contact telephone number. If the patient does not answer the telephone call, the Clinician should then complete the 'Missed appointment' field on the Clinic Outcome Form with the appropriate clinical decision as to whether the patient needs to be rebooked or discharged.

5.6.3 Diagnostics

The diagnostic stage forms part of the non-admitted pathway.

It is important to note that patients can also be referred for some diagnostic investigations directly by their GP. Should this request be for the diagnostic investigation only with the intention that the results will be returned to the GP to inform future patient management decisions, this would not be applicable to RTT and therefore would not start an RTT clock.

Figure 4: Diagnostics Milestone



5.6.3.1 National diagnostic clock rules

The Diagnostic clock starts at the point of the decision to refer for a diagnostic test by either the GP or the consultant and stops at the point at which the patient undergoes the test. For paper referrals, the clock starts upon receipt of referral into the department.

5.6.3.2 Patients with a diagnostic and RTT clock

The diagnostics section of an RTT pathway is a major pathway milestone. A large proportion of patients referred for a diagnostic test will also be on an open RTT pathway. In these circumstances, the patient will have an RTT clock, which started at the point of receipt of the original referral, and a diagnostic clock, which starts at the point of the decision to refer for diagnostic test (often at the first outpatient consultation).

5.6.3.3 Straight-to-test arrangements

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

2WW referrals with a 'straight to test' diagnostic appointment should be booked within 14 days of referral. If not diagnosed with cancer, there is a clinical step-down process where they are passed to the relevant medical secretary to request clinician sign off to remove the patient from the 62-day pathway.

5.6.3.4 Patients with a diagnostic clock only

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

Patients within secondary care, referred for a diagnostic test, may also have just their diagnostic clock running, following a previous clock stop for treatment or non-treatment as part of their ongoing care / monitoring. It is only at the point of a new / substantively different treatment plan that a new RTT clock will start in this scenario. This scenario could occur in respect of surveillance patients.

Example

Mr. L has been under surveillance for Barrett's oesophagus for the past 5 years **[RTT clock stopped]**. As part of his surveillance, he undergoes an annual gastroscopy to monitor any potential changes in his condition. His latest gastroscopy results indicated changes that may require surgical treatment. Consequently, the clinician refers Mr. D to the Upper Gastrointestinal Consultant for consideration of a surgical procedure **[RTT clock starts].**

5.6.3.5 Booking diagnostic appointments

The appointment will be booked as close to the point that the decision to refer for a test was made wherever possible. Patients requiring an XRAY are to be advised to contact the diagnostic department by phone to make their appointment. All other diagnostics including Endoscopy will be sent an appointment from the diagnostics booking team. All patients will be offered a date for their diagnostic test with reasonable notice i.e., no less than 3 weeks' notice (see 4.2.10). However, there are exemptions to this, for example, if a patient is on a 2WW pathway or short notice appointment has become available. In these instances, the patients will be contacted via telephone.

If a patient declines, cancels or does not attend a diagnostic appointment, the diagnostic clock start can be reset to the date of the original appointment by the relevant diagnostic booking team. However, the trust must be able to demonstrate that the patient's original diagnostic appointment fulfilled the reasonableness criteria (no less than 3 weeks' notice) 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.

5.6.3.6 Diagnostic Patient Cancellations

All patients must be informed at the time of the first cancellation that should they cancel the rescheduled diagnostic test again, it is highly likely they will be discharged.

Should a patient contact the trust on a second consecutive occasion to cancel their diagnostic test in Radiology, the patient will be returned to their GP/referring Clinician and the diagnostic RTT clock will be stopped. Communication confirming this is sent to the referring clinician. For GP's, this will be via a letter and for internal Clinicians, this will be via Cerner EPR+ message centre. Should the referring Clinician wish for the patient to rebooked, a re-referral will need to be made. Exceptions to this are patients on a cancer pathway (suspected or diagnosed), vulnerable adults, or patients who are deemed high clinical risk and therefore will be clinically reviewed for a decision on whether the patient should be discharged or rebooked.

Should a patient contact the trust on a second consecutive occasion to cancel their diagnostic test in Endoscopy, the patient will be returned to the referring Clinician and the diagnostic RTT clock will be stopped. Communication confirming this is sent to the referring clinician via

email. Should the referring Clinician wish for the patient to rebooked, a re-referral will need to be made. Exceptions to this are patients on a cancer pathway (suspected or diagnosed), vulnerable adults, or patients who are deemed high clinical risk and therefore will be clinically reviewed for a decision on whether the patient should be discharged or rebooked.

5.6.3.7 Diagnostic Missed Appointment

In regard to patients that miss their appointment for their diagnostic test in Radiology where reasonableness criteria has been met, the patient will be returned to their GP/referring Clinician and the diagnostic RTT clock will be stopped. Communication confirming this is sent to the referring clinician. For GP's, this will be via a letter and for internal Clinicians, this will be via Cerner EPR+ message centre. Should the referring Clinician wish for the patient to rebooked, a re-referral will need to be made. Exceptions to this are patients on a cancer pathway (suspected or diagnosed), vulnerable adults, or patients who are deemed high clinical risk.

In regard to patients that miss their appointment for a diagnostic test in Endoscopy where reasonableness criteria has been met, the patient details will be sent to the referring clinician for a decision on whether the patient needs to be rebooked or discharged. Should the clinician advise that the patient is to be re-booked for a further appointment, the booking team will contact the patient to rebook their appointment. If the clinician deems it is within the patient's best clinical interest to discharge the patient, the booking team will discharge the patient on Cerner EPR+ and the diagnostic RTT clock will be stopped. Exceptions to this are patients on a cancer pathway (suspected or diagnosed), vulnerable adults, or patients who are deemed high clinical risk. Patients who fall within one of these cohorts will be re-booked a further appointment and only escalated to the referring clinician if they miss their diagnostic appointment on a second consecutive occasion.

5.6.3.8 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 commenced treatment. The only exceptions are planned patients (see 4.16.9 below).

All requests for a diagnostic test that is included within the diagnostic DM01 return, should include the appropriate clinical prioritisation code (D Status).

DM01 applicable diagnostics:

- Barium enema
- CT Scan
- Dexa Scan

- Echocardiography
- MRI Scan
- Non-obstetric Ultrasound Scan
- Audiology Assessment
- Sleep Studies
- Urodynamics (CMG's)
- Colonoscopy
- Gastroscopy
- Flexi Sigmoidoscopy
- Cystoscopy

5.6.3.9 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 and visible to the organisation.

In Radiology, the planned patients are actively monitored to ensure the patients are vetted and booked for a future test if required, at the necessary point in time. Please refer to MRI Workflow for Cerner Guidance (section 3.6 Planned Requests).

In Endoscopy, if the patient's wait goes beyond the specified due date for the test, they will be transferred to an active waiting list from their due date and a new diagnostic clock (applicable modalities only) and RTT clock will be started.

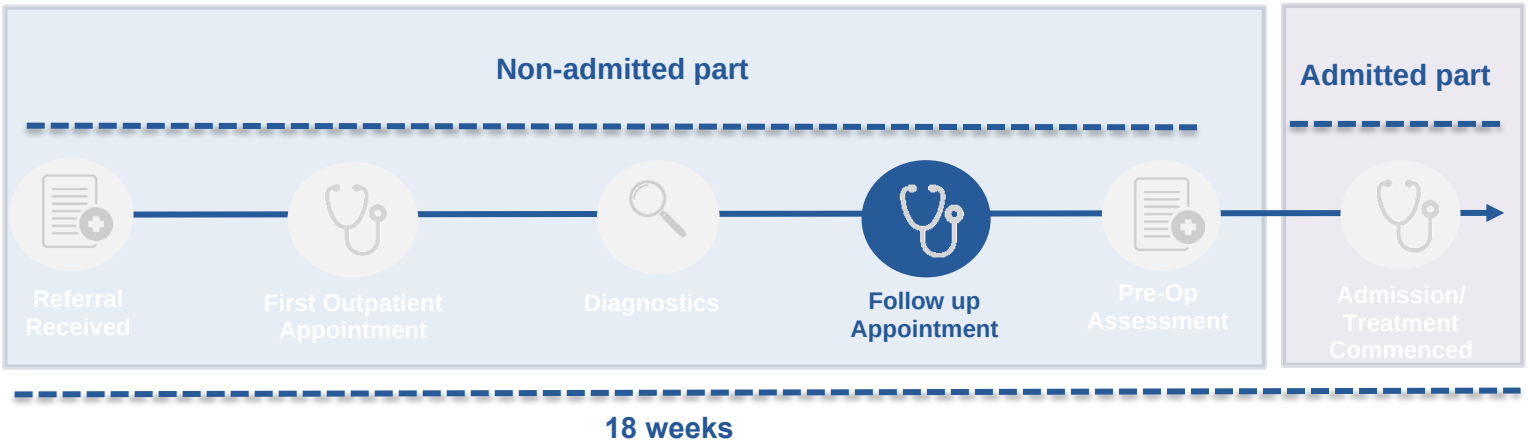
5.6.3.10 Therapeutic procedures

For some patients, a referral to diagnostic services could be for a therapeutic procedure (treatment) alongside their diagnostic test. The diagnostic waiting time standard is applicable to these patients. For example, a referral for a colonoscopy that will also result in a polypectomy.

Where the patient is solely waiting for a therapeutic procedure within a diagnostic setting, the diagnostic waiting time standard is not applicable; however, the RTT clock will be active, for example, a long-term cardiac patient being referred for a stent (a new RTT clock would start, however diagnostic waiting time standard would be non- applicable).

5.6.4 Follow Up Appointment

Figure 5: Follow up Appointment Milestone



5.6.4.1 Booking Follow Up Appointments

Where possible, follow up appointments for 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 specified by the responsible clinician, taking into account the clinical priority and 18-week pathway.

Patients requiring a follow up appointment will either:

- Leave clinic with a booked follow up appointment made by the reception team
- Be added to the follow up (FU) waiting list by the reception team, and their future appointment will be scheduled in chronological order in respect of their 'to be seen' date by the secretarial team.
- Be added to 'Patient Initiated Follow Up' (PIFU) waiting list where the patient can make contact to schedule a follow up appointment if required.

5.6.4.2 Managing the Follow up Waitlist (RTT & Non RTT)

The secretarial teams will proactively manage and maintain the FUWL ensuring any updates are added to the FU validation tracker i.e. patient cancellation, reasons, declined offers and a next 'validation date'. This will ensure patient are managed in a timely way. When a patient is listed for a time specific follow up appointment, all efforts will be made to schedule the appointment on time. At the start of every month, the secretarial teams will work closely with the divisional management team to escalate any patients with a 'to be seen' date where capacity is not available to book a follow up appointment. These patients will be escalated to the responsible clinician to ascertain if:

- Patient must be seen – an appointment must be identified. This could be by overbooking a clinic or displacing a less urgent patient (patient to displace must be identified by the clinician).
- Patient needs to be seen but could wait longer. The waitlist will be updated with the new 'to be seen date'. A letter will be sent to the patient and GP confirming this decision.
- Patient no longer requires an appointment. Patient will be removed from the waitlist and discharged. A letter will be sent to the patient and GP confirming this decision.

5.6.4.3 Follow Up Appointment Cancellations

All patients must be informed at the time of the first cancellation that should they cancel the rescheduled appointment date again, it is highly likely they will be discharged.

Should a patient contact the trust on a second consecutive occasion to cancel their clinical episode, the Medical Secretarial team will email the patient details to the responsible consultant to review.

Following clinical review, the responsible clinician will communicate whether the patient needs to be rebooked for a further appointment or discharged.

Should the Clinician advise that the patient is to be re-booked for a further appointment, the Clinician will email the Medical Secretarial team who will contact the patient to rebook their appointment. This will retain the existing RTT clock start date.

If the clinician deems it is within the patient's best clinical interest to discharge them to the care of their GP, they will email the Medical Secretarial team who will discharge the patient and generate a letter which will be sent to both the patient and the GP. This would stop the RTT clock.

5.6.4.4 Follow Up Appointment - Missed Appointment

In regard to patients that miss their subsequent clinical episode, the Receptionist will ensure that the Clinician reviews the patient record and completes the missed appointments field on the Clinic Outcome Form with the appropriate clinical decision as to whether the patient needs to be rebooked or discharged.

Should the Clinician advise that the patient is to be re-booked for a further appointment, the patient will be rebooked retaining their existing RTT clock start date.

If the clinician requests for the patient to be discharged, the patient will be discharged back to the care of the GP with a letter to both the GP and the patient. This would stop the RTT clock.

Discharging patients following a subsequent missed appointment is a **clinically led decision**. In all cases, the consultant will review the clinical information and if it is recommended to return the patient to the care of the GP then this is done for the patient's best clinical interests.

Telephone and Video Appointments

See 5.6.2.9 First Outpatient Appointment – missed appointments

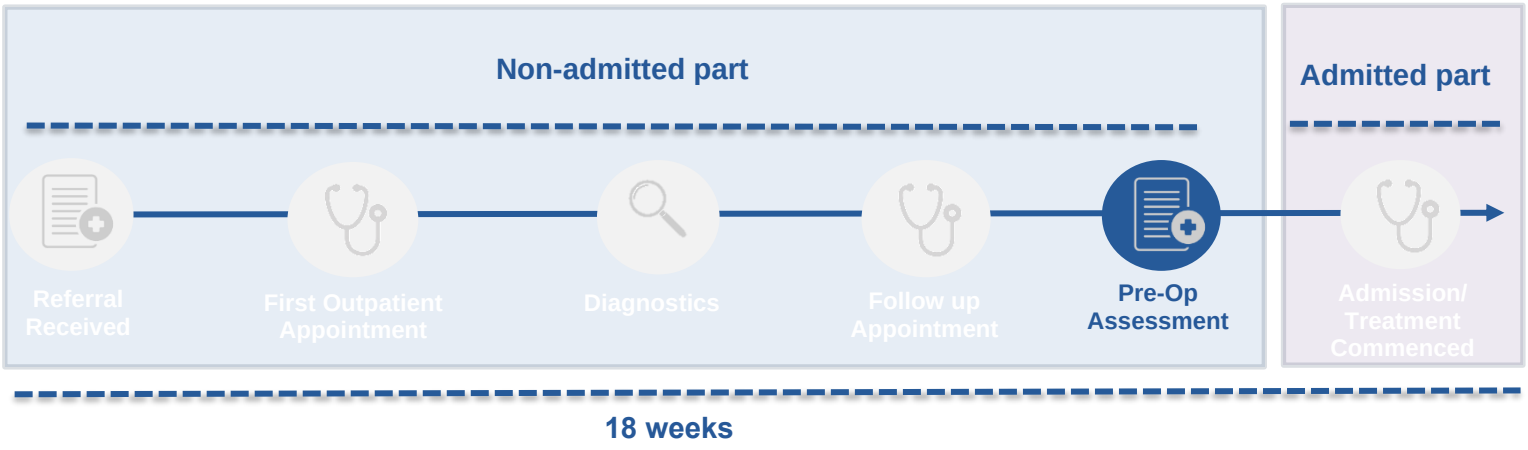
5.6.4.5 Non-Patient Facing RTT Milestones

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 GP/Patient.

Administration staff should update Cerner EPR+ with the clock stop once the letter has been typed. The date recorded will be the day the decision not to treat is communicated to both the patient and the GP.

5.6.5 Pre-operative Assessment

Figure 6: Pre-operative Assessment Milestone



5.6.5.1 Booking Pre-operative Assessments (POA)

A COCH POA is booked by the admissions team at the point of the TCI being offered to the patient.

If a patient is suitable to attend gatekeeper following their OPA, they will be sent directly to the gatekeeper where a decision will be made regarding the point of delivery of their POA. This may be a virtual (via telephone) or face to face appointment with a nurse as well as with a pharmacist and/or an anaesthetist where applicable.

A COCH POA can be offered on the same day as the patient's outpatient and gatekeeper appointment or pre-bookable if the same day appointment is not appropriate / inconvenient. Where services offer same day POA, patients should be made aware in advance that they may need stay longer on the day of their appointment for attendance in POA.

Consideration for POA's is given to all patients whether they are having a procedure under general anaesthetic or local anaesthetic.

5.6.5.2 Pre-operative Assessment Cancellations

All patients must be informed at the time of the first cancellation that should they cancel the rescheduled POA again, it is highly likely they will be discharged.

5.6.5.3 Pre-operative Assessment Missed Appointments

For any patients which fail to attend their POA appointment, the admissions officer will contact the patient to find out the reason behind the missed appointment. The admissions officer will then book another POA for the patient.

If the patient fails to attend on a second consecutive occasion, the admissions officer will send an email with the details to the consultant for a clinical review to see if the patient can be rebooked for a further POA or removed from the waitlist.

5.6.5.4 Unfit for Treatment

If the patient is identified as unfit for the procedure, the nature and duration of the clinical issue should be ascertained by the responsible clinician to determine whether:

Short-term Illness (Unwell)

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

Example

Mrs. S contacted the TCI clerk to report a chest infection. After reviewing her clinical notes, the consultant noted no history of chronic chest conditions and anticipated that she would recover within a few weeks. The consultant instructed the TCI clerk to offer her a new date in a few weeks' time **[RTT clock continues].**

Long-term Illness (Unfit)

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. The patient should be optimised/treated within secondary care (active monitoring), or they should be discharged back to the care of their GP (decision not to treat).

Example

Mr. H attended a pre-operative assessment before scheduling his elective surgery. The pre-op nurse reviewed his diagnostic results and noted that his blood pressure was outside clinical guidelines, prompting a referral back to his GP for treatment to optimise his condition before a surgery date could be set **[RTT clock stops].**

5.6.5.5 Patients Requiring Re-assessment

In some cases, irrespective of if the patent is unwell or unfit; the patient will require reassessment of their symptoms following a period of illness to ensure that the original treatment plan is still clinically appropriate to the patient's symptoms at the point of reassessment. In all instances this will be clearly communicated to the patient.

Example

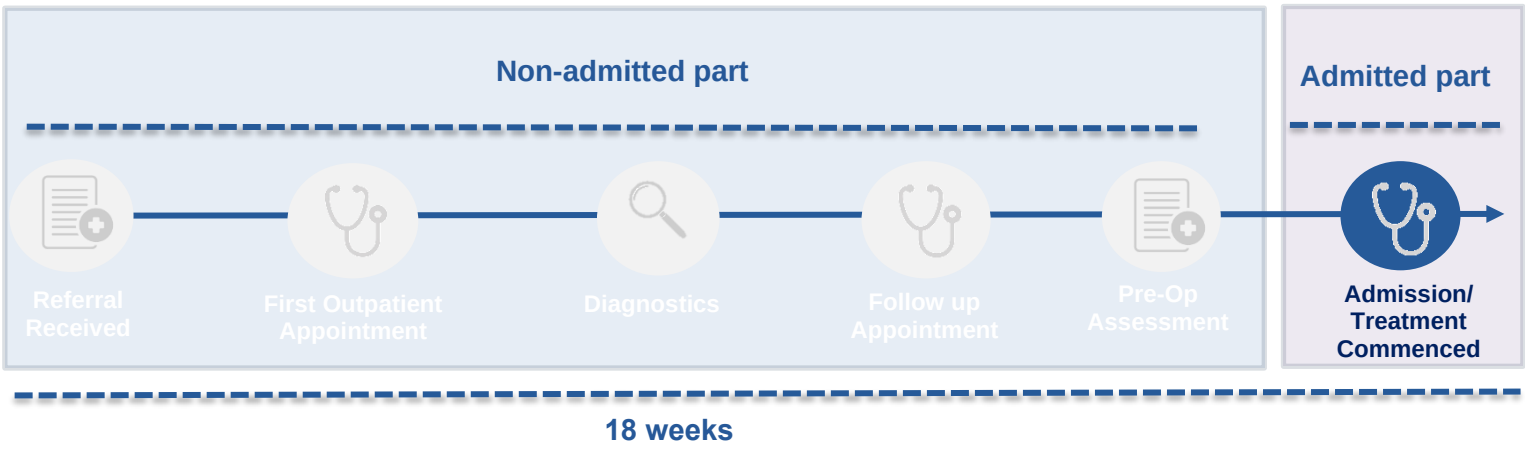
Miss J is scheduled for an elective orthopaedic procedure next week but called the TCI clerk to cancel her admission due to chicken pox. After reviewing her case, the orthopaedic consultant confirmed that, despite the short incubation period, the infection risk necessitates a full reassessment to ensure Miss J is clinically fit for surgery before rescheduling. The consultant dictates a letter to both Miss J and her GP to inform them of this decision **[RTT clock stops].**

5.7 Admitted Pathway

The admission milestone starts from when a decision to admit (DTA) has been made. Admission can be for a diagnostic (such as endoscopy) where the clock *would not* usually stop on admission, or a treatment, where the clock *would* usually stop on admission.

5.7.1 Elective Admissions

Figure 7: Admission Milestone



5.4.7.1.1 Age Restriction to Elective Admissions

No child under the age of 2 may be routinely listed for elective surgery at COCH. However, there are some exceptions based on input from a consultant anaesthetist. Most children under this age are often referred to an appropriate provider with choice.

5.7.1.2 Planned Patients

Patients will only be added to the Planned Waiting List when it is deemed clinically necessary for the patients to undertake a procedure at a defined time in the future. The patient will be added to the waiting list with a due date, as agreed between the patient and responsible clinician.

When patients on planned lists reach their due date and are clinically ready for their treatment, they will be offered a TCI date by the due date. If there is no capacity for the patient to be admitted for the procedure, a new RTT clock will start. For some patients (e.g., surveillance endoscopies) a diagnostic clock would also start.

All patients moved to the elective waiting list when overdue their planned procedure will be clinically reviewed and allocated the appropriate clinical prioritisation code as per the table below (P Status (therapeutic / D Status DM01 applicable diagnostics). This code will be included in the IPWL order.

Code	Suggested wait time for treatment
P1	Emergency
P2	Less than 1 month
P3	Less than 3 months
P4	Greater than 3 months
C2	Patient Choice – Active Monitoring for 4 Weeks
C3	Patient Choice – Active Monitoring for 8 Weeks
C4	Patient Choice – Active Monitoring for 12 Weeks

5.7.1.3 Adding Patients to the Elective Waiting List

All patients requiring admission to COCH will be added to the inpatient waiting list. Admissions can be for elective surgical procedures, or elective IP stays for other reasons, such as diagnostics.

All patients added to the Elective IPWL will be given a clinical prioritisation code (P Status) by the responsible clinician and this will be added to the order in Cerner EPR+.

The inpatient waiting list shows both elective and planned patients, from the date they were added to the inpatient waiting list. To review patients with an open RTT pathway, the RTT PTL can be reviewed and managed which gives details of all patients with an open RTT pathway and the stage of their pathway the patient is at that time.

Patients must 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 POA, or whether they have declared a period of unavailability at the point of the decision to admit.

When adding a patient to the elective inpatient waiting list, the RTT clock will still be ticking from the original clock start date and stop on admission to COCH for their procedure.

Following a previously stopped pathway, should the patient be listed for a procedure that is deemed a substantively new treatment plan which did not form part of the original treatment package, the RTT clock will start on the date the decision was made to add the patient to the inpatient waiting list for the new / substantively different treatment.

Example

Mrs. G is a long-term patient under Gastroenterology for monitoring her inflammatory bowel disease (IBD). After successfully managing her symptoms with medication for the past 3 years, both she and her consultant agree that it is time for surgery to alleviate her current symptoms. Consequently, the Gastroenterologist refers Mrs. G to Colorectal Surgery for consideration of colorectal surgery **[RTT clock starts: referral for surgical assessment].**

5.7.1.4 Patients requiring more than one procedure, or bilateral surgery

A bilateral procedure is one that is performed on both sides of the body at matching anatomical sites, for example cataract removal from both the left and right eyes.

Consultant led bilateral procedures are covered by 18 weeks with a separate clock for each procedure. When the first procedure has been carried out the RTT clock will stop. When the patient becomes fit and ready for the second consultant-led procedure or bilateral procedure, a new RTT clock will start.

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 that formed the original treatment plan, the patient will be added to the active waiting list for the primary (1st) procedure. When the first procedure is complete and the patient is fit, ready and able to undergo the second procedure, the patient will be added (as a new waiting list entry) to the waiting list, however a new RTT clock will not start.

5.7.1.5 Patients requiring thinking time

Patients may wish to spend time thinking about the recommended treatment options before confirming they would like to proceed. The patient's decision to initiate thinking time must be agreed with a clinician and on an individual patient basis with their best clinical interests in mind. It would be appropriate to contact patients after 2 – 3 weeks to enable a decision to be made. If the patient is still undecided a discussion between the Consultant and patient can take place at this point. If there is a shared decision to place the patient on active monitoring

at this point, then the RTT clock would be stopped, and a follow up appointment must be arranged at an agreed future date. A new RTT clock will start from the date of the decision to admit if the patient decides to proceed with surgery.

A further option could be (if appropriate both clinically and from a patient's perspective) to stop the RTT waiting time clock and refer back to primary care e.g., if patient decides to see how they cope with their symptoms. The patient may be re-referred, and a new RTT clock would start when a decision to treat is made.

For cancer referrals it is not appropriate to discharge back to the GP. Cancer patients will often require longer than 5 days thinking time and it is good practice for the clinical nurse specialist to keep in contact with the patient. Under the Cancer Waiting Times guidance, active monitoring cannot be used for patient thinking time, with the exception of low and low-intermediate risk prostate cancer patients.

5.7.1.6 Scheduling Patients to Come in for Admission

Patients awaiting surgery will be listed in priority order; this will be influenced by their P (priority) number as well as their clinical urgency (routine, urgent or urgent suspected cancer). Patients with a P number of 1 and 2 will be prioritised above those with a 3 or a 4. Urgent Suspected Cancer (USC) patients will be seen sooner than those marked urgent or routine.

All patients will be identified from the Trust's PTL, and subject to the clause above about clinical priorities, will be scheduled for admission in chronological order of RTT wait i.e., longest wait first.

Patients will be offered an admission date with a minimum of three weeks' notice where clinically appropriate in line with reasonable criteria. However, more urgent patients, including P2s and USC patients may be seen sooner. More routine admission dates can be offered with less than three weeks' notice and if the patient accepts, this can then be defined as 'reasonable'.

If there is insufficient capacity to offer dates within the required timescale, this issue will be escalated to the relevant Service or Directorate Manager. Any admission offers declined by patients will be recorded on the Cerner EPR+ system. This is important as full and accurate record-keeping is good clinical practice, and the information can also be used at a later date for audit purposes.

5.7.1.7 TCI Patient Cancellations / Decline Reasonable Admission Dates

All patients **must be** informed at the time of the first cancellation / decline that should they cancel / decline a further reasonable offer of a TCI date, it is likely they will be placed onto a period of active monitoring or discharged back to their GP.

Should a patient contact the Trust on a second consecutive occasion to cancel what is deemed as a reasonable admission date, a clinical review will determine whether the delay to treatment is clinically safe. The clinical review may result in:

- the patient being placed onto a period of active monitoring for up to 12 weeks
- the patient being discharged to the care of their GP
- the patient being contacted as the delay is not clinically safe, with the view to persuade the patient not to delay their treatment

For patients who are placed onto a period of active monitoring for up to 12 weeks, the process is:

- Admissions to record the two dates offered on Cerner EPR+
- Email the Patient Pathway Co-ordinator with patient details and dates offered
- Pathway coordinator will update the RTT pathway
- The assistant service manager arranges for a letter to be sent to the patient

For further information, please refer to the RTT guidance for patients declining two reasonable admission dates.

If a patient wishes to remove themselves from the waitlist, admissions will remove them and email the clinician and record on Cerner EPR+.

5.7.1.8 Patients declaring periods of unavailability while on the IP waiting list

If patients contact COCH to communicate periods of unavailability for social reasons (e.g., holidays, exams), this period should be recorded on Cerner EPR+.

The patient's pathway will be reviewed by their consultant. Upon clinical review, the patient's consultant will indicate one of the following:

- The requested delay is clinically acceptable, and the consultant believed the treatment plan will remain the same regardless of the delay (clock continues).
- The requested delay is clinically acceptable, but the clinician feels that the treatment may change or needs further review by the time the patient is ready to proceed with treatment. (clock stops, active monitoring).
- The patient's best clinical interest would be served by discharging them to the care of their GP (clock stops)

5.7.1.9 On-the-day cancellations

Where a patient is cancelled on the day of admission or day of surgery for non-clinical reasons, they will be rebooked within 28 days of the original admission date and the patient must be given reasonable notice of the rearranged date (if a patient agrees a date with less than 3 weeks' notice, this would be deemed 'reasonable').

The patient may choose not to accept a date within 28 days, and as such the patient will not breach the 28-day standard.

5.7.1.10 TCI Missed Appointments

Where a patient fails to attend their admission date, the responsible clinician will be informed, and the admissions officer will contact the patient to see if they require another TCI date.

If the clinician requests for the patient to be discharged, the patient will be discharged back to the care of the GP and admissions will remove the patient from the waitlist. A letter to confirm the discharge will be sent to the GP and the patient.

5.8 Non-consultant led pathway and RTT Clocks

5.8.1 Acute Therapy Services

Acute therapy services consist of physiotherapy and dietetics. Referrals to these services can be:

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

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

5.8.1.1 Physiotherapy

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

Example

Miss G has been diagnosed with Carpal Tunnel Syndrome but has opted not to undergo surgery at this time. She is referred for a course of physiotherapy. Upon attending her first physiotherapy appointment, the RTT clock stops **[RTT clock stop on attendance of first physio appointment].**

For patients on an orthopaedic pathway referred for physiotherapy for symptom control whilst awaiting surgery, the RTT clock continues,

Example

Miss G has been diagnosed with Carpal Tunnel Syndrome and wishes to proceed with surgical treatment. Due to a long waiting list for the procedure, she is referred for a course of physiotherapy to help manage her pain while waiting for admission **[RTT clock continues: treatment ongoing during waiting period]**.

NB: Should the patient be referred to the Physiotherapy service provided by the Community Trust the RTT clock will stop on referral to the community physiotherapy service.

5.8.1.2 Surgical Appliances

For patients on an orthopaedic pathway referred for a surgical appliance as first definitive treatment, the RTT clock stops when the patient is fitted with the appliance,

Example

Miss G has been diagnosed with Carpal Tunnel Syndrome and does not wish to undergo surgery. She is referred for a wrist splint. During the initial appointment, no splints are in stock, so a follow-up appointment is scheduled. At the follow-up, Miss G is issued the splint, and the RTT clock stops at that point **[RTT clock stops when splint is issued].**

For patients on an orthopaedic pathway referred for a surgical appliance for symptom control whilst awaiting surgery the RTT clock continues,

Example

Miss G has been diagnosed with Carpal Tunnel Syndrome and wishes to proceed with surgical treatment. Due to a long waiting list for the procedure, she is referred for a wrist splint to help manage her pain while awaiting admission. The appointment for the splint is scheduled on the same day as her orthopaedic appointment, and the splint is issued that day **[RTT clock continues: treatment ongoing while waiting for surgery].**

5.8.1.3 Dietetics

Patients can be referred to Dietetics for definitive treatment,

Example

Mr. O has been diagnosed with coeliac disease, for which the definitive treatment is a gluten-free diet. The consultant refers him to the dietitian without providing any advice or diet sheets during the clinic visit. The dietitian is available on the same day as the clinic appointment, explains the diet, and sends a prescription request to Mr. O's GP for gluten-free products **[RTT clock stop].**

Alternatively, patients can be referred to dietetics as an important step within their pathway, such as patient requiring bariatric surgery, and therefore the definitive treatment will be the bariatric surgery and appointment with the dietician would not stop the clock

Example

Miss T has been referred for consideration of bariatric surgery. As part of the pre-operative workup, she must attend an appointment with the dietitian. During this appointment, the dietitian explains the dietary requirements Miss T will need to follow post-surgery and discusses the risks associated with not adhering to the diet **[RTT clock continues].**

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

5.9.1 Appointment Reminder Service

COCH provides an appointment reminder service to patients for outpatient appointments, with reminders sent 7 days and again 2 days prior to the scheduled appointment date. Reminders are delivered via SMS to the patient's mobile phone and by email, using the contact details we have for the patient on EPR+. Please note that reminders are not available for landline phones.
For services utilising the Patient Engagement Portal (DrDoctor), patients can also request cancellations or a reschedule of their appointments through the portal up to 4 days before the scheduled date.

5.9.2 Arrivals late for clinic

Patients who arrive late for their appointment due to unforeseen circumstances must still be seen if there is a clinician available in clinic.

Every patient, new and follow-up, whether attended or not, will have an attendance status and outcome recorded using the Clinic Outcome Form (Appendix E) which is then transcribed into Cerner EPR+. The aim is for clinics to be fully outcomed or 'cashed up' within five working days of the clinic taking place by the clinic receptionist or the operational teams responsible for the clinic.

5.9.3 Copy letters to a patient

As a general rule, where possible, letters written by one health professional to another about a patient/service user should be copied to the patient/service user or, where appropriate, parent or legal guardian. Patients/service users can also contact the hospital and request a copy of their letters. All clinical correspondence, therefore, must be typed on the Medisec system.

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 (Appendix F) which is picked up by reception staff immediately following the appointment and transcribed into Cerner EPR+.

When attending clinic, patients may be on an open pathway (i.e., waiting for treatment with an RTT clock running) or 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

RTT statuses at the end of their outpatient attendance, depending on the clinical decision.

The clerk will only input the RTT status code that is ticked by the responsible clinician on the Clinic Outcome Form (Appendix E) Should an outcome form not be received, or the code ticked not be available in Cerner EPR+ to select, the reception team will chase the relevant secretarial team for a Clinic Outcome Form and RTT status.

Accurate and timely recording of RTT statuses at the end of the clinic are therefore critical to supporting the accurate reporting of RTT performance. Therefore, the Reception team will ensure a Clinic Outcome Form (Appendix E) is returned at the end of clinic for every patient (including missed appointments) and will request any missing forms from the clinician at the end of the clinic. Traffic Light posters are visible in all clinic rooms to support the clinicians to tick the correct status (Appendix F). Any clinics whereby the COF is continually not completed by the responsible clinician will be escalated to the relevant Service Manager.

5.11 Reasonableness

Reasonableness is a term applicable to all stages of the elective pathway. Reasonableness refers to specific criteria which should be adhered to when offering routine appointments and admission dates to patients to demonstrate that they have been given sufficient notice and a choice of dates. A reasonable offer is defined as “an offer of 2 dates with 3 weeks’ notice from the date the offer is made:

Should a patient agree to a date with less than the reasonable notice periods defined above, this then becomes a reasonable offer.

5.12 Chronological Booking

Patients will be selected for booking appointments or admission dates according to clinical priority. Clinical priority for patient’s waiting on the ASI list will be determined by the referring GP practice.

Patients of the same clinical priority will be appointed / treated in chronological order according to their referral date, i.e., the patients who have been waiting longest will be seen first. Patients will be selected using the trust’s patient tracking lists (PTLs) only.

In addition, long waiting RTT patients who are likely to breach the nationally mandated timescales should also be prioritised. Liaison between booking teams and specialty teams is required to ensure sufficient capacity is available.

Patients will not be selected from any paper-based systems, and management of patient lists via paper-based systems is strictly prohibited.

5.13 Communication

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

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

6.0 CANCER PATHWAYS

6.1 Introduction and Scope

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

6.1.1 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 to the National Cancer Waiting Times Database within nationally predetermined timescales.

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

6.1.2 Duties and Responsibilities

Role	Responsibility
Trust Lead Cancer Clinician	Responsible for ensuring high standards of cancer clinical care across the organisation in a timely manner, leading the development of the cancer strategy.
Trust Lead Cancer Nurse	Responsible for development of the cancer nursing strategy with professional line management responsibility for the Trust's cancer clinical nurse specialists.
Tumour Group Clinical Leads	Responsible for ensuring clinical pathways are designed to deliver treatment within 62 days of referral. Responsible for reviewing the outputs of any breach root cause analysis to develop actions to resolve any delays to patients.
Head of Operations for Cancer	Responsible for ensuring robust cancer priorities are identified and delivered on with robust plans in place for Cancer Waiting Times (CWT). Ensures operational performance is effectively managed across the Trust in relation to all CWT.
Cancer Manager	Responsible for data required for managing and reporting cancer waiting times, activity, and cancer outcomes. Ensures there is a robust standard operating procedure for the external reporting of performance. They are also responsible for monitoring delivery of key tasks by the MDT coordinators.
Cancer Support Manager	Daily responsibility to ensure MDT Coordinators manage patients on the PTL. They are responsible for the production of data to report all cancer-waiting times by completion of data checks and validation of data in line with national submission deadlines. Ensure escalations are generated where appropriate and directed to the correct person.
MDT Co-ordinators	Responsible for monitoring the cancer pathway for patients following the first attendance, ensuring it is managed in line with this policy and assisting in the proactive management of patient pathways on PAS and the cancer management system.

6.1.3 Cancer Waiting Time Standards

The Trust must comply with the following waiting time standards:

Service Standard	Operational Standard
Maximum 62 days from receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade **to First Definitive Treatment** of cancer	70% by March 2025
Maximum wait of 28 days from receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent referral of any patient with breast symptoms, (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer.	77% by March 2025 moving towards the 80% ambition by March 2026
Maximum 31 days From Decision To Treat/Earliest Clinically Appropriate Date to treatment of cancer.	96%

6.1.4 Summary of the Cancer Rules

6.1.4.1 Clock Starts

A 28-day (FDS) 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)
- Referral from NHS cancer screening programme

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)

A 31-day cancer clock will start following:

- A DTT for first definitive treatment
- A DTT for subsequent treatment
- An ECAD (Earliest Clinically Appropriate Date) 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.

6.1.4.2 Clock Stops

A 62-day cancer clock will stop following:

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

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

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

A 31-day cancel 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.

6.1.5 Referral Methods

All suspected cancer referrals should be referred by the GP/GDP on the relevant cancer pro forma provided and submitted via e-referral or ACJ (Welsh).

Day 0 is the date the referral was received.

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

All Urgent Suspected Cancer referrals will be checked for completeness by the Appointments Hotline team within 24 working hours of receipt of referral.

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

Any Urgent Suspected Cancer referral received by the Trust for a service that the Trust is not commissioned to deliver will be returned electronically to the referring GP within 24 hours of receipt.

Any Urgent Suspected Cancer referral received inadvertently by the Trust which was meant for another Trust will be returned electronically the referring GP within 24 hours of receipt.

6.1.6 Downgrading referrals from two-week wait

The Trust cannot downgrade Urgent Suspected Cancer referrals. If the consultant or member of the clinical team believes the referral does not meet the criteria for an Urgent Suspected Cancer referral they must contact the GP to discuss. If it is decided and agreed the referral does not meet the Urgent Suspected Cancer criteria, the GP can retract it and refer on a non Urgent Suspected Cancer referral pro forma. It is, however, only the GP who can make this decision. Urgent Suspected Cancer referrals received via a RAS on e-RS can be returned to the referrer with advice.

6.1.6.1 Two referrals on the same day

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

6.1.7 Screening Pathways

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

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

6.1.8 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. The upgrade must occur before the DTT date. Patients not upgraded at this point will be measured against the 31-day DTT to first definitive treatment. An upgrade is intended for suspected new primaries only, not those who may be suspected of a recurrence.

Any healthcare professional receiving the referral or reviewing the patient or diagnostic result can upgrade the patient or delegate this responsibility to an identified appropriate

healthcare professional. The consultant or delegated member of the team upgrading the patient is responsible for informing the MDT coordinator at the time 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.

Where a patient is referred to an MDT meeting on suspicion or with a confirmed cancer, the date of this request must be counted as a consultant upgrade. If a patient is being referred to another provider for MDT discussion, the upgrade date is the decision made on or before the date of the inter-provider transfer.

6.1.9 Subsequent Treatment

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

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

6.1.10 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. For advice on reasonable adjustments for those people living with a learning disability who may admitted for elective surgery, please contact the Safeguarding and Complex Care team on 01244 364021.

6.1.11 Waiting Time Adjustments

Unlike RTT it is possible to make adjustments (pauses) to patient clocks:

- Urgent Suspected Cancer Referral: if a patient misses their initial (first) outpatient appointment or attendance at diagnostic appointment, e.g., endoscopy, the clock start date can be reset to the date the patient rebooks their appointment (the date the patient agrees with the new appointment not the new appointment date).

- 62- / 31-day pathways:

a) 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 (only if cancer is diagnosed).
b) If it is deemed clinically essential to treat another medical condition before treatment

for cancer can be given, after a decision to treat the cancer has been made the clock can be adjusted from the point at which it is confirmed that a patient needs treatment for the other medical condition, to the point at which after receiving treatment for this condition the patient is deemed clinically fit to commence their cancer treatment.

c) Where a patient opts for egg harvesting prior to their cancer treatment, an adjustment can be applied from the point at which the decision is made until eggs are harvested.

If the patient during a consultation, or at any other point, while being offered an appointment date states that they are unavailable for a set period of time (e.g., due to holiday or work commitments), a pause can be applied from the date that would have been offered to the patient to the date that they are available. This will apply to admitted treatments only (reference: Cancer Waiting Times Guidance version 12).

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

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

6.1.12 First Appointment 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.

Urgent Suspected Cancer referral patients who cancel their first appointment should be offered another appointment within a reasonable time frame.

6.1.13 Subsequent Cancellations

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

6.1.14 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 a member of the clinical team to identify any factors that may be stopping the patient attending. Another appointment will be offered if the patient agrees.

Patients can be discharged after multiple (two or more) appointment cancellations if this has been agreed with the patient.

6.1.15 Patient Missed Appointments

Patients will be recorded as Missing an appointment 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.

All patients referred as suspected cancer including Urgent Suspected Cancer referrals, screening, upgrade, and breast symptomatic who miss their first outpatient appointment should be offered an alternative date within a reasonable timeframe 14 days of the missed appointment.

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

If a patient misses 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.

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

6.1.16 Patients who are uncontactable or unavailable

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

Two further attempts will be made to contact the patient by phone, one of which must be out of hours after 5.00pm. Each of these calls must be recorded in real time on the EPR+ system. These attempted contacts must be made over a maximum two-day period. If contact cannot be made by such routes, the GP surgery must be contacted to ask for alternative contact routes.

If the patient remains uncontactable:

- For first appointments: An appointment will be sent to the patient offering an appointment within the Urgent Suspected Cancer referral standard, stating the Trust

has attempted to offer a choice of appointment, and that the patient should contact the Appointments Hotline office to rearrange the appointment if it is inconvenient

- Appointments (other than first) on 62-/31- day clinical pathway: Attempts to contact patient will be made as outlined above. If contact cannot be made, the consultant should decide:
    - To send an appointment by letter (without agreeing the date with the patient
    - To discharge the patient back to the GP.

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.

6.1.17 Active Monitoring

Active monitoring is where a cancer diagnosis has been reached, but it is not appropriate to give any active anti-cancer treatment at that point in time, but an active treatment is still intended/may be required at a future date. The FDS clock will stop on the date the diagnosis is communicated to the patient. The decision to whether it is appropriate to give a treatment should only consider the diagnosed cancer and not patient thinking time or other medical conditions that the patient has. The patient is therefore monitored until a point in time when it is appropriate to give an active treatment for the diagnosed cancer. A patient would have to agree that they are choosing to be actively monitored for a period of time rather than receiving active cancer treatment.

Active monitoring may be used for any tumour site if appropriate and it would start on the date of the consultation where this plan of care was agreed with the patient. The one exception to this is a patient who is diagnosed with low or low-intermediate prostate cancer who would be recorded as active monitoring at the point the diagnosis is communicated to the patient, even if the patient is considering their treatment options.

Whilst a patient is being actively monitored, they may receive symptomatic support. If a patient has active anti-cancer treatment planned, but has other comorbidities, as a result of the cancer, which need to be addressed before the active cancer treatment can commence then active monitoring can be used. Examples include:

- dietetics support for malnourished patients
- respiratory support for those with breathing difficulties
- haematology input where patients are anaemic etc.

It is not acceptable to use active monitoring as a means to end a 62-day period if the initial choice of first definitive treatment is not available within the standard time due to capacity problem or patient choice.

It is recognised that patients with low or low-intermediate risk prostate cancer, do not clinically require rapid treatment, and will often benefit from time to consider their future treatment options which can have considerable debilitating side effects. Therefore, these patients are recorded as being on active monitoring from the date the diagnosis is communicated with them, even if they were still considering their treatment options. It is essential that where patients are automatically placed on an active monitoring pathway, the risk classification system (see Prostate Cancer Clinical Risk Category) used is clearly explained to them.

The 62-day clock will be stopped, but the Trust has mechanisms in place to robustly track these patients to ensure they are followed up appropriately. Any future treatment would then be classified as a subsequent treatment and monitored using the 31-day standard.

As soon as a decision is made to proceed with treatment, the 31-day subsequent treatment clock starts immediately.

6.1.18 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.

6.1.19 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.

6.1.20 Tertiary Referrals

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

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

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

6.1.21 Entering patients on the tracking pathway

6.1.21.1 Suspected Cancers: 2WW Urgent Suspected Cancer GP / GDP referrals

On receipt of a 2WW Urgent Suspected Cancer referral from a GP/general dental practitioner, the Appointments Hotline will record the referral (including known adjustments, referring symptoms and first appointment) onto the Trust's PAS system.

The Outpatient 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.

6.1.21.2 Suspected Cancers: Screening Patients

The MDT coordinating 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.

6.1.21.3 Suspected Cancers: Consultant Upgrades

For upgrade before initial appointment, Appointments Hotline will be responsible for entering patient details onto Cerner EPR+ and allocating the patient an appointment within the 2WW Urgent Suspected Cancer guidelines. . The MDT coordinating team will be responsible for entering upgraded patients into cancer management system database. . As Cerner EPR+ does not allow for upgrades to be entered, it is the responsibility of the Appointments Hotline team to inform Cancer Services if an upgrade has occurred following triage of an accepted routine or urgent referral.

For upgrades at any other point of the pathway, the MDT coordinator will be responsible for updating the cancer management system and will begin tracking of the pathway. The Clinical Team is responsible for communicating upgrades to the MDT coordinating team, at the time of the upgrade.

6.1.21.4 Suspected/Confirmed Cancers

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

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

6.1.21.5 Confirmed Cancers

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

6.1.22 Monitoring and Audit

It is the responsibility of the cancer services management 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 coordinator for investigations and correction. Response to the cancer information team must occur within 24 working hours of the anomaly being raised in order not to delay the audit programme and to ensure accurate performance available at all times.

In addition, a regular data quality programme has been established to review the following:

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

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.

Validation of all data before monthly performance upload is completed and is cross-checked with data on NHS Digital. Validation of all referrals that are highlighted as 'error' on Somerset versus the PAS system takes place on a monthly basis. Any patient removed from a 62-day pathway if within a month, the original pathway is reopened and document on Somerset.

7.0 DEFINTIONS

Below are the definitions of the terms used within this policy.

TERM	DEFINITION
28 Day Faster Diagnosis Standard	Maximum 28 days from Receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent referral of any patient with

	breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer
31 Day Pathway	Maximum one month (31 days) from Decision to Treat/Earliest Clinically Appropriate Date to Treatment of cancer
62 Day Pathway	Maximum two months (62 days) from receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer
Active Monitoring (Clinician Initiated)	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures (unless the diagnostic procedure is to monitor the patient's symptoms)
Active Monitoring (Patient Initiated)	Where a patient has requested an appropriate period of thinking time before agreeing to treatment or would like to see how their condition progresses before agreeing to treatment. This must not be used when a patient chooses to wait for treatment for social reasons unless the clinician feels the treatment plan may change during the delay.
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 an intervention.
Admission	The act of admitting a patient for a day case or inpatient procedure.
Admitted Pathway (or Admitted Incomplete Pathway)	A patient on a pathway that is likely to end in a clock stop within an admitted setting (day case or inpatient).
Adult at Risk	The safeguarding duties apply to an adult who: • Has needs for care and support (whether or not the local authority is meeting any of those needs) • Is experiencing, or at risk of, abuse or neglect As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect
Bilateral Procedure	Where the same procedure is required on the same part of both the left and right side of the body.

Breach	A pathway which ends when a patient is seen / received their first treatment outside of the relevant elective care standard (i.e., 14 days for 2WW, 62 days for Cancer treatment, 6 weeks diagnostic, 18 weeks RTT)
Care Professional	A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
Chronological Booking	Refers to the process of booking patient appointment, diagnostic procedures, and admission dates in order of their clock start date
Clinical Decision	A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements.
Consultant Led Service	A service whereby a consultant retains overall clinical responsibility for the care of the patient. Patients may be seen in nurse led clinics, but the consultant would retain overall responsibility for the patient's care.
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' top hospital for diagnostic tests only. These patients are not applicable to RTT.
Elective Care	Any pre-scheduled care which doesn't fall 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.
Fit (and available)	Patients must be fit, i.e., medically fit enough to undergo the intended treatment and available for treatment. Medically fit is determined clinically. As a general guide a minor illness e.g., cold would not be considered serious enough to stop the pathway progressing. However, a major illness such as co-morbidity like a heart condition that needs stabilizing would be deemed sufficient to stop the elective pathway.

	Patients should be made aware that they need to be available for appointments and possibly admission dates. This is the responsibility, in the first instance of the referrer. Once a decision to treat is made, the responsible clinician needs to advise patients.
Full Booking	Where an appointment or admission date has been agreed with the patient at the time of the decision or within 24 hours after the decision.
Incomplete Pathways	Patients who are waiting for treatment on an open RTT pathway, at any of the RTT milestones
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least 1 night.
Interface Service (non-consultant-led interface service)	All arrangements that incorporate any intermediary levels of clinical triage, assessment, and treatment between traditional primary and secondary care.
Daycase	Patients who require admission to the hospital for treatment and are intended to be discharged on the same day as treatment is given.
NHS Provider	An NHS Provider is an organization that can supply services under a commissioning agreement, e.g., GP/GDP, Referral Management Centre, GpwSI, Hospital Trust and Community Services such as Specialist Palliative Care Teams. A cancer or RTT clock can stop at any of these NHS organisations if they provide definitive Treatment on a consultant led pathway.
Non-consultant-led	Where a consultant does not take overall clinical responsibility for the patient e.g., nurse-led services, physiotherapy
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 appointments / admissions are agreed with the patients near to the time it is due.
Planned Waiting List	Patients who are to be admitted for a planned sequence of treatments or requires a procedure to be undertaken at a specific time in the future for clinicals reasons. Patients must be treated at the time the procedure is due. They are

	not part of the active waiting list nor applicable to RTT.
Reasonable Notice	A choice of 2 dates with 3 weeks' notice for an elective appointment or admission, or a date and time verbally agreed with a patient, even if the date is less than 3 weeks.
Straight to Test	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an elective pathway.
Vetting	The process by which clinical staff priorities, approve or reject referrals – also known as clinical triage of referrals.

8.0 ACRONYMS

ASI	Appointment Slot Issues
CATS	Clinical Assessment and Treatment Service
CNS	Clinical Nurse Specialist
COF	Clinic Outcome Form
COSD	Cancer Outcomes and Service Data set
DTT	Decision to Treat
ECAD	Earliest Clinically Appropriate Date
E-RS	Electronic Referral System
FDT	First Definitive Treatment
GDP	General Dental Practitioner
GP	General Practitioner
IPT	Inter-Provider Transfer
MDT	Multi-Disciplinary Team
MDS	Minimum Data Set
PAS	Patient Administration System
PPID	Patient Pathway Identifier
PTL	Patient Tracking List
RACPC	Rapid Access Chest Pain Clinic
RAS	Referral Assessment Service
RMC	Referral Management Centre
RTT	Referral to Treatment
TCI	To Come In (admission date)

9.0 REFERENCES

Title	Publication date	Link
Referral to treatment consultant-led waiting times Rules Suite	Oct-22	Consultant-led treatment: right to start within 18 weeks - GOV.UK
Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care	Feb-24	Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care
Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care: frequently asked questions	Oct-23	NHS England Report Template 1 - long length title
The NHS Constitution	Aug-23	The NHS Constitution for England - GOV.UK
The NHS Choice framework	Oct-24	NHS Choice Framework - what choices are available to you in your NHS care - GOV.UK
Diagnostics waiting times and activity		Statistics » Diagnostics Waiting Times and Activity
Guidance on completing the 'diagnostic waiting times & activity' monthly data collection	Mar-15	DM01-guidance-v-5.32.pdf
Diagnostics FAQs	Feb-15	DM01-FAQs-v-3.0.pdf

Supplementary Diagnostics FAQ	Oct-22	Supplementary-FAQ-v1.0.pdf
Equality Act 2010	Jun-15	Equality Act 2010: guidance - GOV.UK
Cancer waiting times guidance (Version 12)	Aug-23	National Cancer Waiting Times Monitoring Dataset Guidance V12.0
Armed Forces Covenant	Apr-24	Armed Forces Covenant: guidance and support - GOV.UK
How charges for NHS healthcare apply to overseas visitors	Dec-20	How charges for NHS healthcare apply to overseas visitors - GOV.UK

APPENDIX A – RELATED POLICY LINKS

1. Clinical Commissioning Policies
2. Procedures of Limited Clinical Value – Wales
3. Safeguarding Adults Policy
4. Child Was Not Brought (WNB) policy
5. Guidance around the Mental Capacity Act 2005 within the NHS
6. Patient Information and Consent Policy
7. Management of Private Patients
8. Escalation (when no capacity) SOP
9. Dealing with Paper Based Referral SOP - *Document to be linked after being uploaded to Trusts' Document Library on SharePoint*
10. Policy for Overseas Visitor
11. Patient initiated follow up (PIFU) SOPs: *Document to be linked after being uploaded to Trusts' Document Library on SharePoint*
12. Managing the Follow Up Waitlist & Tracker: *Document to be linked after being uploaded to Trusts' Document Library on SharePoint*

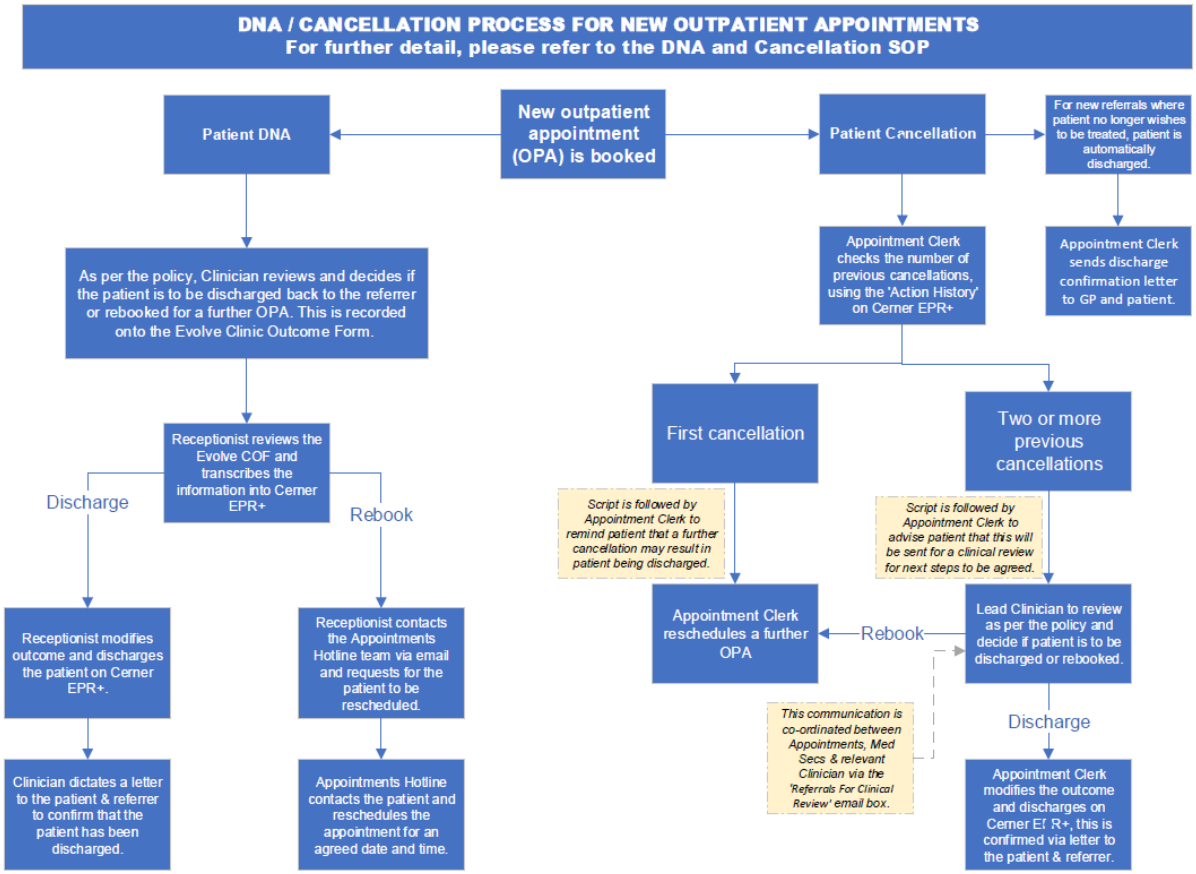
APPENDIX B – WELSH REFERRAL TO TREATMENT RULES

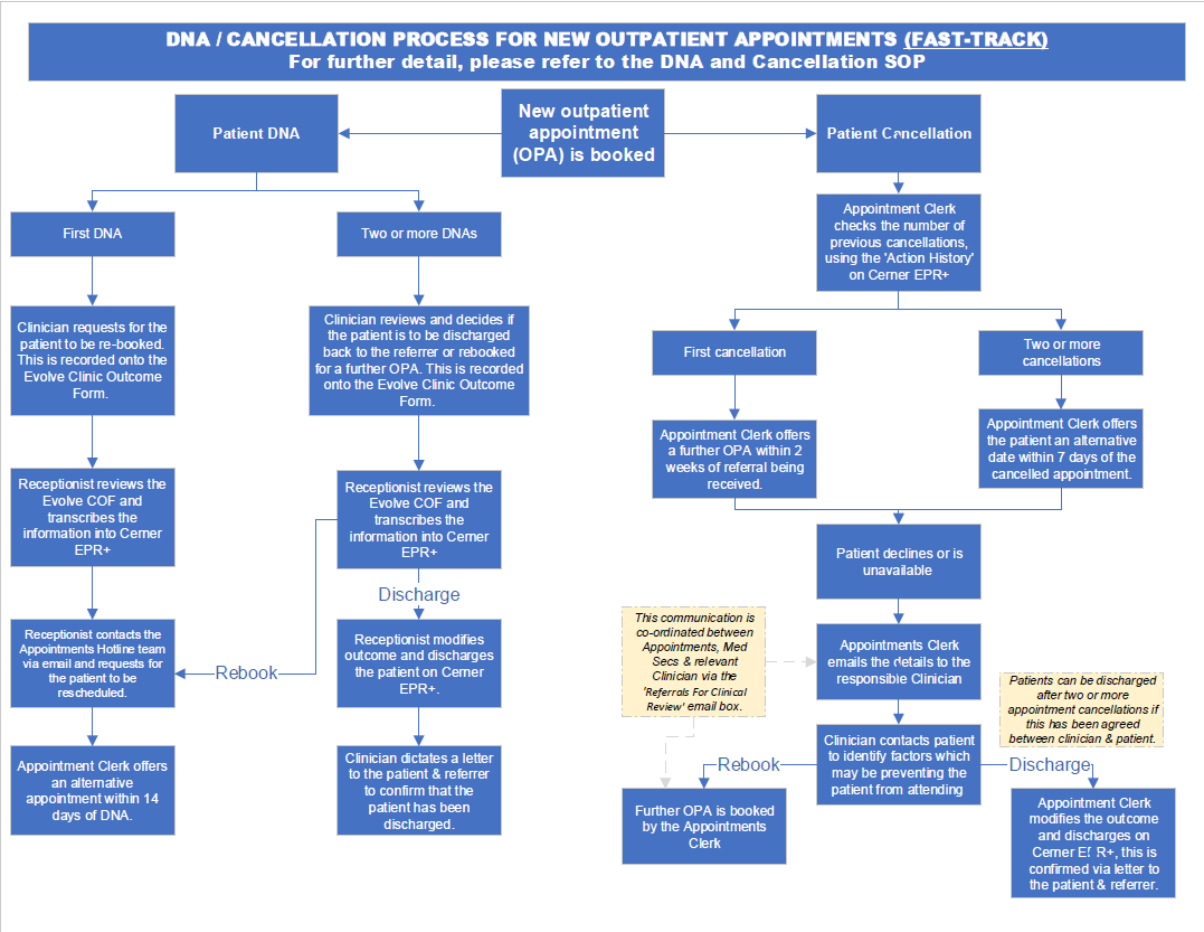
English RTT rules will apply to any Welsh patient referred to the Trust, as agreed in the commissioning contract for this cohort of patients. However, for reporting, Welsh patients will be excluded from the English return and reported separately. Patient level details will be supplied to Welsh Commissioners each month as standard with further details supplied upon request to COCH Information Department.

APPENDIX C – WAITLIST MANAGEMENT ROLES AND RESPONSIBILITIES

RTT PTL	OUTPATIENT PTL	FOLLOW UP PTL	INPATIENT PTL	INTPATIENT PTL (ENDOSCOPY)
• Patient Pathway Service Manager • Patient Pathway Supervisor • Patient Pathway Coordinator	• Assurance – DDs and DMs • Oversight – SMs/ASMs • Appointments Hotline Team Leader • Appointments Hotline Clerks	• Assurance – DDs and DMs • Oversight – SMs/ASMs • Team leaders • Secretaries	• Assurance – DDs and DMs • Oversight – SMs/ASMs • Admissions Team Leader • Admission Officers	• Assurance – DDs and DMs • Oversight – Endoscopy – SMs/ASMs • Endoscopy Admission Officers

APPENDIX D: ADMINISTRATION PROCESSES MISSED APPOINTMENTS / PATIENT CANCELLATION




DNA / CANCELLATION PROCESS FOR NEW OUTPATIENT APPOINTMENTS (FAST-TRACK)
For further detail, please refer to the DNA and Cancellation SOP
New outpatient appointment (OPA) is booked
Patient DNA
Patient Cancellation
First DNA
Two or more DNAs
Clinician requests for the patient to be re-booked. This is recorded onto the Evolve Clinic Outcome Form.
Clinician reviews and decides if the patient is to be discharged back to the referrer or rebooked for a further OPA. This is recorded onto the Evolve Clinic Outcome Form.
Receptionist reviews the Evolve COF and transcribes the information into Cerner EPR+
Receptionist reviews the Evolve COF and transcribes the information into Cerner EPR+
Discharge
Rebook
Receptionist contacts the Appointments Hotline team via email and requests for the patient to be rescheduled.
Receptionist modifies outcome and discharges the patient on Cerner EPR+.
Appointment Clerk offers an alternative appointment within 14 days of DNA.
Clinician dictates a letter to the patient & referrer to confirm that the patient has been discharged.
Appointment Clerk checks the number of previous cancellations, using the 'Action History' on Cerner EPR+
First cancellation
Two or more cancellations
Appointment Clerk offers a further OPA within 2 weeks of referral being received.
Appointment Clerk offers the patient an alternative date within 7 days of the cancelled appointment.
Patient declines or is unavailable
This communication is co-ordinated between Appointments, Med Secs & relevant Clinician via the 'Referrals For Clinical Review' email box.
Appointments Clerk emails the details to the responsible Clinician
Patients can be discharged after two or more appointment cancellations if this has been agreed between clinician & patient.
Clinician contacts patient to identify factors which may be preventing the patient from attending
Rebook
Discharge
Further OPA is booked by the Appointments Clerk
Appointment Clerk modifies the outcome and discharges on Cerner EPR+, this is confirmed via letter to the patient & referrer.

Admin Script for 1st Patient Cancellation

"Good morning/afternoon… you're speaking to the Countess of Chester _____ Department, how can I help?"

Patient requests to cancel/reschedule their clinical episode

Review Cerner EPR+ to check for any previous cancellations. 1st cancellation:

"We can cancel and reschedule this for you today. Please note that should you cancel on a second occasion; it is probable that you will be discharged back to the care of your GP"

Rebook episode and send confirmation letter

RTT CODE: No change

Admin Script for 2nd Patient Cancellation

"Good morning/afternoon… you're speaking to the Countess of Chester _____ Department, how can I help?"

Patient requests to cancel/reschedule their clinical episode

Review Cerner EPR+ to check for any previous cancellations. 2nd cancellation:

"We can cancel this for you today but unfortunately, as this is the second consecutive cancellation, we will forward your details to the responsible clinician for review and following this review you may be discharged back to the care of your GP"

Email patient details to Clinician and request a clinical review (RTT code: No change)

Await response from Clinician:

Rebook: Contact patient to rebook episode and send confirmation letter (RTT code: No change)

Discharge: Discharge patient on Cerner EPR+ and send confirmation letter (RTT code: 34)

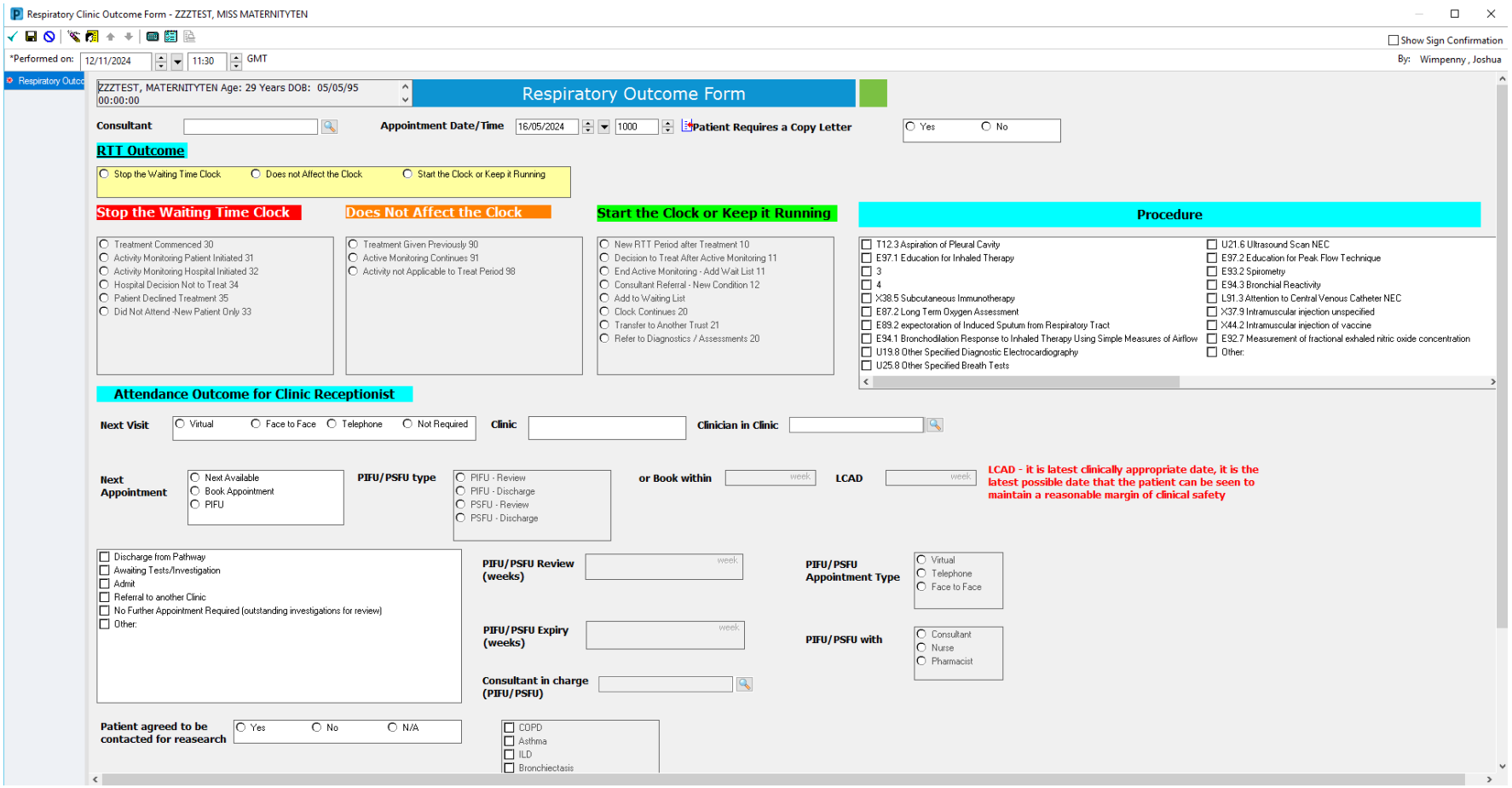
APPENDIX E: INTER PROVIDER TRANSFER FORM / MDS

Referring organisation to complete and send within 48 hours of decision to refer

For Referring Organisation:	
Referring organisation name: **Countess of Chester Hospital**	Referring organisation code:
Referring clinician:	Referring clinician registration code:
Referring treatment function code:	**8 Contact name:**
Contact phone:	Contact e-mail:
Patient Details:	
Patient's family name:	Patient's fore name:
Title:	Date of Birth:
NHS number:	Local Patient Identifier:
Correspondence address: Post code:	Contact details: Patient Name of lead contact if not the patient: Home Work Mobile e-mail
GP Details	
GP name:	GP practice code:
Referral To Treatment Information:	
Patient Pathway Identifier: **Email Mark Simms for this number**	Allocated by (organisational code) **RBL** (Organisation that received the original referral that started the clock)
Is the patient on an active 18 Weeks RTT pathway: Yes ✓□ No □ **(This is always yes)**	
Is this referral the: Continuation of an active pathway – (1st definitive treatment not given) Continuing treatment for a stopped pathway – (1st definitive treatment given) Start of a new pathway- (New condition or change of treatment)	

Is this referral for: Diagnostic tests only □ Opinion only □

APPENDIX F: CLINIC OUTCOME FORM



APPENDIX G: CLINIC OUTCOME FORM CLINIC TRAFFIC LIGHT