

Elective Service Access Policy

Version:	Version 6.0
Ratified by:	Royal Free London CQRG
Date ratified:	25/09/2019
Name of originator/author:	Amy Caldwell-Nichols – Director of Performance & Analytics Kelly Rank – Senior Operations Manager, Elective Access
Name of responsible individual:	Debbie Sanders, Group Chief Nurse
Date issued:	October 2019
Review date:	September 2020
Target audience:	All trust staff
Intranet:	http://freenet/trustpolicies.asp
Related policies:	Elective Access Operational Policy Cancer Validation Policy PoLCE Policy ERS and paper referrals Policy Overseas visitors Policy NCEL Inter-Trust Transfer (ITT) Policy
Date equality analysis completed.	

Version Control Sheet

Version	Date	Author	Status	Comment
1	24/07/2014	Darrien Bold	FINAL	First signed off version of combined BCF/RF policy
2	02/12/2015	Darrien Bold	DRAFT	Revised version incorporating changes to national guidance and standardising of trust procedures

3	15/09/2017	Kelly Rank	Revised Draft	Shared with CCGs and LECs for review (8 th December 2017)
4	03/08/2018	Amy Caldwell-Nichols	Draft	Shared internally 03/08/2018
5	10/09/2018	Amy Caldwell-Nichols	Draft	Submitted to RFL GEC on 18/09/2018
6	18/09/2018	Amy Caldwell-Nichols	Draft	Submitted to CQRG on 26/09/2018
7	18/09/2019	Amy Caldwell-Nichols	Final	Submitted to CQRG on 25/09/2019
8	25/09/2019	Amy Caldwell-Nichols	Final	Approved at CQRG on 25/09/2019

Table of Contents

Section		Page
1	Introduction, purpose and equality statement	4
2	RTT principles and standards	4
3	Governance, performance monitoring and roles and responsibilities	8
4	Eligibility and exclusions	10
5	Waiting lists and booking principles	13
6	RTT training	16
7	Non-admitted pathways	17
8	Admitted pathways	22
9	Planned patients	27
10	Acute therapy services	27
11	Diagnostics pathways	28
12	Cancer pathways	31
Appendix		
Appendix 1	Equality Analysis	43
Appendix 2	Royal Free London turnaround time standards	47
Appendix 3	Outcome Form	52
Appendix 4	Minimum Data Set	54
Appendix 5	Exclusions from e-referrals	56
Appendix 6	Macmillan Leaflet on making treatment decisions	57

1. Introduction, purpose and equality statement

This policy sets out how the Royal Free London manages patients on an elective (i.e. non-emergency) pathway. It outlines the key principles of the 18 week Referral to Treatment (RTT) standard, the 6 week diagnostic standard and the 2 week wait, 31 day and 62 day cancer standards.

The purpose of this policy is to guide staff in the efficient management of patients on admitted, non-admitted, diagnostic, planned and suspected cancer pathways. It covers patients at all sites, including outreach and community clinics.

This policy applies to all clinical and administrative staff and services relating to elective patient access at the trust. It also highlights the expectations of the trust and local commissioners on the management of referrals and admissions into and within the organisation, and defines the principles on which the policy is based.

This policy has been agreed by the Royal Free London NHS Foundation Trust, in consultation with its clinical commissioning groups. The trust will review and update the policy on an annual basis, or earlier if significant changes are introduced to national targets. Any changes will be ratified by the Royal Free London Group Executive Committee.

Equality Statement

This document forms part of the trust's commitment to ensuring that the policies, procedures and obligation in respect of promoting equality and diversity are adhered to in relation to both staff and service delivery. The Royal Free London NHS Foundation Trust is committed to creating a positive culture of respect for all individuals, including job applicants, employees, patients, their families and carers as well as community partners. All patients are to be treated fairly and equitably regardless of race, sex, religion or sexual orientation.

This policy reflects this commitment by ensuring that access to the trust's services is governed by a clear set of principles that are applied equitably to all patients. No negative impact on equality and diversity has been identified. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability (including HIV status), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation. The equality analysis for this policy is attached as Appendix 1.

The intention is also to use the Human Rights Act 1998 to treat fairly and value equality of opportunity regardless of socio-economic status, domestic circumstances, employment status, political affiliation or trade union membership, and to promote positive practice and value the diversity of all individuals and communities.

2. RTT principles and standards

The NHS Constitution¹ clearly sets out a series of pledges and rights stating what patients, the public and staff can expect from the NHS. This includes that patients have the "right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible."

¹ <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>

The Handbook to the NHS constitution² states that patients have the right to:

- start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions;
- be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected; and

If this is not possible, the NHS has to take all reasonable steps to offer a suitable alternative. A suitable alternative provider is one that can provide clinically appropriate treatment and is commissioned by a clinical commissioning group or NHS England. Patients referred to the Royal Free London will need to contact either the Royal Free London or their local clinical commissioning group before alternatives can be investigated.

Patients' right to start treatment within 18 weeks from referral will include treatments where a consultant retains overall clinical responsibility for the service or team, or for treatment. This means the consultant will not necessarily be physically present for each appointment, but will take overall responsibility for the patient's care. The setting of consultant-led treatment, for example whether hospital based or in a GP-based clinic, will not affect patients' right to start treatment within 18 weeks.

In addition, patients have the right to choose the organisation or team that provides their NHS care when they are referred for their first outpatient appointment with a service led by a consultant or by a named health care professional.

There are certain exceptions to the right to choose including:

- persons detained under the Mental Health Act 1983;
- serving members of the Armed Forces;
- prisoners, including those on temporary release from prison or detained in other prescribed accommodation (e.g. a court, secure children's home, secure training centre, an immigration removal centre and a young offender institution),
- services where speed of access to diagnosis and treatment is particularly important, for example emergency attendances/admissions,
- attendances at a Rapid Access Chest Pain Clinic under the two-week maximum waiting time,
- attendance at cancer services under the two-week maximum waiting time, and
- maternity services.

Further details on the choices available to NHS patients are set out in the NHS Choice Framework³.

The Handbook to the NHS constitution also sets out that the right to be seen within the maximum waiting times does not apply if:

1. the patient chooses to wait longer,
2. delaying the start of the treatment is in the best clinical interests of the patient, for example where smoking cessation or weight management is likely to improve the outcome of the treatment (note that in both of these scenarios the patient's RTT clock continues to tick),

²

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/474450/NHS_Constitution_Handbook_v2.pdf

³

<https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs>

3. it is clinically appropriate for the patient's condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures,
4. patients fail to attend appointments which they had chosen from a set of reasonable options, and/or
5. the treatment is no longer necessary.

In relation to elective access waiting times, the Government's mandate to NHS England for 2019-20 sets the following standards:

- that at least 92% of patients on incomplete non-emergency pathways to have been waiting no more than 18 weeks from referral to treatment (RTT), the 8% tolerance being applied to account for patient-initiated delays;
- no-one waits more than 52 weeks from referral; and
- less than 1% of patients waiting for a diagnostic test to wait more than 6 weeks from referral.⁴

The full set of commitments set out in the mandate and the NHS constitution are shown in the table below.

4

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/803114/accountability-framework-to-nhse-and-nhsi-2019-to-2020.pdf

Service Standard (maximum)	Definition	Operational Standard
Referral to treatment	Waits on non-emergency pathways are no more than 18 weeks from referral to treatment	92%
	No patient waits more than 52 weeks from referral to treatment	100%
Diagnostic tests	Waits for a diagnostic test should be less than 6 weeks from referral for the test	99%
14 day cancer standards	GP referral to first seen (suspected cancer)	93%
	GP referral to first seen (breast symptomatic)	93%
62 day cancer standards	GP referral to first treatment	85%
	Screening referral to first treatment	90%
	Consultant upgrade to first treatment	No national operational standard
31 day cancer standards	Decision to first treatment	96%
	Decision to subsequent treatment (surgery)	94%
	Decision to subsequent treatment (drugs)	98%
	Decision to subsequent treatment (radiotherapy)	94%
31 days rare cancers	GP referral to first treatment for acute leukaemia, testicular cancer and children's cancers	monitored as part of 62 days from urgent
Cancelled operations	Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days	100%

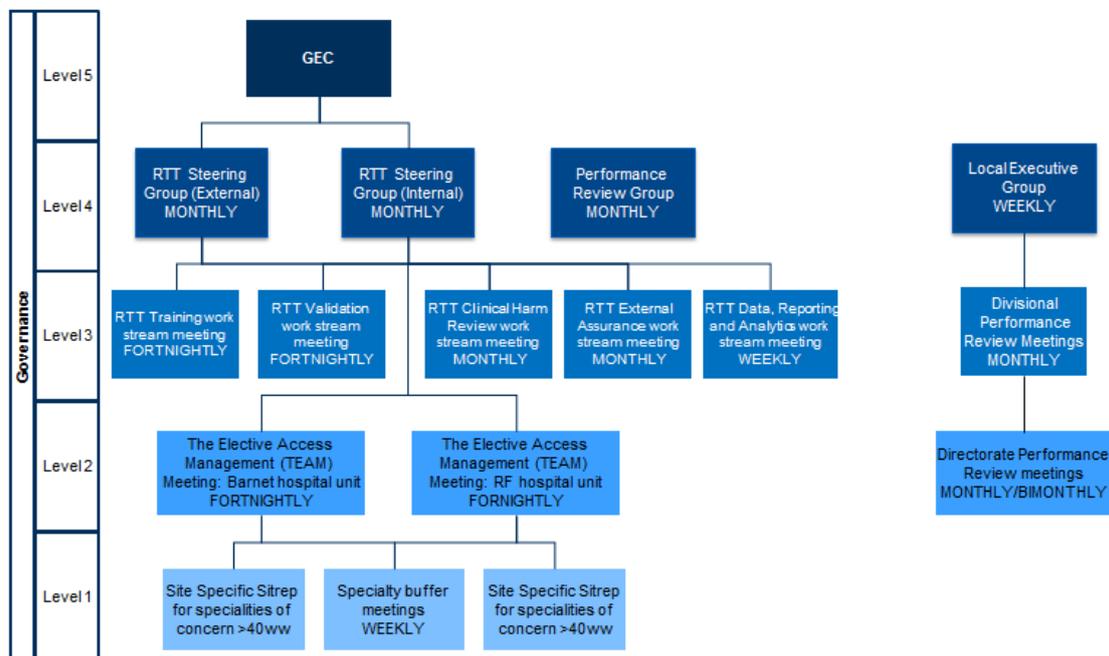
A summary of the local service turnaround time commitments made by the Royal Free London in this policy is shown in Appendix 2.

3. Governance, performance monitoring and roles and responsibilities

3.1 Governance of elective access at The Royal Free London

Governance of elective access at the Royal Free London is managed according to the governance structure shown in the diagram below.

- An RTT steering group led by the Royal Free London Group Chief Finance and Compliance Officer meets monthly with representatives from our commissioners and regulators to oversee and assure performance improvement plans.
- A waiting list capacity group (The Elective Access Management Meeting) takes place on a fortnightly basis on each site to discuss performance, the current size and shape of the patient tracking list (PTL), and review of long waiting patients.
- Situation Report (SitRep) meetings that review individual long waiting patients and agree actions to move their treatment forwards.
- Further meetings are regularly scheduled to oversee training, validation, clinical harm and data, reporting & analytics



The Trust Board, Group Executive and Local Executive Committees also receive monthly performance reports including progress towards meeting elective access standards, with any areas for concern highlighted for discussion.

3.2 Roles and responsibilities

Responsibility for achieving the standards set out in the NHS constitution and the annual NHS mandate lies collectively with the Divisional Directors, Divisional Directors of Operations, Executive teams and ultimately the trust board.

Within the Royal Free London:

- Divisional Directors and Divisional Directors of Operations are accountable for implementing, monitoring and ensuring compliance with this policy within their divisions. They are also accountable for monitoring compliance with waiting times standards in their divisions and delivery of agreed actions that are intended to improve performance against the standards set out in this policy.
- Consultants and their clinical teams are responsible for agreeing and following timed pathways for their specialties. They are also responsible for ensuring that outcomes are communicated for every scheduled patient contact (using the InTouch system where available or the trust outcome form, examples shown in Appendix 3) and any further updates to patient's clinical status (such as diagnostic results) are communicated to local administrative teams for them to action in the trust PAS system.
- Clinical Directors working alongside the operational management team are responsible for ensuring the NHS e-referral service directory of services (DOS) is accurate and up to date.
- Senior Operations Managers and Operations Managers should support Divisional Directors of Operations. They are accountable for:
 - ensuring that Specialty Service Managers comply with this policy and attend relevant training,
 - collaborating with service clinical leadership to collect and analyse available evidence to develop plans for service development and implement these where agreed by Divisional leadership, and
 - overseeing validation of pathways in their services.
- Speciality Service Managers are responsible for daily, weekly, and monthly monitoring of the RTT pathways to ensure pathways are compliant. This should include regular specialty review of waiting lists. Escalation of any delayed pathways which could cause an 18 week breach should be highlighted to the service operational manager. Service managers are responsible for daily review of any patients waiting over 52 weeks.
- Waiting list administrators for outpatients, diagnostics and elective inpatient or day care services are responsible for the day-to-day management of their lists and are supported in this function by the operational managers, Divisional Directors and Divisional Directors of Operations.
- The Senior Operations Manager for Elective Access will provide oversight on RTT training and being accountable for management of central validation services as well as delivery of shared corporate operational teams including the Outpatient Appointment Centre and Central Admissions. They are responsible for ensuring their teams and operational colleagues across the trust adhere to this policy and the RTT Operational and Validation Policies.
- The Elective Access Validation Team is responsible for ensuring the accuracy of PTLs through validation and oversight of open pathways. They will ensure all technical corrections are actioned in a timely manner and support operational teams with managing their patient lists. They will provide training to operational teams on validation processes and support in delivery of RTT and Elective Access training.
- The Data Quality Team are responsible for ensuring the quality of all trust data is of a high standard by supporting in workflow design, organising the delivery of training and overseeing and taking action to correct recorded data. They will ensure that when corrections are made that RTT variables are considered and escalate any pathway issues to the Validation Team or relevant service.

- The Head of Information Management is responsible for the timely production of patient tracking lists (PTLs) which support the divisions in managing waiting lists and RTT standards to ensure compliance with this policy; national waiting time submissions and providing expert guidance and oversight on national reporting standards and rules. They are also responsible for ensuring the information can be reliably extracted from the trust Data Warehouse.
- The Director of Performance & Analytics is responsible for ensuring performance is reported, audited and that there are forums where it is discussed and improvement actions agreed at site and group level. They are also responsible for engaging with commissioners and regulators on performance improvement.

Staff involved in managing patients' pathways for elective care must not carry out any action about which they feel uncertain or that might contradict this policy. Staff should use the escalation routes set out in the trust Elective Access Operational Policy where they have concerns.

Outside the Royal Free London:

- General practitioners (GPs) and other referrers should ensure patients are fully informed during their consultation of the likely waiting times for a new outpatient consultation and of the need to be contactable and available when referred. GPs should also inform patients whether they are being referred on a cancer diagnostic pathway to ensure patients are able to comply with the faster pathways.
- The CCGs are responsible for ensuring there are robust communication links for feeding back information to GPs. GPs should ensure quality referrals are submitted to the appropriate provider first time.
- Some CCGs use Referral Management Services (RMS) or Clinical Assessment Services to manage referrals to secondary care in their areas. As clock starts when referrals are received by an RMS service, these services must ensure referrals are managed in a timely fashion so as to ensure patient treatment is not delayed.
- Patients also have a responsibility to engage with their care pathway as they can make a significant contribution to their own, and their families, good health and wellbeing, and should take personal responsibility for it. The NHS Constitution recommends the following actions patients can take to help in the management of their condition:
 - Register with a GP practice as this is the main point of access to NHS care as commissioned by NHS bodies.
 - Provide accurate information about their health, condition, status and up-to-date contact details.
 - Keep appointments, or cancel within a reasonable timeframe.

4. Eligibility and exclusions

4.1 Eligibility

4.1.1 Overseas Visitors

Patients should be 'ordinarily resident' in the United Kingdom to be entitled to NHS treatment. The trust will check every patient's eligibility for treatment. At the first point of entry, patients should be asked questions that will help the trust assess their 'ordinarily resident' status.

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

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

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

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

More information, including a decision flowchart for clinical use, is available on the trust intranet⁵.

4.1.2 Patients transferring between NHS and Private Healthcare

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

If the trust is notified of a patient decision to seek private care, the RTT pathways of this patient will be closed with a clock stop applied on the date of this being disclosed by the patient.

4.1.3 Military Veterans

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

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

4.1.4 Prisoners

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

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

⁵ <http://freenet/freenetcms/Default.aspx?&s=31&p=1692&m=2355>

4.1.5 Residents of Wales, Scotland and Northern Ireland

Wherever patients live in the United Kingdom, generally they can use the NHS. However, the NHS is organised differently in each of the four countries – Wales, England Scotland and Northern Ireland⁶.

Governments and NHS bodies on either side of the English/Welsh border have made some simple agreements, including a ‘cross border protocol’⁷.

- Patients with a GP in Wales referred to the Royal Free London should expect to be treated within the standards set by the NHS in Wales. The target relating to referral to treatment times in Wales is for 95% of patients to be treated within a maximum referral to treatment time of 26 weeks. The target is assessed using figures for patients waiting to start treatment at the end of the month⁸.
- Patients resident in Wales with a GP in England should expect to be treated within the standards set out in the NHS constitution, summarised above.

4.1.6 Patients without a registered GP

When a referral is received for a patient who is not registered with a GP, for example through an Urgent Treatment Centre (UCC), including where the patient does not have an NHS number, the referral will be processed as for other patients and an appropriate appointment made.

The Outpatient Appointment Centre will inform the Overseas Department and they will investigate the patient’s eligibility to NHS funding care and advise the relevant staff of action to take.

4.2 Exclusions

For patients who are eligible for NHS treatment as set out in Section 3.1, a referral to most consultant-led services starts an RTT clock and should be reported on the trust waiting list.

4.2.1 Services and patient types not reported

The following services and types of patients are excluded from reporting the 18 week RTT pathway:

- Emergency patients and emergency pathway non-elective follow-up activity.
- Obstetric and midwifery patients.
- Patients undergoing planned procedures – e.g. surveillance endoscopies intended to be done at a specified time, unless the due date for the procedure has passed (see section 9 below for more information).
- Referrals to a service which is not consultant-led⁹.
- Referrals from non-English commissioners.

4.2.2 Services not provided at the Royal Free London

If a referral is received for a service not provided by the Royal Free London, it will be rejected back to the referring GP advising that the patient needs to be referred elsewhere. This will stop the patient’s RTT clock. Services not provided at the Royal Free London include (but are not necessarily exclusive to):

- Neurosurgery, and

⁶ <https://www.england.nhs.uk/ourwork/part-rel/x-border-health/xb-faq/>

⁷ <https://www.england.nhs.uk/wp-content/uploads/2013/03/england-wales-protocol.pdf>

⁸ <http://www.nhsdirect.wales.nhs.uk/encyclopaedia/w/article/waitingtimes/>

⁹ Direct access referrals to Audiology are recorded and measured against a separate standard.

- Cardiac surgery.

4.2.3 Other exclusions from RTT reporting

Other reasons why patients who are still on treatment pathways at the Royal Free London are excluded from RTT reporting include:

- Patients who have received first definitive treatment but continue to be followed up at the Trust.
- Patients whose conditions require active monitoring and where no formal treatment or intervention is needed at that time.
- Patients being actively monitored who undergo tests to monitor their condition.
- Tertiary referrals from other Trusts for patient who have already received first definitive treatment for the same condition at the other provider¹⁰.
- Patients who are offered treatment but request an extended period to consider their options or try living with their symptoms, therefore placing themselves on a patient initiated watchful waiting period.
- Patients who have been referred from the Royal Free London to another trust for treatment.

5. Waiting lists and booking principles

The 18 week RTT pathway commences with a clock start, which typically occurs when the Royal Free London is made aware of a GP referral. This is usually once a patient's eRS Unique Booking Reference Number (UBRN) is converted into a booking. The UBRN is generated when a GP creates a referral in eRS and is provided to the patient at the time of creation. The patient can then at the same time or later log in to the eRS website to convert their UBRN into a booking.

The RTT pathway ends with a clock stop, which occurs on the date the patient receives first definitive treatment, or when a clinical decision is made that treatment is not required or on the date the patient opts to decline treatment. Between clock starts and stops there are usually a series of events (such as diagnostic investigations) where the clock continues. Patients are added to the RTT waiting list when an RTT reportable clock start occurs and removed when a relevant clock stop is applied.

Patients should only be added to waiting lists for surgery if they are clinically fit for assessment and treatment. As well as the expectation that patients receive definitive treatment in a timely fashion, there is also an onus on patients themselves to be ready and willing to attend appointments throughout their pathway.

5.1 Clock Starts

A waiting time clock starts ticking when a referral to a consultant-led service is received from any care professional or service permitted by an English NHS commissioner to make such referrals.

- If the patient is referred via e-RS (formerly Choose & Book), clock start date is the date the patient converts their Unique Booking Reference Number (UBRN).
- If the Outpatient Appointment Centre receives a paper referral directly from the referrer (in practice, usually the GP or dentist) the clock start date is receipt of

¹⁰ A referral for a new condition or change in condition would start an RTT clock.

referral. Referrals should be stamped on receipt and inputted into PAS within 48 hours.

- If the referral is received via a referral management or assessment service – e.g. Enfield Referral Service – the clock starts on the date the referral management or assessment service receives the referral.

A waiting time clock also starts upon a self-referral by a patient to a consultant-led service where these pathways have been pre-agreed locally by commissioners and the Royal Free London. If a service accepts self-referrals, the waiting time clock starts on receipt.

5.2 New clock starts for the same condition

Upon completion of an RTT pathway, a new RTT waiting time clock for the same condition begins under the following scenarios:

- When the patient is fit and ready for the second stage of a 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.
- Upon a decision to treat that is made following a period of active monitoring.
- When a patient rebooks their appointment following a non-attendance of a first appointment that nullified the original clock.
- Upon receipt of a new GP referral following discharge

5.3 Clock Stops for first definitive treatment

The RTT clock stops on the date of first *definitive* treatment of the patient's condition, injury or disease. First Definitive Treatment is the first clinical intervention intended to manage a patient's disease, condition or injury and avoid further clinical interventions. What constitutes First Definitive Treatment is a matter of clinical judgement in consultation with others, where appropriate, including the patient.

This could be:

- Treatment provided by an interface service (e.g. the musculoskeletal (MSK) service)
- Treatment provided by a consultant-led service (e.g. surgery, prescription of medicines intended to treat the patient's condition)
- therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions
- Patient given advice intended to help manage their condition, e.g. ENT patients with congestion/sinus problems taught Valsalva manoeuvre; T&O patients with back problems advised on lifestyle modifications, good posture, exercise, etc.
- A clinical decision is made and communicated to the patient, their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

5.4 Clock Stops for Non-treatment

The RTT clock also stops at the date the clinician or patient decides intervention is not required or wanted and this is communicated to the patient, and subsequently their GP or other referring practitioner without undue delay. This may take the form of:

- A clinical decision is made to discharge the patient to primary care. This may include for any non-consultant-led treatment in primary care or following clinical review after a patient has not attended more than one appointment.
- A clinical decision is made not to treat.
- A patient declines treatment.

- Patient does not attend (DNAs) their first appointment following the initial referral that started their waiting time clock. This is provided that the trust can demonstrate that the appointment was clearly communicated to the patient within a reasonable timeframe. If the appointment is rebooked, the original clock is nullified and a new clock begins when the patient is informed of their rebooked appointment.
- Active monitoring. This is defined as when a patient's condition does not currently warrant treatment and either the patient or clinician decides they would prefer to monitor their condition. Patients can also instigate a period of active monitoring if they would like an extended period of time (weeks or months) to consider their options e.g. if they are offered surgery but do not wish to proceed immediately to see how they cope with their symptoms¹¹. This should only be used where clinically safe, please refer to section 8.4.4.

5.5 Booking order

Patients will be treated in order of clinical priority (urgent before routine). Patients with the same clinical need will be treated in chronological order of referral received date. This order of treatment will be supported by the use of patient tracking lists and the accurate recording of all patient activity on the trust's Patient Administration System (PAS). Patients will be selected for booking from the trust patient tracking lists for RTT but also the following lists that may include services and patients not reportable against the RTT standard:

- Cancer waiting list,
- Appointment Slot issues list,
- First outpatients appointments,
- Inpatient and day-cases,
- Planned procedures, and
- Follow-up appointments.

This applies to all elective care services as set out in this document.

5.6 Waiting list reporting

The management and reporting of waiting times will be transparent both to the individual patient and to partner organisations and will be open to inspection, monitoring and regular audit.

The trust will maintain six waiting lists to manage delivery of waiting times standards. These are summarised in the table below.

Waiting list	Summary description	Data source
Outpatients	All elective and cancer patients who are waiting for a first outpatient appointment regardless of point on the pathway	Cerner
Inpatients and day-cases	All elective and cancer patients waiting for a procedure classed as a day case or requiring an overnight stay	Cerner
RTT incompletes (the RTT PTL)	All RTT reportable patients waiting for first definitive treatment or discharge. This will include filters to enable viewing of admitted and non-admitted patients	Cerner
Appointment Slot Issues (ASI)	All patients referred via eRS who have not yet been booked an appointment on Cerner	NHS Digital

¹¹ Activity monitoring should not be used when a patient wishes to spend a few days thinking about their treatment, but is intended for use where a patient asks to think about their options for e.g. several weeks or months.

Planned	Patients who are waiting for a procedure classed as day-case or requiring overnight stay scheduled for a specific time or frequency	Cerner
Cancer	All Cancer patients waiting for first definitive treatment or discharge on a GP referral, screening or upgrade pathway	Infoflex

The Information Management team are responsible for the creation of these waiting lists and ensuring they are accessible to relevant staff.

Patients who have had a stopped clock or are on a non-RTT pathway, but require follow-up care should be managed using Cerner worklists. Specialties should ensure that patients are booked according to clinical instructions for their ongoing management and that patients who are discharged have this recorded appropriately.

All staff with access to and a duty to maintain elective care information systems are accountable for the accurate recording and maintenance of the data that is used to generate waiting lists.

5.7 Waiting list audit

It is the responsibility of the Royal Free London Elective Access, Information Management and Performance teams to run a programme of audits for data completeness and data anomalies. For further information staff should refer to the trust Elective Access Operational Policy.

6. RTT training

The Trust has a programme of Elective Access training which is intended to provide staff with the appropriate knowledge and understanding of all elective access targets including RTT. There are a variety of levels and methods of delivery which are tailored to each team across the organisation. Training is delivered by subject matter experts and ongoing support following training is provided by the Elective Pathway Team. Entry level (level 1) RTT training is part of the Royal Free London's mandatory and statutory training (MaST) programme for all staff who have access to the Patient Administration System (PAS).

6.1 Competency

- As a key part of their induction programme, all new starters to the trust will undergo mandatory elective care training applicable to their role which covers general principles and local guidance.
- Staff whose role requires this will undergo mandatory elective care training on at least an annual basis which covers general principles and local guidance.
- Staff whose role requires this will carry out competency tests that are clearly documented to provide evidence that they have the required level of knowledge and ability.
- This policy, along with the supporting suite of SOPs, will form the basis of contextual training programmes (refer to the elective care training strategy for more information).

6.2 Compliance

- Functional teams, specialties and staff will be performance managed against key performance indicators (KPIs) applicable to their role. Role- specific KPIs are based

on the principles in this policy and specific aspects of the trust's standard operating procedures. For internal staff seeking more information, please refer to the trust Elective Access Operational Policy.

- In the event of non-compliance, a resolution should initially be sought by the team, specialty or individual's line manager. The matter should then be dealt with via the trust's disciplinary or capability procedure.

A comprehensive module covering the principles of RTT can be found on the trust e-learning portal. Further information regarding rules and tolerances can also be obtained via the elective access portal on the Royal Free London intranet (freenet). Any queries relating to RTT may also be communicated to rf.rttmailbox@nhs.net.

7. Non-admitted pathways

Outpatient encounters will be monitored via the Outpatient Waiting List (OPWL) and RTT "No Decision To Admit" (NDTA) section of the Patient Tracking List (PTL).

7.1 Referrals

A patient will be added to these lists once a referral has been received by the Royal Free London. If a referral is clinically appropriate and the trust provides the relevant service then the referral must be accepted. Where a referral is received without the minimum data set (MDS) necessary to record a clock start the referrer will be contacted by the OAC for additional information. The MDS is provided in Appendix 4. However, the RTT clock will remain active, assuming for inter provider referrals the patient has not already received definitive treatment at the tertiary site and has been referred to RFL for opinion only.

7.1.1 Electronic referrals

From October 2018 all GP referrals made to consultant led services must be made via the e-Referrals System (eRS).

Patients who have been referred via e-RS should be able to choose, book and confirm their appointment before the trust receives and accepts the referral. If there are insufficient slots available for the selected service at the time of attempting to book (or convert their Unique Booking Reference Number UBRN), the patient will appear on the appointment slot issue (ASI) work list. The RTT clock starts from the point at which the patient attempted to book. Patients on the ASI list must be contacted within two working days by the OAC to agree an appointment.

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

7.1.2 Paper referrals

Paper referrals will only be accepted if excluded from the national paper switch off policy. A list of accepted exclusions can be found in Appendix 5.

Any paper referrals received should be date stamped upon receipt. This date stamp will represent the clock start and will be documented on PAS. A copy of the letter will also be scanned and stored in the patient's electronic records.

All referrals will be forwarded to the respective specialty within one working day of receipt. The individual who is triaging should clearly state the priority status for treatment, indicate any investigations required and return the referral to the appointments office within two working days.

Any paper referral received from a GP to a consultant led service which is not an acceptable exclusion will be rejected and returned to the referrer and re-referral requested via the eRS system. The OAC should ensure that the referral is recorded on PAS to activate the RTT clock. Once the eRS referral is received, staff in the OAC will endeavour to ensure that the clock is recorded as the date of receipt of the paper referral.

7.1.3 Inter-provider transfers (IPTs)

7.1.3.1 Incoming IPTs

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

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

7.1.3.2 Outgoing IPTs

The trust aims to ensure that outgoing IPTs are processed as quickly as possible to avoid any unnecessary delays in the patient's pathway. The trust intention is that an accompanying MDS pro forma will be sent with each IPT, detailing the patient's current RTT status (the receiving trust will inherit any RTT wait already incurred if the patient has not yet been treated). If the patient has been referred for a new treatment plan for the same condition, a new RTT clock will start on receipt at the receiving trust. The patient's patient pathway identifier (PPID) will also be provided.

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

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

7.1.4 External Consultant to Royal Free London consultant referrals

Consultant to consultant referrals in the following scenarios will be accepted:

- referrals that are part of the continuation of investigation or treatment of the condition for which the patient was referred – this includes referrals to pain management where surgical intervention is not intended, and referrals to oncology for patients with a cancer diagnosis.

- urgent referrals for a new condition.
- suspected cancer referral in a different specialty- this will be vetted and dated by the receiving consultant and upgraded if deemed necessary. Once upgraded the patient will be treated within 62 days of the date the referral was received by consultant. See Section 12.6 below for further information.

7.1.5 Internal consultant to consultant referrals

Where a patient requires an internal second opinion or requires treatment as a joint case, clinical responsibility for the patient and management of the patient pathway remains with the specialty that initially received the referral.

Where clinical responsibility for patient should be transferred, this should be clearly agreed between specialties, and operational teams informed to ensure that patient records are updated.

7.2 Referrals for Procedures of Limited Clinical Effectiveness (PoLCE) procedures

Procedures of Low Clinical Effectiveness (PoLCE) are a list of treatments which are not routinely offered by the NHS and should not be carried out unless more conservative alternatives have failed and/or strict exclusion criteria are met by the patient. The process to access these treatments requires the GP to apply to their clinical commissioner for funding approval. Once this is received, the GP should send a referral through RMS with the approval attached.

All referrals for PoLCE procedures must be sent through a local Referral Management System (RMS), otherwise the service manager should ensure the referral is returned to the GP, as per the agreement with North Central London (NCL) commissioners.

If a referral for a PoLCE treatment is received that does not have approval attached, the triaging clinician can make an assessment based on the exclusion criteria and choose to either accept this patient for treatment or return the referral to the GP. There is an agreement that PoLCE eligibility will be managed and audited by the Trust, and regular assurance will be provided to commissioners regarding compliance.

RTT clocks will not be stopped until the patient has received first definitive treatment or has been discharged following a clinical decision that the PoLCE is not required.

Further information on PoLCE in NCL can be obtained from the link below¹².

7.3 Booking non-admitted appointments

7.3.1 First appointments

As the majority of GP referrals will now be made using eRS, patients and referrers will be responsible for booking first appointments on this system. Service specific booking timeframes are dictated by the 'polling range' on eRS, it is the responsibility of the RFL OAC to work with services to determine the most appropriate timeframes for polling ranges to ensure directly bookable slots are available in reasonable timeframes. Where referrals are received and accepted outside of eRS, OAC staff will aim to book first appointments as early as possible on the 18 week pathway, based on clinical prioritisation at triage. Patients will be offered a choice of at least two dates with three weeks' notice within the agreed first

¹² <http://www.northlondonpartners.org.uk/ourplan/Areas-of-work/polce-review.htm>

appointment milestone for the specialty concerned. Appointment dates can be offered with less than three weeks' notice and if the patient accepts, this can then be defined as 'reasonable'.

For an appointment to be considered 'booked' an appointment must be allocated on PAS and the patient notified of the appointment time and date. The appointment letter advises the patient of the relevant telephone number to use in order to contact the trust should the date and time of the allocated appointment be inconvenient.

Each specialty should have an agreed time-frame, signed off by senior operations managers and service line leads, in which non-urgent first outpatient appointments should be scheduled. If a non-urgent appointment cannot be made within this agreed time-frame due to a lack of capacity, a request will be sent to the relevant operational manager to authorise overbooking. If this request is not answered within 36 hours the service should attempt overbooking the patient into a clinic in accordance with the clinical priority identified at triage.

If a patient attempts to book using eRS and there are no slots available this generates as 'Appointment Slot Issue' (ASI) and the referral is 'Deferred To Provider' (DTP) which adds the referral to a worklist in eRS that OAC need to manage. This list is effectively a waiting list for eRS and should be managed in line with paper referrals awaiting first OPA booking.

The trust will aim to book patients from the ASI list in a timely way. In circumstances where outpatient capacity constraints are generating extended waits (as defined in the escalation policy) for first outpatient appointments (via the ASI list or on locally held waiting lists) the issue should be escalated in line with the trust escalation policy set out as part of the trust Elective Access Operational Policy.

7.3.2 Follow-up Appointments

Follow-up appointments should be scheduled according to clinical intent, i.e. if the clinician requests a follow-up in 3 months, it should be booked at 3 months.

Similarly to first appointments, in circumstances where outpatient capacity constraints are generating extended waits for follow-up appointments the issue should be escalated in line with the trust escalation policy set out as part of the trust Elective Access Operational Policy.

7.3 Clinic Outcomes

All patients attending clinic should be accurately recorded on PAS. A patient will be "checked in" to outpatient clinic, undergo their consultation, and the correct RTT status should be used to reconcile and "check out" their appointment. All clinics should be fully outcomed or 'cashed up' within one working day of the clinic taking place. This will help maintain accuracy along each RTT pathway.

This process is administered using the InTouch system where available or the outpatient outcome form, shown in Appendix 3. The form is completed by the clinician in clinic in order to identify the 'live' RTT status of the patient at the point of being checked out of clinic or otherwise outcomed. The clinician should also indicate on the outcome form any future appointments which may need to be scheduled. This form should be forwarded to the relevant administration staff immediately using agreed trust protocols. In line with the trust digital strategy, the Royal Free London will move towards using electronic outcome forms.

7.4 Patient Choice

7.4.1 Patient-initiated cancellations and rescheduling

If the patient declines a first outpatient appointment due to personal circumstances, they will be given a 'reasonable' offer of a further appointment. A reasonable offer is an offer of at least two times and dates three or more weeks (21 days) from the time the offer was made.

- Patients have the right to cancel their appointment ahead of the appointment time, if they are unable to attend. It is good practice to agree a date for another appointment at the time of cancellation where possible, and should be offered before the timed pathway milestone to reduce the likelihood of any potential breach. If this is not possible this requires to be escalated to the relevant Service Manager. It is important that a new appointment date and time is agreed with the patient so they are able to attend.
- All patients will receive a new appointment letter confirming their new appointment details. Details of the reason for cancellation are recorded on PAS against the original appointment.
- If an appointment is not available within two weeks, this must be escalated according to the trust RTT escalation policy (part of the trust Elective Access Operational Policy) for resolution as the RTT clock is still ticking.
- If a patient cancels their first routine outpatient appointment and does not wish to have another appointment, the referral should be discharged on PAS or cancelled on the e-Referral system, and the RTT clock stopped. A discharge letter must be sent to the patient and to their GP and/or original referrer.
- If a patient cancels a subsequent appointment for reasons other than ill health, then their case will be reviewed by the consultant-led team in charge of their care. They may be discharged back to the care of their GP or referrer if the consultant team decides that it is in their best clinical interests.
- The following patients should always be contacted to attempt re-booking:
 - vulnerable patients¹³,
 - a suspected cancer patient,
 - a paediatric patient, and/or
 - if the trust cannot demonstrate that the appointment was clearly communicated to the patient within a reasonable timeframe.

7.4.2 Failing to Attend an Outpatient Appointment

Patients should be recorded as a "did not attend" (DNA) when they give no advance warning of not attending a clinic appointment. All DNAs (new and subsequent) will be reviewed by the clinician at the end of clinic.

Patients who fail to attend their first appointment following the initial referral that started their waiting time clock should be contacted to attempt re-booking. However, clinicians should use their clinical judgement to decide if this is appropriate and ensure that, if the patient is to be discharged, the patient's GP is informed of the DNA. If a patient fails to attend their first outpatient appointment a second time, or a subsequent appointment, that has been clearly communicated and booked with reasonable notice, their case will be

¹³ A vulnerable adult is defined as a person who is 18 years of age or over who is being harmed or neglected, such that there is a threat to their safety. It may be a person unable to protect themselves effectively against significant harm or exploitation, or it may be someone who is unable to take care of themselves.

reviewed by the consultant-led team in charge of their care. They may be discharged back to the care of their GP or referrer if the consultant-led team decides that it is in their best clinical interests. Clinicians should contact the referring clinician (GP or otherwise) if they require additional information to support this review. Clinicians will use the trust outcome form to record their decision.

The following patients should always be contacted to attempt re-booking:

- the patient is defined as vulnerable (as defined above),
- suspected cancer patients,
- paediatric patients, and/or
- if the trust cannot demonstrate that the appointment was clearly communicated to the patient within a reasonable timeframe.

Where a decision to discharge is made, a discharge letter will be sent to the patient and to their GP and/or original referrer. All discharged patients should be discharged from PAS system and cancelled on the e-Referral Service if appropriate. Discharging back to the GP will stop the 18-week clock.

If the patient DNAs a first appointment the 18 week pathway is annulled. Should a further appointment be given a new clock would start on the date that the patient agrees the new appointment date (not the date of the rescheduled appointment itself).

The Trust must offer a second appointment following a DNA to any patient where it is clear that administrative error has led to the patient not attending their appointment (or where it is not clear that the date has been communicated to the patient).

7.4.3 Reasonable offers – non-admitted services

For patients on an RTT pathway, an offer of a non-admitted appointment will be deemed to be reasonable if at least two appointment dates have been offered and three or more weeks (21 days) notice of an appointment is given.

When considering what is reasonable, individual circumstances should be taken into consideration, for example, where the patient has role as a carer and arrangements need to be made to delegate these responsibilities.

7.4.4 Patient choice related to religious events

When the patient delays appointments due to religious events, this will be accommodated.

7.5 Hospital-initiated cancellations

Hospital-initiated changes to appointments will be avoided as far as possible as they are poor practice and cause inconvenience to patients. Patients should be contacted immediately if the need for the cancellation is identified, and offered an alternative date(s) that will allow patients on open RTT pathways to be treated within 18 weeks.

To support this, six weeks' notice must be given of all planned leave affecting clinics. The only acceptable reason for any clinic to be cancelled or reduced is due to the planned absence of medical or specialist nursing/AHP staff. If less than six weeks' notice is given, the clinic cancellation team will refer the request to the relevant Divisional Director and Divisional Director of Operations for authorisation.

Patients that have been previously cancelled should not be cancelled a second time.

8. Admitted pathways

Waiting lists for both inpatients and day-cases are split as follows:

- Referral to Treatment Patient Tracking List (RTT PTL) – the patient requires an elective procedure that is reportable under the RTT guidelines and a decision to admit (DTA) is made.
- Inpatient and Day-case Waiting List (IPWL) – all patients requiring an elective procedure.

As there will be overlap between these lists, the Royal Free London has set out how it expects staff to use these lists in its trust Elective Access Operational Policy. Training will also be provided as part of the trust RTT training programme.

8.1 Adding Patients to the Inpatient and Day-case Waiting List

Patients should be fit, ready and available before being added to the IPWL. However, they will be added to the admitted waiting list without delay following a decision to admit, regardless of whether they have undergone pre-operative assessment or whether they have declared a period of unavailability at the point of the decision to admit.

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

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

The RTT clock will stop upon admission, providing that the procedure is not cancelled.

8.1.1 Patients requiring more than one procedure

If more than one procedure will be performed during the same surgery by the same surgeon, the patient should be added as a single entry to the waiting list with the additional procedures noted.

If different surgeons will work together to perform more than one procedure, the patient should be added as a single entry to the inpatient waiting list of the consultant surgeon for the priority procedure with the additional procedures noted.

If a patient requires more than one procedure performed on separate occasions by different (or the same) surgeon(s), such as a bilateral procedure:

- The patient will be added to the active waiting list for the primary (first) procedure and the initial RTT 18 week clock will stop when surgery is performed for this procedure.
- When the first procedure is complete and the patient is fit, ready and able to undergo the second procedure and listed by the consultant for surgery, the patient will be added as a new waiting list entry to the PTL and a new RTT clock will start.

8.2 Pre-Operative Assessment

Our aim is to offer all patients with a decision to admit (DTA) requiring a general anaesthetic an opportunity to attend a Pre-Operative Assessment (POA) clinic on the same day as the decision to admit, to assess their fitness for surgery. The exceptions will be patients who want additional thinking time – in these cases we will aim to agree an appointment for POA on the same day as the decision to admit. The majority of patients can be assessed by the trust's dedicated POA nurse specialists.

For patients with complex health issues requiring a POA appointment with a nurse consultant or anaesthetist, the trust will aim to agree this date with the patient before they leave the clinic. The trust will aim to agree an appointment no later than seven working days from the decision to admit.

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

Once the patient attends POA, if they are identified as unfit for the procedure, the nature and duration of the clinical issue should be established.

8.2.1 Short-term illnesses

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

8.2.2 Longer term illnesses

If the clinical issue is more serious and the patient requires optimisation and / treatment for it, POA should indicate to administration staff if it is clinically appropriate for the patient to be removed from the waiting list, and if so whether the patient should be:

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

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

Patients who DNA their POA appointment will be contacted by an administrator to agree a further appointment. If they DNA again, they will be returned to their responsible consultant so a decision can be made about their future treatment. The RTT clock continues to tick throughout this process and will only be stopped should the patient be discharged back to the care of their GP.

8.3 Arranging Admission

Patients who require elective admission should be given a reasonable offer for their TCI date. For routine cases, a reasonable offer is at least two admission dates three or more weeks (21 days) from the time the offer was made.

At least three weeks prior to the intended date of their procedure patients will be contacted to agree an admission date. Usually this is undertaken via telephone with contact being attempted at different times of the working day. Further information on the booking process is available in the admissions standard operating procedures, part of the trust Elective Access Operational Policy.

For urgent cases, patients will be contacted by telephone or by letter if telephone contact cannot be made. If less than 21 days' notice is given and the patient declines the appointment, the admission date cannot be recorded as an earliest reasonable offer and the cancellation cannot be deemed to be patient-initiated.

8.4 Patient Choice

The Royal Free London will maintain a local record of all patient-initiated delays to support good waiting list management and to ensure patients are treated in order of clinical priority. Patients who are actively waiting for treatment will be seen ahead of those who have exercised their right of patient choice.

8.4.1 Patient initiated cancellation or rescheduling of Admission Dates

When a patient declines a reasonable offer of admission (as defined above), the date should be recorded on PAS as a patient-initiated cancellation and the reason for the cancellation should be clearly documented. In these cases a new date should be offered within a six week period of their request to cancel.

If a patient requests to reschedule again, then their case will be reviewed by the consultant-led team in charge of their care. They may be discharged back to the care of their GP or referrer if the consultant team decides that it is in their best clinical interests.

The following patients should always be contacted to attempt re-booking:

- vulnerable patients¹⁴,
- a suspected cancer patient,
- a paediatric patient,
- if the trust cannot demonstrate that the TCI was clearly communicated to the patient within a reasonable timeframe, and/ or
- there are discretionary factors that should be considered, e.g. bereavement.

If the patient is to be discharged, a discharge letter will be sent to the patient and to their GP and/or original referrer signed by the responsible consultant.

Where a patient cancels their TCI date at short notice – i.e. less than 24 hours – for reasons other than ill health, the admissions team will make the patient aware that they may be discharged from the speciality following the process above.

If a patient cancels their admission and does not wish to re-book this must be brought to the immediate attention of the clinical team and consultant and a decision must be made regarding the appropriate action to be taken. If this results in the patient being discharged a letter must be sent to the patient and to their GP and/or original referrer signed by the responsible consultant.

8.4.2 Patient does not attend

If a patient fails to attend an admission date, this will not necessarily stop the RTT clock.

In the event that a patient fails to attend their first scheduled admission date, Theatres staff will inform the Admissions team who will contact the patient by phone within 24 hours to understand why they did not attend. If they are able to speak to the patient, they will offer the patient another date within a six week period. If the patient cannot be contacted by phone, a letter is issued requesting that contact is made with the admissions team.

¹⁴ A vulnerable adult is defined as a person who is 18 years of age or over who is being harmed or neglected, such that there is a threat to their safety. It may be a person unable to protect themselves effectively against significant harm or exploitation, or it may be someone who is unable to take care of themselves.

Where the DNA has been an administrative failure on the part of the Trust, the patient is to be offered another date as close as possible to their original admission date or within their breach date, whichever is the sooner.

Where the patient reports a short term illness or other discretionary factors affected their attendance e.g. bereavement, they are to be offered another date as close as possible to their original admission date or within their breach date, whichever is the sooner.

Where neither of these eventualities is reported, or there is no other compelling reason why the patient should be offered another date, the patient's case will be reviewed by the consultant-led team in charge of their care. They may be discharged back to the care of their GP or referrer if the consultant team decides that it is in their best clinical interests.

The following patients should always be contacted to attempt re-booking:

- vulnerable patients¹⁵,
- a suspected cancer patient,
- a paediatric patient,
- if the trust cannot demonstrate that the TCI was clearly communicated to the patient within a reasonable timeframe, and/ or
- there are discretionary factors that should be considered, e.g. bereavement.

If the patient is to be discharged a discharge letter is to be sent to the patient and to their GP or original referrer signed by the responsible consultant.

8.4.3 Reasonable offers – admitted services

For patients on an RTT pathway, an offer of an admission date will be deemed to be reasonable if at least two dates have been offered and three or more weeks (21 days) notice of an appointment is given.

When considering what is reasonable, individual circumstances should be taken into consideration, for example, where the patient has role as a carer and arrangements need to be made to delegate these responsibilities.

8.4.4 Patients declaring periods of unavailability or requesting thinking time

Patients may wish to spend time thinking about the recommended treatment options before confirming they would like proceed. We will not stop RTT clocks where thinking time or unavailability is up to or including 3 weeks. Patients will be asked to make contact before the end of this period with their decision or to make themselves available.

If at the end of this period, the patient would like more thinking time, the patient will be clinically reviewed. Upon this review, the clinician should indicate one of the following:

- It is clinically safe to delay, and it is in the patient's best clinical interests to either (selecting one):
 - Continue their current RTT pathway,
 - Be entered into active monitoring, or
 - Be discharged back to their GP and their RTT clock stopped on the day this is communicated to the patient and their GP.

¹⁵ A vulnerable adult is defined as a person who is 18 years of age or over who is being harmed or neglected, such that there is a threat to their safety. It may be a person unable to protect themselves effectively against significant harm or exploitation, or it may be someone who is unable to take care of themselves.

- It is clinically unsafe to delay for the period of thinking time or unavailability requested and the patient should be contacted with a view to persuading the patient not to delay.

Following this conversation, if a patient still does not make themselves available, further clinical review should determine whether it is in the patient's best clinical interests to be discharged back to their GP and their RTT clock stopped on the day this is communicated to the patient and their GP.

8.4.5 Patient choice related to religious events

When the patient delays admission due to religious events, this will be accommodated.

8.5 On the day cancellations

If, on admission, the patient is found to be unfit for surgery they should be removed from the waiting list and either returned to outpatients for a clinical review or discharged to the care of their GP.

If a patient is unwell on the day of admission and there is a clinical decision not to proceed, this will be recorded as a clinical cancellation. The RTT clock will continue to tick unless a clinical decision is made that the patient is unsuitable for surgery/treatment and they are discharged back to primary care or a decision not to treat is made.

If a patient's operation is cancelled by the hospital on the day of admission for non-clinical reasons, a rescheduled TCI date must be arranged within a maximum of 28 days, subject to patient choice. Non-clinical reasons include cancellations due to lack of beds, equipment or technical failure, theatre list overruns or the surgeon is unavailable.

An operation which is rescheduled to a time within 24 hours of the original scheduled procedure will count as a postponement and not a cancellation.

9. Planned patients

Patients will join the Planned Patient Tracking List (Planned PTL) if they require a procedure as part of a planned sequence of care. In these cases the TCI date is determined on clinical grounds, for example:

- surveillance endoscopy to be done at 6 months, or
- staged injections 4 weeks apart, where the first set of injections are on an active RTT list and subsequent injections on the planned list.

Patients on planned lists should have their TCI booked at the clinically specified time, i.e. if the due date for the procedure is 6 months it should be booked at 6 months. This is the Guaranteed Admission Date (GAD). If the patient cannot be immediately booked in, Administrators should ensure that they record the patients' GAD so that patients can be tracked using the Planned PTL. If the GAD date passes, the patient should be moved to the RTT PTL with a new RTT clock started.

10. Acute therapy services

This section offers information on the management of clock start events following referral to acute therapy services. Acute therapy services consist of physiotherapy, dietetics, orthotics and surgical appliances. Referrals to these services can be:

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

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

10.1 Physiotherapy

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

10.2 Surgical appliances

If patients are referred for a surgical appliance with no other form of treatment agreed, the fitting of the appliance constitutes first definitive treatment and therefore the RTT clock stops when this occurs.

10.3 Dietetics

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

11. Diagnostics pathways

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

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

The maximum waiting time for a routine diagnostic test is 6 weeks. Diagnostics may be defined in the following fashion:

- Pure Diagnostic – a test intended to aid diagnosis of a patient’s disease or condition. This is a 6 week diagnostic pathway. It may become therapeutic at the time of the diagnostic.
- Therapeutic Diagnostic – defined as a test where the patient also receives treatment which stops the 18 week RTT clock, e.g. an endoscopy with removal of polyp, or an ultrasound scan with steroid injection. The 6 week target does not apply to these patients.

The diagnostic clock starts when the clinician requests a diagnostic test or procedure. The diagnostic clock stops on the date the test or procedure is done. If the test or procedure is purely diagnostic, the RTT clock continues ticking. If it is a therapeutic diagnostic it may constitute a clock stop, provided it is *definitive* treatment of the patient’s disease, condition or injury.

11.1 Direct Access Diagnostics

Direct Access (DA) diagnostics occur when the GP requests a diagnostic test only. Upon completion of the test the patient is referred back to the care of the GP. The 18 week RTT standard does not apply to DA patients.

11.2 Straight to Test Diagnostics

Straight to test (STT) referrals occur when a GP refers a patient to a consultant-led service where the first stage is review and, if appropriate, the first attendance to be a diagnostic test. As with other referrals, an RTT clock will start on receipt of the referral. Services where this currently may happen at the Royal Free London include (but may not be exclusive to):

- Colorectal
- Respiratory
- Gynaecology
- Gastroenterology

11.3 Booking diagnostic appointments

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

11.4 Patient-initiated cancellations, declines or failure to attend

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

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

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

11.5 Reasonableness – diagnostic appointments

For patients on diagnostic pathway, an offer of a date for a diagnostic test or procedure will be deemed to be reasonable if at least two dates have been offered and three or more weeks (21 days) notice of an appointment is given. Where possible, this should be recorded on PAS.

When considering what is reasonable, individual circumstances should be taken into consideration, for example, where the patient has a role as a carer and arrangements need to be made to delegate these responsibilities.

11.5 Active diagnostic waiting list

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

11.6 Planned diagnostic appointments

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

11.7 Clinical review of diagnostics resulting in an RTT clock stop

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

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

12. Cancer Pathways

Introduction and scope

This section describes how the trust manages waiting times for patients with suspected and confirmed cancer, to ensure that such patients are diagnosed and treated in a timely and patient-centred way, within the national cancer waiting times standards. This policy is consistent with the latest version of the Department of Health's *Cancer Waiting Times Guidance* and includes national dataset requirements for both waiting times and clinical datasets.

This policy is relevant for patients referred on a suspected cancer pathway, cancer screening, consultant upgraded from routine or emergency pathways, as well as the management of patients with a known or previous cancer diagnosis.

Principles

As defined in the NHS Constitution and summarised in Section 2 of this policy, patients have the right to expect to be seen and treated within national operational standards ensuring timely diagnosis and treatment, equity of care and patient choice.

Patients will, wherever possible, be offered dates for appointment or treatment in chronological order, based on the number of days remaining on their cancer pathway, unless there are clinical exceptions. In addition, wherever possible, patients will be given reasonable notice and choice of appointments and TCI dates as defined within the policy.

Where national guidance allows for local interpretation, the interpretation will be made within the 'spirit' of this guidance so as always to ensure that the patients' best interests and wishes are at the forefront of the Trust policies and practices.

Accurate data on the trust's performance against the national cancer waiting times is recorded in the cancer management system and reported to the National Cancer Waiting Times Database within nationally predetermined timescales.

Where patients are at risk of breaching any of the cancer standards it is expected that all staff will follow the cancer escalation policy set out in the overall Trust Cancer Operational Policy.

The Trust provides cancer care as part of a network, where hospitals work together to achieve the best clinical outcomes. Some specialist services are only delivered at designated hospitals and therefore patients may require transfer to Royal Free London or from Royal Free London to another Trust during their pathway. Where this is applicable the Trust will follow agreed network guidance and transfer care as quickly and smoothly as possible. In these circumstances patient choice is not offered, due to the nature of specialist services, with agreed clinical pathways followed.

12.1 Cancer waiting times standards

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

Service Standard (maximum)	Definition	Operational Standard
14 day Standards	GP referral to first seen (suspected cancer)	93%
	GP referral to first seen (breast symptomatic)	93%
62 day Standards	GP referral to first treatment	85%
	Screening referral to first treatment	90%
	Consultant upgrade to first treatment	No national operational standard
31 day Standards	Decision to first treatment	96%
	Decision to subsequent treatment (surgery)	94%
	Decision to subsequent treatment (drugs)	98%
	Decision to subsequent treatment (radiotherapy)	94%
31 days rare cancers	GP referral to first treatment for acute leukaemia, testicular cancer and children's cancers	Monitored as part of 62 days from urgent

12.2 Summary of the cancer rules

12.2.1 Clock starts

2 week wait

There are two referral pathways where patients should be seen with 2 weeks from referral:

- urgent General Practitioner (GP) – which could be a General Medical Practitioner (GMP), General Dental Practitioner (GDP) or Optometrist – referral for suspected cancer to first outpatient attendance or investigation, and
- referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment.

A two week wait clock starts when the Royal Free London receives the referral (day zero).

62 day

A 62-day cancer clock can start following:

- an urgent two-week wait referral for suspected cancer,

- an urgent two-week wait referral for breast symptoms (where cancer is not suspected),
- a consultant upgrade, or
- a referral from NHS cancer screening programme.

This access standard also monitors maximum one month (31 days) from urgent GP referral to first treatment for acute leukaemia, testicular cancer and children's cancers.

31 day

A 31-day cancer clock will start following:

- the patient agreeing a treatment plan with their clinician – this is the Decision To Treat (DTT) plan for first definitive treatment,
- a DTT for subsequent treatment (including after a period of active monitoring), and/or
- an Earliest Clinically Available Date (ECAD) following a first definitive treatment for cancer – this may be where a patient needs to recover following their first definitive treatment.

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

Subsequent treatments

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

12.2.2 Clock stops

2 week wait

A two week wait clock will stop following:

- patient attendance at a first outpatient appointment
- patient attendance for an investigation or diagnostic relevant to the referral (for Straight To Test pathways).

62 day

A 62-day cancer clock will stop following:

- delivery of first definitive treatment
- placing a patient with a confirmed cancer diagnosis onto active monitoring¹⁶

Patients are removed from the 62-day pathway (not reported) in the following circumstances:

- in the case of a decision not to treat,
- a patient declining all diagnostic tests or all treatment options,
- confirmation of a non-malignant diagnosis, or
- Patients receiving diagnostic services and treatment privately.

31 day

A 31-day cancer clock will stop following:

¹⁶ Active monitoring should only be used if patients request an extended period of thinking time and it is judged clinically safe to do so. Otherwise the patient should be contacted with a view to persuading them not to delay. Please see section 8.4.4.

- delivery of first definitive treatment or subsequent treatment,
- placing a patient with a confirmed cancer diagnosis onto active monitoring, or
- confirmation of a non-malignant diagnosis.

For a more detailed breakdown of the cancer rules please read the latest *Cancer waiting times guidance*¹⁷ or the Cancer Operational Policy.

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

12.2.3 Waiting-time adjustments

Unlike RTT it is possible to make adjustments (pauses) to patient clocks on cancer pathways.

Only two adjustments are allowed on a cancer pathway:

- two week wait: If a patient Does Not Attend (DNAs) their first outpatient appointment or attendance at investigation or diagnostic appointment, e.g. endoscopy, the clock start date can be reset to the date the patient rebooks their appointment (the date the patient agrees the new appointment not the new appointment date).
- 62-/31-day pathways: If a patient declines admission for an inpatient or day case procedure, providing the offer of admission was 'reasonable' the clock can be paused from the date offered to the date the patient is available. The Royal Free London definition of 'reasonable' is provided in Section 11.7 below.

With respect to adjustments for admitted patient care, this will also apply if a patient states that they are unavailable for a set period of time (e.g. due to holiday or work commitments). The adjustment will be applied from the earliest reasonable 'To Come In' (TCI) date that could have been offered to the date the patient makes themselves available again. The patient does not need to be offered the actual date, this would be inappropriate as they have informed the Trust they are unavailable. Relevant information must be documented against the patient's records.

If a treatment is to be delivered in an outpatient setting a pause **cannot** be applied. No adjustments are permissible for medical illness or other co-morbidities.

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

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

12.2.3 Eligibility and private patients

Cancer waiting times service standards are applicable to all patients entitled to NHS-funded care. These are subject to the same exclusions as set out in Section 4 of this policy.

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

¹⁷ <https://digital.nhs.uk/services/screening-services/cancer-waiting-times>

Patients who have diagnostic tests privately before returning to the NHS for cancer treatment, only the two week standard and 31 day standard apply. A patient is excluded from the 62 day standard. If a patient transfers from a private provider onto an NHS waiting list they will need to be upgraded if they have not made a Decision to Treat (DTT) and the consultant wants them to be managed against the 62-day target. If a DTT has been made in a private setting the 31-day clock will start on the day the referral was received by the trust.

12.3 GP/GDP suspected cancer two-week wait referrals

GPs (and other referrers) should make two-week wait referrals where indicated in line with NICE guidelines on referring for suspected cancer¹⁸. Key aspects of the referral process at the Royal Free London include:

- The relevant tumour site Pan-London suspected cancer referral form must be used and include all relevant clinical and demographic information, completed with the minimal dataset.
- Suspected cancer referrals must only be submitted electronically via e-RS. GP referrals through other routes are now not accepted in line with national policy. Clinicians who do not have access to e-RS (General Dental Practitioners and Optometrists) must send the referrals, using the Pan-London suspected cancer referral form. Referrals must not be sent to local departments or directly to consultant secretaries, as this may lead to a delay in patient assessment and tracking. Fax referrals are not accepted.
- The duty of care is with the referring practice. The referrer must have a local system in place to track suspected cancer referrals made.
- It is essential the referrer ensures the patient is given information on, and understands they are being referred to investigation symptoms that may lead to a cancer diagnosis.
- The referrer must inform the patient they will be offered an appointment within two weeks, and in many cases one week, and encourage acceptance of subsequent investigation and assessment appointments on an urgent basis.
- The referrer must inform the patient that they are likely to have an investigation(s) as part of the initial assessment.
- Where there are exceptional clinical reasons for not being explicit about the nature of referral, the referrer must make this clear on the referral form.
- the referrer must provide the patient with information set out in section 12.3.7 of this policy (information patients should receive at referral).

All two week wait referrals will be checked for completeness by the two week wait team within 24 working hours of receipt of referral.

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

12.3.1 Referrals for services not provided at the Royal Free London

For any two week wait referral received by the trust for a service that the trust is not commissioned to deliver, the two week wait team will liaise with the GP (which includes

¹⁸ <https://www.nice.org.uk/guidance/ng12>

GMP, GDP or Optometrist) and ask them to withdraw the referral and re-refer to a correct provider.

12.3.2 Downgrading referrals from two-week wait

The trust cannot downgrade two week wait referrals. If the consultant believes the referral does not meet the criteria for a two week wait referral they must contact the GP to discuss. If it is decided and agreed the referral does not meet the two week wait criteria, the GP can retract it and refer on a routine or urgent referral pro forma. Only the GP can make this decision. The communication between consultant and GP must be documented in the patients' records.

12.3.3 Two referrals on the same day

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

12.3.4 Paediatric Referrals

All suspected cancer referrals for anyone under the age of 16 years will be received and seen by the paediatric department or tumour specialty where locally clinically appropriate. On diagnosis of cancer patients will be referred to the Paediatric Cancer Principle Treatment Centre (PTC) at Great Ormond Street Hospital.

12.3.5 Referrals for 16 to 18 year olds

For suspected cancer referrals for 16 to 18 year olds (up to their 19th birthday)

- All referrals will be referred on to the PTC at UCLH, unless there is an agreement with the Teenage and Young Adult (TYA) service at tumour site level to manage the diagnostic pathway.
- The Outpatient booking team will redirect referrals at the point of referral.

Any TYA in this age range 16-18 suspected of Cancer not via a suspected cancer referral will also be referred to the TYA PTC at UCLH for diagnostics and treatment.

12.3.6 Referrals for 19 to 24 year olds

All suspected cancer referrals for anyone between the ages of 19 to 24 (up to their 25th birthday) will be seen by the specialty they are referred to through the adult diagnostic pathway, as clinically appropriate.

- Patients diagnosed with cancer are given the choice to continue with treatment locally within the adult service, or referred to a designated TYA centre or the PTC. This is defined with each tumour site MDT operational policy.
- Patients who chose to remain in adult care locally, must be referred to the TYA MDT at the PTC at UCLH to review treatment plans and for the provision of psycho-social care.

12.3.7 Information patients should receive at referral

NICE Suspected cancer guidelines¹⁹ suggest the following information is made available by the referrer to the patient on referral for suspected cancer.

- An explanation that the person is being referred with suspected cancer and that they are being referred to a cancer service. Reassurance, as appropriate, that most

¹⁹ <https://www.nice.org.uk/guidance/ng12>

people referred will not have a diagnosis of cancer, and a discussion of alternative diagnoses with them.

- An offer of information on the possible diagnosis (both benign and malignant) in accordance with the person's wishes for information (see also the NICE guidelines on patient experience in adult NHS services).
- The information given to people with suspected cancer and their families and/or carers should cover, among other issues:
 - where the person is being referred to,
 - how long they will have to wait for the appointment,
 - how to obtain further information about the type of cancer suspected or help before,
 - the specialist appointment,
 - what to expect from the service the person will be attending,
 - what type of tests may be carried out, and what will happen during diagnostic procedures,
 - how long it will take to get a diagnosis or test results,
 - whether they can take someone with them to the appointment, and
 - who to contact if they do not receive confirmation of an appointment
 - other sources of support.

12.3.8 Tracking cancer referrals

All cancer patients are tracked on a regular basis on the Trust cancer database. For further information refer to the Cancer Tracking SOP in the trust Cancer Operational Policy.

12.4 Booking two week wait appointments

Patients will be able to choose their appointment for many Tumour sites at the point of referral through e-RS. Given the urgency of the referral GP must encourage patients to accept the earliest possible appointment.

The GP must choose the correct appointment type for the condition that the patient is being referred for. If the appointment type is incorrect and this is identified before the appointment, the patient will be contacted to change the appointment.

There are some specialties where there is a clinical triage process to determine the most appropriate first appointment or investigation. Where this is applicable, the patient will be contacted to book the first appointment.

All two week wait referrals will be appointed by day 14 (the national target). The Trust has an internal target of appointing two week wait referrals by day 7 where possible. Once the appointment has been chosen within 14 days, the appointment should not be changed.

12.4.1 Contacting patients to make appointments – paper referrals

When patients are not booked through e-RS, the outpatient booking team will make all reasonable efforts to contact the patient to arrange their appointment. The booking team will attempt to contact the patient on at least two occasions at different times to agree the appointment date and time. The Royal Free London has set out its definition of reasonable in Section 12.7.

Administrators will contact patients on the assumption that the referrer has discussed the nature of the referral (suspected cancer) and relevant information to support patients has been provided. If a patient wants to delay accepting an appointment within 14 days then

the two week wait clerk will inform the patient that they have been referred for an urgent appointment within 2 weeks in order to exclude cancer according to a pre-agreed script. If the patient requests further information the two week wait clerk will advise the patient to contact their GP for further details.

On confirmation of an appointment, the outpatient booking team will send out a confirmation letter to the patient confirming the appointment details and enclosing any relevant supplementary patient information leaflets. Fixed appointment letters are not sent before either a date has been agreed, or at least two attempts to contact the patient by telephone at different times have been made.

An appointment letter will not be sent to a patient in circumstances where it is known that they will be unavailable to attend in order to induce a series of DNAs resulting in referral back to the GP/GDP.

12.4.2 Patients without a registered GP

When a two-week wait referral is received for a patient who is not registered with a GP, for example through an Urgent Treatment Centre (UCC), including where the patient does not have an NHS number, the referral will be processed and appropriate appointment made.

The Outpatient Appointment Centre will inform the Overseas Department and they will investigate the patient's eligibility to NHS funding care and advise the relevant staff of action to take.

12.4.3 Patients who are unaware of pathway status

Where the trust identifies that a patient has not been informed by their GP that they are on a cancer pathway, the trust will inform the patient using a pre-agreed script that has been tested with patients. The trust will also aim to include in the initial letter to the relevant GP that the patient was not informed in line with national guidance.

12.4.4

In circumstances where capacity constraints are generating extended waits for first appointments (via the ASI list or on locally held waiting lists) the issue should be escalated in line with the trust escalation policy. This is incorporated into the trust Cancer Operational Policy.

12.5 Screening pathways

For patients who have been referred following attendance at an NHS screening programme appointment, the clock start is when the Royal Free London receives the referral from the screening programme (day 0). For the individual screening programmes this is as follows:

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

12.6 Consultant upgrades

The Royal Free London will manage patients who are not referred by their GP on a two week wait referral or through the screening programmes, but who have symptoms or signs indicating a high suspicion of cancer, on the 62-day pathway. This is achieved by upgrading the patients onto a 62-day upgrade pathway.

The 62-day pathway starts (day 0) from the date the patient is upgraded. Upgrade must occur before the DTT date. Patients not upgraded at this point will be measured against the 31-day DTT to first definitive treatment. An upgrade is intended for suspected new primaries only, not those who may be suspected of a recurrence.

12.6.1 Who can upgrade patients onto a 62-day pathway

The specialist team receiving the referral and/or reviewing the patient or diagnostic result is responsible for the patient. However, they can delegate the responsibility to upgrade the patient. This could be to:

- A specialist nurse/practitioner, either by triaging the referral form/letter or at nurse led initial clinic.
- A specialist registrar either by triaging the referral form/letter or at initial clinic.
- A radiologist/histologist/other trust clinicians who are reviewing patients and/or diagnostics.

12.6.2 Responsibilities for upgraded patients

The consultant or delegated member of the team upgrading the patient is responsible for informing the MDT co-ordinator that an upgrade has occurred, in order for the patient to be tracked on the correct pathway.

If a patient has been upgraded to a 62-day pathway this must be communicated with the patient so they understand why they are being upgraded, and the GP should be notified. The specialist team responsible for the patient should ensure that patients are informed at their next appointment and GPs are informed either by letter or by telephone. However, they can also delegate this responsibility to a specialist nurse or practitioner.

Each MDT should nominate a responsible clinician who will clinically assume care of patients and ensure that patients and GPs are informed of upgrades. Where a clinical delegate (from the list above) is upgrading the patient, they should inform the MDT's responsible clinician.

12.7 Reasonableness

For patients on a cancer pathway, an offer will be deemed to be reasonable if 48 hours' notice of an appointment, starting preparation for a test or admission is given. There may be some clinically exceptions to this individual cases related to medication changes.

For patients on a cancer pathway, it is reasonable to expect them to be contactable within 24 hours of first attempted contact. If the patient is uncontactable after 24 hours, and two or more attempts to first contact them, escalation action should be taken, which may exclude other methods of communication or involvement of the GP.

Offers of appointments, investigations or treatment can always be made as soon as possible, and offers on the same day or next can be appropriate.

When considering what is reasonable, individual circumstances should be taken into consideration, for example, where the patients has role as a carer and arrangements need to be made to delegate these responsibilities.

When agreeing a TCI date, if a patient states that they are unavailable for a set period of time before a reasonable treatment date is offered, an adjustment will be made according to the rules set out in Section 12.2.3.

12.8 Patient choice

12.8.1 Patient cancellations

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

First appointment cancellations

For two week wait referral patients who cancel their first appointment, we will aim to offer an alternative appointment that is still compliant with the two week wait clock. If this is not possible, we will aim to offer another appointment within seven days of notification of the cancellation.

Cancellations of subsequent appointments or diagnostics

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

Multiple cancellations

The Royal Free London will discharge patient after multiple (two or more) consecutive appointment cancellations, if this has been agreed with the patient and it is judged to be in the patient's best clinical interests. However, where a patient has cancelled multiple outpatient or diagnostic appointments on a 62-day GP pathway, screening pathway or breast symptomatic referral, an appropriate member of staff will contact the patient to identify any factors that may be stopping the patient attending and another appointment will be offered if the patient agrees.

When reviewing the clinical appropriateness of discharging the patient, it can be safer for the patient to be under the sole responsibility of the GP, who will have a holistic view of the patient. The GP will be informed when patients have cancelled more than one appointment during their pathway by the consultant in charge of their care.

12.8.2 Patient DNAs

Patients will be recorded as a DNA if they do not turn up to a clinic or diagnostic appointment, turn up late or turn up in a condition where the trust cannot carry out whatever was planned for them. This includes arriving without having followed preparation instructions where these were provided, for example bowel prep or fasting.

First appointment

All patients referred as suspected cancer including two week wait, screening, upgrade and breast symptomatic who DNA their first appointment (outpatient or test) should be offered an alternative date within 14 days of the DNA.

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

If a patient DNAs their first appointment twice they should be escalated to the consultant in clinic for a decision on the next step which may include discharge back to the GP. If a decision is made to discharge the patient, this will be communicated via letter within two working days of the discharge to the patient and GP.

Subsequent appointments

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

12.8.3 Patients who are uncontactable

If the patient is uncontactable at any time on their 62-/31- day pathway, a record of the time and date of the call to them on PAS should be made at the time of the call. Two further attempts will be made to contact the patient by phone, one of which must be after 5.00pm. Each of these calls must be recorded in real time on PAS. These attempted contacts must be made over a minimum two-day period.

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

- For first appointments: an appointment will be sent to the patient offering an appointment within the two week wait standard, stating the trust has attempted to offer a choice of appointment, and that the patient should contact the two week wait office to rearrange the appointment if it is inconvenient.
- Appointments (other than first) on 62-/31- day clinical pathway for patients without a diagnosis: attempts to contact patient will be made as outlined above. If contact cannot be made, the consultant should decide:
 - to send a 'no choice' appointment by letter
 - to discharge the patient back to the GP.
- Appointments (other than first) on 62-/31- day clinical pathway for patients who have a confirmed cancer diagnosis, the consultant should decide:
 - to send a 'no choice' appointment by letter, or
 - to discharge the patient back to the GP if there has been a period of four weeks since final contact. Should the GP then be successful in resuming communication with the patient and establish that the patient is willing to resume investigations/treatment the patient will be recorded on a 31-day pathway.

12.8.4 Patients who are unavailable

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

12.8.5 Choice of consultant or treatment location

The Trust should always offer the patient the earliest appropriate treatment date. If the patient wishes to be treated by a specific consultant and/or location where a treatment date cannot be offered within the waiting time standard this should be accommodated wherever possible, and an adjustment will be from the original offer to the actual treatment date.

12.8.6 Patient choice related to religious events

When the patient delays treatment due to religious events, this will be accommodated and no adjustment will be made.

12.8.7 Thinking time for diagnosed patients

If patient diagnosed with cancer requests thinking time to consider their options, a CNS should contact the patient within 24 hours of the request. The patient should also be given a date for a follow-up telephone appointment within 7 days.

- If the patient DNAs this appointment, we will follow the process set out in the section on Patient DNAs above.
- If the patient attends the appointment but would like further time, a clinician will review their case and make contact again within 24 hours.

The trust will also provide a Macmillan patient information leaflet on making treatment decisions. A link is provided in Appendix 6.

12.8.8 Refusing treatment

Patients have the right to refuse treatment. Where a patient makes a fully informed choice to decline all treatment, this must be comprehensively documented. If the patient later agreed to treatment this would be a separate 31 day subsequent treatment period.

12.9 Diagnostics

The trust will maintain a two week wait for all diagnostic 'straight to tests' for patients on a cancer pathway. Turn-around times or other diagnostic tests on a patient's 62-/31- day pathway will be managed in line with agreed timed pathways.

12.9.1 Refusal of a diagnostic test

If a patient refuses a diagnostic test, the refusal will be escalated to the clinical team to contact the patient within 24 hours. If the patient continues to refuse, they will be offered an outpatient or telephone appointment within 7 days for further discussion.

If the patient refuses all diagnostic tests they will be removed from the cancer pathway and discharged back to their GP.

12.10 Tertiary referrals

Inter provider transfer (IPT) forms will be used for all outbound referrals for patients on a cancer pathway. All information will be transferred between trusts electronically. Transfers will be completed via a named NHS contact. A minimum dataset and all relevant diagnostic test results and images will be provided when the patient is referred. For further information refer to the NCEL Inter-Trust Transfer (ITT) Policy.

12.11 Data monitoring and audit

It is the responsibility of the Royal Free London Cancer Management, Information Management and Performance teams to run a programme of audits for data completeness and data anomalies. Further information is available for staff in the trust Cancer Data Validation policy.

Appendix 1: Equality Analysis

Royal Free London NHS Foundation Trust Equality Analysis for: Elective Access Policy

Name of the policy / function / service development being assessed	Elective Access Policy
Briefly describe its aims and objectives:	The aim of this policy is to ensure that the Royal Free London is compliant with the legislation and associated rules and guidance regarding how long NHS patients should expect to wait for elective care.
Directorate and Lead:	Chief Finance and Compliance Officer
Evidence sources: DH, legislation. JSNA, audits, patient and staff feedback	DH, NHS England, NHS Improvement
Is the Trust Equality Statement present?	Yes

Protected Characteristic (Equality Act 2010)	Identify negative impacts	What evidence, engagement or audit has been used?	How will you address the issues identified?	Identifies who will lead the work for the changes required and when?	Please list positive impacts and existing support structures
Age	None	Internal review	No issues identified		This policy is designed to provide equal access to elective NHS care. It is also drafted
Disability	None				

Protected Characteristic (Equality Act 2010)	Identify negative impacts	What evidence, engagement or audit has been used?	How will you address the issues identified?	Identifies who will lead the work for the changes required and when?	Please list positive impacts and existing support structures
Gender Reassignment	None				to ensure that appropriate consideration is paid to patients who are vulnerable, or children and accommodate the preferences of those who wish to reschedule or delay appointments due to religious events. It is also designed to ensure that consideration is paid to patients and their carers.
Marriage and Civil Partnership	None				
Pregnancy and maternity	None				
Race	None				
Religion or Belief	None				
Sex	None				
Sexual Orientation	None				
Carers	None				

It is important to record the names of everyone who has contributed to the policy, practice, function, business case, project or service change.

Equality Analysis completed by: (please include every person who has read or commented and approval committee(s). Add more lines if necessary)	Role and organisation if appropriate	Date
Amy Caldwell-Nichols	Head of Performance, RFL	September 2018
Kelly Rank	Senior Operations, Elective Access, RFL	September 2018
Jamie McFetters	Senior Operations Manager, Haematology and Oncology	September 2018
Kate Cox	Divisional Director of Operations, SAS, Barnet Hospital	September 2018
Linda McGurrin	Divisional Director of Operations, SAS, Royal Free Hospital	September 2018
Sara McGee	Operations Manager, Breast and Plastics	September 2018
Andrea Francis	Improvement Manager – Elective Care, NHS Improvement	September 2018
Royal Free Group Executive Committee		September 2018

Appendix 2: Royal Free London turnaround time standards

1. RTT

Area	Section	Commitment	Responsible team
New referrals – electronic	7.1.1	Patients on the Appointment Slot Issues (ASI) list must be contacted within two working days by the OAC to agree an appointment.	OAC
New referrals – paper	7.1.2	Referrals should be stamped on receipt and inputted into PAS within 48 hours.	OAC
New referrals – paper	7.1.2	All referrals will be forwarded to the respective specialty within one working day of receipt for triage.	OAC
New referrals – paper	7.1.2	Specialty triage should clearly state the priority status for treatment, indicate any investigations required and return the referral to the appointments office within two working days.	Specialties
Outgoing IPTs	7.1.3.2	Referrals and the accompanying MDS will be emailed securely from the specialty NHS.net account to the generic central booking office NHS account. The Outpatient Appointment Centre will verify (and correct if necessary) the correct RTT status for the patient. They will then forward to the receiving trust within one working day of receipt into the generic email inbox. If the patient has not yet been treated, upon confirmation of receipt by the receiving trust, the RTT clock will be nullified at this trust.	OAC
First appointments	7.3.1	Patients will be offered a choice of at least two dates with three weeks' notice within the agreed first appointment milestone for the specialty concerned.	OAC (offer), Specialties (capacity)

Area	Section	Commitment	Responsible team
First appointments	7.3.1	Each specialty should have an agreed time-frame, signed off by senior operations managers and service line leads, in which non-urgent first outpatient appointments should be scheduled.	Specialties
First appointments	7.3.1	If a non-urgent appointment cannot be made within agreed time-frames due to a lack of capacity, a request will be sent to the relevant operational manager to authorise overbooking. If this request is not answered within 36 hours the patient will be overbooked into clinic in accordance with the clinical priority identified at triage.	OAC
Clinic Outcomes	7.3	All clinics should be fully outcomed or 'cashed up' within one working day of the clinic taking place.	Specialties
Reasonable offers - NDTA	7.4	A reasonable offer is an offer of at least two times and dates three or more weeks (21 days) from the time the offer was made.	OAC (offer), Specialties (capacity)
Appointment offers after patient reschedules	7.4.1	New appointments should be offered within 2 weeks of original appointment date.	OAC (offer), Specialties (capacity)
Hospital cancellations	7.5	Six weeks' notice must be given of all planned leave affecting clinics. The only acceptable reason for any clinic to be cancelled or reduced is due to the planned absence of medical or specialist nursing/AHP staff.	Specialties
POA	8.2	All patients with a decision to admit (DTA) requiring a general anaesthetic to attend a Pre-Operative Assessment (POA) clinic on the same day as the decision to admit to assess their fitness for surgery, if appropriate.	POA
POA	8.2	For patients with complex health issues requiring a POA appointment with a nurse consultant or anaesthetist, the trust will aim to agree this date with the patient before they leave the clinic. The trust will aim to agree an appointment no later than seven working days from the decision to admit.	POA

Area	Section	Commitment	Responsible team
Reasonable offers - DTA	8.3	A reasonable offer is at least two admission dates three or more weeks (21 days) from the time the offer was made.	Admissions (offer), Specialties (capacity)
Arranging admission	8.3	At least three weeks prior to the intended date of their procedure patients will be contacted to agree an admission date.	Admissions
Patient DNA admission	8.4.2	Theatres staff will inform the Admissions team who will contact the patient by phone within 24 hours to understand why they did not attend.	Theatres staff, Admissions
Patient thinking time	8.4.4	Where it is identified to be clinically unsafe, a clinician will contact the patient within 48 hours with a view to persuading the patient not to delay.	Specialties
Reasonable offers - diagnostics	11.5	At least two dates have been offered and three or more weeks (21 days) notice of an appointment is given.	OAC / diagnostics booking teams (offer), diagnostics (capacity)
Diagnostics – outcome of tests	11.7	Where clinicians review test results in the office setting and make a clinical decision not to treat, the RTT clock will be stopped on the day this is communicated in writing to the patient. Diagnostic administration staff should update PAS with the clock stop immediately.	Diagnostics admin

2. Cancer

Area	Section	Commitment	Responsible team
New referrals	12.3	All two week wait referrals will be checked for completeness by the outpatient booking team within 24 working hours of receipt of referral.	OAC / specialty booking team
New referrals	12.3	For two week wait referrals received by the trust without key information the outpatient booking team will contact the relevant GP surgery by phone within 48 hours of receipt of referral to obtain the missing information.	OAC / specialty booking team
New referrals	12.3	The Trust has an internal target of appointing two week wait referrals by day 7 where possible.	OAC (booking), Specialties (capacity)
Reasonable offers	12.7	For patients on a cancer pathway, an offer will be deemed to be reasonable if 48 hours' notice of an appointment, starting preparation for a test or admission is given.	OAC / specialty or diagnostics booking team (offer), specialties or diagnostics (capacity)
First appointment cancellations	12.8.1	We will aim to offer an alternative appointment that is still compliant with the two week wait clock. If this is not possible, we will aim to offer another appointment within seven days of notification of the cancellation.	OAC / specialty booking team (offer), specialties (capacity)
Subsequent appointment cancellations	12.8.1	We will offer an alternative date within seven days of the cancelled appointment	OAC / specialty booking team (offer), specialties (capacity)

Area	Section	Commitment	Responsible team
Contacting patients	12.8.3	If the patient is uncontactable, a record of the time and date of the call should be made at the time of the call. Two further attempts will be made to contact the patient by phone, one of which must be after 5.00pm. Each of these calls must be recorded in real time. These attempted contacts must be made over a minimum two-day period.	OAC, Specialties
Patient thinking time	12.8.7	If patient diagnosed with cancer requests thinking time to consider their options, a CNS should contact the patient within 24 hours of the request. The patient should also be given a date for a follow-up telephone appointment within 7 days. <ul style="list-style-type: none"> • If the patient DNAs this appointment, we will follow the process set out in the section on Patient DNAs above. • If the patient attends the appointment but would like further time, a clinician will review their case and make contact again within 24 hours. 	Specialties
Diagnostics	12.9	The trust will maintain a two week wait for all diagnostic 'straight to test' for patients on a cancer pathway.	Diagnostics
Refusal of diagnostics	12.9.1	If a patient refuses a diagnostic test, the refusal will be escalated to the clinical team to contact the patient within 24 hours. If the patient continues to refuse, they will be offered an outpatient or telephone appointment within 7 days for further discussion.	Specialties

Appendix 3: Outcome Forms

- A PDF version of the Trust Clinic Outcome Form is available on Freenet at:

<http://freenet/Docs/rtt/010%20Out-patient%20outcome%20form.pdf>

- The clinic outcome form is also available in electronic format on the Intouch system – please see screenshot on the following page

Outcomes

Did patient attend? No Yes

Procedures

Have any procedures been carried out today? No Yes

Pathway Outcome

Clinic Outcome

- 1st definitive treatment given today
- Actively monitor patient condition until it warrants treatment
- DNA
- Patient already treated/being monitored
- Patient considering options
- Patient sent for diagnostics

This field is mandatory, even if your patient did not attend.

Please choose the appropriate RTT status before completing the outcome form.

Attendance Outcome

Book another attendance? No Yes

Appointment Type	<input type="radio"/> New <input checked="" type="radio"/> Follow-up
Specialty to book into	<input type="text" value="Rheumatology"/>
Clinic to be seen in	<input type="text" value="CF-MAPE-2A-CON-1"/>
Clinician to see	<input type="text" value="Consultant Only"/> <small>Either select from list or type new</small>
Priority	<input checked="" type="radio"/> Routine <input type="radio"/> Urgent
Waiting List (Ensure relevant form complete)	<input type="radio"/> Add to waiting list <input type="radio"/> Add to Inpatient Waiting List <input type="radio"/> Emergency Admission <input type="radio"/> Laser Treatment <input type="radio"/> Macular Service <input checked="" type="radio"/> Orthoptist <input type="radio"/> None
Book Appointment in	<input type="text" value="6"/> <input type="radio"/> Days <input type="radio"/> Weeks <input checked="" type="radio"/> Months <input type="radio"/> Book Appointment at a later date <input type="radio"/> Next Available
	And <input type="checkbox"/> Appointment to follow results
	<input type="checkbox"/> Overbook if required
Transport required	<input checked="" type="radio"/> No <input type="radio"/> Yes <input checked="" type="radio"/> Walking <input type="radio"/> Chair <input type="radio"/> Stretcher
Further Instructions	<input type="text"/>

Appendix 4: Minimum Data Set

Inter- Provider Transfer - Minimum Dataset for Tertiary Referrals

Referring Organisation:

Organisation name:	Royal Free London NHS Foundation Trust	Organisation code	RAL
Referring Clinician:		Clinician GMC code:	
Speciality:		Form Completed by:	
Contact Name:		Designation:	
Contact Phone:		Contact Email:	

Patient details: (fix addressograph or as stated in the referring letter if sending one)

Patient Title & Full Name:	Address:		
Date of birth:			
NHS Number:	Local Patient Identifier/MRN:		
Work Phone:	Mobile:		
Home phone:	Email:		

GP details: (as stated in the referring letter if this information is on the letter)

Name of GP:	GP practice code:
GP practice post code:	PCT code:

18 week information: (Referral to Treatment Information)

<p>Is the patient on an 18 week RTT pathway? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>(NB: all patients included except A&E, obstetrics, fracture clinic)</p> <p>If YES, is this referral part of an existing pathway or the start of a new pathway? EXISTING <input type="checkbox"/> NEW <input type="checkbox"/></p>		
<p>Pathway Status</p> <p>Is this referral the:</p> <ul style="list-style-type: none"> • Start of new pathway (New condition or change of treatment) <input type="checkbox"/> • Continuation of an active pathway (1st definitive treatment <u>not given</u>) <input type="checkbox"/> • Continuing treatment for a stopped pathway (1st Definitive <u>treatment given</u>) <input type="checkbox"/> • Active Monitoring <input type="checkbox"/> 		
<p>Is this referral for: Opinion only <input type="checkbox"/> Diagnostics Tests <input type="checkbox"/></p> <p style="padding-left: 40px;">Other <input type="checkbox"/></p>		
<p>Unique pathway identifier (where available):</p>		<p>Allocated by (Organisation Code):</p>
<p>Latest 18 week clock start date:</p>		<p>Date of decision to refer to tertiary hospital:</p>
<p>List all Organisations involved in the 18 week pathway: Royal Free London NHS Foundation Trust</p>		

Receiving organisation details:

<p>Hospital name:</p>	<p>Organisation code:</p>
<p>Receiving consultant:</p>	<p>Speciality:</p>

Date and time MDS sent:

Appendix 5: Exclusions from e-referrals

Paper referrals will only be accepted if excluded from the national paper switch off policy. Accepted exclusions include:

- Services for which GP referral is not required (such as accident and emergency services or urgent care/walk-in centre services/minor injuries units).
- Non-acute and non-consultant-led services such as community services, mental health and learning disability services, diagnostic, screening or pathology services.
- Referrals made by clinicians other than GPs such as other primary care professionals, dentists, optometrists or hospital consultants (including tertiary referrals).
- Referrals made by Out of Hours Service and Urgent Care Centre GPs.
- Referrals for Defence Medical Services patients based outside England, such as military personnel and dependents, associated civilians and others.
- Referrals from prison GPs
- Referrals from private GPs
- Referrals for Scottish or Welsh registered patients
- Referrals to same-day outpatient appointment such as termination of pregnancy services, obstetric services, and diagnostic or assessment services, (for example, referrals to deep vein thrombosis (DVT) clinics, amongst others).
- Referrals for follow up appointments

Appendix 6: Macmillan Leaflet on making cancer treatment decisions

<http://be.macmillan.org.uk/Downloads/CancerInformation/TestsAndTreatments/MAC12163Making-treatment-decisionsE03lowrespdf20160727.pdf>