Trust Policy and Procedure **Document Ref. No: PP(23)138**

Suffolk & North East Essex (SNEE) Elective Access Policy

For use in:	The SNEE system, comprising: • West Suffolk Hospital NHS Foundation Trust (WSFT) including community services • East Suffolk and North Essex NHS Foundation Trust (ESNEFT)
For use by:	All Staff
For use for:	Management of elective care waiting lists, comprising: • Referral to Treatment (RTT) • Diagnostics • Cancer • Non-RTT • Community services (as appropriate)
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Section 1 Introduction

1.1 Policy Statement and Rationale

1.1.1 All providers within the SNEE system are committed to delivering high quality and timely elective care to patients.

This policy sets out the SNEE (subsequently referred as 'the system') elective access policy. The aim of this policy is to ensure that patients are treated promptly, efficiently and consistently in line with national guidance and good practice. It will provide guidance for staff within the system about the requirements and processes for effective management of elective patient access. The purpose of this policy is to ensure all patients requiring access to outpatient appointments, diagnostics or elective treatment are managed equitably and consistently, in line with national waiting time standards and the NHS Constitution. This policy:

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

1.1.2 This policy is to be followed and applied to the management of patient pathways by all employees within the system.

1.1.3 The main principles which serve as the foundation of this policy are:

- The system will ensure that simple and efficient processes support positive patient experiences of services provided by the system.
- The system will ensure that the management of patient access is transparent, fair, equitable, and managed according to clinical priority. Patients with the same clinical priority will be treated in chronological order, with the exception of those services where appointments are directly booked, where patients select a date and time convenient to them.
- Under the NHS Constitution, all patients have a right to start consultant-led treatment within the RTT target of the date of receipt of their referral. If we do not meet these obligations that patient has the right to ask us to resolve the situation.
- By applying the structured and systemic approach to managing patient access, the systems will increase the likelihood that patients will choose the systems for their care and treatment.
- Allow patients to maximise their right to patient choice in the care and treatment that they need.

- Ensure that patients' treatment is in line with other local and national policies, including the Overseas Patient Policy, Evidence Based Intervention (EBI) Clinical Policies and any other relevant guidance in relation to the treatment of serving military personnel, their immediate families, war veterans and reservists as per the Armed Forces Covenant 2022. **Armed_Forces_Covenant_Duty_Statutory_Guidance.pdf (publishing.service.gov.uk)**
- All patients are to be treated fairly and equitably in accordance with The Equality Act 2010.
- The system recognises the importance of good quality data and legal responsibilities for all NHS Hospital Trusts over data quality. As part of the False or Misleading Information (FOMI) legislation, it is an offence to provide information that is false or misleading.

1.2 Key Principles

1.2.1 The system relies on GPs and other referrers to ensure patients understand their responsibilities (including providing an accurate address and contact details) and potential pathway steps and timescales when being referred. This will help ensure that:

- Patients are referred under the appropriate clinical guidelines, or via self-referral where appropriate (mostly in community settings).
- Referrals include information relating to the need for translators or other issues relating to accessible information needs.
- Pre-referral diagnostics have been completed as part of the referral process by the GP or referring practitioner.
- Patients are aware of the speed at which their pathway may be progressed.
- Any patients potentially needing EBI or individual funding request procedures have been informed of the criteria, and initial assessment where appropriate, has taken place prior to referral.
- Patients are in the best position to accept timely appointments throughout their treatment.
- Everyone involved in patient access should have a clear understanding of their own roles and responsibilities.
- The policy is applied consistently and fairly across all services provided by the system. Communications with patients should be timely, informative, clear, and concise, preferably in writing to the patient's address provided by the referrer, but there is also a requirement to be mindful and to meet the different accessible information and communication needs of patients that will arise such as the need for large font, text to speech, easy read, interpretation, and translation etc as appropriate.
- The process of waiting list management is transparent to patients.
- The system has a responsibility to ensure no patient is added to a list inappropriately.

- Patients have responsibilities, e.g., for keeping appointments and giving reasonable notice to the system if unable to attend as well as providing the system with up-to-date demographic details such as address and contact numbers.

1.2.2 The maximum wait for the whole of the pathway from GP referral to first definitive treatment is a maximum of 18 Weeks for at least 92% of patients on an incomplete pathway. This includes patients at all stages of a pathway: outpatient consultation, diagnostics, inpatient treatment or via home visits within community services.

1.2.3 As a general principle, the system expects that before a referral is made for treatment on an 18 Week pathway, the patient is clinically fit for assessment, possible treatment of their condition, and ready to start their pathway.

1.2.4 Patients will only be added to, or remain on, an elective waiting list if they are fit for surgery, and will be in a position to accept dates for treatment within reasonable timeframes as defined within this policy.

1.2.5 The current national operational standards for elective care are provided below:

92% of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 Weeks from Referral
Diagnostic Waiting Times
99% of patients will wait no longer than 6 weeks for a diagnostic test, investigation, or image
Cancer Waits – 2 Week Wait
93% of patients will be seen within two weeks of an urgent GP referral for suspected cancer or where identified as breast symptomatic
Cancer Waits – 28 Days
The 28 day Faster Diagnostic Standard pathway ends only at the point of communication with the patient, whether that is to inform them of a diagnosis of cancer, a ruling out, or if they are going to have treatment before a clinical diagnosis of cancer can be made – target is 75%
Cancer Waits – 31 days
98% of patients will wait a maximum of one month (31 days) from decision to treat to first definitive treatment for all cancers
94% of patients will wait a maximum of one month (31 days) from DTT (decision to treat)/ECAD (Earliest Clinically Appropriate Date) for subsequent treatment where treatment is surgery
94% of patients will wait a maximum of one month (31 days) from DTT/ECAD for subsequent treatment where treatment is a course of radiotherapy
98% of patients will wait a maximum of one month (31 days) from DTT/ECAD for treatment where treatment is anti-cancer drug regimen
Cancer Waits – 62 days
85% of patients will wait a maximum of two months (62 days) from urgent referral received for suspected cancer to first treatment for all cancers
90% of patients will wait a maximum of two months (62 days) from NHS cancer screening service referral received to first definitive treatment

1.3 Overarching Roles and Responsibilities

1.3.1 All staff with access to and a duty to maintain elective care information systems are accountable for their accurate upkeep and ensuring high quality and timely elective care to patients.

For example:

- The Head of Information Services is responsible for the timely production of patient tracking lists (PTLs) which support the divisions in managing waiting lists and RTT standards
- Associate Directors of Operations (ADOs) or equivalent roles are accountable for implementing, monitoring, and ensuring compliance with the policy within their divisions.
- Data Quality team responsible for day-to-day validation and updating patient pathways.

- Divisional teams, including secretaries and divisional managers are responsible for day-to-day RTT tracking.
- Waiting list administrators, including clinic staff, secretaries and booking clerks are responsible to ADOs, or equivalent roles, for compliance with all aspects of the systems elective access policy.
- Waiting list administrators for outpatients, diagnostic and elective surgery are responsible for the day-to-day management of their lists and are supported in this function by the ADOs who are responsible for achieving access standards
- ADOs and/or equivalent service leads are responsible for ensuring data is accurate and services are compliant with the policy.
- General practitioners (GP's) and other referrers play a pivotal role in ensuring patients are fully informed during their consultation of the likely waiting time for a new outpatient consultation and for the need to be ready, willing and able to attend when contacted.
- Integrated Care Board (ICB) are responsible for ensuring all patients are aware of their right to treatment at an alternative provider in the event that that their RTT wait goes beyond 18 Weeks or if it is likely to do so.
- In the event that patients' RTT wait goes beyond 18 Weeks, ICBs 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 an Integrated Care Board or NHS England.
- GP's and other referrers should ensure quality referrals are submitted to the system first time.

1.4 Competency and Compliance

1.4.1 As part of their induction programme, all new starters with undertake mandatory contextual and technical elective care training applicable to their role.

1.4.2 All existing staff will undergo mandatory contextual elective care training on an annual basis

1.4.3 Functional teams, specialties and staff will be performance managed against key performance indicators applicable to their role. Role specific KPI's are based on the principles set out in this policy and specific aspects of the systems standard operating procedures. In the event of non-compliance, resolution should be sought by the team, specialty, or individual's line manager. Staff should then be dealt with in accordance with the systems disciplinary or capability policy.

1.5 General Elective Access Principles

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

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

1.6 UK and EU Citizens

1.6.1 The NHS provides healthcare for people who are ordinarily resident in the United Kingdom. People who are not ordinarily resident in the United Kingdom are not automatically entitled to use the NHS free of charge – regardless of their nationality or whether they hold a British passport or have lived in and paid National Insurance contributions and taxes in this country in the past.

1.6.2 All NHS Trusts have a legal obligation to identify patients who are not eligible for free NHS treatment and specifically:

- Ensure patients who are not ordinarily resident in the UK are identified;
- Assess liability for charges in accordance with Department of Health overseas visitor guidance
- Charge those liable to pay in accordance with Department of Health overseas visitor guidance.

1.6.3 Patients registered with a GP in either Northern Ireland, Scotland or Wales are also eligible for elective treatment, subject to prior approval from their local health board.

1.6.4 An NHS Number does not give automatic entitlement to free NHS treatment. Therefore, at first point of entry, patients must be asked questions which will assist the systems in assessing 'ordinarily resident status'. The only exception to this is being in an emergency.

1.6.5 The Human Rights Act 1998 prohibits discrimination against a person on any ground such as race, colour, language or religion.

1.6.6 Some visitors from abroad, who are not ordinarily resident, may receive free healthcare such as those that:

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

1.7 Patients Moving Between NHS and Private Care

1.7.1 Patients can choose to convert between an NHS and private status at any point during their treatment without prejudice.

1.7.2 The NHS Constitution does not apply to private patients however should a private patient move to NHS funded services (and if the patient is yet to receive first definitive treatment and their treatment is applicable to RTT rules) then the RTT clock will start when the referral is received by the hospital.

1.7.3 The elective RTT pathway of a patient who notifies the system of their decision to seek private care will be closed as a pathway stop event on the date of this being disclosed by the patient.

1.8 Commissioner-approved Procedures

1.8.1 Patients referred for treatments outlined in The Evidence Based Intervention (EBI) Clinical Policies, or which may be considered cosmetic can only be accepted with the prior approval of the relevant ICB.

1.9 Military Veterans

1.9.1 In line with the Armed Forces Covenant published by the Ministry of Defence in 2022, there is a commitment that veterans in Great Britain may be considered for priority access to NHS services providing focused treatment for conditions arising from their Service, compared to non-Service patients with the same level of clinical need. This is a clinical decision made by the relevant physician. More information about prioritisation, and veteran-specific services through the NHS, is available for England, Wales and Scotland.

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

1.10 Prisoners

1.10.1 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.

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

1.11 Vulnerable Patients

1.11.1 Patients who are vulnerable and/or require additional support may require additional communication between the system clinician and the GP or other referrer. Such patients should be identified at the outset at the point of referral.

1.11.2 Staff should always refer to related policies and resources relating to vulnerable or at-risk patients.

1.11.3 Patients with specific information or communication needs because of a disability, impairment or sensory loss must be identified at the outset at the point of referral and relevant details provided as part of the minimum data set, in accordance with the Accessible Information Standard.

Section 2 – Overview of RTT Rules and Principles

2.1 Key principles

2.1.1 Patients should be treated according to their clinical priority and then in the order in which they were added to the waiting list.

2.1.2 Patients may have more than one RTT clock ticking simultaneously. Each one must be measured separately.

2.1.3 RTT waiting time clocks only start or stop. There are no suspensions or pauses.

2.2 Clock Starts

2.2.1 The RTT waiting time clock starts when a referral is made by any care professional or service permitted by an English NHS Commissioner to make such referrals to:

- A consultant-led service (regardless of setting) with the intention to assess and if appropriate to treat;
- An interface or assessment service which may result in an onward referral to a consultant-led service; or

- A consultant-led service where a patient self-refers as part of pre-agreed pathways.

2.2.2 The RTT clock start date is the date that the system receives the referrals. For referrals received through NHS e-Referral Service, the RTT clock starts when the unique booking reference number (URBN) is converted into an appointment.

2.3 New Clock Starts for the Same Condition

2.3.1 Upon completion of a consultant-led referral to treatment period, a new RTT clock may also start for the circumstances below.

- **Following Active Monitoring**
  In active monitoring (or watchful waiting) the patient is kept under review to undergo regular monitoring as part of an agreed programme of care. If a decision to treat is made after a period of active monitoring, a new RTT clock commences on the date the decision to treat is made.

- **Following a Decision to Start a substantively New Treatment**
  Where further (substantively new or different) treatment may be required that did not form part of the patient's original treatment plan, a new RTT clock should start, and the patient should receive their first definitive treatment within 18 Weeks. This will include situations where a previous treatment has not been successful and more aggressive treatment is required for the same condition (if the additional treatment did not form part of the patient's previously agreed care plan).

- **For the Second Side of a Bilateral Procedure**
  When the patient is medically fit and says they are available for the second bilateral procedure a new RTT clock starts. This is because bilateral procedures (carried out at both left and right sides of the body) for example cataract removals for both eyes will have separate RTT waiting time clocks. The clock for the first procedure will stop on the date that the procedure takes place.

- **For a Rebooked New Outpatient Appointment**
  If the patient DNAs a first outpatient appointment, their RTT clock should be stopped and nullified on the date of the DNA'd appointment, providing the system can evidence the appointment was appropriately communicated. A new RTT clock would start if the Clinician wished to give the patient another

appointment.

2.4 Planned Patients Transferred to the Active Waiting List

All patients added to the planned list will be given a target treatment date by which their planned procedure/test should take place. Where a patient reaches their target treatment date without a procedure booked, they will be transferred to an active pathway and a new RTT clock started.

2.5 Clock Stops – First Definitive Treatment

2.5.1 Once an RTT waiting time clock has started it continues to tick until first definitive treatment starts (for the condition they were referred for), or a clinical decision is made that stops the clock or the patient declines treatment.

2.5.2 First definitive treatment is an intervention (including attempted intervention) intended to manage a patient's disease, condition or injury and avoid further intervention. The date that the first definitive treatment starts will stop the clock.

2.5.3 The key factors when determining a clock stop for first definitive treatment are:

- What do the care professionals in charge of the patient's care consider to be the start of treatment?
- When does the patient perceive their treatment as being started?

What constitutes first definitive treatment is a matter of clinical judgement.

2.5.4 A clock will also stop when a clinical decision is made to add a patient to a transplant list.

2.6 Clock Stops for Non-Treatment

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

- It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care;
- A clinical decision is made not to treat
- A patient Did Not Attend (DNA) which results in them being discharged, providing that discharging the patient is not contrary to their best clinical interests
- A clinician decision is made to start a period of active monitoring
- A patient decision is made to start a period of active monitoring

- A patient declines all treatment offered. This does not include when a patient feels they have insufficient information to proceed with treatment. Patients may delay treatment while they seek further information or a clinical review, patients should be given a 4-week timeframe for this. This does not stop the clock and the pathway continues
- The RTT clock also stops when a patient declines two reasonable offers of inpatient treatment and is removed from the waiting list.

2.7 Active Monitoring

2.7.1 There are occasions when it is clinically appropriate to stop an RTT waiting time clock to monitor a patient without clinical intervention. Active monitoring is a decision jointly agreed by consultant and patient that the most clinically appropriate option is to actively monitor the condition for a period, but active treatment is still intended or may be required at a later date.

2.7.2 The following guidance is provided to determine if a patient should be regarded as active monitoring:

- Requirement for diagnosis. The patient must have a confirmed diagnosis or understand the clinical risk relating to the condition which is being monitored. This must be recorded as part of the clinical correspondence to both the patient and GP.

- Clinical decision. A clinical decision/agreement is documented that the most appropriate course of action (at this point) is to monitor the condition rather than offer treatment.

- Patient awareness. The patient must know that they are not being treated at this time and why. The clinician should discuss the decision to start active monitoring with the patient in person. Once the decision to start active monitoring has been jointly agreed it must be communicated to the GP.

- Period of active monitoring. The active monitoring period is usually three months or more, however this is clinically defined on a case-by-case basis. The active monitoring period may end sooner than planned if a patient's condition changes or deteriorates.

- Booked review. When agreeing to monitor a patient's condition a follow-up appointment must be booked in the future to ensure the condition is monitored and the patient is not lost to follow-up. This may include additional investigations.

- Active monitoring can also be initiated by the patient, for example, where they wish to see if they can manage symptoms without further clinical intervention or where an extended period of thinking time is requested.

- Stopping a patient's RTT clock for a period of active monitoring requires careful consideration. Where a period of 'thinking time' is agreed with the patient, the effect on the RTT clock will depend on the individual scenario.

    - A short period of thinking time, for example where the patient would like a few days to consider proposed surgery, before confirming they wish to go ahead would not initiate active monitoring and the clock will continue.

    - If a longer period of thinking time is agreed, then active monitoring is more appropriate. This will include where the patient wants to see how their condition can be managed or progresses before deciding as to whether to proceed with the proposed treatment (clock stop for active monitoring).

2.11.3 The use of active monitoring for thinking time should be consistent with the patient's perception of their wait. There should be a clear plan for monitoring during this period. A common-sense judgement to differentiate between shorter and longer periods of thinking time should be made (Source: NHS England, Reporting RTT Waiting Times, October 2015). Active Monitoring should not be used where a patient wishes to delay treatment beyond 8 weeks due to availability. In this case, pending clinical review patients should be discharged back to their GP until such time as they are ready to proceed.

2.11.4 It is important that patients are given full information about their options and supported to make an informed decision about the treatment options offered to them.

2.11.5 The clock is stopped on the date the decision to start active monitoring is made and discussed with the patient. A new RTT clock commences when a new decision to treat is made.

2.12 Non-Clock Starts (excluded from RTT reporting)

2.12.1 The following patient pathways are excluded from the RTT reporting target:

- Emergency Department activity
- Emergency admissions from the Emergency Department
- Elective patients undergoing planned procedures
- Activity in fracture clinics
- Antenatal and maternity appointments
- Direct Access diagnostics referred by GPs which are not 'straight to test'
- referrals
- Patients receiving on-going care for a condition whose first definitive treatment has already occurred
- Patients whose RTT clock has stopped for active monitoring and has not been re-instated, even though they may still be followed-up by their consultant
- Referrals into non-consultant led services.

Section 3 – Outpatients

3.1 NHS e-Referral System

3.1.1 The NHS e-Referral Service (eRS) is a national electronic referral service that gives patents a choice of place, date and time for their first consultant outpatient appointment. The patient is allocated a Unique Booking Reference Number (UBRN).

3.1.2 The RTT clock starts when the UBRN is converted into an appointment by the patient's referring health professional or by the patient themselves.

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

3.1.4 As of October 2018, in line with NHS England referrals from GP practices to Consultants will only be accepted if sent via eRS. Paper referrals will be returned to the GP practice with the exception of 2Week Wait, Urgent referrals and other services on the exemption list.

3.2 Minimum Dataset for Referrals

3.2.1 The following information must be provided on all referrals to the system. This is known as the referral minimum data set (MDS):

- Clinical priority of the referral (routine or urgent);
- The specialty the patient is being referred into and sub-specialty if known;
- Patient details (full name, date of birth, gender, NHS number, ethnicity address and contact telephone number – home and mobile);
- Relevant clinical details of the patient, e.g. pre-existing conditions, medication; Referrers must record any special requirements, e.g. physical disability, mental health issues or spoken language interpreter etc. Referrers must also record any specific information or communication needs relating to disability, impairment or sensory loss as per the Accessible Information Standard;
- Expected action or response (advice, diagnosis, treatment); Date of decision to refer;
- Contact details for the referrer (name, telephone number and email address); and
- Where relevant, the current RTT status, including the original clock start date.

3.2.2 Minimum data sets are a legal requirement for NHS Trusts and must be included on any referral to, or from, the system. If a referral is missing any of the minimum data set, the receiving department will contact the referrer within 1 working day of receipt to request the missing information. Patients must not be disadvantaged

because it has not been provided and this does not constitute a reason to refer the patient back to their GP or other referrer.

3.3 Registration of Referrals

3.3.1 Referrals made via eRs are downloaded and reviewed by the outpatient booking team for data quality checks (patient address etc) and passed through to the relevant department for clinical triage.

3.3.2 Once triaged by the clinical teams, patients will either be booked where capacity allows or added to the relevant speciality worklist with the referral sent to Evolve for scanning.

3.3.3 Referrals outside of eRs will be directed to the outpatient booking team to register and triage in the same way, this includes internal consultant to consultant referrals or referrals from external Hospitals.

3.3.4 Tricare Referrals are received electronically from the accounts department, these are registered by the outpatient booking team and sent to the relevant department the same way as above.

3.3.5 ASI lists are pulled from eRs on a weekly basis and cross checked the speciality work lists.

3.4 Advice and Guidance

3.4.1 GPs can request individual consultants to provide advice and guidance under the NHS eRS. Any advice and guidance requests must be reviewed by the clinician to whom they are directed and responded to as soon as possible within clinically appropriate time frames.

3.4.2 Where a consultant converts an advice and guidance request to an appointment referral in eRS, this starts the RTT clock for the patient. **Advice and guidance changes implemented in early 2021 - NHS Digital**

3.5 Prioritisation and Clinical Review of Referrals (triaging)

3.5.1 Once referrals have been received, the referral is either managed by the Cancer 2 Week Wait Team for immediate booking (for suspected cancer or breast symptomatic referrals for eRS) or directed to the appropriate consultant or clinical team for triaging.

3.5.2 For referrals to be triaged, referral letters must be passed to the consultant within 2 working days of receipt:

- Urgent referrals should be triaged within 3 working days

- Routine referrals should be triaged within 5 working days of receipt by the consultant or a nominated clinician to whom the patient has been referred.

3.6 Upgrading or downgrading a referral

3.6.1 Where a consultant to clinical team suspect the possibility of cancer, the referral should be upgraded from routine to urgent. The GP or other referrer must be informed at this time by the person triaging the referral that the clinical priority of their patient has changed. The change will be adapted and managed within the PAS system (see cancer operational policy for further detail on upgrades).

3.6.2 Non-2WW referrals can be downgraded by the receiving consultant following triage.

3.7 Redirecting Referrals

3.7.1 Where the referral has been made to the incorrect clinical team or consultant, the receiver should redirect the referral to the correct clinical service. This redirection occurs within eRS. This does not affect the patient's RTT pathway and the clock should continue to tick from the referral received date.

3.8 Rejecting Referrals

3.8.1 At the point of clinical triaging, referrals deemed inappropriate will be returned to the GP or other referrer with an explanation as to why it has been rejected. It is then the referrer's responsibility to notify the patient that the referral was rejected to ensure the patient does not attend a previously arranged appointment. The duty of care rests with the referrer until such time as the referral is accepted by the system. The RTT clock will be nullified.

3.9 Consultant to Consultant Referrals

3.9.1 Consultant to consultant referrals must follow the guidelines agreed locally by the ICB. Patients can be referred to another consultant in a different specialty in the patient's best interest without the need for the patient to be re-referred back to the hospital via the GP.

3.9.2 A clinician must not refer a patient to another clinician where the presenting conditions are unrelated to the original referral from primary care except where the referrals are classed as clinically urgent by a referring consultant.

3.9.3 As such, patients will be returned to primary care where a presenting condition is not classed as clinically urgent or related to the original referral.

3.9.4 In cases where the patient is identified as having suspected cancer, the patient must be transferred to the care of the appropriate service with 48 hours. It is the

responsibility of the referring clinician to inform the patient's GP or other referrer that the patient has been referred to another team.

3.9.5 When this occurs and the patient is still awaiting treatment, the RTT clock continues from the original referral date.

3.10 Rapid Access Chest Pain Clinic Referrals

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

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

3.11 Cross Site Transfers

3.11.1 Where patients are referred from one site to another for treatment as part of mutual aid, an Intra-Provider Trust form is to be completed, accompanied with clinical information and an RTT clock start date.

3.11.2 The transfer should be agreed with the patient and sent electronically to the agreed email addresses.

3.11.3 The RTT clock continues from the original referral.

3.11.4 Once the referral is active on the receiving Trust's PTL, the pathway RTT code is updated to a 21 – transfer to alternative provider, once the patient has a clock stop at the receiving site documentation of this will be sent on the referring site to the RTT pathway can be stopped.

3.12 Inter-Provider Transfers (including community services)

3.12.1 The system accepts referrals from other secondary care Trusts for both urgent (including suspected cancer) and routine tertiary care and community providers.

3.12.2 Where patients are transferred between providers, including primary care intermediate services, an Inter-Provider Transfer (IPT) form must accompany the referral.

3.12.3 The principle need for this IPT form is to ensure all service providers involved in a patient's pathway have adequate information regarding RTT treatment status and clock start dates to enable the patient's management to be conducted within appropriate time frames. The receiving Trust will inherit any RTT wait already incurred if the patient has not yet been treated.

3.12.4 Both the patient and the receiving Trust Consultant must consent to the IPT, whether for diagnostics, treatment or clinical opinion.

3.12.5 If a patient is referred from one provider to another during their RTT period, these patients will be reported on the RTT return. The provider Trust that holds current clinical responsibility for the patient (i.e. at the time when the data snapshot is taken) should report the RTT time.

3.12.6 When a patient is transferred for treatment in the middle of a pathway, the patient's RTT clock will continue but the responsibility to report this will transfer to the onward provider.

3.12.7 Consultants may accept a referral to treat a patient referred to the by a consultant from another hospital for a condition where the RTT pathway to treat has already commenced. This RTT clock will continue from the date it commenced at the referring hospital

3.12.8 The referring Trust is obligated to ensure that the IPT form and referral letter are transferred within 5 working days, so as to make achievement of RTT reasonable and possible. Any incurred breach of RTT will be reported by the reporting organisation and breaches may be recorded as 'shared', where appropriate.

3.11.9 If a patient is referred to the system for a clinical opinion or diagnostic test only, the clinical responsibility for the patient remains with the originating referrer and the system does not record this as an RTT period or urgent suspected cancer pathway.

3.12.10 If the patient is referred to the system from a secondary care provider after receiving the first definitive treatment with a request for a new or substantively different treatment, a new RTT clock starts when the referral is received.

3.12.11 Transfers to this hospital for after care (such as chemotherapy, radiotherapy, rehabilitation, or specialist follow up) following first definitive treatment for the same condition at the other Trust are not subject to RTT requirements. However, referrals for cancer related treatment may still be subject to cancer targets.

3.13 Outpatient booking processes – general principles and standards for outpatient booking

3.13.1 Appointments are booked in order of clinical priority (urgent over routine) and then in chronological order to ensure equity of access.

3.13.2 Appointment letters must be sent to the patient within 24 hours of the appointment being booked.

3.13.3 War pensioners and service personnel must receive priority access for any conditions which are related to their service (over other patients with same level of clinical need).

3.13.4 If a patient is not medically fit and/or unable to accept a date for their first appointment, they will be referred back to their GP to ensure the clinical condition is monitored. They are re-referred either as soon as they are fit to be treated or able to accept a further appointment offer. This will stop the RTT clock.

3.13.5 Patients should be made aware of the system policy at the time of referral to reduce DNA problems and unavailability for telephone contact and appointments. The patient should be advised they will be returned to their referring GP or other referrer for re-referral when they are ready and available. A new RTT clock will then start.

3.13.6 For those specialties which are partially booked, patients needing follow up will be placed on the waiting list detailing the level of follow up and timescale required if the appointment is outside of 6 weeks from the date of request. Appointments within 6 weeks will be given at the time of request whenever possible.

3.14 Reasonable Offer of Appointment

3.14.1 Patients should be offered reasonable notice of appointment. For an offer of appointment to be deemed reasonable for routine appointments, this is an appointment date with at least 3 weeks' notice and a choice of 2 dates, two weeks apart.

3.14.2 Appointments with shorter notice may also be offered although are only deemed reasonable if they are accepted by the patient. The patient should be contacted by phone to arrange a suitable appointment, if it is not possible to contact the patient a letter will be sent to them to request they call within the next 14 days, failure to contact will result in the patient being referred back to their GP to re-refer if and when the patient is able to accept a date. If a patient accepts an offer at shorter notice this also represents a reasonable offer in respect of subsequent cancellations or DNAs.

3.14.3 Patients referred as suspected cancer or breast symptomatic must be offered appointments (to be seen) within 14 days and as such will not be routinely offered a choice of appointment date. However, patients that choose an appointment outside of 2 weeks do not exempt themselves from the standards.

3.14.4 A patient may refuse the offer of a 'reasonable' appointment and indicate that they still require an appointment. This date will be recorded and a further appointment date will be offered when they are available. Only two reasonable offers of an appointment date will be offered with a minimum of three weeks' notice. If the patient refuses the second reasonable appointment, they should be discussed with the clinical team and considered for referral back to the care of the GP.

3.15 Reminding patients

3.15.1 In an effort to reduce the number of patients not attending their appointment, the system encourages all services to remind patients of their upcoming appointments. This could be telephoning the patient in person, or by sending a text reminder.

3.15.2 Patients will be sent a confirmation letter of their booked appointment with details of who to contact about any queries. The letter will explain the system policy for not attending or cancelling appointments.

3.16 Cancellations and Appointment Changes – Hospital initiated

3.16.1 The system will avoid cancelling outpatient appointments wherever possible.

3.16.2 If a patient's appointment has to be rescheduled due to a hospital cancellation, the patient will be rebooked to as close to the original appointment date to enable treatment to take place within the RTT breach date. If the appointment is under 7 days, the patient will be contacted by telephone and letter. The reason for cancellation should be recorded on the PAS system. The RTT clock continues to tick during this time.

3.16.3 Clinicians are actively encouraged to book annual leave and study leave requests as early as possible and ideally the year ahead.

3.16.4 Clinicians should follow the 'Consultant Leave Policy' when cancelling clinics and provide as much notice as they, in all but exceptional circumstances, to cancel or reduce any outpatient or diagnostic session for reasons due to annual, study leave or on-call commitments. If it is necessary, in exceptional circumstances, to cancel or reduce any outpatient sessions, the relevant Assistant Service Manager or dedicated operational lead for that specialty must authorise and where practical, agree a re- provision of lost capacity to ensure patients are not disadvantaged and wait times do not increase.

3.16.5 All short notice (less than 6 weeks) clinic cancellations must be authorised by the appropriate operational lead. Short notice cancellations without appropriate authorisation will not be actioned.

3.17 Patient initiated cancellations

3.17.1 The letter to patients confirming an outpatient appointment will clearly state that the patient can only cancel and rearrange an outpatient appointment once, providing the appointment was made with reasonableness and regardless of the referral method used. Subsequent cancellations will result in the patient being discharged back to the care of their GP after discussion with the clinical team. If it is decided to reappoint the patient, the RTT clock continues and they will receive one further appointment offer.

3.17.2 In the event that patients repeatedly cancel outpatient appointments (minimum two successive), regardless of the referral method used, the system reserves the right to discharge the patient back to the care of their GP and remove from the waiting list and stop the RTT clock. This will give the GP the opportunity to discuss with their patient whether they wish to start treatment prior to re-referral to a secondary care provider. The system will only do this in exceptional circumstances where it clearly appears the patient is ambivalent about being seen and potentially treated.

3.17.3 There must be specific protection for the clinical interests of suspected cancer patients, children and young people under 18 years and vulnerable adults. We will endeavour to gain an understanding of the circumstances when reviewing patient cancellations.

3.17.4 Where the patient has experienced delays and inconvenience through hospital cancellations or reschedules, this should be taken into consideration when deciding.

3.17.5 Patients who cancel and then contact the system and declare an extended period of unavailability due to social/personal reasons will follow that part of the policy.

3.18 Did Not Attend (DNA)

3.18.1 A DNA is defined as a patient failing to give prior notice that they will not be attending their appointment. Patients who give prior notice (irrespective of how short the period of notice they give) are not classed as DNAs and this will be treated as patient cancellations as such follow that part of the policy.

3.18.2 All patients who do not attend for their appointment must be reviewed by the clinician. The clinician will review the patient's notes and referral information in order for a clinical decision to be made regarding next steps, considering the individual circumstances. This would ordinarily happen directly after clinic.

3.18.3 If the appointment was reasonable and clearly communicated, including sent to the correct patient address, the clinician may decide to discharge the patient back to the care of their referrer.

3.18.4 A further appointment would not be routinely offered and the patient will be discharged back to the GP/original referrer, unless:

- Discharging the patient would be contrary to the patient's best clinic interests.
- If the appointment has been requested as a 2 Week Wait or Rapid Access.
- There is specific protection for the clinical interests of suspected cancer patients, children and young people under 18 years and vulnerable adults.

3.18.5 The system will endeavour to be as flexible as possible where reasons for the DNA were beyond the patient's control; administrative staff should try to contact the patient to ascertain their reason for the DNA and the reason should be recorded on the PAS system.

3.19 First Outpatient Appointment DNAs

3.19.1 If the patient DNAs their first appointment, their RTT clock can be stopped and nullified on the date of the DNAd appointment provided the patient had agreed to the appointment and it was clearly communicated.

3.19.2 If the clinician decides another first appointment should be offered, a new RTT clock will be started (at zero) on the day the clinician makes that decision.

3.19.3 Patient DNAs at any other point on the RTT pathway will not stop the RTT clock, unless the patient is being discharged (following clinical review) back to the care of their GP.

3.20 Subsequent (follow up) Appointment DNAs

3.20.1 If a patient DNAs a follow up appointment the RTT clock continues if the clinician indicates that a further appointment should be offered.

3.20.2 If the clinician indicates another appointment should not be offered, the RTT clock stops on the date that the patient is discharged back to the care of their GP or other referrer.

3.21 Adult Patients who are vulnerable DNAs

3.21.1 The patient/carer must be contacted in person and offered another appointment and the GP or other referrer should be informed of the date and time. If the patient does not attend the second consecutive appointment, consider for discharge back to the care of their GP or other referrer.

3.21.2 A decision must not be made without first contacting the patient or their carer to gain an understanding of the circumstances. The clinician is responsible for liaising with the GP or other referrer to assess the risk and consider further actions as appropriate.

3.21.3 Staff should always refer to related policies and resources relating to at risk patients available on the system intranet.

3.22 Suspected Cancer Patients

3.22.1 Suspected cancer patients will be offered one further appointment. If they fail to attend a second consecutive appointment, the referral will be assessed by the clinical team and they too may be discharged back to the care of their GP. Patients should only be referred to their GP after multiple (two or more) DNAs.

3.23 Children and Young People who are not brought in

3.23.1 The Children Acts 1989 and 2004 define a child as anyone who has not yet reached their 18th birthday. The fact that a child has become sixteen years of age, is living independently or is in further education, the armed forces or is in hospital, prison or young offenders institute does not change their status or their entitlement to services or protection under the Children Act 1989.

3.23.2 If a child is not brought in for their first appointment, they will be offered a further appointment unless a clinician indicates a discharge after reviewing clinical information. Please see the system's Safeguarding Policy for further guidance around consecutive appointments when children are not brought in in appendix

3.24 Patients who arrive late for their appointment

3.24.1 The system asks all patients to keep their appointments and arrive in good time.

3.24.2 If a patient arrives after their appointment time, every effort will be made to see them for their consultation, for example, if delayed arrival is the responsibility of the Patient Transport Service. Patients who arrive late may have to be seen last or it may need another member of the team seeing the patient, if clinically appropriate.

3.24.3 If the patient arrives too late to be seen and cannot be accommodated within the scheduled time of the clinic, their appointment should be cancelled and another appointment should be made. This will be treated as a patient cancellation and as such follow that part of the policy (it is important that the appointment is cancelled and not rescheduled). Details of this action and reason for delay should be recorded on the PAS system.

3.25 Follow Up Appointments

3.25.1 Follow up appointments, prior to first definitive treatment, are appropriate when a patient's condition requires the continued intervention of specialist clinical expertise. In situations where there is no evidence that a further specialist clinic intervention is required (for example, a patient no longer has symptoms or primary healthcare support is considered more appropriate) the patient should be discharged to the care of their GP. This will stop the RTT clock.

3.25.2 Follow up appointments should be booked at a clinically determined interval.

3.25.3 If the results of diagnostic tests are negative, the requirement for a further follow up appointment may not be necessary. A suitable letter to the patient and GP may be sufficient, but this is subject to clinical judgement. The patient may be discharged and if appropriate the referral closed. This will stop the RTT clock.

3.25.4 If the follow up appointment is required in over 6 weeks; the patient will be added to the appropriate follow up waiting list to be booked. 6 weeks before the appointment is due a letter will be sent to the patient with the appointment date.

3.26 Patient Initiated Follow Up (PIFU)

3.26.1 PIFU is established for certain pathways where patient have stable long-term conditions requiring regular follow ups or acute conditions that infrequently require follow up in the hospital. Instead of being offered regular clinic visits or routine check-ups, patients can (if agreed between themselves and their clinician) request an appointment by telephone only when / if required for an agreed time frame. If no further appointment is requested within the agreed timeframe, the pathway will be closed. Any further appointment will require a new GP referral, unless the service has a planned review after the end of the PIFU period. Please see PIFU Standard Operating Procedures for further details on managing patients on PIFU.

3.27 Patient and GP / Referral Communications

3.27.1 All correspondence with the patient and their GP / original referrer must be accurately recorded on the PAS system/Evolve.

3.28 Clinic Outcomes

3.28.1 Every patient, new and follow-up, whether attended or not, will have an attendance status and outcome recorded on the PAS system.

3.28.1 Every attendance must have a defined clinical outcome and RTT status recorded as part of the clinic outcome on the PAS system directly after the patient's attendance. The RTT status must relate to the outcome of the current activity not next activity.

Section 4 - Diagnostics

4.1 Diagnostic Booking Process

4.1.1 Referrals for diagnostic tests / procedures are accepted from the following sources:

- GPs, other referrers, or direct access
- Consultant referral (internal)
- Consultant referral (tertiary).

4.1.2 Patients should only be referred for a diagnostic if they are ready and available to attend their appointment in the next 6 weeks unless the diagnostic test is planned for a specific time. It is the responsibility of the referrer to ensure the patient is made aware of this.

4.1.3 Once diagnostic tests are requested as an order on the PAS system or on ICE for primary care direct access the request is triaged and prioritised. Requests can be upgraded, downgraded or rejected.

4.1.4 Patients should wait no longer than 6 weeks for any routine diagnostic test and no longer than 2 weeks for urgent cases.

4.1.5 For all urgent suspected cancer referrals, the diagnostic request must be clearly marked as 'rapid access'.

4.2 National Diagnostic Clock Rules

4.2.1 Diagnostic clock start:

- When the request for a diagnostic tests or procedure is made (often at a first outpatient appointment).

4.2.2 Diagnostic clock stop:

- When the patient receives the diagnostic test / procedure.

4.2.3 A large proportion of patients referred for a diagnostic test will also be on an open RTT pathway. The 6-week diagnostic clock is not the same as an RTT clock, which will continue to tick. In these circumstances, the patient will have both types of clock running concurrently.

4.2.4 If a patient undergoes a diagnostic procedure, during which treatment is also carried out, then the 6-week waiting time target still applies in accordance with the National Diagnostic Waiting Times Guidance. The completion of the procedure during this appointment will stop the patients RTT clock.

4.2.5 Where a patient's RTT pathway is closed (treatment already completed) and it is decided during a follow up appointment that a new diagnostic is required, then a new diagnostic clock would start at the point of request. It is the outcome of the clinic appointment that will determine whether a new RTT clock needs to be started as well.

4.3 Priority Coding (D Codes)

4.3.1 The clinical validation of diagnostic waiting lists project will produce a clinically validated waiting list that allows diagnostic lists to run effectively, by:

- Prioritising access to procedures based on individual patient needs, while considering the need of the population.
- Facilitating good communication between the patient, GP and secondary care provider.
- Producing a validating waiting list that is up to date and that allows procedures to run effectively.
- Minimising waits where possible, but particularly for those with immediate need.
- Recognising that for less urgent or routine diagnostics, some patients may experience a delay.

4.3.2 All patients who are listed for surgery should have a clinical priority decision at the point of listing a patient for a diagnostic based on the clinical urgency and the options that can be selected are:

- D1: Potentially life-threatening or time-critical conditions e.g., cancer (i.e., spinal cord compression), acute heart failure with no recent imaging, significant bleeding, chest pain with murmur or heart failure and no recent imaging, renal failure, vision loss

- D2: Potential to cause severe disability or severe reduction to of quality of life e.g., intractable pain. Urgent patients, including 2ww for investigation of suspected cancer, would fit within this category.
- D3: Chronic complaints that impact on quality of life and may result in mild or moderate disability
- Routine patients that would normally be seen within the next 4-6 weeks
- D4: Chronic complaints that impact on quality of life and may result in mild or moderate disability – Routine patients that would normally be seen within the next 6-12 weeks.

4.4 Diagnostic Booking Standards

4.4.1 General principles and standards for diagnostic booking:

- Tests are booked in order of clinical priority (urgent over routine) and then in chronological order.
- Clinicians or administrator inform patients of the likely waiting time for diagnostic appointments.
- The decision to add patients to the diagnostic waiting list must be made by the consultant or designated clinical member of the team. It is the responsibility of the clinician or designated clinical member of the team to place the order for the patient to enable them to be added to the waiting list.
- Every effort is made to contact the patient directly to agree the diagnostic test or procedure date.
- If the patient cannot be contacted (following unsuccessful telephone contact and checking with the GP or other referrer that the system has the correct contact details) the patient will be given the next available appointment date and sent an appointment confirmation letter.
- Where individuals have specific communication needs, services will provide help and information in formats that they can understand.
- The system requires patients to be offered a choice of 2 appointment dates with at least 3 weeks' notice of the appointment (reasonableness criteria). This does not preclude offering patients the choice of an earlier date if they agree.
- The appointment must be booked before the 6-week target. The cancer and RTT clock and status should always be checked.
- If a patient turns down reasonable appointment, i.e. two separate dates with three weeks' notice, the diagnostic waiting time for that test / procedure can be set to zero from the first date offered. The RTT clock continues to tick.

4.5 Diagnostic Cancellations and the DNAs Hospital Initiated

4.5.1 Every attempt should be made not to cancel diagnostic tests / procedures, however if the system cancels a diagnostic appointment, the patient's appointment should be rebooked as close as possible to their original appointment and within the 6-week target date, with consideration to RTT and

Cancer Target dates where applicable. The diagnostic clock continues and is not restarted.

4.6 Patient Initiated Cancellations and DNA's

4.6.1 The same rules apply for diagnostics for patient cancellations and DNAs as for any other clinical appointment where the patient has been given reasonable notice.

4.6.2 The new diagnostic appointment should be a reasonable offer and ideally as close to their cancelled or DNAd appointment as possible, and within the new / recalculated 6-week target date, with consideration to RTT and Cancer Target dates where applicable.

4.6.3 If the patient was not given reasonable notice the diagnostic clock would continue to tick and a new appointment should be offered if clinically appropriate.

4.6.4 Where a diagnostic test is rebooked following a patient cancellation or DNA (as long as the appointment was reasonable), a new diagnostic clock is started on the date of the cancellation / DNAd appointment.

4.6.5 If a clinical decision is taken that the patient no longer requires the diagnostic test, the patient will be removed from the diagnostic waiting list and a letter will be sent to the original referrer (for the diagnostic). Where there is an RTT clock this will continue.

Section 5 – Elective Inpatients and Day case procedures

5.1 Elective Booking Process - Adding a Patient to the Waiting List

5.1.1 The decision to add patients to the waiting list must be made by the consultant or designated clinical member of the team.

5.1.2 The patient must have accepted the clinician's advice on elective treatment prior to being added to the waiting list.

5.1.3 Patients must be made aware of the waiting times and the rules around the number of admission dates able to be offered. They should be asked if they are available for short notice and this information should be entered on the PAS system with contact telephone numbers.

5.1.4 The clinician requests an order for treatment in clinic, at which point a Waiting List officer will add the patient to the waiting list.

5.1.5 Patients must not be added to the waiting list if:

- They are unfit for the procedure
- Further investigations are required to first confirm suitability for the surgical procedure
- Not ready for the surgical phase of treatment
- They need to lose weight, stop smoking or change lifestyle

- Clinically the operation cannot or should not be done sooner due to clinical reason (see planned waiting list).

5.1.6 The waiting list must only contain patients who are medically fit and socially ready and able to have their procedure. Patients who are not fit for treatment, ready and able to come in at the time of the decision to admit is made should not be added to the waiting list. They should be discharged and re- referred once they are fit and ready for treatment. This will stop the RTT clock.

5.1.7 Where patients either attend at hospital or are admitted for treatment, or contacted with a treatment date, but are found to be unfit then, if the condition is considered transitory in nature the clock should continue and the patient be rebooked 2 to 3 weeks later.

- Chest Infection
- UTI
- Patient with a known condition (e.g.: angina) with recent episodes that require Cardiology follow-up and investigation.

5.1.8 Patients who have been Covid positive should have their treatment/ procedure delayed for 7 weeks. Clinical prioritisation can however overrule this if the consultant feels it is in the best interest.

5.1.9 If a patient is unlikely to be fit for treatment within the foreseeable future (> 8 weeks) the following options should be considered:

- discharging to primary care for optimisation
- discharging with a decision not to treat
- placed on active monitoring, with a clinical plan to review back in clinic

5.1.10 In all three scenarios this would stop the RTT clock and the patient should be removed from the waiting list.

5.1.11 Any periods of unfitness longer than 4 weeks, should be reflected to the relevant clinician to decide on the next steps, these should be in the patient's best interest and following the advice of the clinician. Where appropriate a patient can be placed on active monitoring or discharged following this review, providing this is in the patient's best interest and clearly documented.

5.1.12 Patients requiring thinking time regarding if a treatment is suitable for them will not normally stop the clock. There is an expectation that the clinician will have discussed a suitable timeframe of no more than 4 weeks for this decision to be made, this may be shorter for cancer pathways.

5.1.13 Where a patient opts to think about non-cancer RTT treatment for longer than 4 weeks, a period of patient initiated active monitoring will commence and the patient will be given an appointment for review with the clinician for 3 months' time. This will stop the RTT clock.

5.2 Booking Standards

5.2.1 Clinically urgent patients will be prioritised and booked according to need, based on their clinical prioritisation, with cancer patients being booked first.

5.2.2 All routine elective patients must be booked chronologically, meaning patients on the waiting list the longest are booked first. However, patients will be taken out of order to maximise theatre utilisation.

5.2.3 War pensioners and service personnel must receive priority access for any conditions which are related to their service (over other patients with the same level of clinical need).

5.2.4 To ensure patients are seen in a timely manner and work towards meeting the RTT national target, the system encourages pooling of appropriate cases. This enables patients to be listed to the most appropriate clinician with the shorted possible wait time.

5.2.5 The Waiting List Office have responsibility for liaising with Operational Leads regarding the waiting list and relevant capacity.

5.2.6 Waiting lists will consist of active and planned patients.

5.2.7 A selection of patients to replace cancellations should be taken from those who have been pre-assessed and who require completion of their RTT pathway within certain timescales.

5.2.8 For an offer of To Come In (TCI) date to be deemed reasonable, the system must agree an admission date with the patient giving them at least 3 weeks' notice and a choice of 2 dates, 2 weeks apart. Admission dates with shorter notice may also be offered although are only deemed reasonable if they are accepted by the patient. Patients will have the opportunity to decline without any adverse effect on their waiting time or RTT clock. A patient will be offered a maximum of 3 dates during their patient pathway.

5.2.9 Patients will be contacted by telephone to arrange their admission dates and this date confirmed in writing.

5.2.10 Where the patient does not respond to letters or phone calls, i.e. 2 phone calls on different days, at different times or haven't responded to a call to book letter within 21 days (3 weeks) of the letter date, then the patient is not fulfilling their obligation to make themselves available for admission and they will be discharged back to their GP. This will stop the RTT clock

5.2.11 Where individuals have specific communication needs, services will provide help and information in formats that they can understand.

5.3 Priority Coding (P Codes)

5.3.1 The clinical validation of waiting lists allows lists to run effectively by:

- Prioritising access to procedure based on individual patient needs, while considering the need of the population
- Facilitating good communication between the patient, GP and secondary care provider
- Producing a validated waiting list that is up to date and that allows procedures to run effectively
- Minimising waits where possible, but particularly those with immediate need
- Recognising that for less urgent or routine procedures, some patients may experience a delay.

5.3.2 All patients who are listed for surgery should have a clinical priority decision at the point of listing a patient for surgery based on the clinical urgency and the options that can be selected are:

- P1 – surgery is urgent/life threatening
- P2 – surgery to be carried out within 4 weeks
- P3 – surgery to be carried out in less than 3 months
- P4 – surgery to be carried out in 3 - 4 months

5.3.3 All patients will remain on the appropriate waiting list(s) and therefore will be visible. In line with current waiting list rules, waiting times will not be 'paused' and the RTT clock will continue through a period that the patient chooses not to attend.

5.3.4 Where patients decline reasonable offers for 'other' reasons they will be treated in line with the Elective Access Policy.

5.4 Outsourcing

5.4.1 Where there are capacity limitations, the system may decide to outsource the treatment of patients for certain procedures to another qualified provider. Appropriate patients will be identified by the service and contacted by the Waiting List Team. The patient must agree to the outsourcing of their treatment prior to any information being transferred.

5.5 Patient Unavailability for Personal or Social Reasons

5.5.1 Some patients will turn down admission dates because they wish to plan their treatment around personal or social circumstances. Patients who declare an extended period of unavailability must be brought to the attention of the clinical team to be reviewed.

5.5.2 If the patient is not available for admission for 6 weeks or more from the date of first being contacted to arrange a TCI, the patient will be brought to the attention of the clinical team to be reviewed.

5.5.3 The patient may be discharged back to their GP and the RTT clock will stop, unless it is agreed by the consultant that this is contrary to their best clinical interest.

5.5.4 Ultimately, patients will be considered on a case-by-case basis however it is generally not in a patient's best interest to be left on a waiting list for extended periods of time (i.e., several months). There must be specific protection for the clinical interests of suspected cancer patients, children and young people under 18 years and vulnerable adults.

5.6 C Codes

5.6.1 The following codes should be applied where patient decline TCI offers either at their existing provider or an alternative provider.

- Following declining a 1st TCI, the patients priority (P) code should be updated to reflect the patient has declined a date and recoded to a C (Choice) code, the options will be C1/2/3/4, aligning with the patients current P coding.

A second TCI should be offered which is within 6 weeks of the 1st TCI.TCIs offered should be reasonable (i.e., with 3 weeks-notice)

If a patient declines a second TCI date, refer to point 5.5 and follow clinical guidance.

If the patient is to remain on the waiting list following clinical review their priority (C) code should remain/

5.7 Admission Patient Initiated Cancellations

5.7.1 Patients can cancel their admission date once. If they cancel and ask to rearrange a second time, they should be discussed with the clinical team and considered for referral back to the care of the GP. This can only be considered if the admission was reasonable and clearly communicated. There must be specific protection for the clinical interests of suspected cancer patients, children and young people under 18 years and vulnerable adults.

5.7.2 Patients who either call in to cancel an agreed date for surgery due to sickness or extreme personal circumstances, or are deferred on the day of surgery due to a short and measurable medical condition which can be resolved within a 2-week period, will be cancelled and a new date agreed with the patient within 6 weeks' time. The RTT clock will continue throughout this period.

5.8 Admission Hospital Initiated Cancellations

5.8.1 The system's objective is to have all patients on the waiting list treated within their RTT breach date.

5.8.2 In the event that the system has to cancel a patient's elective procedure for a non-clinical reason either on the day of admission or day of surgery, the patient must be contacted within 5 days and offered an admission date that is within 28 days of the cancelled operation date (in order to meet the NHS Constitution guarantee on cancelled operation), or the RTT date, whichever is sooner. The RTT clock will continue throughout until treatment is started.

5.8.3 Approved cancelled theatre sessions should be taken up by other clinicians wherever possible to ensure maximum theatre utilisation and this managed by the SOM for Theatres and reviewed at the weekly Theatre Utilisation Reference Meeting (TURM).

5.8.4 All non-clinical cancellations on the day must be authorised by the Strategic manager following review by the appropriate ADO or SOM. No action can be taken on any on the day cancellations without appropriate authorisation See appendix 7. Any unauthorised on day cancellations will be investigated.

5.9 Admission Did Not Attends (DNAs)

5.9.1 Patients who fail to attend for reason unknown for their agreed inpatient procedure date should be removed from the waiting list and referred back to their GP and the consultant will be informed. Patients must be informed clearly in all Trust correspondence that in the event that they DNA either their pre-operative assessment appointment or inpatient procedure, that they will be referred back to their GP. This will stop the RTT clock.

5.9.2 A further admission would not be routinely offered, and the patient will be discharged back to their GP / original referrer, where the following criteria is met:

- Discharging the patient would not be contrary to the patient's best clinical interests
- The appointment was reasonable and was clearly communicated, including sent to the correct patient address
- There must be specific protection for the clinical interests of suspected cancer patients, children and young people under 18 years and vulnerable adults.

5.9.3 Only a consultant or admissions manager can reinstate the patient onto the Waiting List following a DNA as there is the opportunity for a patient to respond to their DNA letter within 7 days with mitigating circumstances. This will start a new RTT clock.

5.10 Patients who are medically unfit for surgery

5.10.1 When a patient is temporarily unfit (i.e. cold) then patients should contact the Waiting List Office and a new admission date will be agreed with the patient, normally within 6 weeks of the original date. This will allow patients with minor acute clinical reasons for delay time to recover. The RTT clock will continue

throughout this period. If a patient is not fit after this period, they will be raised to the clinical team for review, where the decision may be that they will be discharged and returned to the care of their GP. This will stop the RTT clock.

5.10.2 For patients identified as likely to be unfit for an extended period of time due to more serious clinical issues the patient should be clinically reviewed and considered for removal from the waiting list and possible discharge. The consultant may decide to actively monitor the patient until they become fit for treatment, or may decide to discharge the patient back to the care of the GP / referrer. This will stop the RTT clock.

5.10.3 If a clinically complex patient has multiple conditions with a clinical reason why the surgery cannot go ahead, it is appropriate to stop the RTT clock for these patients and start a new one when the patient is medically fit and ready to start their treatment. If the patient is not fit after 8 weeks, the patient will be referred back to the GP.

5.10.4 Ultimately patients should be clinically considered on a case-by-case basis and decisions will be based on the patient's best interests and what would be least detrimental to their overall RTT pathway, please refer to Patient fitness for elective intervention for detailed guidance.

5.10.5 Re-referrals should be made by the GP when the patient is fit for surgery. The patient will either be added to the inpatient waiting list by the consultant after completing a new order for surgery or be seen in outpatients if the consultant feels that the original condition may have changed. This will start a new RTT clock

5.10.6 Clock stops should not be applied when it is identified that further work up is required prior to treatment i.e. cardio review or scans. These tests should be accommodated within RTT guidance, and the clock should continue.

5.11 Pre-Operative Assessment

5.11.1 Pre-operative assessment establishes whether a patient is fit for surgery including anaesthesia and confirms that the patient is available, fully informed and wishes to proceed with surgery. Patient information leaflets will be available to issue to the patient at the time of the appointment. Patients should be booked for their pre-op assessment as soon as possible once they are listed for treatment. The sooner the patient attends for pre-op assessment the earlier the patient can be optimised to have their surgery.

5.11.2 The following sets outpatient scenarios following pre-operative assessment. It is important to note that all decisions regarding the RTT clock (whether it continues or stops) should be a clinical one. This decision can be made by the POA nurse, an anaesthetist or any other consultant who is involved in assessing the patient's fitness for surgery. In the event of a clock stop, this

decision should always be made by the anaesthetist or another consultant. The following scenarios are guidance to support with clinical decisions regarding the application of the rules:

a. The patient is not fit due to a transitory and temporary illness (e.g., a cold, chest infection) which is expected to last no more than 4 weeks – clock continues

b. The patient is not fit due to Covid – clock continues (a period of 7 weeks should be incurred before offering the patient a TCI date)

c. The patient is not fit due to co-morbidities (e.g., uncontrolled diabetes, anaemia, heart disease) which require optimisation or treatment. In this scenario it is highly likely that the patient will remain unfit for more than 8 weeks. However, it may be possible that they become fit within a shorter timeframe – clock stop is the most likely clinical decision but dependant on the nature of the condition requiring optimisation or treatment, the clock may continue

5.11.3 All patients undergoing elective surgery will undergo pre-operative assessment following the decision to list, in the preoperative assessment setting. MRSA swabs should be obtained from all eligible patients when attending for pre-operative assessment. Where patients are found to be colonised they are treated immediately in line with Trusts MRSA policy. This does not stop the RTT clock.

5.11.4 If at the initial pre-operative assessment appointment, further anaesthetic assessment is required, an anaesthetic review will be booked.

5.11.5 If after anaesthetic review a patient is deemed fit for surgery, the patient will be informed that they can proceed and offered dates for surgery by the Waiting List Office.

5.11.6 If a patient requires additional investigations or is not fit to proceed with surgery they should be clinically reviewed and a decision made as to whether they remain on the waiting list, are removed from the waiting list, or actively monitored.

5.11.7 If a decision is made that the patient should be removed from the waiting list or placed on active monitoring, the GP will be informed of the decision and will be provided with relevant information to support the GP in managing the patient's health to a level, if possible, where they can proceed with surgery. The patient will also be informed that they cannot proceed with the agreed surgery. The RTT clock will stop.

5.11.8 Patients who are returned to the care of their GP but are subsequently re-referred in within the next 6-month period should be added back onto the elective waiting list using the date the letter was received as the new clock start date. The consultant should complete an order for surgery on the PAS system as per the normal process. A new RTT clock will start.

5.11.9 If a patient fails to attend a pre-operative assessment appointment, then the patient should be contacted by the pre-assessment team to discuss the reason. It is expected that one of two outcomes will occur:

- A further date for a pre-operative assessment should be agreed. The RTT clock will continue or
- Discharged back to the care of the GP. This will stop the RTT clock.

5.11.10 Where the patient does not respond to letters or phone calls, i.e. 2 phone calls on different days, at different times, or haven't responded to a call to book letter within 21 days (3 weeks) of the letter date, then the patient is not fulfilling their obligation to make themselves available for admission and they will be discharged back to their GP. This will stop the RTT clock

5.12 Bilateral Procedures

5.12.1 A bilateral procedure is a procedure that is performed on both sides of the body at matching anatomical sites and the need for both is identified and recorded at the initial decision to admit.

5.12.2 Where a patient requires a bilateral procedure and the second procedure is not undertaken at the same time as the first, the original RTT clock stops when the first procedure is performed. A new RTT clock starts when the patient is fit and ready to be offered dates for the second procedure and has confirmed with the system that they are available for treatment.

5.13 Patients Admitted from an Emergency Referral

5.13.1 Patients admitted as emergency referrals are not subject to RTT targets. If a patient was already on an RTT pathway for a treatment that is carried out during the emergency admission the RTT clock will stop.

5.13.2 If the emergency admission does not undertake the elective procedure they were waiting for, the RTT clock will not stop. However, if the patient is no longer fit to have the procedure and the clinical decision is made to refer the patient back to the GP, the RTT clock stops at the time this is communicated to the patient. If the reason for being unfit is expected to be temporary the RTT clock would not stop.

5.14 Elective Planned Patients

5.14.1 Planned care means an appointment or procedure or series of appointments/procedures as part of an agreed programme of care which is required, for clinical reasons, to be carried out at a specific time or repeated at a specific frequency.

5.14.2 Patients on the planned elective list will not be on an 18-week RTT pathway and will not form part of the 'active' waiting list.

5.14.2 Examples of procedures which should be on a planned list are:

- Patients waiting for more than one procedure where the procedures need, for clinical reasons, to be undertaken in a certain order i.e. drug treatments, injections and infusions
- Follow up surveillance or check procedures such as cystoscopies, colonoscopies Patients proceeding to the next stage of treatment i.e. patients undergoing chemotherapy or removal of screws or metalwork
- Sterilisation following pregnancy when the procedure cannot be undertaken until after the pregnancy
- Age- or growth-related surgery

5.14.3 This list is not exhaustive. A clinician or clinician's representative will decide whether a patient should be added to, or remain on the planned waiting list and in conjunction with the patient decide a date by which the next stage of treatment will commence.

5.14.4 There are strong clinical governance and safety reasons for the correct inclusion of patients onto the planned waiting list, and why planned activity should not be deferred beyond the clinically determined dates.

5.14.5 When patients on planned lists are clinically ready for their care to begin and reach their target treatment date for their planned procedure, they will either be admitted for the procedure or be transferred to the relevant active waiting list and appropriate clock start i.e., RTT or DM01 6-week target

Section 6 – Cancer Pathways

6.1 Introduction

6.1.1 The Cancer Waiting Times initiative was introduced in response to the NHS Cancer Plan published in 2000 which was further developed in the Cancer Reform Strategy in 2007 and the Improving Outcomes: A strategy for Cancer. The documents set out the expectation of NHS Hospital Trusts when receiving referrals for, diagnosing and treating Cancer Patients ensuring a high standard of care and timely treatment. This policy aims to support the system in achieving the targets ensuring a high level of compliance with the Cancer Waiting Times Guidance

6.1.2 This policy outlines the ways in which the system monitors and reports performance in accordance with the CWT Guidance (Version 11.0); detailing the standards and procedures that must be adhered to.

6.1.3 This policy should be used in conjunction with the Cancer Operational Policy which aims to ensure that patients are progressed along their pathways in a timely manner preventing delays in delivering treatment, maintaining a high standard of care and to avoid breaching performance targets. The systems performance against CWT targets is monitored and reported internally with external reporting taking place monthly.

6.1.4 This policy does not provide guidance to clinical teams in relation to patient care. The care of patients and appropriate treatment planning is of key importance; however Clinical Teams must ensure that they are aware of related performance targets and the requirement to progress patient pathways within specified timescales.

6.1.5 The aim of the policy is to ensure clarity and consistency regarding the systems compliance with CWT guidance, ensuring the system progresses all patients referred in with a suspicion of cancer in a pro-active and efficient manner achieving a high level of cancer performance. All staff members involved in cancer pathways are expected to comply with local and national policies as determined in this document.

6.1.6 This policy applies to all Trust staff involved in patient pathways referred in suspicious for malignancy, through diagnostics and treatment of confirmed cancers. The responsibility of staff is to ensure that patients progress along their pathway in a timely fashion, maintaining a high standard of clinical care and preventing delays in the diagnostics and delivery of cancer treatment in order to achieve the best clinical outcome.

6.2 Cancer Wait Times Standards

6.2.1 The Cancer Waiting Times service standards are:

- Maximum two weeks (14 days) wait from:
  - Urgent GP referral from suspected cancer to first outpatient attendance (Operational Standard of 93%)
  - Referral of any patient with breast symptoms (where cancer is not suspected) to first assessment with the hospital (Operational Standard of 93%)
- Maximum 28 days from:
  - Receipt of 2 Week Wait referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical) and receipt of 2 Week Wait of any patient with breast symptoms (where cancer is not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer
- Maximum one month (31 days) from:
  - Decision to treat to first definitive treatment (Operational Standard of 96%)
  - Decision to treat / earliest clinically appropriate date to start of second subsequent treatment(s) for all cancer patients, including those diagnosed with a recurrence where the subsequent treatment is:
    - Surgery (Operational Standard of 94%)
    - Drug Treatment (Operational Standard of 98%)
- Maximum two month (62 days) from:
  - Urgent GP referral for suspected cancer to first treatment (62-day standard) (Operational Standard of 85%)
  - Urgent referral from NHS Cancer Screening Programme (Breast, Bowel or Cervical) for suspected cancer to first treatment (Operational Standard of 90%)
  - Consultant upgrade of patient to first treatment (currently no Operational Standard)
- Maximum one month (31 days) from:
  - Urgent GP referral to first treatment for rare cancers (including Testicular Cancer, Paediatric Cancer or Acute Leukaemia) (currently no Operational Standard, monitored within 62-day urgent GP referral for suspected cancer but recorded separately).

6.2.2 The operational standards identified determine the systems overall performance when all tumour sites are reported together. It is expected that some tumour sites

will exceed the timeframe due to the complexity associated with reaching a diagnosis and will therefore report below the operational standards.

6.3 New Patient 2WW Suspected Cancer Referrals

6.3.1 All patients referred in from a General Practitioner (GP), General Dental Practitioner (GDP) or Optometrist (in accordance with the Cancer Waiting Times guidance) as a 2WW suspected cancer must be seen within 14 days from receipt of referral (Day 0) – compliance target 93%. Referrals can be received from locally approved providers (for example GPSIs and nurse specialists).

6.3.2 The referring practitioner must complete the 2WW referral form specific to the tumour site of concern, attach any relevant send via the NHS eReferral Service. Referrals should be received within 24 hours of the decision to refer.

6.3.3 The GP should ensure that the patient is fully aware that they are being referred via a fast track process with a suspicion of cancer and that they should be available to attend an appointment or diagnostic investigation within the next 14 days. The GP should encourage patients to attend and advise them that they may need to attend for some tests prior to seeing a consultant.

6.3.4 GPs should ensure that patients have had all necessary tests completed to accompany the referral. Referrals received by the system should have the appropriate clinical information available for the clinician to review and include full demographic details including NHS number and telephone numbers (both day and evening if possible) to reduce any delay in contacting the patient.

6.3.5 2WW referrals will be prioritised for action prior to urgent or routine referrals and in order of receipt of referral date.

6.3.6 Any referrals that are received outside of the TAC department must be forwarded immediately to TAC for registration.

6.3.7 The 2WW standard also applies to patients referred in with specific breast symptoms that the referring healthcare professional believes are not suspicious of cancer but should be investigated by a specialist; these referrals can come from a multitude of sources.

6.3.8 All referrals received must have appointments or diagnostic investigations booked within 14 days from receipt of referral; this excludes patients that have been referred in from a family history clinic or for cosmetic breast surgery – compliance target 93%.

6.3.9 Upon receipt of the 2WW referral the TAC department will register the referral ensuring the correct suspected cancer tumour site is entered onto both the PAS system and the Somerset as the Cancer registry.

6.3.10 2WW Breach - The system must ensure an appointment is made available to the patient within 14 days. If this is not achieved the referral must be recorded as a 2ww breach with full details added to the comments section on Somerset to explain the delay.

6.3.11 Referrals requiring an outpatient consultation will be booked by the rapid access team in TAC.

6.3.12 Patient contact - The TAC team will make two attempts to contact the patient by telephone at different times and on different days OR; where possible contact the patient by telephone using the preferred telephone number to agree the earliest convenient date for the patient to attend their first appointment. If it is not

possible to contact the patient a letter must be sent first class giving an appointment within 14 days.

6.3.13 The letter will advise the patient that, if the given date and time is inconvenient, they should ring the TAC department.

6.3.14 Once an appointment is allocated a letter of confirmation will be sent to the patient's current address.

6.3.15 If a patient contacts to rebook their 14-day appointment, the booking clerks will make every attempt to offer another appointment and encourage the patient to attend within the 14-day period.

6.3.16 If the patient is unable to attend, the TAC team must update Somerset with the dates the patient cannot attend and the reasons why. Should the patient select an appointment outside the 14-day period this will then be recorded as a breach of 2ww target due to patient choice.

6.3.17 In the exceptional circumstances that the hospital cancels a 2ww appointment it must be rearranged within the original 14-day timeframe and as close to the date previously offered.

6.3.18 Where referrals require a diagnostic investigation ('straight to test') the appropriate clinician must request the diagnostic investigation as a 2ww electronically as an order on the PAS system.

6.3.19 The pathway co-ordinators will track the patient until the patient the patient has had cancer ruled out or completed treatment.

6.4 Escalation

6.4.1 The system will ensure that all consultant led new patient clinics have sufficient 2WW appointment slots available to book patients into.

6.4.2 If there are any issues regarding capacity it is essential that this is escalated immediately. If the issues are in relation to:

- Outpatient clinic capacity – the TAC team will advise the appropriate Speciality Assistant Service Manager
- Diagnostic service capacity – the respective team must escalate to the relevant Assistant Service Manager for immediate action.

6.4.3 CWT guidance actively encourages patients to be referred at the earliest possible opportunity but the operational standards applied do consider the number of patients that choose to delay their pathway.

6.4.4 In order to be able to accommodate patient choice within the 2WW part of the pathway, all specialties should be able to offer appointments within both the first and second week in order to achieve compliance with the standard.

6.4.5 Patients will be made aware of the importance to attend appointments and investigations initially by the outpatient booking clerks and then by the clinicians seen throughout the pathway. If felt appropriate the referring GP can be contacted by the Consultant, clinician or departmental booking clerks to make them aware of the patient's choice to delay the pathway and if appropriate encourage the patient to attend.

6.5 Did Not Attend (DNA)

6.5.1 If a patient agrees to an appointment but then does not attend, this is classed as a patient 'DNA'. A patient may DNA for various reasons, such as ill-health, or last-minute emergencies.

6.5.2 A single patient DNA, for a patient on a 'potential cancer pathway' or 2WW referral, does not warrant a referral back to the GP. If the patient DNAs their first attendance appointment they should be offered an alternative appointment.

6.5.3 All details must be entered on to Somerset to explain the delay and provide a clear audit trail. If the patient DNA's their second appointment / straight to test diagnostic appointment, they will be referred back to their GP asking the GP to review and re-refer if required.

6.6 Cancellations/Rescheduling

6.6.1 If a patient calls to reschedule appointments or informs the department that they will not be attending, the patient is 'engaging with the pathway' and every effort must be made to ensure that they are seen within the 2ww target date or at the earliest opportunity to prevent any further delay in the pathway.

6.6.2 Patients must not be referred back to GPs solely because they are cancelling appointments as the patient is 'engaging with the pathway'

6.7 Inappropriate, Incorrect and Downgrading Referrals

6.7.1 If a referral is received and is deemed inappropriate or incorrect, Consultants are unable to reject or downgrade these referrals without the approval of the GP. It is the responsibility of the Consultant to contact the GP practice to discuss the patient's case and agree appropriate action. The patient's GP is the only practitioner able to downgrade a referral, and therefore may agree to withdraw from the 2WW pathway, unless previous agreements have been made on clinical pathways with full agreement and safety netting in place, or if a patient states their symptoms have resolved and they no longer need to be seen.

6.7.2 If, after the discussion, the GP agrees to withdraw or downgrade the referral, the GP must confirm the withdrawal by email or re-refer the patient using a standard urgent or routine letter. Confirmation of this discussion should be entered onto the patient's referral which will be passed back through to the TAC team.

6.7.3 If the patient advises the TAC rapid access Team that they no longer wish for the referral to be processed the Team will contact the referring GP to advise of the patients' decision and discuss.

6.8 Emergency Admissions

6.8.1 If a patient is admitted via A&E, exhibiting the same symptoms for which they were referred as a 2WW, and are seen before their initial consultation, this admission will supersede the 2WW referral and the patient would continue on a 31-day pathway.

6.8.2 If the patient is admitted to hospital before the date first seen and is investigated for symptoms related to another condition only, this will not affect the 62-day pathway which will continue **to be active.**

6.9 Screening Pathway

6.9.1 The NHS runs three Cancer Screening Programmes (Cervical, Breast and Colorectal) to identify cancer in high risk groups of the community. Patients who are identified as suspicious of, or confirmed as having cancer during the course of the investigations at screening appointments are referred in to their local Trust for

treatment. Receipt of the referral at the system is recorded as the Cancer referral to treatment period start date initiating the 62-day screening pathway.

6.10 Inter-Provider Transfers

6.10.1 Where patients are transferred between providers the cancer pathway co-ordinators are responsible for the completion of the MDT inter provider form.

6.10.2 The principle needs for using these forms is to ensure all service providers involved in a patient's pathways have adequate information about CWT data to enable the patient's management to be conducted within appropriate time frames.

6.11 Faster diagnosis Standard

6.11.1 The faster diagnosis standard applies to all 2WW Urgent referrals for suspected cancer; Breast symptomatic Referrals and Urgent Screening Referrals.

6.12 Ending the Faster Diagnosis Standard Pathway

6.12.1 The 28-day FDS pathway ends only at the point of communication with the patient, whether that is to inform them of a diagnosis of cancer, a ruling out, or if they are going to have treatment before a clinical diagnosis of cancer can be made.

6.12.2 Where all reasonable diagnostics to exclude cancer have been completed and the patient is discharged back to their GP, the point that this is communicated to the patient should be recorded as the end of the 28-day FDS pathway. In these circumstances this should be recorded as a 'ruling out of cancer'.

6.13 Communication Diagnosis to the Patient

6.13.1 All diagnoses of cancer should be shared with the patient through direct face-to-face communication with the patient unless explicitly agreed with the patient.

6.13.2 Reasonable forms of communication with patient to confirm cancer has been ruled out include:

- Direct communication with the patient, over the phone or video consultation
- Written communication by letter or email.

6.13.3 Where direct communication is not possible due to the patient not having the mental capacity to understand a diagnosis either temporarily, or permanently, communication to the patient's recognised carer or parent/guardian should be recorded in the same way as if the patient was told directly. Examples where this could apply are:

- Patients with advanced dementia
- Patients who are unconscious
- A child where they are too young to understand the diagnosis.

6.13.4 The faster diagnosis end date would be recorded as the date the patient was told face to face; the date of the telephone call; or the date of the letter should the patient be informed in writing.

6.14 Exclusions from the Faster Diagnosis Standards

6.14.1 There are a few instances where patients can be excluded from the faster diagnosis pathway:

- Where a patient dies before communication of diagnosis - 01
- Where a patient declines all diagnostic appointments - 02
- Where a patient declined all appointments - 03
- Where a patient opted for private diagnostics (patient may come back for NHS funded treatment) - 04
- Repeated DNAs / patient triggered cancellations - 05
- Patient ineligible for NHS funded care – 06

6.14.2 The pathway should be closed on Somerset with the end reason being set as option 3 - excluded from the faster diagnosis standard, the cancer faster diagnosis pathway end date being set as the date the patient is discharged back to the GP and the cancer pathway exclusion reason being selected from the above list.

6.14.3 The 28-day FDS standard will not apply to these patients with the exception of 01 – patient died before communication of diagnosis is selected as the cancer faster diagnosis exclusion reason in which case the patient would be included if the date of death is more than 28 days after the clock start.

6.15 First Definitive Treatments – Surgery

6.15.1 The waiting list officer is responsible for booking the pre-assessment appointment and date of surgery (TCI) in accordance with the 62 day and 31day pathway target dates.

6.15.2 A treatment date i.e. TCI date should be offered within 31 days from the Decision to Treat (DTT) date and not breaching the 62-day breach date. If this not possible it must be escalated to the Speciality Assistant Service Manager.

6.15.3 Clinical considerations - If a patient is admitted for a procedure whereby the intent is to treat the cancer, but on operating the surgeon is unable to proceed due to clinical findings, this would be classed as 'open and close' surgery and would still class as treatment because the intent was to treat. However, this does not apply if the patient is reviewed pre-operatively and deemed unfit to proceed.

6.16 First Definitive Treatments – Enabling Treatments

6.16.1 Enabling treatments can be given to patients for numerous reasons; some enabling treatments in certain circumstances can be used as a treatment in their own right and used to end the 62-day pathway.

6.16.2 These enabling treatments include:

- Colostomy for bowel obstruction
- Insertion of an oesophageal stent
- Insertion of a pancreatic stent if being used to resolve jaundice before the patient has a resection or starts chemotherapy
- Gastrojejunostomy
- Cystodiathermy
- Dental extractions to enable radiotherapy
- Drugs which form part of chemotherapy regimens which commence prior to chemotherapy drugs for example B12 vitamin.

6.16.3 If a patient is admitted to hospital to have an enabling treatment that is not listed above, and remains an inpatient in the period of time between the enabling treatment and the main anti-cancer treatment, the date of admission will be recorded as the start of treatment date ending the 62-day pathway.

6.17 Breach Reasons and Waiting time adjustments – 62 days (refers to cancer waiting times guidance)

6.17.1 Under the Cancer Waiting Times (CWT) guidance it is accepted that not all patients will be able to attend for appointments or surgical intervention within the target timeframe allotted. This could be due to a delay in clinical diagnostics or patient circumstances impacting on their availability for appointments or treatment. There are very few occurrences in which adjustments to the pathway are able to be applied, the CWT guidance has limited this to patients who request later appointments and surgical treatment dates later than recommended, patients who miss their first appointments and clinically complex patients that are unable to be treated within the timeframe due to fitness for intervention.

6.17.2 It is expected that all tracking information is clearly entered on to patient records (e.g.-Care and Somerset) providing a clear audit trail of data.

6.17.3 Any pauses or breaches must be able to be evidenced clearly within the patient records for audit purposes.

6.18 Patient Choices

6.18.1 CWT guidance actively encourages patients to be referred at the earliest possible opportunity but the operational standards applied do consider the number of patients that choose to delay their pathway.

6.18.2 Patients will be made aware of the importance to attend for treatment initially by the waiting list clerks and then by the clinicians seen throughout the pathway.

6.18.3 If felt appropriate the referring GP can be contacted by the Consultant, clinician or departmental booking clerks to make them aware of the patient's choice to delay the pathway and if appropriate encourage the patient to attend.

6.18.4 Patients must not be discharged back to the GP solely because they are unable to accept a treatment date or have chosen to delay treatment as the patient is 'engaging with the pathway'

6.18.5 Adjustments are able to be applied to patient pathways where there is a confirmed cancer diagnosis and the patient declines reasonable treatment dates offered for inpatient admission such as:

- Choosing to accept a date that is out of target or
- Initially accepting a date within target and then cancelling the booking and choosing a date out of target.

6.18.6 In this circumstance, under the CWT guidance, the clock can be paused from the earliest treatment date offered to the earliest date that the patient would be available i.e. on their return from holiday.

6.18.7 Pauses cannot be applied to pathways where patients are unable to attend due to religious events or treatment that will be completed on an outpatient basis

6.18.8 Patients must not be referred back to GPs solely because they are cancelling dates for treatment as the patient is 'engaging with the pathway'.

6.18.9 If a patient chooses to decline all treatment options offered to them, provided they are making an informed choice to decline all treatment, they have removed themselves from the 62-day pathway.

6.18.10 The Consultant must be informed and contact the GP to agree appropriate outcome. This must then be confirmed by letter before the referral can be closed on the PAS system and Somerset.

6.18.11 If the patient contacts the system at a later date and advises that they would now like to proceed with treatment, this will be managed on a 31-day pathway.

6.19 Did Not Attends

6.19.1 If the patient DNAs an admission for treatment the patient cannot be discharged.

6.19.2 TCI for surgery - The waiting list office should contact the patient and establish the reason for non-attendance and rebook as soon as possible.

6.19.3 The waiting list team must inform the relevant clinical team and action should be taken to encourage the patient to attend e.g. CNS should contact patient or Consultant contact the GP. The GP is unable to withdraw the referral as the patient has already been seen and as such an acceptable outcome needs to be agreed with the GP and patient.

6.19.4 TCI for chemotherapy – The chemotherapy unit will contact the patient and establish the reason and rebook as soon as possible.

6.20 Emergency Admissions

6.20.1 If a patient is admitted via A&E, exhibiting the same symptoms and undergo surgery as an emergency this date of treatment will be recorded as first definitive treatment.

6.20.2 However if the A&E admission relates to another condition the 31/62-day referral still applies and the patient remains on the pathway until treated

Section 7 Training and Education

7.1 This policy will be actively promoted and distributed to all employees who are involved with managing patient pathways and especially all those employees working within the Outpatient Department, the Waiting List Office, the MDT and Cancer offices and all Medical Secretaries. It will also be available to all employees on the intranet.

7.2 Any new members of staff appointed to the above-mentioned departments will be made aware of this policy as part of their local induction.

7.3 Additional training is provided by the RTT Team for both clinical and non-clinical staff to support this policy during the course of their employment with the system.

7.4 It will be incorporated into elective care training and for all appropriate staff it will be a requirement to read this policy as well as complete the online e-learning training, see appendix 008 for e-learning matrix.

Section 8 Monitoring

WHAT	HOW	WHO	WHEN	WHICH GROUP
Policy is to ensure that patients are treated promptly, efficiently and consistently in line with national guidance and good practice.	Regular review of performance and continuous spot checks by data quality team.	Head of Elective Access	Annual	Insight

Author(s):	**Interim Head of Access**
Other contributors:	
Approvals and endorsements:	**Scrutiny Committee**
Consultation:	
Issue no:	8
File name:	CharlieS/Personnel/Policies 2016/PP071 Corporate Access Policy
Supercedes:	PP(21)071
Equality Assessed	Yes – form completed
Implementation	Policies will be distributed by the IG Manager to General Managers, Service Managers and all Ward/Department Managers. Policy will be available on the Trust Intranet Site.
Monitoring: (give brief details how this will be done)	Implementation, compliance and effectiveness of this policy will be monitored by the HR & Communications Directorate on an ongoing basis. This will be achieved by monitoring the use of Fixed term Contracts across the Trust. 100% of contracts issued must be inline with the regulations as stated in the policy.
Other relevant policies/documents & references:	

APPENDIX 1
Scheme of Delegation

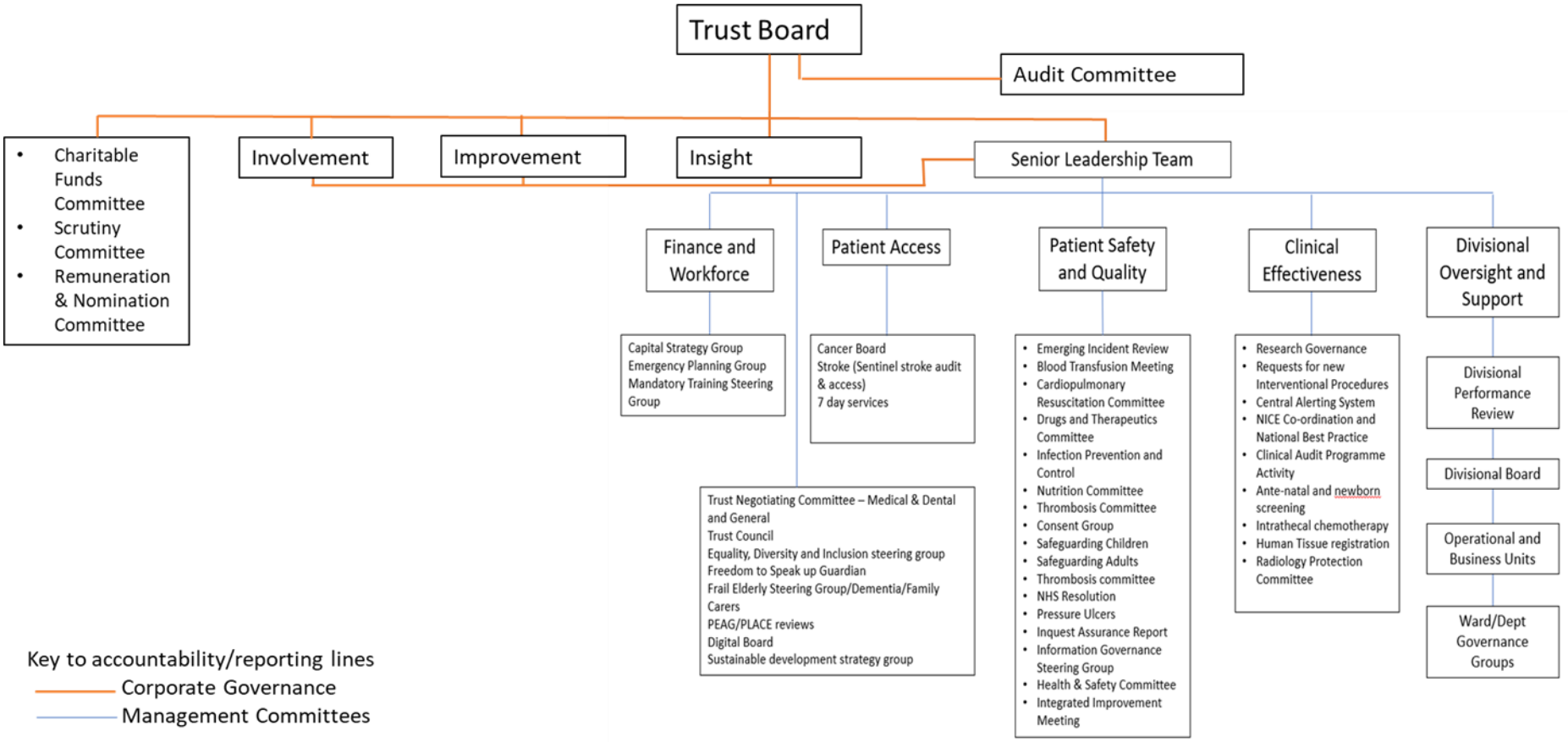

Figure 1 WSFT Delegation

ESNEFT TO FOLLOW

Appendix 2

EQUALITY/DIVERSITY ASSESSMENT TOOL

Title of Document	Elective Access Policy
Date of assessment	19/01/2023
Date for review	19/01/2026
Division	Corporate
Completed by	Hannah Knights
Date	19/01/2023

	Yes/No	**Rationale**
Does the document affect one group less or more favourably than another on the basis of:		
• Race	N	
• Gender	N	
• Sexual orientation	N	
• Age	N	
• Disability	N	
• Marriage and Civil Partnership	N	
• Pregnancy and Maternity	N	
• Culture	N	
Does this document affect an individual's human rights?	n	

If the answer to any of the above is 'yes' then:	**Tick**	**Rationale**
Demonstrate that such a disadvantage or advantage can be justified		
Adjust the policy to minimise the disadvantage identified or better promote equality		
If neither of the above is possible, submit to Trust Council for review		

Appendix 3
Glossary and Acronyms

Common terms and abbreviations used i

Appendix 4
Patients who are unfit SOP

SOP for unfit patients.docx

Appendix 5
Children who are not brought in