CORPORATE DOCUMENT	
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SECTION 1: INTRODUCTION

1.1 Policy Statement and Rational

1.1.2 This policy sets out the Bedfordshire Hospitals NHS Foundation Trust (subsequently referred as 'the Trust') local 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 Trust about the requirements and processes for effective management of elective patient access. This policy reflects the requirement to comply with the NHS Constitution, the Referral to Treatment target (RTT) and current Outpatient, Inpatient and Diagnostic waiting times.

1.1.3 This policy is to be followed and applied to the management of patient pathways by all Employees of the Trust.

1.1.4 This latest version of this policy was developed and agreed in consultation with staff, representatives from the Clinical Commissioning Group (CCG) including lay representatives and clinical leads. It will be reviewed and ratified every 3 years by the Trust Policy Approval Group or earlier to reflect changes in national guidance or local processes.

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

- The Trust will ensure that simple and efficient processes support positive patient experiences of services provided by the Trust.

- The Trust 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. Those referred urgently with suspected cancer or breast symptoms must be offered and appointment with two weeks. 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 Trust will increase the likelihood that patients will choose the Trust for their care and treatment. The Trust will provide capacity to ensure patients will be treated within 18 Weeks. The management of elective activity will be transparent to the public.

- 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 2015.

- All patients are to be treated fairly and equitably in accordance with The Equality Act 2010.

- The Trust 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.

1.1.6 This policy relates to the treatment of patients on active RTT Pathways. However patients not on a RTT pathway such as emergency and elective planned patients can expect their ongoing care to be managed within the same principles i.e. careful monitoring of planned waiting lists, booking and treating patients in date order.

1.2 Key Principles

1.2.1 The Trust 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.
- That referrals include information relating to the need for translators or other issues relating to accessible information needs.
- That pre-referral diagnostics have been completed as part of the referral process by the GP or referring practitioner.
- Aware of the speed at which their pathway may be progressed.
- That 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 will be applied consistently and fairly across all services provided by the Trust.
- 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 should be transparent to patients.
- The Trust 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 Trust if unable to attend as well as providing the Trust 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 or inpatient treatment.

This is a maximum wait time, not a target and the majority of patients will need to be seen in a much shorter timeframe to ensure compliance with the overall target, and the Trust's intention is to treat all patients within 18 Weeks where clinically and socially appropriate to do so.

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

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

1.2.4 The current operational standards for elective care are provided below:

RTT Waiting Times for non-urgent consultant-led treatment
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 Roles and Responsibilities

1.3.1 Although responsibility achieving standards lies with the General Managers and ultimately the Trust Board, all staff with access to and a duty to maintain elective care information systems are accountable for their accurate upkeep.

Head of Clinical Information / RTT Team	Responsible for the timely production of patient tracking lists (PTLs) which support the specialties in managing waiting lists and RTT standards.
Managers	General Managers are responsible for ensuring the data is accurate and the policy is complied with. This includes ensuring staff are fully trained in RTT and associated operating procedures for this policy. Service Managers are responsible for ensuring the lists are validated, taking responsibility for ensuring treatment plans are in place for long waiters, and ensuring the NHS e-Referral Service Directory of Services is accurate and up to date
RTT Team	Responsible for day-to-day RTT tracking, validation and updating patient pathways. To assist Service/General Managers with treatment plans
Administrative Staff	Responsible for day-to-day management of their lists and are supported in this function by Service/General Managers who are responsible for achieving access targets. They are also responsible for communicating with or responding to patients appropriately and promptly.

Information Services	Responsible for producing and maintaining regular reports to enable specialties to accurately manage elective pathways.
The Patient	Patients should provide accurate information about their contact details. Patients should be ready, willing and available to come to appointments and start treatment. Patients should attend appointments, or cancel as soon as possible if they cannot attend
The Patient's GP 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, of the need to be contactable and available when referred and the importance of keeping appointments, or cancelling within reasonable time. All referrals must contain minimum referral datasets, including highlighting and special requirements and access in line with the NHSE guidance on Accessible Information Standards.
The Patient's CCG	CCGs are responsible for ensuring robust communication links are in place to feedback information to GPs

1.3.2 CCGs 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, CCGs must take all reasonable steps to offer a suitable alternative provider, or if there is more than one, a range of suitable alternative Providers, able to see or treat patients more quickly than the provider to which they were referred. A suitable alternative provider is one that can provide clinically appropriate treatment and is commissioned by a Clinical Commissioning Group or NHS England.

1.4 General Access Arrangements

Patient Eligibility

1.4.1 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.

1.4.2 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.

1.4.3 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.

1.4.4 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 Trust in assessing 'ordinarily resident status'. The only exception to this is being in an emergency.

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

1.4.6 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.

1.4.7 Citizens of the European Union (EU) that hold a European Health Insurance Card (EHIC) or a UK Global Health Insurance Card (GHIC) are also entitled to free emergency healthcare, although the Trust may recover the cost of treatment from the country of origin.

Contacting the Overseas Visitors Officers

1.4.8 All staff are responsible for ensuring the identification of patients that are not ordinarily resident in the UK. All staff are responsible for referring to the Overseas Visitors Officers for determination of a patient's eligibility following the undertaking od the baseline questionnaire at the point of patient's registration to the Trust (and before their first outpatient appointment is booked).

Patients moving between NHS and Private Care

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

1.4.10 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.

1.4.11 The elective RTT pathway of a patient who notifies the Trust 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.

Commissioner-Approved Procedures

1.4.12 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 CCG.

Military Veterans

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

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

Prisoners

1.4.15 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.

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

Vulnerable Patients

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

1.4.18 Staff should always refer to related policies and resources relating to vulnerable or at risk patients: Safeguarding Policies.

1.4.19 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 are as follows:

- Patients should be treated according to their clinical priority and then in the order in which they were added to the waiting list.
- Patients may have more than one RTT clock ticking simultaneously. Each one must be measured separately.
- 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 Trust 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.

2.4 Following Active Monitoring

2.4.1 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.

2.5 Following a Decision to Start a Substantively New Treatment

2.5.1 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 with 18 Weeks.

2.5.2 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).

2.6 For the Second Side of a Bilateral Procedure

2.6.1 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.

2.7 For a Rebooked New Outpatient Appointment

2.7.1 If the patient DNAs a first outpatient appointment, their RTT clock can be stopped and nullified on the date of the DNA'd appointment having fulfilled the criteria in the DNA policy (see section 3.22).

2.8 Planned Patients Transferred to the Active Waiting List

2.8.1 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.

2.9 Clock Stops – First Definitive Treatment

2.9.1 Once a 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.

2.9.2 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.

2.9.3 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 and may be in consultation with others, where appropriate, including the patient.

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

2.10 Clock Stops – for Non-Treatment

2.10.1 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 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. This does not stop the clock and the pathway continues; or
- The RTT clock also stops when a patient declines two reasonable offers of inpatient treatment and is removed from the Waiting List.

2.11 Active Monitoring

2.11.1 There are occasions when it is clinically appropriate to stop a 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.

2.11.2 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 making a decision as to whether to proceed with the proposed treatment (clock stop for active monitoring).
  - 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).

2.11.3 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.

2.11.4 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 Service

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 Trust, 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 2 Week 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 Trust. 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 Trust. 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 All referrals for an eRS directly bookable service will be automatically uploaded from eRS to IPM within 1 working day of the appointment being made. Failed uploads will be managed by the Outpatient Department

3.3.2 The referrals in the 'Appointment Slot Issue' (ASI) worklist in eRS where the patient has not previously been booked an appointment under the same UBRN will not be automatically uploaded until the referral is booked into an appointment in IPM.

3.3.3 Referrals for a 'Referral Assessment Service' (RAS) will not automatically upload to IPM until the referral is booked into an appointment in IPM.

3.3.4 Recording a referral must include recording the RTT clock start date. An RTT clock start date is the date that the original provider receives the referral. For referrals made via:

- The NHS e-Referral service; this is the date the Unique Booking Reference Number (URBN) is received as an ASI, RAS or directly booked into the Trust.

- Another Trust or community provider; the RTT clock start date recorded by the either Trust or community provider.
- Consultant to consultant.
- Via email or letter (non-GP letters) direct to the Trust; this is the date the referral is received by the Trust (and may include an existing RTT clock start date if no treatment has taken place for the condition the patient was originally referred for).

3.3.5 The Trust requires all new referrals to be saved in the patient's electronic health record prior to the patient attending clinic. For eRS, this is at the point the appointment is made. For non-eRS, this is at the point the referral is received into the Trust.

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 requests the GP to convert the advice and guidance to a referral, once authorised by the GP, this results in a referral being generated on eRS. This starts the RTT clock for the patient.

3.5 Prioritisation and Clinical Review of Referrals (triaging)

3.5.1 Once referrals have been recorded on IPM, 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. Cancer 2WW also operate a Referral Assessment Service (RAS) for some tumour sites. Referrals are retrieved from eRS, sent to Outpatients and an appointment booked. Referrals received via eRS without the letter will be managed through the Missing Referral Letter worklist and the Outpatient Department will contact the GP to inform them that the referral cannot be accessed without the letter.

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 Changing the Status of Referrals

3.6.1 The recommended timeframe for changing the status of referrals is within 2 working days of registration.

3.7 Patient Delay in Converting UBRN

3.7.1 Where patients choose to delay converting their UBRN, longer than 3 weeks from submission of referral on eRS by their referrer, the Trust reserves the right to amend the clock start date to the date the patient converts their UBRN.

3.8 Upgrading or Downgrading a Referral

3.8.1 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 IPM system.

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

3.9 Redirecting Referrals

3.9.1 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.

3.10 Rejecting Referrals

3.10.1 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 Trust. The RTT clock will be nullified.

3.11 Consultant to Consultant Referrals

3.11.1 Consultant to consultant referrals must follow the guidelines agreed locally by the CCG. 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. This will be audited regularly to measure the appropriateness of consultant to consultant referrals. Refer to the Intra-Hospital (including Consultant to Consultant) Referral Policy on the Trust intranet for full details.

3.11.2 A clinician must not refer a patient to another clinician where the presenting conditions are unrelated to the original referral from primary care, except in circumstances listed in the Intra-Hospital (including Consultant to Consultant) Referral Policy. The exceptions include referrals classed as clinically urgent by a referring consultant.

3.11.3 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.

3.11.4 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.

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

3.12 Rapid Access Chest Pain Clinic (RACPC) Referrals

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

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

3.13 Cross-Site Transfers

3.13.1 Where patients are referred from one site to another for treatment, within Bedfordshire Hospitals NHS Foundation Trust, an Intra-Provider Trust form is to be completed, accompanied with clinical information and a RTT clock start date.

3.13.2 The transfer should be agreed with the patient and sent electronically to the RTT team and the Outpatient Department.

3.13.3 Once the referral is active on IPM at the receiving Trust, the pathway and referral are closed on the original site. The RTT clock continues from the original referral.

3.14 Inter-Provider Transfers (including community services)

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

3.14.2 Where patients are transferred between providers, including primary care intermediate services, an Inter-Provider Transfer (IPT) form (see Appendix 3) must accompany the referral.

3.14.3 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.

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

3.14.5 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.

3.14.6 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.

3.14.7 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

3.14.8 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.

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

3.14.10 If the patient is referred to the Trust 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.

3.14.11 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.

3.15 Outpatient Booking Processes

General Principles and Standards for Outpatient Booking

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

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

3.15.3 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).

3.15.4 The Trust will ensure that all consultant led new patient clinics have sufficient slots available for GPs/patients to book into via the NHS eRS in line with national targets. If there are insufficient slots available for the selected service at the time of attempting to book, the patient will appear on the Trust's Appointment Slot Issue (ASI) work list. A member of the Outpatient Team will contact the patient directly to arrange an appointment,

3.15.5 Where a non-GP referral is received a member of the Outpatient Team will contact the patient to arrange an appointment in accordance with the Trust Outpatient SOPs.

3.15.6 If a patient is not medically fit they will normally be referred back to the GP to ensure the clinical condition is monitored and they are re-referred as soon as they are fit to be treated. This will stop the RTT clock.

3.15.7 Patients should be made aware of the Trust 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.

3.15.8 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.

3.16 Reasonable Offer of Appointment

3.16.1 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.

3.16.2 Appointments with shorter notice may also be offered although are only deemed reasonable if they are accepted by the patient. The patient is usually contacted by letter with an appointment. If the appointment is under 7 days, the patient will also be contacted by telephone. If a patient accepts an offer at shorter notice this also represents a reasonable offer in respect of subsequent cancellations or DNAs.

3.16.3 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.

3.16.4 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.

3.17 Contacting Patients

3.17.1 The time frames for contacting patients must be done in accordance with the Outpatient SOPs. Where individuals have specific communication needs, services will provide help and information in formats that the patient can understand in line with the NHS guidance on Accessible Information Standards.

3.18 Reminding Patients

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

3.18.2 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 Trust policy for not attending or cancelling appointments.

3.19 RTT Clock Pauses

3.19.1 The Trust will not pause the RTT clock for patients waiting for outpatient appointments (new or follow up) for either clinical (e.g. medically unfit) or social (e.g. holidays) reasons.

3.20 Cancellations and Appointment Changes
Hospital Initiated Cancellations

3.20.1 The Trust will avoid cancelling outpatient appointments wherever possible.

3.20.2 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 IPM. The RTT clock continues to tick during this time.

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

3.20.4 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 Service Manager or General Manager 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.

3.20.5 All short notice (less than 8 weeks) clinic cancellations must be authorised by the appropriate Service Manager or General Manager. The Outpatient Department will not action any short notice cancellations without appropriate authorisation.

3.20.6 Best practice suggest that 'fire break' clinics at six to eight week intervals be built into the annual plan to manage unforeseen circumstances. The patients of the cancelled clinic can then be moved to the fire break clinic thus minimising the amount of administrative work required and inconvenience to patients.

3.21 Patient Initiated Cancellations

3.21.1 The letter to patients confirming an outpatient appointment will clearly state that the patient can only cancel and rearrange an outpatient appointment ONCE, regardless of the referral method used. Subsequent cancellations would normally 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.

3.21.2 In the event that patients repeatedly cancel outpatient appointments (minimum two successive), regardless of the referral method used, the Trust 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 Trust will only do this in exceptional circumstances where it clearly appears the patient is ambivalent about being seen and potentially treated.

3.21.3 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.

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

3.21.5 Patients who cancel and then contact the Trust and declare an extended period of unavailability due to social/personal reasons will follow that part of the policy (see 5.5).

3.22 Did not Attend (DNA)

3.22.1 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.

3.22.2 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, taking into account the individual circumstances. This would ordinarily happen directly after clinic.

3.22.3 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.

3.22.4 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.

3.22.5 The Trust 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 IPM.

3.23 First Outpatient Appointment DNAs

3.23.1 If the patient DNAs their first appointment, their RTT clock can be stopped and nullified on the date of the DNAd appointment provided the criteria described above.

3.23.2 If the clinician decides another first appointment should be offered, a new RTT clock will be started (at zero) on the day the new appointment is booked.

3.23.3 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.

3.24 Subsequent (follow up) Appointment DNAs

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

3.24.2 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.

3.25 Adult Patients who are Vulnerable

3.25.1 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.

3.25.2 A decision must not be made without first making contact with 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.

3.25.3 Staff should always refer to related policies and resources relating to e or at risk patients available on the Trust intranet.

3.26 Suspected Cancer Patients

3.26.1 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 back to their GP after multiple (two or more) DNAs.

3.26.2 Staff should refer to the 2 Week Wait SOP.

3.27 Children and Young People who are not Brought in

3.27.1 A child is defined as anyone who has not reached their 16th birthday by the date of their appointment. It is important that this policy is used for young people aged 16 – 17 who have been transitioned to adult services and are seen within the adult outpatient environment.

3.27.2 If a child DNAs a first appointment, they will be offered a further appointment unless a clinician indicates a discharge after reviewing clinical information. Please see the Trust's Safeguarding Policy for further guidance around consecutive DNAs.

3.28 Patients who arrive Late for their Appointment

3.28.1 The Trust asks all patients to keep their appointments and arrive in good time.

3.28.2 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.

3.28.3 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 IPM.

3.29 Follow Up Appointments

3.29.1 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.

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

3.29.3 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.

3.29.4 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 partially booked (where specialties are offering this service). 6 weeks before the appointment is due a letter will be sent to the patient with the appointment date.

3.30 Patient Initiated Follow Up (PIFU)

3.30.1 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.

3.31 Subsequent Appointments

3.31.1 The Trust aims to ensure that, where possible, patients requiring further appointments in their RTT pathway, either outpatient, diagnostic or inpatient / day case treatment, should leave the hospital with an appropriate date if within 6 weeks or to be added to a partial booking waiting list to ensure this is booked by the Outpatient Department.

3.32 Patient and GP / Referrer Communications

3.32.1 All correspondence with the patient and their GP / original referrer must be accurately recorded on IPM/Evolve.

3.33 Clinic Templates

3.33.1 Clinic templates should be reviewed annually. This will take into account capacity and demand planning, clinicians' planned leave and additional commitments, such as on call and MDT meetings. This review should include a review of the e-Referral Service Directory of Services to ensure capacity is accurately represented.

3.33.2 The start and finish time of the clinic should reflect the actual time the clinician is expected to be in the clinic - face to face with the patient.

3.33.3 The clinician is expected to arrive in clinic on time, allowing for any preparation required for the first appointment and administration time within the four-hour session.

3.33.4 The lead clinician should be involved in any discussions around changing clinic templates. Other departments, such as the outpatient nursing team, phlebotomy, radiology and other diagnostic teams should be consulted in relation to resource and room availability, to support any changes to clinic templates

3.34 Clinic Outcome Forms

3.34.1 Every patient, new and follow-up, whether attended or not, will have an attendance status and outcome recorded on IPM.

3.34.2 Clinical outcome forms are essential to capturing the decisions that determine a patient's progress along their RTT pathway.

3.34.3 Every attendance must have a defined clinical outcome and RTT status recorded by clinicians on the clinic outcome form directly after the patient's attendance. The RTT status must relate to the outcome of the current activity not next activity. The form must be completed on the day of the clinic and provided to reception staff. This should be recorded on IPM as part of the check in and check out process. These actions should take place on day of clinic and it is the responsibility of the clinic manager to assure this is kept up to date. Outcome forms can be used to outcome telephone and virtual clinics.

SECTION 4: DIAGNOSTICS

4.1 Diagnostic Booking Processes
Referrals for Diagnostic Tests / Procedures

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 The policy is that all referrals are recorded within 1 working day of receipt. The administration teams are responsible for ensuring that the internal request lists are reviewed and cleared on a daily basis to avoid delays in booking.

4.1.4 Once diagnostic tests are requested on ICE (diagnostic management system) the request is triaged and prioritised by the clinical radiology team. Requests can be upgraded, downgraded or rejected.

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

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

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 Diagnostic Booking Standards

4.3.1 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 Trust have 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 Trust require 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.

4.4 Diagnostic Cancellations and DNAs Hospital Initiated

4.4.1 Every attempt should be made not to cancel diagnostic tests / procedures, however if the Trust 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.

4.5 Patient Initiated Cancellations and DNAs

4.5.1 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.

4.5.2 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.

4.5.3 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.

4.5.4 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.

4.5.5 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 / DAYCASE PROCEDURES

5.1 Inpatient Booking Processes
Adding a Patient to an Inpatient 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 into IPM with contact telephone numbers.

5.1.4 The clinician requests an electronic TCI (eTCI) for treatment in clinic, at which point a Waiting List Clerk has 2 working days to add the patient to the inpatient waiting list. It is the responsibility of the clinician (or designated clinical team member) to action the request (request eTCI) for the patient to enable them to be added to the waiting list.

5.1.5 Patients must not be added to the inpatient 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 reasons (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 must 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 Any medical condition that is not thought to be clinically appropriate, easily manageable or of more than 2 weeks' duration, should be referred back to the care of their GP. This will stop the RTT clock.

5.1.8 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 3 weeks for this decision to be made, this may be shorter for cancer pathways.

5.1.9 Where a patient opts to think about non-cancer RTT treatment for longer than 3 weeks, a period of 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 Inpatient Booking Standards

5.2.1 Clinically urgent patients will be prioritised and booked according to need, with 2 Week Waits first, then other urgent patients.

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 with the use of STAT timings which are surgeon specific.

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 Trust 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 Clerks have responsibility for liaising with Service Managers regarding the waiting list and relevant capacity.

5.2.6 Waiting lists will consist of active and planned patients.

5.2.7 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 Trust has to agree an admission date with the patient giving them at least 3 weeks' notice and a choice of 2 dates. 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.

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. tried for at least a week with 2 phone calls or haven't responded to a validation 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 can 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
- 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 Trust 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.

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 of up to 6 weeks of first being contacted to arrange a TCI, the patient will be brought to the attention of the clinical team to be reviewed. The patient will 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.

5.5.3 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 Periods of Patient Unavailability

5.6.1 If the patient is unavailable at the time of being listed for surgery for longer than 4 weeks, the patient can either opt to be placed on active monitoring with a follow up to be booked when they are available, for their condition to be re-reviewed. In some circumstances, the patient will be directly re-listed for surgery. Alternatively, if it is anticipated that the period of unavailability will be for greater than 3 months, the patient will be returned to their GP and a re-referral will be required. If

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. Unless it is clinically inappropriate (and the admission was reasonable and clearly communicated) the patient will be discharged. 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 cancel their own elective admission date for reasons other than sickness or extreme personal circumstances at less than 48 hours' notice, after receiving reasonable notice of this date (and the admission was reasonable and clearly communicated) will be removed from the waiting list and discharged back to their GP for further action in primary care or re-referral when ready, willing and able to proceed. The consultant will be informed. This will stop the RTT clock.

5.7.3 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 for a maximum of 6 weeks' time. The RTT clock will continue throughout this period.

5.7.4 If the patient is either not willing to accept a new date within this timescale or is not fit to accept a new date within this timescale then they must be discharged back to the onward care of their GP until fit and ready to proceed. The consultant will be informed. The RTT clock will stop on date of discharge.

5.8 Admission Hospital Initiated Cancellations

5.8.1 The Trust'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 Trust 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 Theatre and Clinic Sessions should not be cancelled without a minimum of 8 weeks' notice (agreed Trust Policy).

5.8.4 Approved cancelled theatre sessions should be taken up by other clinicians wherever possible to ensure maximum theatre utilisation and is managed by the General Manager for Theatres and reviewed at the weekly Theatre Operation Group (TOG).

5.8.5 All non-clinical cancellations on the day must be authorised by the Chief Executive or Deputy Chief Executive following review by the appropriate General Manager or Service Manager. No action can be taken on any on the day cancellations without appropriate authorisation. Any unauthorised on day cancellations will be investigated.

5.9 Admission Did Not Attend (DNA)

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 Waiting List 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.

5.9.4 The Trust's clinical pathways have been developed to allow patients who have been discharged back to their GP and re-referred to be treated in chronological order dependent upon their clinical condition. This is to ensure the most appropriate use of resources. As this is a new referral, a new RTT clock would start.

5.10 Patients who are Medically Unfit for Surgery

5.10.1 Waiting List Clerks should ascertain the nature and duration of the clinical issues and whether the patient is temporarily unfit.

5.10.2 When a patient is temporarily unfit (i.e. cold) then patients should contact the Waiting List Team 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 discharged and returned to the care of their GP where this is clinically appropriate for the management of their ongoing chronic clinical condition. This will stop the RTT clock.

5.10.3 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.

5.10.4 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.

5.10.5 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.

5.10.6 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 eTCI form or be seen in outpatients if the consultant feels that the original condition may have changed. This will start a new RTT clock.

5.10.7 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 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. At the point of being listed for surgery, patients should be asked to attend the pre-operative assessment clinic as a walk-in session or they should have a pre-booked appointment several weeks before their admission date. The sooner the patient attends for pre-op assessment the earlier the patient can be optimised to have their surgery.

5.11.2 All patients undergoing elective surgery will undergo initial nurse led 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.

5.11.3 If at the initial pre-operative assessment appointment, further anaesthetic assessment is required, the notes will first be reviewed by an anaesthetist within 5 working days and a decision made as to whether the patient requires a face to face review or can be added to the list.

5.11.4 They will be given an appointment for review in the Anaesthetic Review Clinic. This must be within a two-week timescale, with an immediate outcome for each patient from this clinic as the RTT clock continues.

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 Team.

5.11.6 If a patient requires additional investigations, or is not fit to proceed with surgery they will either be removed from the waiting list or actively monitored for a 3-month period. The consultant and the GP will be informed by the anaesthetist 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.

5.11.7 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 decision to admit date. The consultant should complete a new TCI form and submit this on ICE as per the normal process. A new RTT clock will start.

5.11.8 If a patient fails to attend a pre-operative assessment appointment then the patient should be contacted by the Waiting List 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.

5.11.9 If it is not possible to contact the patient, a text message or letter will be sent requesting the patient to contact the Waiting List Office. If they do not respond, they will be replaced on the theatre list with an open TCI and if the patient fails to attend on the day of surgery, they will be sent a DNA letter and discharged. 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 Trust that they are available for treatment.

5.13 Patients Admitted from an Emergency Referral via a GP or ED

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 RTT Clock Pauses

5.14.1 The Trust will not pause patient waiting for an inpatient or day case treatment for either clinical or social reasons.

5.15 After the RTT Clock Stops

5.15.1 A patient’s care often extends beyond the RTT period and there may be a number of planned treatments beyond the first definitive treatment.

5.15.2 Upon completion of a RTT period, a new RTT clock starts:

- When a patient becomes fit and ready for the second consultant-led bilateral procedure
- Upon the decision to start a substantively new or different treatment that does not already form part of the patient’s agreed care plan
- For subsequent treatment episodes from the same condition which are not planned care
- Upon a patient being re-referred into a consultant-led service as a new referral
- When a decision to treat is made following a period of active monitoring
- When a patient rebooks their appointment following a first appointment DNA that stopped and nullified their earlier clock.

5.16 Elective Planned Patients

5.16.1 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.

5.16.2 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.

5.16.3 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
- The second procedure of a bilateral procedure

5.16.4 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.

5.16.5 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.

5.17 Inclusion Criteria for Planned Procedures and Diagnostic Tests

5.17.1 Patients will only be added to an admitted planned waiting list where clinically they need to undergo a procedure at a specific time. The due date for their planned procedure will be included in the planned waiting list entry.

5.17.2 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 trust 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 Trust 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 Trusts performance against CWT targets is monitored and reported internally with external reporting taking place on a monthly basis.

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 Trusts compliance with CWT guidance, ensuring the Trust 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.

6.2 Duties and Responsibilities

6.2.1 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.

6.3 Consultation and Communication with Stakeholders

6.3.1 The Bedfordshire Hospitals NHS Foundation Trust are members of the East of England Strategic Cancer Network and the Beds and Herts Cancer Forum. Members of the Cancer Team regularly attend and participate in meetings with other providers within the Network to establish agreed working patterns and discuss key issues within the Network. The Trust also regularly attends meetings with the Local CCGs to discuss the delivery of cancer care to the local communities and provides detailed Root Cause Analysis (RCA) for any breaches.

6.4 CWT Service Standards

6.4.1 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).

6.4.2 The operational standards identified determine the Trusts 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.

6.5 Outpatients and Diagnostics – 2WW Referrals
New Patient 2WW Suspected Cancer Referrals

6.5.1 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%.

6.5.2 Referrals can be received from locally approved providers (for example GPSIs and nurse specialists) and these will need to be approved by the Cancer Manager and the CCG.

6.5.3 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

6.5.4 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.

6.5.5 GPs should ensure that patients have had all necessary tests completed to accompany the referral. Referrals received by the Trust 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.

6.5.6 2WW referrals will be prioritised for action prior to urgent or routine referrals and in order of receipt of referral date.

6.5.7 The referral should only ever be held in one of 3 locations:

- Outpatient Department
- Consultant's office
- Uploaded onto patient's Electronic Health Record

6.5.8 Any referrals that are received outside of the Outpatient Department must be forwarded immediately to Outpatients for registration.

6.6 Breast Symptomatic Referrals

6.6.1 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.

6.6.2 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%.

6.6.3 Upon receipt of the referral, the Outpatient Department will register the referral ensuring that the correct suspected cancer tumour site is entered onto both IPM and that the referral is logged as "Exhibited (non-cancer) Breast Symptoms" in accordance with the Outpatient Administration Department Protocol. Following this the referral will proceed in the same manner as suspected cancer referrals.

6.7 Date First Seen (DFS) Initial Consultation

6.7.1 Following receipt of referral, the referring practitioner will be able to see when the appointment is booked via eRS.

6.7.2 Upon receipt of the 2WW referral the Outpatient Department will register the referral ensuring the correct suspected cancer tumour site is entered onto both PAS and the manual audit log sheet in accordance with the Outpatient Administration Department Protocol.

6.7.3 The referral records will transfer (daily) on to the Trust Cancer Information System (InfoFlex / Somerset).

6.7.4 The date the patient attempts to book an appointment (known as the UBRN conversion date is manually recorded as the 'Cancer Referral to Treatment Period Start Date', and is deemed as 'Day 0' i.e. the start of the pathway.

6.7.5 To initiate a Date First Seen (DFS), the Outpatient Department will deliver the referral letters within 12 working hours to the appropriate clinicians for advice on whether either an Outpatient appointment or a diagnostic investigation is to be arranged. If there is a prior arrangement with that specialty to book the appointments direct to a clinic, the booking clerks will follow this guidance which is held within the Cancer Bureau.

6.7.6 The 2WW referrals where the clinician's decision is for the patient to attend for an outpatient clinic consultation will be sent by email to the Outpatient Department.

6.7.7 If the clinician is unable to review the referral within 24 hours, it is the responsibility of the clinician to ensure appropriate cover is arranged to process these referrals ensuring no delay is incurred to patient pathways in their absence.

6.7.8 2WW Breach - The Trust 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 IPM to explain the delay.

6.8 DFS – Outpatient Clinic Consultation

6.8.1 Referrals requiring an outpatient consultation will be allocated to the relevant booking clerk for an appointment to be arranged.

6.8.2 Patient contact - The outpatient booking clerk 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. The letter will advise the patient that, if the given date and time is inconvenient, they should ring the hospital or use Bedfordshire Hospitals NHS Foundation Trusts website to reschedule the appointment.

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

6.8.4 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.

6.8.5 If the patient is unable to attend, the booking clerk must update IPM 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.

6.8.6 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.

6.9 DFS, Diagnostic Investigation (e.g. colonoscopy, CT Scan)

6.9.1 Where referrals require a diagnostic investigation ('straight to test') the Consultant must request the diagnostic investigation as a 2ww either electronically via ICE or if not available on ICE by completing the relevant request form.

6.9.2 It is the responsibility of the medical secretary to ensure the request form is delivered to the appropriate department. The department will book the appointment by day 14 from receipt of referral in outpatients in accordance with the departments respective booking procedures.

6.9.3 The Outpatient Department will track the patient until the patient has attended the initial diagnostic test via PAS. The MDT co-ordinators will check all referrals and record the date first seen on InfoFlex / Somerset.

6.10 Escalation Process

6.10.1 The Trust will ensure that all consultant led new patient clinics have sufficient 2WW appointment slots available for GPs/patients to book into via the NHS eReferral Service

or for booking by the Outpatient Department via faxed 2ww referral in line with CWT targets.

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

6.10.3 An information report is generated identifying breast patients that are referred and referred and dated out of target, this is reviewed daily by the outpatient team to ensure all patients have appointments allocated within the timeframe allocated.

6.11 Breach Reasons and Waiting Time Adjustments – 2WW

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

6.11.2 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.

6.11.3 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.

6.12 Did Not Attend (DNA)

6.12.1 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.

6.12.2 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.

6.12.3 A waiting time adjustment (pause) is applied from the receipt of referral date to the date that the patient makes contact to rearrange an appointment, this will start the pathway again at 'Day 0' giving the Trust 14 days to book another appointment.

6.12.4 All details must be entered on to IPM 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.

6.12.5 Department's individual booking procedures must be followed to minimise the potential of a patient not attending resulting in a delay in the patients' pathway. All actions in relation to DNAs and rescheduling of appointments must be recorded on PAS for tracking purposes.

6.13 Cancellations / Rescheduling

6.13.1 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.

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

6.14 Inappropriate, Incorrect and Downgrading Referrals

6.14.1 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.

6.14.2 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. The Consultant should note the date, time and outcome of the discussion on the 2WW form and notify the Outpatient 2WW Team of the decision. The referral should continue to be processed as a 2WW until written correspondence is received from the GP to state otherwise.

6.14.3 If the patient advises the Outpatient 2WW 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 appropriate action (as above).

6.15 Emergency Admissions

6.15.1 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.

6.15.2 However if the A&E admission relates to another condition the 2ww referral still applies and the patient must be seen within the 14-day period.

6.15.3 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.

6.16 Screening Pathways

6.16.1 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 Trust is recorded as the Cancer referral to treatment period start date initiating the 62-day screening pathway.

6.16.2 The Trust is also participating in the pilot for the Targeted Lung Health Check screening programme.

6.17 Breast Screening

6.17.1 The Trust is the host of the regional screening unit. Screening services are offered for any women eligible, within the Herts, Beds and Bucks area. Patients from outside of the catchment often find themselves splitting their pathways between the Trust and their local Trust, and often opt for treatment at their local Trust too.

6.17.2 The referral is triggered by the final reader who initiates the assessment appointment. The patient pathway starts from the receipt of referral to the assessment clinic (date of receipt of referral is Day 0).

6.17.3 The Breast Screening Unit is responsible for formulating an accurate screening spreadsheet of the details of patients referred and discussed at the Breast Screening MDT; and bringing this to the attention of the Breast MDT pathway facilitator via email.

6.17.4 Any patients that are continuing for treatment at the Trust will be registered on IPM by the screening service. The referral must be coded 'BRSC' and entered as an 'Urgent' referral to distinguish as a screening programme patient. The MDT pathway facilitator is then responsible for reviewing the spreadsheet and accurately entering patient information onto PAS for those patients proceeding to investigation or treatment elsewhere, ensuring that tertiary referrals are sent in accordance with the Inter Provider Transfer Agreement.

6.18 Bowel Screening

6.18.1 The regional screening programme for bowel cancer is located at the Trust.

6.18.2 The referral will be triggered by a positive Faecal Immunochemical Test (FIT) result. The date that the test kit is read as positive, is the referral start date. This marks the start of the 62-day pathway (Day 0).

6.18.3 Open Exeter is used to record patient data.

6.18.4 The Bowel Screening Admin Team are responsible for registering the patients on IPM. The referral must be coded CA:BCSP and entered as an 'Urgent' referral, to distinguish as a screening programme patient.

6.18.5 The MDT pathway facilitator is responsible for reviewing the spreadsheet, accurately entering the new details on to the patient's pathway on Infoflex / Somerset and onward tracking until first treatment.

6.19 Gynaecological Screening

6.19.1 A Suspected Cancer Referral will be triggered by the following smear result:

- Moderate and severe dyskaryosis.
- Glandular neoplasia (possible adenocarcinoma of cervix).
- Invasive (possible squamous cell carcinoma of cervix).

The patient pathway will start from the receipt of result/referral from cytology (Day 0).

6.19.2 Cytology/histology are responsible for sending all reports and results to the colposcopy unit in gynaecology; who are then responsible for compiling an accurate list of patient details and subsequently making outpatient administration department aware.

6.19.3 The outpatient booking clerk is responsible for registering the patients on IPM. The referral must be coded 'GYCS' and entered as an 'Urgent' referral, to distinguish as a screening programme patient and next to the first OPA '6WW' must written in the tracking to indicate that the initial part of the patient's pathway can span up to 6 weeks.

6.19.4 The gynaecology MDT pathway facilitator is then responsible for accurately entering the new details on to the patient's pathway on Infoflex / Somerset and onward tracking until first treatment.

6.20 First Appointment from Screening Referral

6.20.1 If a patient DNA's their first screening appointment, another appointment should be offered. A waiting time adjustment (pause) is applied from receipt of referral to the date that the patient contacts to re-arrange an appointment. All details are recorded in IPM and InfoFlex / Somerset. If a patient subsequently DNA's a second appointment they will be discharged from the service and their GP will be informed of this outcome.

6.20.2 If a patient declines the first appointment offered, another should be offered within 5 working days, no pause will apply.

6.21 Hospital Cancellations

6.21.1 In the exceptional circumstance that a 2WW outpatient appointment or diagnostic investigation is cancelled an appointment must be made as close to the original appointment as possible to prevent any delay in the pathway.

6.22 Subsequent Appointments

6.22.1 Patients requiring further appointments, either outpatient, diagnostic or inpatient / day case treatment, must be booked in accordance with clinicians request to prevent any delay in the 2WW pathway. The appointments are booked in accordance with the request made on the clinic outcome form completed by the consultants; or on request from the CNS or medical secretary.

6.23 To Come In (TCI) Form

6.23.1 Once the decision to add a patient to the inpatient or day case waiting list has been made, the (TCI) form must be completed on ICE. This form must be completed at the time of the decision to admit, which in most cases will be during the outpatient appointment or following a MDT discussion. It is the responsibility of the clinician seeing the patient to ensure that a request identifying a 2WW priority is placed on ICE. It is important that the appropriate procedure type is selected i.e. theatre or non-theatre. (Non-theatre includes Cardiology, Gastroenterology and Respiratory).

6.24 Inter-Provider Transfers (Tertiary Referrals)

6.24.1 Where patients are transferred between providers the cancer MDT office are responsible for the completion of the MDT inter provider form.

6.24.2 The principle need 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.

6.25 Faster Diagnosis Standard
Faster Diagnosis Standard Inclusion

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

6.26 Adjustments

6.26.1 The only adjustments that can be used for the faster diagnosis standard are those that apply to first seen date where a patient DNAs their 1st attendance.

6.27 Ending the Faster Diagnosis Standard Pathway

6.27.1 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.

6.27.2 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'.

6.28 Communicating the Diagnosis to the Patient

6.28.1 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.

6.28.2 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.

6.28.3 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.

6.28.4 This would not be appropriate where it is not possible to contact the patient.

6.28.5 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.

6.29 Patients having Interval Scans / Tests

6.29.1 In a case where a patient is ordered an interval scan / test the 28-day clock will stop. The pathway end date should be recorded as the date the patient is informed of the plan; with the pathway end reason being recorded as 04 – interval scanning.

6.30 Diagnostic Uncertainty

6.30.1 If a patient on the cancer pathway cannot be given a formal non-malignant diagnosis and is followed up due to diagnostic uncertainty the patient remains on the 28-day tracking until a cancer diagnosis is made or ruled out and communicated to the patient.

6.31 Exclusions from the Faster Diagnosis Standard

6.31.1 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

6.31.2 The pathway should be closed on Infoflex / 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.

6.31.3 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.

SECTION 7: ELECTIVE INPATIENTS / DAY CASE PROCEDURES – 2WW REFERRALS

7.1 First Definitive Treatments

Surgery

7.1.1 All cancer and suspected cancer surgical procedures (except for those that require to be referred to an alternative Trust due to the speciality and/or Beds and Herts Improving Outcome Guidance (IOG) agreement are undertaken by the respective surgical team within the Trust.

7.1.2 Under the IOG agreement, the Trust is responsible for the surgical treatment of all Head and Neck cancer patients from East and North Herts.

7.1.3 Following MDT discussion and agreement with the patient it is the responsibility of the treating clinician to complete an eTCI to place the patient on the waiting list.

7.1.4 The patient must be identified as a 2WW priority.

7.1.5 To ensure the patient is seen in a timely manner and work towards meeting the 2 week national targets, the Trust encourages pooling of appropriate cases. This enables patients to be listed to the most appropriate clinician with the shortest possible wait time. The decision to add the patient to a pooled list is made in agreement with the patient and consultant responsible for their care.

7.1.6 The waiting list clerk is responsible for booking the pre-assessment appointment and date of surgery (TCI) in accordance with the 62 day and 31day pathway target dates following the agreed Waiting List Office procedures.

7.1.7 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 Service Manager and copied to the Cancer Business Manager by the Waiting List Office team.

7.1.8 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.

7.2 Chemotherapy

7.2.1 The Oncologist will see the patient in the oncology clinic to discuss and agree the treatment plan. Once this has been agreed, the consultant will complete the chemotherapy referral form.

7.2.2 The chemotherapy form will be delivered to the chemotherapy.

7.2.3 The chemotherapy administrator will date the patient in accordance to breach dates, contact the patient by telephone to agree appointment date and advise the waiting list office.

7.2.4 The chemotherapy administrator will request the waiting list clerk to book the patients onto IPM.

7.2.5 A copy of the referral form (post treatment) is collected from the chemotherapy unit by the MDT support office to enter the treatment details onto InfoFlex / Somerset and for the onward tracking of the patient until treatment has commenced.

7.3 Enabling Treatments

7.3.1 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.

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.

7.3.2 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.

7.4 Breach Reasons and Waiting Times Adjustments – 62 Days (Refers to Cancer Waiting Times Guidance)

7.4.1 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.

7.4.2 It is expected that all tracking information is clearly entered on to patient records (e.g. IPM and InfoFlex / Somerset) providing a clear audit trail of data.

7.4.3 Any pauses, breaches or ECADs (refer to sections below) must be able to be evidenced clearly within the patient records for audit purposes.

7.5 Patient Choice

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

7.5.2 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.

7.5.3 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.

7.5.4 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'.

7.6 Declining a Treatment Date

7.6.1 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.

7.6.2 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.

7.6.3 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.

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

7.7 Declining Treatment

7.7.1 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.

7.7.2 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 InfoFlex or Somerset / IPM.

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

7.8 'Earliest Clinically Appropriate Date' (ECAD)

7.8.1 An ECAD is defined as the earliest clinically appropriate date for the next treatment or activity to take place progressing a patient's pathway and cancer treatment. The "activity" is not always the start of treatment but could be the next treatment planning appointment. The reasons for clinical delay should be discussed and agreed with a patient in clinic by the consultant managing their care with follow up arranged. This information will be clearly identified in the patients records and recorded on InfoFlex / Somerset by the MDT pathway facilitator.

7.9 Did Not Attend (DNA)

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

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

7.9.3 The waiting list clerk must inform the relevant team and MDT office 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.

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

7.10 Emergency Admissions

7.10.1 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 FDT.

7.10.2 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

7.11 Pre-Operative Assessment

7.11.1 A pre-operative assessment establishes that the patient is fit for surgery and 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. Pre-operative assessment occurs at a pre-booked appointment before the admission date.

7.11.2 All patients undergoing elective surgery will undergo initial nurse led 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.

7.11.3 If at the initial pre-operative assessment appointment, further anaesthetic assessment is required, the notes will first be reviewed by an anaesthetist as a matter of urgency and a decision made as to whether the patient requires a face to face review or can continue with surgery.

7.11.4 If the patient requires a face to face review, they will be given an appointment to attend the Anaesthetic Review Clinic as soon as possible. Following the appointment, the outcome from this clinic will be sent to the treating consultant.

7.11.5 If after anaesthetic review a patient is deemed fit for surgery, the patient will be informed that they can proceed.

7.11.6 If a patient requires additional investigations, or is not fit to proceed with surgery they will be removed from the waiting list. The consultant will be informed by the anaesthetist of the decision and treatment plan reviewed possibly at the respective MDT. The Consultant will discuss the treatment plan with the patient if they cannot proceed with the agreed surgery.

7.11.7 If a patient fails to attend a pre-operative assessment appointment the patient should be contacted by the booking team to discuss the reason. A further date for a pre-operative assessment must be agreed.

7.12 Hospital Cancellations

7.12.1 In the exceptional circumstance that the Trust has to cancel a 2ww patient's procedure for a non-clinical reason, either on the day of admission or day of surgery, the patient must be contacted as soon as possible and offered an alternative admission date.

7.12.2 All cancellations on the day must be authorised by the Chief Executive following review by the appropriate General Manager. No action can be taken on any on the day cancellations without appropriate authorisation. Any unauthorised on the day cancellations will be investigated.

7.13 After the First Definitive Treatment (FDT)

7.13.1 A patient's care often extends beyond the 2WW referral to treatment period and there may be a number of planned treatments beyond the first definitive treatment.

7.13.2 Upon completion of the FDT on the 62 day pathway, any subsequent treatments will need to be dated in accordance with 31 day standard i.e. from the decision to treat/earliest clinically appropriate date to start second or subsequent treatment such as chemotherapy or further surgery.

SECTION 8: TRAINING AND EDUCATION

8.1 Training

8.1.1 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.

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

8.1.3 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 Trust.

8.1.4 It will be incorporated into elective care training and for all appropriate staff it will be a requirement to read this policy.

SECTION 9: AUDIT AND MONITORING

What is the standard audit/criteria	Time frame/ Format/how often	How/Method	Reviewed and action plan development by who/which group	Action plans monitored by and how often
92% of incomplete pathways to be completed within 18 weeks	Monthly	Monthly returns submitted by Information Department	Weekly PTL meetings	Executive Lead via Escalation Report
Number of patients who are waiting longer than 18 weeks	Weekly	Weekly report sent by Information Department	Weekly PTL meetings	Weekly PTL meetings

SUPPORTING REFERENCES:

Accessible Information Standard
NHS England » Accessible Information Standard

Armed Forces Covenant - GOV.UK (www.gov.uk)

Evidence-Based Interventions
Home - aomrcebi

Referral to treatment consultant-led waiting times rules suite: October 2015
Consultant-led treatment: right to start within 18 weeks - GOV.UK (www.gov.uk)

The NHS Constitution for England
NHS Constitution for England - GOV.UK (www.gov.uk)

Appendix 1 Governance	
Training: *(training requirements – if applicable)*	**Training to be provided by RTT Team**
References:	
Search Terms:	Patient Access, Access Policy, Patient Rights, RTT, 18 Weeks, Treatment, Waiting list, Waiting Times, Cancer, Targets, Outpatient appointments, DNA, Partial booking Inpatient treatment, Accessible Information, Inclusion
Equality Impact Assessment date completed:	**27 April 2022**
Monitoring Criteria /Audit Criteria: Including the method, frequency, reporting arrangements and the responsible owner (s): **General Manager Patient Access**	

APPENDIX 2: A DOCTOR'S GUIDE

Delivering the Referral to Treatment (RTT) Pathway

What is RTT?

RTT is the maximum time in which patients should commence treatment after being referred by their GP, dentist, optician or other clinician (unless the patient chooses to delay their there is an underlying clinical reason that the patient should wait longer). All hospital appointments, diagnostics and treatment should occur within 18 weeks (126 days).

Did Not Attend (DNA)

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.

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, taking into account the individual circumstances. This would ordinarily happen directly after clinic. A further appointment would not be routinely offered and the patient will be discharged back t0 the GP/original referrer, where the following criteria is met:

- Discharging the patient would not be contrary to the patient's best clinic interests.
- If the appointment has been requested as a 2 Week Wait or Rapid Access.
- The appointment was reasonable and clearly communicated, including send to the correct patient address.
- There is specific protection for the clinical interests of suspected cancer patients, children and young people under 18 years and vulnerable adults.

The Trust 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 IPM.

First Appointment DNAs

If the patient DNAs their first appointment, their RTT clock can be stopped and nullified on the date of the DNAd appointment provided the criteria described above. If the clinician decides another first appointment should be offered, a new RTT clock will be started (at zero) on the day the new appointment is agreed with the patient.

Subsequent (follow up) Appointment DNAs

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

Periods of Patient Unavailability

If the patient is unavailable at the time of being listed for surgery for longer than 4 weeks, the patient can either opt to be placed on active monitoring with a follow up to be booked when they are available, for their condition to be re-reviewed. Alternatively, if it is anticipated that the period of unavailability will be for greater than 3 months, the patient will be returned to their GP and a re-referral will be required.

Clock Stops and Examples

CLOCK STOP	EXAMPLE
Definitive Treatment Started	Prescription given, lifestyle modification
Treatment Previously Given/Ongoing	Treatment already started and to continue
No Suitable Treatment Available or Needed	Condition has resolved
Treatment Offered and Declined by Patient	Surgery offered and declined
Active Monitoring	Review condition in a few months
Tertiary Referral	Referred to another provider for treatment

APPENDIX 3 – INTER-PROVIDER TRANSFER FORM

FOR REFERRING ORGANISATION:	
Referring organisation name: Bedfordshire Hospitals NHS Foundation Trust	Referring organisation code: RC9
Referring clinician:	Referring clinician registration code:
Referring treatment function code:	Contact Name: Phone Number Email
PATIENT DETAILS	
Patient's Surname:	Patient's Forename(s):
Title:	Date of Birth:
NHS number:	Local Patient Number:
Correspondence Address: Postcode:	Contact Details: Patient: Yes ☐ No ☐ Name of lead contact if not patient: Home: Work: Mobile: Email:
GP DETAILS	
GP Name:	GP Practice Code:
REFERRAL TO TREATMENT INFORMATION	
Patient Pathway Identifier	Allocated By (Organisation Code): RC9 (organisation that received the original referral that started the clock)
Is this patient on an active 18 Week RTT Pathway? Yes ☐ No ☐	
Is the referral the: Start of a new pathway – (new condition or change of treatment) ☐ Continuation of an active pathway – (1st definitive treatment not given) ☐ Continuing treatment for a stopped pathway – (1st definitive treatment given) ☐	
Is the referral for: Diagnostic tests only ☐ Opinion only ☐	
Date of decision to refer to receiving organisation:	Clock Start date:
List of all the organisations involved in the 18 Week Pathway:	
RECEIVING ORGANISATION DETAILS	

Receiving organisation name: Receiving organisation code:	
Receiving Clinician:	Receiving treatment function code:
Date and time MDS sent:	
FOR RECEIVING ORGANISATION	
Date/Time received:	

APPENDIX 4: DEFINITONS

Abbreviation	Definition
RTT period	The part of the patient's care following initial referral which initiates a clock start, leading up to the start of the first definitive treatment or other RTT clock stop point
Accessible Information Standard	Information which is able to be read or received and understood by the individual or group for which it is intended
Active Monitoring	Where it is clinically decided to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage
Active Waiting List	The list of elective patients who are fit and able to be treated at that given point in time. The active waiting list is also the list used to report national waiting times statistics
ASIs	Appointment Slot Issues
Cancelled Operations/Procedure	If the Trust cancels a patient's admission on the day of the admission/procedure for a non-clinical reason (e.g. lack of theatre time), the Trust is required to rearrange a new operation/procedure date within 28 days of the cancelled date, or within the breach date, whichever is soonest
NHS eRS	NHS eReferral Service is a national electronic referral service that gives patients a choice of place, date and time for their first Consultant outpatient appointment. This replaced Choose and Book
Chronological Order (in turn)	This is a general principle that applies to patients categorised as requiring routine treatment (as opposed to urgent treatment). All these patients should be seen or treated in the order they were initially referred for treatment (clock start)
Decision to Admit	Where a clinical decision is taken to admit the patient for either a day case or inpatient treatment
Decision to Treat	Where a clinical decision is taken to treat a patient as an inpatient, day case and/or performed in other settings e.g. outpatients
Did Not Attend (DNA)	Patients who have been informed of their date of admission or pre-assessment (inpatients/day cases), diagnostics or appointment date (outpatients) and who, without notifying the hospital, did not attend
DM01	Diagnostic Monthly Reporting
DoH	Department of Health
EBI	Evidence Based Interventions programme is to improve the quality of care being offered to patients by reducing unnecessary interventions and preventing avoidable harm
Elective Admission / Elective Patients	Inpatients are classified into two groups: emergency and elective. Elective patients are so called because the Trust can 'elect' when to treat them
Elective Planned	Patients who are to be admitted as part of a

	planned sequence of treatment or investigations
Elective Waiting	Patients awaiting elective admission who have yet to be given an admission date
English NHS Commissioner	Clinical Commissioning Groups are responsible for commissioning most hospital and community NHS services. NHS England is responsible for primary care and specialised services
First Definitive Treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes First Definitive treatment is a matter of clinical judgement in consultation with others as appropriate, including the patient
Outpatients	Patients referred by a General Practitioner (medical or dental) or another Consultant/health professional for clinical advice or treatment
Military Veteran	Anyone who has served 1 day or more in HM Armed Forces whether as a regular or reservist member
PTL	Patient Tracking List. A report used to track the patient journey throughout their RTT pathway
RTT	Referral to Treatment
TCI (To Come In)	A proposed future date for elective admission
Tertiary Referrals	A tertiary referral hospital or tertiary centre is a hospital that provides tertiary care, which is health care from specialists after referral from primary and secondary care
UBRN	Unique Booking Reference Number. When an appointment has been booked through NHS eReferral Service, the URBN is converted

Equality Analysis - Impact Assessment Screening Tool for Policies

AREA	NEGATIVE IMPACT		SIGNIFICANT Y/N?	
	Y ✓	**N ✗**	**Y ✓**	**N ✗**
1. Gender		**N ✗**		**N ✗**
2. Religion/ belief		**N ✗**		**N ✗**
3. Age		**N ✗**		**N ✗**
4. Disability (includes: mental health, learning disability, physical, sensory)		**N ✗**		**N ✗**
5. Ethnicity (includes: travellers and gypsies)		**N ✗**		**N ✗**
6. Sexual Orientation (includes: gay, lesbian, bisexual)		**N ✗**		**N ✗**
7. Transgender / Tran-sexual		**N ✗**		**N ✗**
8. Marriage or Civil Partnership		**N ✗**		**N ✗**
9.Pregnancy or Maternity		**N ✗**		**N ✗**
Additionally		**N ✗**		**N ✗**
10. Social / Economic		**N ✗**		**N ✗**
11. Rural / Urban		**N ✗**		**N ✗**
12. Health Inequalities		**N ✗**		**N ✗**
13. Application of NHS Accessible Information Standard		**N ✗**		**N ✗**

Impacts are usually measured in terms of positive, neutral and negative impact. E.g. it is useful to record if an impact is significantly positive for one group and neutral or negative for another group and to weigh up this along with the size of the groups within decisions.

For the purposes of this policy it is a significant positive impact to include and ensure that all these factors will be considered and embedded in all strategies, policies, procedures and frameworks written. This is along with the use of the Equality Analysis - Impact Assessment Screening Tool for Policies which will ensure that informed decisions are made that enable fair treatment, access and inclusion.

For any boxes marked as 'yes' above please complete details below

Area	Issue	Further Steps to be Taken

Negative Impact

Q1.	Will the policy create any problems or barriers to any community or group?	N
Q2.	Will any group be excluded because of the policy?	N
Q3.	Will the policy have a negative impact on community relations?	N

If yes, a full equality assessment must be done.

WILL THE POLICY…	POSITIVE IMPACT		State how, i.e. evidence used to reach this decision
	Y ✓	N ✗	
1. Remove the risk of direct or indirect discrimination			This policy advocates that all patients on an elective pathway will be treated equally with exceptions made for vulnerable children/adults (for example section 1.1.5, 1.4.17, 1.4.18, 3.25)
2. Remove the risk of poor conduct or harassment	✓		The policy advises on the overarching rules related to RTT, where guidance is unclear employees should refer back to the RTT Team (see section 8.1)
3. Promote good community relations	✓		This policy was created with stakeholder involvement from clinicians, GPs, Senior Managers, CCG and the RTT Team
4. Promote a positive attitude between and to people of different groups	✓		Every patient is treated fairly and equally and therefore this policy does not allow for discrimination (see section 1.2)
5. Encourage participation of people from different and under-represented groups	✓		Where there is a requirement for additional need, this policy allows for flexibility
6. Consider more favourable treatment of disabled people	✓		This policy promotes gaining further understanding with regards to vulnerable children/adults (for example sections 1.4.17, 1.4.18, 3.25)
7. Promote and protect human rights	✓		All patients are to be treated fairly and equitably in accordance with The Equality Act 2010 (see section 1.2)
8. Promote Equal Opportunities and Fair Treatment	✓		All patients are to be treated fairly and equitably in accordance with The Equality Act 2010 (see section 1.2)
9. Promote Access and inclusion	✓		All patients are to be treated fairly and equitably in accordance with The Equality Act 2010 (see section 1.2)
10. Promote Dignity and Respect	✓		All patients are to be treated fairly and equitably in accordance with The Equality Act 2010 (see section 1.2)

Assessed by (Name/s) Georgina Coupe and Samila Hussain

Signed	Georgina Coupe	Post:	GM Patient Access	Date:	27-04-2022
Signed	Samila Hussain	Post:	RTT Manager	Date:	27-04-2022