Interim Management and Support

Elective Care Guide

Referral to Treatment Pathways:

A Guide for Managing Efficient Elective Care

Second edition (January 2014)

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1. Introduction

1.1. How the guide works and its intended audience

The guide is designed to walk you through the essential elements of a Referral to Treatment (RTT) pathway; from pre-referral advice and outpatients, all the way through diagnostics to patient admissions. The guide also covers a number of key areas which support the operational delivery of a good RTT pathway, including demand and capacity planning, elective access policies, performance management and reporting.

The guide is a collection of the advice and expertise of the NHS IMAS Elective Care Intensive Support Team (IST), which has been built up over the years through supporting various NHS organisations across the country delivering and sustaining low waiting times for treatment.

The intended audience for this document is primarily NHS staff who are involved in any aspect of RTT pathway management and who want to understand how best to manage or deliver RTT pathways. This will include staff within acute trusts, NHS Foundation Trusts, Area Teams (ATs) and Clinical Commissioning Groups (CCGs).

The guide is regularly updated, and all comments and ideas for inclusion in future versions, are welcome. This edition (January 2014) includes for the first time an RTT 'Drivers Tree' which has been developed jointly with Mckinsey Hospitals Institute and the NHS Trust Development Authority. The 'Drivers Tree' is designed for use by Trusts to help assess their position against the key drivers for good RTT performance and thereby to 'self diagnose' the issues that may be causing any remaining difficulties or challenges in regards to elective waiting times.

1.2 Understanding principles and rules: 18 weeks and cancer rules, maximising efficiency, productivity and experience.

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

- The individual patient rights (as per the NHS Constitution);
- The standards by which, individual providers and commissioners are held accountable by the Department of Health for delivering (as per the NHS Operating and NHS Performance Frameworks)

It is important to draw the distinction between the individual patient rights and the method by which the NHS assesses organisational performance. They are not the same.

Individual Patient rights under the NHS Constitution

For English Patients (from an individual patient perspective) the current maximum waiting times for elective care are set out in the NHS Constitution and the handbook to the NHS Constitution. This can be found at:

NHS Constitution 2013
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf

Handbook to the NHS Constitution 2013
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170649/Handbook_to_the_NHS_Constitution.pdf

The NHS Constitution sets out the following rights:

- 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;
- start your 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.

The handbook also lists the specific circumstances where the right will cease to apply and those services not covered by the right.

NHS assessment of performance – the Provider Standards

In addition to the individual patient rights as set out in the NHS Constitution (and its supporting handbook) there is a set of waiting time performance measures for which the NHS is held accountable for delivering by NHS England.

These measures are set out in the current NHS England document: Everyone Counts: Planning for Patients 2013/14. This can be found at:
http://www.england.nhs.uk/everyonecounts/

NHS Foundation Trusts

NHS Foundation Trusts are held accountable through Monitor via the NHS Foundation Trust (NHSFT) Compliance Framework. This can be found at:
http://www.monitor-nhsft.gov.uk/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/compliance-framework-

Rules and definitions

In order to ensure reported performance is consistent and comparable across providers, the measurement and reporting of waiting times is subject to a set of rules and definitions.

For 18 Week Referral to Treatment times these can be found at:
http://www.england.nhs.uk/statistics/rtt-waiting-times/rtt-guidance/

For Cancer services the guidance on cancer waiting times can be found at:
http://www.nwlcn.nhs.uk/Downloads/Cancer%20Intelligence/Going%20Forward%20on%20Cancer%20Waits%20A%20Guide%20Version%208.0.pdf

In some circumstances it is for the NHS locally to decide how these guidelines are applied to individual patients, pathways and specialties, based on clinical judgment and in consultation with other NHS staff, commissioners and, of course, patients. The guidance is designed to ensure that reported waiting times are a true reflection of patient experience.

When considering how to apply the rules locally to a particular pathway the key question is ‘does the local application of the rules accurately reflect the actual patient’s waiting time experience?’

2. Managing capacity and demand

2.1. Guiding principles

The successful delivery of any maximum waiting time standard (e.g. 18 Weeks) is predicated on the following factors:

- Patient pathways are capable of delivering a short wait, and clearly describe what should happen, in what order and when;
- A balanced position between demand and capacity;
- A maximum number of patients waiting that is consistent with the level of demand and key pathway milestones e.g., maximum time from referral to first out-patient appointment and decision to admit;
- Patients are treated in order by clinical priority; and then in the order they were added to the waiting list;
- Patients are actively managed against the pathway for their condition and the key milestones.

While all of these factors are important, a balanced position between demand and capacity is essential, as if demand exceeds capacity then the numbers of patients waiting will grow and waiting times will lengthen.

Of equal importance is the size of the waiting list. It is possible to calculate the maximum size a waiting list should be that is consistent with a particular waiting time for a given level of demand.

The most efficient way of understanding the dynamic between demand and capacity and to calculate maximum list sizes, is to use a modeling tool. There are many different modeling tools both commercial and in-house developed solutions and the model an organisation chooses to use is less important – the models are there to improve understanding and support discussions around how a service can predict demand and plan services accordingly.

Later in this section are details on how to access the models that the IST routinely use when working with client organisations to help them understand their particular service.

Issues such as appropriate levels of capacity to deal with variation in demand are explained within the models.

Dos & Don'ts

The following list of dos and don'ts is based on the practical experience gained by the IST of helping organisations develop and use demand and capacity models. They are designed to act as simple checklists to avoid the most common pitfalls.

Do:

- Involve clinicians from the start of the process.
- Adopt a logical and consistent approach to the process.
- Ensure that the demand and capacity planning process is *led* by the general/service managers and *involves* the information team, rather than the other way around.
- Agree the common data requests based on the inputs of the models to avoid multiple ad-hoc information requests.
- Decide what's in and what's out so that you compare like for like in terms of demand, capacity and what is on the waiting list(s).
- Document important information and decisions about the data and any assumptions you have used, especially when building models at sub-specialty or consultant level. It is recommended that you keep this information in a separate spreadsheet within the model.
- Sense check data with those closest to the operational challenges e.g., service managers should sense check data with booking staff. This is especially important when verifying core and additional capacity.
- Sense check for logical relationships between related data items e.g. whether the size of a waiting list at the beginning and end of the yearmakes sense when you look at how many patients were added and removed (for all reasons) over that same period?
- Review demand and capacity on a rolling basis - monitor trends in demand and revise capacity plans if required.
- Share plans and ensure all the key stakeholders, including commissioners, are signed up to, and understand, the plans.

Don't:

- Become a slave to the models - they are there to support conversations and improve understanding, not to replace them.

- Be concerned when the first run through/population of the model doesn't work perfectly. Some of the data items may not currently be commonly requested reports and may require refinement to get them right.
- When looking at current core capacity don't count over-bookings, ad-hoc or out-sourced activity.
- See demand and capacity planning as a one-off exercise. Models should be regularly reviewed particularly with regard to the anticipated level of demand. Some of the data items may have been based on an educated/informed guess rather than hard data.
- Forget that by their very nature, a modeled position will never exactly match reality. Even the most sophisticated model cannot predict the precise nature of the variables that were used to create the model scenario.

2.2. Information requirements

As stated above, service managers will need the help of information colleagues to pull together the various data items that will be required to complete the demand and capacity models. It is important therefore that both the operational management and information teams go through the models together to understand the various data inputs. The information team will need to be very clear as to exactly what is "in" and what is "out" when they are writing queries to extract the data. Experience shows that this can be an iterative process and it's quite normal not to get it right the first time.

Whilst models are subtly different, the list of data items might well include the following:

- 52 weeks of historical referral data.
- 52 weeks of historical decision to admit (DTA) / additions to the waiting list data.
- Removal other than treatment (ROTT) rates for both the first outpatient and admitted waiting list.
- First outpatient attendances for the last 12 months.
- First outpatient Do Not Attends (DNAs) for the last 12 months.
- First outpatient DNAs rebooked for the last 12 months.
- Admissions for the last 12 months.
- Cancelled admissions (if capacity was genuinely lost) for the last 12 months.
- Rebooked cancelled admissions for the last 12 months.
- The current sizes of the first outpatient and admitted waiting lists (both with and without dates).

- The waiting list sizes of the first outpatient and admitted waiting lists (both with and without dates) at the beginning and end of the 52 week referral / activity data collection period.
- The baseline core capacity to see first and follow-up outpatient attendances (taking account of clinics lost due to annual leave, study leave, bank holidays, on-call, etc.)
- The baseline core capacity to undertake surgical procedures (again factored down for the elements as described above).

Some of the data items (e.g. first outpatient ROTT rate, cancelled surgical admissions, where capacity was genuinely lost) are not common sets of routinely extracted data. Perhaps surprisingly, robust, clean referral data is often quite challenging for organisations to extract. Given that referrals are, for the vast majority of elective care pathways, the initial driver it is important that providers understand their demand data.

Agreeing (and testing) initial trawls and extraction of the common data items should standardise the requests made to the information team and avoid multiple ad hoc requests where the specification of the data items may vary based on an individual's understanding of what is required.

When working with clients to develop demand and capacity models, the IST often uses a set of simple comparisons to sense check the initial inputs into the model. Some of these are set out below:

- Compare number of referrals against the number of first out patients seen for last 12 months
- Compare number of additions to the waiting list against actual admissions
- Consider whether major differences in the above can be explained by changes in the first outpatient or admitted waiting lists
- Consider whether there is a logical explanation for high ROTT rates. For example:
  - high first outpatient waiting list ROTT driven by rejection of referrals that do not meet clinical thresholds (e.g. breast surgery for cosmetic reasons)
  - high admitted waiting list ROTT driven by patient drop-out at pre-assessment (e.g. degenerative spinal surgery).

2.3. Role of demand and capacity in supporting delivery

Some models include an option both to plan required dips in activity to meet the anticipated demand and also to record "actuals" as they occur. This is most helpful as it provides metrics against which the delivery of the plan can be measured and service areas be held accountable for their individual performance.

For example, if a modeled waiting list is not at a predicted size at a particular point in time, the base drivers can be reviewed to understand why this might be so. Given that the waiting list size will be principally dictated by the additions and the removals from it (i.e. activity) one should be able to determine whether the level of demand differs from that originally anticipated or the planned level of activity has not been delivered.

In reviewing demand and capacity dynamics, it is often the case that there is a shortfall in capacity that is adversely affecting waiting times. Shortfalls in capacity can be addressed through increasing the level of resource, making the current resource more productive, or a combination of the two.

There are many existing resources focused around increasing productivity and this paper does not aim to duplicate them. Colleagues however may find the following links offer help in signposting them to these resources:

http://www.steyn.org.uk/
http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_operating_theatre.html
http://www.improvement.nhs.uk/enhancedrecovery/

2.4. Getting help

Through its experience of working with NHS Trusts and commissioners, the IST has developed a series of demand and capacity models designed to help organisations achieve an appropriate balance between demand and capacity, and to ensure that waiting lists are of an appropriate size. These models can act as a helpful starting point

for organisations to better understand demand and plan capacity accordingly. The models are freely available via the NHS IMAS website using the following link: www.nhsimas.nhs.uk/ist

For those organisations who are challenged in their delivery of the maximum waiting time standards and/or who wish to receive external assurance around their demand and capacity planning processes, requests can be made, currently via the SHAs (please note this will change in the future), to receive support from the NHS IMAS Elective Care Intensive Support Team (IST).

Details of NHS IMAS and the IST are available through the same web link. NHS organisations can email the IST Director, Nigel Coomber on nigel.coomber@nhs.net

3. Operational Delivery

3.1. Pathways capable of delivering shorter waits

It is important for local health economies (LHEs) to take a pathway approach to managing RTT services. One of the benefits of introducing the 18 week RTT standard was that it helped organisations manage patients' care on a pathway basis and to remove hidden waits. This has ensured fewer patients wait over 18 weeks from GP referral for their treatment.

In particular it is recommended organisations establish a detailed and good understanding of pathways at a speciality level and not just at an aggregate level. This includes establishing where and when key milestones occur. For example; for a surgical speciality "X", first outpatient attendances should occur at week five of a RTT pathway or decisions to admit a patient on a current RTT pathway to occur at week 10. Whereas for a speciality like dermatology the first milestone might be set at 10 weeks, if most patients are treated in outpatients at this point.

Taking a pathway approach to managing RTT services brings the following benefits to NHS organisations: it helps manage to the RTT standards (at specialty level); it identifies any hidden waits; allows organisations to track patients correctly; identifies any specialty specific issues; and delivers more sustainable services.

NHS organisations must also consider the information flows to support the management of patients in a pathway approach as well as identifying what reporting tools will help identify bottlenecks in RTT pathways.

This section aims to explain how to operationally deliver the RTT standards.

3.2. Managing patients along their RTT and Cancer pathways

i. Pre-referral

RTT Patient Information

As detailed in section one above, NHS England; Everyone Counts: Planning for Patients 2013/14 sets out the NHS Constitution and a patient's right to commence treatment within 18 weeks of referral to a consultant led service. The NHS Constitution outlines 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 patients a range of suitable alternative providers where this is not possible. All outpatient letters will soon include information on the NHS Constitution and this right from 2013/14. Choose and Book now shows referrers and patients what the percentage likelihood is of being treated within 18 weeks for the selected specialty at each provider.

Access Policies and Patient's Responsibilities

Creating and updating LHE's access policies is covered in section 3.3.i of this guide. It is important that LHEs have an agreed access policy in place. The agreed versions must be shared with primary care colleagues and be made available to GPs electronically and signed off by commissioners. This will enable GPs to make patients aware of their rights to have treatment within 18 weeks of referral for RTT pathways as per the NHS Constitution. It also helps GPs outline to patients prior to referral the patient's responsibilities to attend appointments and how cancelling or not attending appointments can affect their right to have treatment within 18 weeks of referral. LHEs must ensure the appropriate mechanisms are in place locally to support this work.

Prior Approval Panels

Commissioners must have in place processes and the appropriate framework to assess any requests in a timely manner from GPs for treatment which require prior approval. The same priority and emphasis on reaching a decision promptly should be given by commissioners and providers for processing both referrals and for those patients who have already started an RTT pathway, but subsequently require prior approval before

being treated. Clock stops can only be made to a patient's RTT pathway when treatment occurs or a decision not to treat is made. No adjustments or clock stops can be made to a pathway whilst a panel or approval board assesses requests. Commissioners are therefore to hold approval panels in line with the 18 week timeframes for any patient referred for assessment who has already commenced an RTT pathway.

The Operating Framework for the NHS in England 2012/13 outlined that decisions on appropriate referrals should be made by clinicians in line with best clinical evidence. Commissioners should ensure all patients are seen on the basis of clinical need, which means there is no justification for the use of minimum waits (that one or more providers are required to comply with) or 'blanket bans' that do not take account of healthcare needs of individual patients.

Shared Decision Making and Other Tools

The Operating Framework for the NHS in England 2012/13 stated that the NHS should learn from and take advantage of successful initiatives and apply the learning to their own services and plans. These initiatives include pre-referral initiatives, tools such as patient decision aids, health investment packs, the Atlas of Variation and programme budgeting.

Information about shared decision making aids for patients can be found at: http://www.nhsdirect.nhs.uk/decisionaids

RTT Rules and Referral management services

The Department of Health's *Referral to treatment consultant-led waiting times - How to Measure* includes clear guidance on the rules relating to interface services/intermediate clinical assessment and treatment services, (ICATS), which can be accessed using the link below:
http://www.england.nhs.uk/statistics/rtt-waiting-times/rtt-guidance/

LHEs should review all such interface arrangements to ensure that the relevant processes and policies are in place to capture RTT pathways accurately. This includes agreeing if a service falls under the definition of an interface service. If it does, interface staff must have access to the relevant training to understand how RTT rules apply to patients referred in to the service. This includes providing the staff with training and scenarios on clock starts and stops.

The clinical assessment and treatment services (CATS) checklist sets out a series of attributes or processes identified as important in the creation or maintenance of a

successful CATS service. LHEs should consult the checklist either to assess existing services or as a guide for establishing CATS.

Referral Management Centres (RMCs)

A referral management or assessment service is defined as a service that does not provide treatment, but accepts GP (or other) referrals and may provide advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may not, physically see or assess the patient. Referrals to referral management or assessment services should also start an 18 week RTT clock.

A number of LHEs have implemented referral management centres to help with the management or referrals in to secondary care. It is important that RMCs do not affect the right of patients to commence consultant-led treatment within 18 weeks of referral.

	Good Practice	***Comments***
1.	Commissioners and operational managers must ensure the RMC works to clear turnaround times for referrals to be triaged or vetted upon receipt.	This will ensure referrals are processed in a timely manner and patients care is not delayed unnecessarily. These turnaround times should be performance managed regularly by the commissioners.
2.	LHEs should undertake demand and capacity analysis to ensure there is enough capacity within the RMC to manage referrals.	This will ensure during peak periods of demand referrals are still processed within the agreed turnaround times and the patient's care is not delayed.
3.	LHEs should ensure the relevant compliant processes are in place to provide key information to onward referring providers, especially concerning the patient's clock start date.	Many RMCs use inter-provider transfer forms to ensure the correct patient details and clock start dates are recorded accurately and forwarded.
4.	LHEs should assess the mechanisms in place for using Choose & Book in RMCs and ensure the correct start dates are captured.	For Choose & Book patients who are referred to secondary care via an RMC, there may be two UBRNs (Unique Booking Reference Numbers) associated with the same pathway. When a second UBRN is created along the same RTT period this will be linked

	Good Practice	Comments
		with the first UBRN and the date of conversion of the first UBRN will be the date of the RTT clock start.
5.	RMCs should provide regular training to staff on RTT rules.	This will help staff understand their role and responsibility with managing patients' pathways within 18 weeks for referral to treatment for consultant led services.

ii. Outpatients: scheduling, booking, templates, validation

These guidelines aim to support teams in the delivery of effective and efficient outpatient services. The individual sections focus on a specific part of the outpatient operational journey and indicates practices that are considered either as 'best' or 'good' practice. Appropriate allocation of roles and responsibilities are also outlined where applicable.

Receipt of referral - central point of receipt

On an 18 Week RTT pathway, the clock starts at the point of receipt; therefore it is of the upmost importance there is no delay in the processing of the referral once it has been received within the organisation. Choose and Book should be encouraged as the primary method of referral and all Providers should have all routine/urgent elective and suspected cancer 2WW services published on Choose and Book or have action plans with clearly defined timescales in place to implement this. For Choose and Book referrals the 18 week RTT pathway starts on the date the (first) Unique Booking Reference Number (UBRN) is converted, i.e. the appointment is booked. For patients referred and booked through Choose and Book many of the steps detailed in the following sections will have been automatically completed;

- Patients will be booked into an appropriate appointment, according to the priority of the referral
- Patients will be registered on the provider's patient administration system (PAS).
- The referral information will be on a Choose and Book worklist for the relevant clinician/team to review as soon as attached by the referrer.

Best practice guidelines for the management of Choose and Book within secondary care can be found here: http://www.chooseandbook.nhs.uk/staff

Paper referrals

Also refer to Section iv Diagnostics

A full electronic referral process is a more secure and efficient way of managing outpatient referrals and is considered best practice. All organisations still receiving paper referrals or working to paper-based systems should be actively working towards implementing electronic referral management. (See section above relating to Choose and Book).

In organisations where paper referrals are still received, good practice suggests that organisations should implement robust processes so that referrals are sent directly by the referrer to a single point of receipt within the organisation. This has three key benefits:

1. It limits the risk of referrals being received within individual offices and departments which do not have formalised processes in place to manage the referral process, thus potentially delaying the first appointment.
2. It reduces the number of duplicate referrals the Provider receives and registers on its PAS.
3. It eliminates unnecessary 'hand-offs' and 'transport' of referrals.

Organisations will need to ensure that they have a clear communications strategy to inform GPs of the contact details for this single point of receipt and that non-compliance is escalated and vigorously addressed with the relevant referrer.

Organisations will need to make a risk-assessed judgement on whether the single point of receipt for referral types such as suspected cancer referrals and other rapid access referrals are managed by the same team. At the very least, there must be a process to identify these urgent referrals quickly and process them in timely manner. If these referrals are not going to be sent to a single point of access, the organisation must ensure the appropriate governance structures are put in place to manage referrals in a safe and timely manner.

Central administration teams

One good practice approach to tightening up the referral process is the implementation of a central administration team that has a remit to manage referrals as they enter an organisation, through to the booking of first outpatient appointment. Some central teams will also be responsible for the booking of diagnostic appointments such as endoscopy.

Staff with a responsibility for the referral management process, whether as part of a devolved structure or working in a central team, should receive appropriate mandatory training on a regular basis in the following areas:

- patient administration system (PAS) referral registration and appointment booking functions, including processes relating to Did not Attends (DNAs) and cancellations, and discharge processes;
- choose and book;
- elective access policy;
- 18 Weeks rules; and
- cancer waiting times rules.

Registration of referrals

Also refer to Section iv Diagnostics

All referrals should be registered on the organisation's PAS. Dependant on the type of referral, it may also need to be registered on a separate database (e.g. suspected cancer referrals will need to be registered on the organisation's cancer waiting times database). Organisations should set clear turnaround timescales for receipt of referral to registration on PAS and other systems. Good practice would suggest a maximum 24 hour timeframe for this task.

Pre-registration checks - the minimum dataset

Also refer to Section iv Diagnostics

Organisations should clarify the expected minimum data that is required for a referral to be valid. This minimum dataset should be agreed with the LHE and form part of the commissioner's contract with the provider.

It is common practice for two week wait (2WW) suspected referrals to be sent using a standard referral proforma to ensure that the referral contains the minimum required information. Organisations should consider implementing a standard referral proforma for routine referrals (see appendix 5 for an example of a GP booking proforma).

Regardless of the format of the referral (whether proforma or traditional letter), it is considered best practice that all referrals should contain a minimum dataset (MDS). An example of an MDS is set out in Appendix one.

Organisations should have a clear process in place to manage referrals which do not contain the minimum required level of information so as to not unfairly disadvantage the patient.

Prioritisation and triage of referrals

For 2WW suspected cancer referrals and 2WW breast symptomatic referrals there should be no prioritisation process as all appointments should take place within 14 days of the date of receipt of the referral. However, for non-cancer referrals the process to determine the urgency of the referral should be carried out by a member of the clinical team and the organisation should set timescales for this to be completed within for example, 24 hours of registration.

For some specialties/tumour sites such as lower GI and upper GI where a patient may go 'straight to test' in endoscopy, organisations should encourage the referring GP to provide specific patient status information. This referral information will help feed local protocols for determining which is the most appropriate test or clinic for the referral.

Booking of appointments

Also refer to section iv Diagnostics

Appointments should be booked correctly, quickly and efficiently every time. Organisations should adopt processes which are patient focused and geared towards offering the patient a choice of appointment in a set period. Referrals should be booked in clinical priority and then chronological order.

Good practice suggests that a provider should negotiate the first outpatient appointment with the patient. In some organisations, a 'contact letter' is sent to the patient inviting them to telephone the hospital within a set period to agree an appointment. Some organisations have gone even further to telephone the patient directly to arrange the appointment rather than relying on the patient making contact, and at least three attempts are made to contact the patient at different times of the day over a set period. It is important that there is the facility for the patient to contact the organisation and/or for staff to be available to contact the patient at a time when the patient is likely to be available (i.e. 8.00-9.00am or after 5.00pm).

Fixed appointments (non-negotiated appointments) should only be sent to the patient after a reasonable attempt is made to contact the patient. Organisations should implement a policy and "script" to support staff to leave a clear and consistent message on patients' landlines and mobile voicemails where necessary.

An appointment confirmation letter should be sent to the patient. The letter must be clear and informative and should include a point of contact and telephone number to call if the patient has any queries. The letter should explain any consequences of not attending, arriving late to the appointment, or cancelling their appointment. Additional information relating to the clinic or tests the patient will undergo, as well as transport arrangements should be included as appropriate. For services on Choose and Book this information should be clearly described in the Instructions section of the Directory of Services template.

Organisations should put processes in place to monitor the various elements of this process to ensure that:

- patients are offered a choice of appointment;
- every effort is made to negotiate the appointment with the patient rather than sending a 'fixed' appointment;
- patients are booked in priority and chronological order; and
- patients are booked according to their 18 RTT, Cancer 2WW and diagnostics six week wait

Outpatient clinic template

Ensuring that an organisation has sufficient outpatient capacity to meet demand is not just about creating new capacity, but also about utilising current capacity better – i.e. ensuring no appointment slots are wasted, DNAs are minimised, and new-to-follow-up ratios are reduced where appropriate. It is essential that clinics reflect reality and are structured to maximum benefit. Accurate templates which allow all theoretical activity to be included make the operational management more effective and the service development process more informed.

Organisations should adhere to some key principles when reviewing clinic templates:

- There should be a regular review of clinic templates across all services within a provider (at least on an annual basis to coincide with capacity and demand planning for the year ahead).
- There should be an organisational approach to clinic durations and sessions.
- The start and finish time of the clinic should reflect the actual time the clinician is expected to be in the clinic.
- The named consultant should be involved in any discussions around changing clinic templates; other departments, such as the outpatient nursing team, phlebotomy,

radiology and other diagnostic teams should be consulted in relation to resource availability.

Clinic outcome forms

To allow RTT measurement, the RTT status should be recorded at each stage on the patient journey by capturing information about what happened during each event. Clinic outcome forms are an essential tool to help capture decisions that determine a patient's progress along their RTT pathway.

The format of the clinic outcome form varies but it is important to record detail on the outcome of the outpatient attendance in terms of what had actually happened (e.g. treatment in outpatients) and any intended next step on the patient pathway. This should be completed accurately and in a timely manner (immediately at the end of the patient's attendance).

Click on the link for the good practice document from the Department of Health: Referral to treatment consultant-led waiting times - How to Measure" DH, Jan 2012:
http://www.england.nhs.uk/statistics/rtt-waiting-times/rtt-guidance/

Consultant to consultant referrals

Providers should be fully aware of their commissioner-agreed policy regarding consultant-to-consultant referrals. Internally, there should be locally agreed processes in place to manage internal referrals from one consultant to another.

The RTT rules state:

If in the case of a referral being accepted internally from one team to another for the same condition – the RTT clock will continue to tick. The patient should not be added to the end of the waiting list. If the referral is for a new condition – a new RTT clock will start.

In the case of the latter scenario, where a referral is made to another team for a different condition, a decision should be made on whether a clock stop should be made in relation to the original referral, or whether the patient is actually on two RTT pathways and the original clock should continue to tick.

Appropriate communication should be in place to inform the patient's GP that the patient has been referred to another team.

Inter-provider transfers

A locally agreed policy for the management of inter-provider transfers should be in place. As with all other referrals, those referrals from other providers should also be received at a central point within the organisation. A minimum referral data set should be agreed for the LHE. For example, clock start date, referral originating provider, and this should be communicated via the commissioners to all relevant providers. In some case with inter-provider transfers the RTT clock continues to tick upon referral to another organisation, so it is important this information is communicated promptly and accurately.

Whilst there are no recognised national breach sharing arrangements between providers in relation to 18 Weeks RTT pathways, there is an expectation that providers will work together to develop 18 Week compliant inter-provider pathways.

Providers should be aware of particular pathways where it is likely that patients will be referred on to other organisations for diagnostics or treatment and appropriate pathway milestone monitoring should be in place here. Additionally, there should be clear and timely communication channels between providers to share information relating to the patient's RTT status and progress along the pathway e.g., clock stops.

Commissioners have a key role to play in performance managing organisations where there is continuous late referral (beyond agreeing milestone timescales). For example, via the relevant contracts process, Commissioning for Quality and Innovation CQUINS, indicators.

Management of Did not Attends (DNAs)

Also refer to section on Developing a local Elective Access Policy.

DNAs are a very costly waste of resource within the NHS and so it is important for providers to have a focused plan of action to proactively manage them. As a minimum, organisations should be monitoring data such as DNA rates by specialty per month, and making local decisions on what is an acceptable DNA rate for the organisation or specialty to achieve.

Providers may consider including a leaflet confirming their DNA policy with the booking letter.

It is good practice to ask the patient to write down the appointment details which helps commit to memory. If a patient does not attend, no further appointment need be offered and the request should be returned to the referrer, but *only* if the organisation can demonstrate the appointment was clearly communicated and agreed with the patient with

appropriate notice. However, vulnerable patient groups, urgent and suspected cancer patients may be exempt from this policy according to the local agreement. It is good practice when rebooking, for staff to agree and directly book the new appointment with the patient at the time of contact. It is also good practice to advise the referrer of a DNA if a patient is in a vulnerable group, an urgent referral or has suspected cancer. Providers must ensure there are local policies in place to deal with DNAs and patient cancellations, which reflect the spirit of 18 weeks and RTT but are also in line with the organisation's access policy.

See website for tools on how to manage DNAs:
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/dnas_-_reducing_did_not_attends.html

Organisations may also wish to benchmark DNA performance against other organisations (see:www.nhscomparators.nhs.uk).

Patient cancellations and re-books

Also refer to section on Developing a local Elective Access Policy

A patient cancellation may be an appointment cancelled by the patient or by the GP on behalf of the patient. A patient cancellation is a valid action therefore it is important there is a clearly agreed list of criteria setting out when it is appropriate to reschedule the appointment (this should be actioned within two weeks) and when it is appropriate to discharge a patient from the RTT pathway following one or several cancellations.

If a patient is discharged following one or several patient cancellations and they are subsequently re-referred to the service, a new patient pathway and RTT clock will start.

Providers should monitor patient cancellations, specifically patients on an RTT pathway, with more than one cancellation.

Hospital cancellations

Also refer to section on Developing a local Elective Access Policy.

The cancellation of patients' appointments by the hospital is very poor practice which causes inconvenience to the patient and reduces the efficiency of the service. Cancellations of patients' appointments by the provider should be a rare occurrence that should only be authorised where no other options to cover the clinic are available or appropriate.

Providers should adhere to the following principles when developing local clinic/appointment cancellation policies:

- implementing policies encouraging clinicians to book annual leave requests for the year ahead;
- a minimum cancellation timescale in place for requests to cancel clinics e.g., minimum six weeks;
- limiting "acceptable" clinic cancellation reasons to sickness, immediate family emergency, etc.; and
- implementing "fire-break" clinics at six to eight week intervals to manage unforeseen circumstances. 'Fire break' clinics are clinics which are left empty in case a fully booked clinic needs to be cancelled and rearranged due to unforeseen reasons. The patients of the cancelled clinic are then moved to the fire break clinic, thus minimising the amount of rebooking/administrative work required.

iii. Inpatient: scheduling/planned patients, pausing, booking, theatres

Booking of surgical admissions

The efficient booking of surgical patients underpins delivery of 18 weeks pathways. Below is a suggested list of tasks relating to the management of the admitted patient tracking list (PTL) and admissions processes that staff should be aware of and understand their role in undertaking, to ensure patients are treated within 18 weeks of referral.

	Good practice	*Comments*	*What does good look like?*
1.	**Operational managers must ensure that To Come In (TCI) cards are completed for all decision to admit (DTA) (preferably after pre-assessment) and agree a time frame for entering onto PAS, (for example 24 hours)**	This will ensure that all the correct details including the type of operation, patient's details, any surgical kit requests and comorbidities are recorded. It will also ensure the admitted PTL is kept up-to-date.	No patient waiting more than 24 hours to be placed on a waiting list for surgery. Organisations using electronic booking systems to reduce duplication of efforts and errors
2.	**General managers must check that**	Validated lists with general managers and where	No patient having a social pause applied to

	Good practice	*Comments*	*What does good look like?*
	patients are booked in clinical priority and then chronological date order according to the admitted PTL (and that patients are being given reasonable notice (three weeks) with up-to-date operating and anaesthetic timings	applicable surgeons on case mix and operating times.	an admitted pathway between weeks nought to three from decision to admit and all patients booked in date order.
3.	**Timely, clinically led review of prospective lists**	This should be done looking at theatre lists i.e. three to four weeks in advance to ensure lists are full and will not over run and should be led by a lead clinician who has the experience and authority to increase a list where possible.	A reduction over time of theatre lists that overrun and improved theatre list productivity.
4.	**General managers should confirm with each specialty the internal milestone target from referral to DTA to admission, which is in line with an overall 18 week RTT pathway.**	Setting speciality level internal milestones from DTA to admission is seen as good practice in managing overall 18 week pathways. It is important to do this at speciality level because each speciality (or even sub-speciality) will have different demands on the admitted part of the RTT pathway.	Each speciality has clear internal milestones which are RTT compliant. Early warning and escalation systems in place to detect deviations from the speciality specific milestones.
5.	**Good practice would suggest that the organisation telephones the patient**	Rather than relying on the patient making contact it is more efficient for the provider to make a number of	Patients are contacted by admissions staff over the phone to be offered a choice of dates for

	Good practice	*Comments*	*What does good look like?*
	directly to offer patients a choice of two dates with three weeks reasonable notice.	attempts to contact the patient at different times of the day.	surgery.
6.	**Admission staff must escalate if they do not have sufficient capacity to book patients within the target (and with reasonable notice – three weeks). Providers should have an agreed escalation process in place for admissions staff to use to bring such issues to the attention of general managers and executive leads.**	This helps to manage capacity issues prospectively and prevent patients waiting longer than 18 weeks for their treatment.	Efficient and responsive systems in place to alert booking staff to vacant theatre lists in order to resolve capacity issues. Clear escalation policies in place with details of accountable officers and timelines to approach when capacity issues are identified.
7.	**Operational managers should meet with consultants to share their admitted PTL (those patients dated and undated)**	This will help communicate progress against the national operational standards and make the individual consultants aware of their waiting list sizes.	Consultants have an accurate understanding of the size of their admitted PTLs and case mix on a bi-weekly basis.
8.	**Operational managers should implement processes for double-checking TCI lists.**	This helps pick up errors or issues such as patients who are listed as coming in the next day but who failed to attend pre-operative assessment This list should be checked on paper and on the PAS.	Electronic booking systems in place which automatically flag patients with an imminent TCI who failed pre-operative assessments or who have not confirmed their TCI.

	Good practice	*Comments*	*What does good look like?*
9.	**A suggested 24 hour cut off to creating final theatre lists should be agreed, with a clear escalation process and details of who is permitted to make any changes.**	This avoids last minute reorganisation that lead to lists over running or running late.	Booking systems which automatically freeze theatre lists 24 hours before the day with good control systems in place to manage any changes.
10.	**Admissions staff should regularly validate patients prior to offering dates for surgery and just before the TCI date (suggested five to seven days before) to ensure the patient is fit, willing and able for their admission.**	This will help to pick up any issues (social or medical) which may prevent a DNA or cancellation on the day of surgery and a loss in theatre capacity. Good practice is to phone patients in the evenings five to seven days prior to admission. All conversations with the patient should be recorded on PAS in the waiting list entry. It is also good practice to check any medical issues found through validation with clinical staff for any actions.	Low DNA rates or cancellations on the day of surgery for medical or social reasons.
11.	**All conversations with patients should be recorded clearly with dates and names in the waiting list entry on PAS.**	This includes conversations around social pauses and dates offered (earliest reasonable offer dates).	Waiting list systems with detailed accurate audit trails of contact with patients.
12.	**Staggered admission times should be used, with sufficient staff to admit patients. It is seen as good practice to have a central admissions team to**	This helps prevent delays on the day of surgery and provides a better patient experience.	Low waiting times for patients between admission time and operation start time. (less than 2.5 hours average).

	Good practice	*Comments*	*What does good look like?*
	manage all inpatient/day case waiting lists.		
13.	**Where possible and clinically appropriate look to pool surgical lists.**	This helps to offer patients more choice, equalise waiting lists for surgery and prevents patients waiting more than 18 weeks from referral to treatment.	Over 50 per cent pooled waiting lists across surgery.
14.	**Pre-operative assessment should take place on the day of listing to identify any medical problems.**	This helps to ensure patients are fit for surgery upon listing and picks up any comorbidities which may require treating before surgery can take place.	Low cancellation rates due to medical issues on the day of surgery.
15.	**Monthly reports should be run by admissions offices and checked to pick up those patients who were admitted incorrectly to the hospital for another condition or as an emergency but where the to-come-in (TCI) waiting list entry was used on PAS incorrectly.**	This helps pick up RTT pathways that clerks need to amend and also picks up patients not coming in for their surgery. Some patients disappear from booking lists and PTLs this way.	A reduction in patients admitted incorrectly using the waiting list entry each month.
16.	**Each business unit or admissions offices must confirm process for dealing with cancellations by hospital.**	There are clear national standards for rebooking patients whose operations have been cancelled on or after the day of admission, for non-clinical reasons within 28 days. It is important the admissions office can demonstrate their processes	All patients who are cancelled on the day to be re-dated within 28 days and to leave the hospital with a new date for their surgery – or for the treatment to be funded at the time and hospital of the patient's

	Good practice	*Comments*	*What does good look like?*
		meet the requirements for this standard.	choice.
17.	**Agree KPIs for theatre productivity. For example downtime between surgical cases.**	These can be identified and agreed from the Productive Operating Theatre documentation from the NHS Improving Quality.	Regular review of KPIs with corrective actions devised.
18.	**Organisations should aim to outline local timescales for periodic checks of theatre lists.**	This approach is seen as good practice to ensure theatre lists are fully booked and it helps to reduce cancellations on the day. Providers may want to change the timescales.	Six weeks check patients are booked, four weeks finalised lists, two weeks ensure equipment ordered.
19.	**General managers must ensure that there are local policies in place to deal with DNAs and patient cancellations of operations, which reflect the spirit of 18 weeks and RTT but are also in line with the Provider's access policy.**	This should include that patients are given reasonable notice for offers of admission (three weeks) and clearly outlining how vulnerable patients and the clinical needs of the patients will be considered before discharging patients following a DNA or cancellation.	In admission offices, visible and well documented policies for booking staff to use. Policies reflect up-to-date RTT national guidance and are assessed regularly.
20.	**General managers are advised to have in place audit arrangements to ensure good practice admissions processes are being followed.**	This helps to pick up any training issues as well as keeping the admissions processes up-to-date. For example outline timescales for dating patients and implementing escalation processes when there is no capacity to date patients within 18 weeks.	Yearly audit arrangements in place and carried out.

	Good practice	*Comments*	*What does good look like?*
21.	**General managers should ensure there are clear and detailed standard operating procedures in place and readily available to staff.**	This will help with cover arrangements for admissions staff, ensure staff are working to agreed practices and in line with the national RTT rules. It will also make it easier to train new admissions staff.	Clear and detailed standard operating policies with clear timelines and contact numbers.
22.	**General managers should ensure there are regular and detailed training programmes in place for admissions staff to support the use of any standard operating procedures.**		Six month training programmes in place.

Planned Waiting Lists

The Data Dictionary definition of "Planned Patients" is:

A patient admitted, having been given a date or approximate date at the time that the DECISION TO ADMIT was made. This is usually part of a planned sequence of clinical care determined mainly on clinical criteria (e.g. check cystoscopy).

There should be no patients on a planned waiting list for social reasons - RTT rules should be applied to these patients.

The Department of Health and NHS England have set out guidance and a policy for patients who require appointments for assessment, review and/or treatment – use of planned (pending or review) lists. This can be accessed via the link below:

http://transparency.dh.gov.uk/files/2012/06/Planned-Patients-Guidance.doc

It states:*"Patients should only be added to a planned list where clinically they need to wait for a period of time. This includes planned diagnostic tests or treatments or a series of procedures carried out as part of a treatment plan - which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Patients*

on planned lists should be booked in for an appointment at the clinically appropriate time and they should not have to wait a further period after this time has elapsed. For example, a patient due to have a re-test in six months time should be booked in around six months later and they should not get to six months, then have to wait again for non-clinical reasons. This is not an acceptable use of a planned list".

This requirement applies regardless of where the appointment / treatment takes place i.e. outpatients, diagnostics or admitted patients. It also applies where there is a subcontracting relationship or where the activity takes place in the community or primary care interface services.

Providers should be able to provide robust and detailed evidence of compliance to this requirement. The IST recommends the following are in place, as a minimum:

- specific and accurate policies / procedures detailed in the provider and LHE access policy, regarding the management of planned lists;
- each specialty asked to define the types of patients / treatments that they may wish to record as planned and by which process they can check that the definition is being used appropriately;
- quantify the number of planned patients by activity type, specialty and number of weeks wait;
- a process in place to review all patients prior to their admit-by-date to ensure that there is a clinical reason only for being classified as planned and that the patient still requires the procedure;
- every patient on the planned list to have a 'treat by' date, i.e. a date on which they can expect to be offered the attendance / treatment / diagnostic test; and
- regular audit of the planned list to check that only patients / procedures identified under the second bullet point are included, and that there are no patients still waiting on a planned list that are past their 'treat by' date.

Note: Patients who wait significantly beyond their planned by date should be returned to the active waiting list with a new clock start. It is a matter of clinical judgment as to how long this period should be and should be judged on a case by case basis.

Clock Pauses

The national RTT rules state the following in relation to patient pauses to RTT pathways:

A clock may be paused <u>only</u> where a decision to admit has been made, and the patient has declined at least two reasonable appointment offers for admission. The clock is paused for the duration of the time between the earliest reasonable

appointment offer date (EROD) and the date from which the patient makes themselves available again for admission.

The full rules and details on clock pauses can be found in the "How to Measure" Department of Health document on page 17 of this guide and separate guidance on the application of patient initiated pauses can be found using the following link:

http://media.dh.gov.uk/network/261/files/2012/06/Patient-initiated-clock-pauses-guidance-Oct-2012.pdf

Providers should ensure adequate processes are in place to support the correct application of patient pauses to RTT pathways. The IST recommends the following is in place as a minimum:

- specific and accurate policies / procedures detailed in the Provider and local Health Economy access policy, regarding the management of clock pauses;
- a process is in place to review and audit all patients whose pathways are currently paused to ensure the current national guidance and local application of the rules is applied correctly;
- every patient on the planned list has 'treat by' date, i.e. a date on which they can expect to be offered the attendance / treatment / diagnostic test;
- ensure the provider has processes to identify any adjusted pathways that are less than three weeks in length. It is not possible to apply clock pauses to patient pathways where the patient has waited between nought to three weeks from decision to admit. This is because RTT clocks can be paused from the earliest reasonable offer date (EROD) until the date the patient is available for admission. National rules state that for an offer to be reasonable the patient must have at least three weeks' notice. Therefore, even if the decision to admit were made on day nought of a patient's pathway and the patient starts treatment promptly after becoming available for admission, the shortest possible admitted pathway with clock pause adjustments applied would be one of three weeks' length; and
- a process to identify unusually high levels of clock pauses by specialty – this suggests both a potential misuse of adjustments to RTT pathways and an inaccurate application of the national RTT rules.

iv. Diagnostics: endoscopy, imaging

Efficient booking of patients referred for diagnostics underpins delivery of 18 week and cancer pathways. Below is a suggested list of tasks relating to the management of diagnostic processes, and staff should be aware of and understand their role in ensuring patients receive timely access to diagnostics. Useful Resources:

http://transparency.dh.gov.uk/2012/07/05/diagnostics-information/

Transforming your Radiology Service, Focus on: Improving Booking Processes:
http://www.institute.nhs.uk/news/quality_and_value/launch_of_transforming_your_radiology_services_kit%3a__focus_on_reporting_process.html

Rapid Review of Endoscopy Services
http://www.improvement.nhs.uk/documents/endoscopyreview.pdf#search="endoscopy"

http://www.improvement.nhs.uk/diagnostics/

Paper referrals

Also refer to section ii Outpatients

Diagnostic departments should actively encourage the use of standard request forms (see Appendix two) to provide clarity of required information and to identify incomplete referrals. Referrer self-vetting criteria should be confirmed to minimise inappropriate referrals. Sufficient guidelines should be provided to enable administrative staff to book diagnostics reducing the need for clinical input in this process. This should be supported by a clear escalation process which clarifies the process for staff needing to raise queries regarding specific diagnostic requirements, or who need to escalate capacity issues.

In addition to the training described in the Outpatients section above, administration teams will also require appropriate mandatory training on the six week diagnostic rules, and planned patient scheduling.

Advantages of Electronic Referrals

Organisations should aim to transfer to electronic referrals as they enable single point electronic capture of information and transfer to the diagnostic information system, providing:

- reduced clinical risk due to accurate demographics and legible clinical details;
- the minimum data is provided on the referral before submission;
- accurate monitoring of request date for 18 week returns;
- instant availability of request in the diagnostic department;
- reduced administrative time, eliminating referral registration;
- reduced delays contributing to shortened inpatient stay and achieving 18 week targets; and
- reduced paper and storage costs.

Registration of referrals

Also refer to Section ii Outpatients

All referrals should be registered on the organisation's diagnostic information system, and providers should set clear turnaround timescales for receipt of referral to registration. Same day registration is considered good practice as it facilitates vetting of referrals within 24 hours of receipt. This also ensures diagnostic modalities have visibility of true waiting list size. Hard copy referrals should be registered prior to forwarding to clinical staff for vetting and a scanned copy of the referral should be retained.

The use of electronic referral processes facilitates the automatic registration of referrals and the ability to direct to vetting with limited administrative input.

Pre-registration checks - the minimum dataset

Organisations should clarify the expected minimum data that is required for a referral to be valid, and consider implementing a standard referral proforma for routine referrals. Regardless of the format of the referral (whether proforma or traditional letter), it is considered best practice that all referrals should contain a minimum dataset (see Appendix one) and should be accurate and legible.

Organisations should have a clear process in place to manage incomplete referrals so as to not unfairly disadvantage the patient. Providers should have a robust system in place for monitoring referral demand on an on-going basis, by modality, to ensure capacity is sufficient to meet demand.

Vetting of referrals

Timely, clinically-led vetting of referrals will ensure referrals are appropriate, assist in identifying whether an alternative diagnostic modality is more suitable for confirming diagnosis, and ensures Ionising Radiation (Medical Exposure) Regulations (IRMER) requirements (where applicable) are adhered to.

The vetting can be carried out by an appropriately trained pool of staff[1] which increases the vetting capacity and minimises the delay in vetting referrals. The staff should follow clear protocols and be subject to on-going monitoring and audit.

Please refer to Appendix Three for good practice principles.

[1] Which can include nurses, radiographers, technologists, technicians, advanced practitioners and administrative staff

Electronic Vetting of Referrals

Diagnostic information systems can provide functionality to enable electronic vetting of referrals reducing the need to print referrals for review by the clinical team. Electronic vetting also enables the referral to be available for booking immediately once it has been vetted, rather than waiting for the paper copy to be returned to the bookings team for review. Referrals should be vetted in order of urgency and date of receipt to ensure there are no undue delays. Diagnostic information systems can provide functionality to enable electronic work lists to support workload prioritisation and to reduce the variation in referral vetting times between patients.

Scanning Protocols

Providers should ensure modalities have standardised scanning protocols agreed by the diagnostic department. The booking team should be provided with clear principle-based guidelines for the booking of diagnostic examinations including for each examination:

- diagnostic procedures;
- specific equipment requirements (i.e. differentiated by physical equipment limitations);
- the length of time slot required;
- requirement for delayed imaging (i.e. Nuclear Medicine);
- who can perform the examination and when;
- what preparation is required;
- special patient instructions; and
- if there is a requirement for direct consultant participation, based on their clinical specialisation.

In addition, timeslots for procedures should be minimised with procedures falling into one of three or less time slots to facilitate capacity and demand planning. For example, 10, 20 and 30 minutes.

Booking of appointments

Also refer to Section ii Outpatients

Appointments should be booked correctly, quickly and efficiently every time. Organisations should adopt patient-focused processes geared towards offering the patient a choice of appointments in a set period. Referrals should be booked in clinical priority and chronological order across all modalities. There should be visibility of both the 18 week RTT status and the six week diagnostic target and patients scheduled accordingly. Administrative staff should book patients under standard written guidance from the relevant clinician, such as senior radiographers, radiologists and technologists.

It is essential to have administrative cross-cover to ensure all modalities are booked to minimise the impact of absenteeism and leave.

Confirming Appointments

Also refer to Section ii Outpatients

In line with good practice, providers should facilitate direct booking of diagnostics via an electronic booking system (i.e. Choose and Book) or by enabling patients to contact the department for an appointment following their outpatient attendance.

A diagnostic Patient Tracking List (PTL) will ensure patients are prioritised appropriately.

Patient Preparation

Bookings staff should ensure patients receive any guidelines or instructions relevant to their diagnostic prior to their appointment, for example, fasting instructions. They should also ensure patients have contact details of the department should they wish to seek further clarification or information on their procedure. A member of the clinical team should confirm if the patient requires more extensive preparation. Pre-assessment may be required for certain procedures for example, interventional radiology and endoscopy. Appropriate preparation of the patient prior to their appointment will minimise the likelihood of the cancellations on the day and the appointment having to be rescheduled.

Providers should ensure removal of paper diaries where an electronic schedule is available.

Scanner Utilisation and Scheduling

Providers should ensure that they have in place appropriate capacity to meet the demand and that the capacity is used effectively so that, for example, DNAs are minimised and appointment slots not wasted. Providers should therefore:

- minimise or eliminate carve out of slots;
- ensure booking requirements are based on key criteria (refer to booking section above);
- confirm release timeframes where the equipment will be released for booking other procedures if the equipment time is not fully utilised;
- have in place a system of on-going monitoring of equipment to ensure effective utilisation; and
- have a forward plan of scheduled service and quality assurance activities to minimise the effect these activities have on the capacity required to meet service demand.

Also see section ii Outpatients for general good practice guidance in establishing booking principles.

The capacity within the schedule should be sufficiently flexible to meet variations in demand such as emergencies, inpatients, urgent and planned patients. Extended day and weekend working will increase capacity to meet this variation as well as address any temporary backlogs in individual modalities.

Reporting

The National Imaging Board guidance states that investigations will be seen and accurately reported within a short a time as possible. It also stresses the importance of providing high quality and effective patient-centred imaging services to support the whole patient pathway through the reporting of images in a timely manner.

The guidelines set the following expectations in reporting standards:

- Urgent cases: Immediate (within 30 minutes)
- Inpatient and A&E: Same working day
- All other cases: By next working day

The guidance recognises that exceptions will occur where multi-disciplinary team discussions or specialist opinion is required and therefore stated that a tolerance of 90 per cent achievement is reasonable. The National Imaging Board best practice guidance for radiology reporting times can be found at the link below:

http://www.improvement.nhs.uk/documents/radiology_reporting_times_best_practice_guidance.pdf

Reporting Performance Monitoring

The provider should ensure:

- there is on-going improvement of reporting turnaround times until standards are achieved to support effective management of the service and appropriate support to clinical specialties and referrers;
- ongoing monitoring of report turnaround time, including:
    - report completion turnaround times;
    - report verification turnaround times (including minimum, average and maximum report times by modality to inform initiatives to reduce variation); and
    - unreported monitoring for those unreported beyond the agreed reporting timeframe, and ensure follow up and work prioritisation.

- consultant rotas are designed to allocate sessions to be covered by a pool of reporters so they are not adversely affected by annual leave. Radiologists / Consultant schedules could be revised to allow shorter sessions that enable more focused reporting and reduce the impact of annual leave and multidisciplinary meeting attendance on the modality;
- radiographer / Technologist / Technician / Advanced Practitioner-led reporting to clinical protocols is in place to provide improved reporting times; this requires the agreement of the team and appropriate training for the staff; and
- a process for clinical audit is in place to ensure reporting quality is achieved particularly where reporting is completed by non-consultant staff.

Unexpected Findings

Providers should ensure a protocol is in place to notify referrers of unexpected findings identified as part of the attendance for diagnostic procedures. This should include a mechanism for notification to the relevant tumour site if required to ensure timely referral to treatment. NPSA Note 16 provides guidelines for communicating unexpected significant findings. Please see link below.

http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59817

Management of DNAs

Also refer to Section ii Outpatients on management of DNAs.

Booking staff should explain the DNA policy to the patient at the time of booking, remind patients of their responsibility to inform the organisation if they are unable to attend in advance, and that they will not be offered another appointment if they fail to attend.

Hospital cancellations

Also refer to section on Developing a local Elective Access Policy.

Cancellation of patients' appointments by the hospital is very poor practice which causes inconvenience to the patient and a loss of efficiency for the service. Such cancellations should be treated as a rare occurrence that should only be authorised where no other option to cover the diagnostic list is available / appropriate.

Walk in Services

Walk in services reduce the timeframe from referral to treatment. As a result, providers should evaluate the feasibility and implementation of walk in diagnostics which would not only contribute to a reduction in referral to treatment time but would potentially improve the convenience for patients already on site to attend, for example, an outpatient appointment.

Refer to Managing High Value Capital Equipment in the NHS in England Report by the National Audit Office.

http://www.nao.org.uk/report/managing-high-value-capital-equipment-in-the-nhs-in-england/

Direct Access Diagnostics

Providers should agree with local Clinical Commissioning Groups (CCGs), where appropriate, to GP direct access to diagnostics as it can assist in reducing the length of a patient's non-admitted pathway as well as enabling more timely access to diagnostic services. Direct access can also negate the need for onward referral to a consultant-led service.

Planned Patient Scheduling

There are strong clinical governance and safety reasons why patients on a planned care pathway should not be deferred and these patients should be treated at the right time and in order of clinical priority. A significant portion of planned activity is associated with surveillance of high risk groups of patients who are at risk of significant clinical deterioration if not managed correctly. It is important all providers have robust procedures in place to review planned lists to ensure that patients are reviewed in the clinically appropriate timeframe.

Should a patient not receive their planned diagnostic procedure by the planned due date, they must be transferred to the active waiting list and managed in accordance with the diagnostic pathway targets.

3.3. Supporting processes

i. Access policies – elective care and cancer

Managers seeking to develop an effective Access Policy may find the guidelines in appendix six helpful; they include the key areas to be considered when developing an Elective Care Access Policy (ECAP).

An ECAP should be developed in conjunction with all participants of the Local Health Economy (LHE) including patients and agreed with clinicians. Draft policies will need to be agreed in line with the internal governance arrangements of both the commissioner and provider. Copies of the completed policy should be made available for the general public via the provider website although the policy should also be made available in formats for those who are not able to, or do not have access to web-based information. Examples include printed copies in outpatients or in the Patient Advisory Liaison service. Consideration should also be given to the languages in which they are produced. A summary of the completed policy may also be developed for patients.

The ECAP should be supported by a series of Standard Operating Procedures (SOPs) which can be adapted and amended as relevant local or national policy changes occur. SOPs should include the escalation process for dealing with issues that arise with clearly set out timescales for response and resolution. The SOPs provide staff with a single reference point which enables them to understand their role in ensuring the ECAP is consistently applied throughout the organisation. These should be referenced, as appropriate, throughout the ECAP. The SOPs may be provided as an appendix to the ECAP.

The ECAP should also make reference to relevant local policies such as ‘Overseas Visitors’, ‘Prior / Commissioner Approval’ etc.

ii. Patient Tracking List (PTL) and other monitoring meetings

A PTL meeting should be held ideally weekly and be chaired by the senior manager responsible for the delivery of the RTT and cancer operational standards. The meetings need to be attended by the team with the operational responsibility for delivering the standards (see Appendix three for a suggested list of attendees).

It is beneficial to have local commissioners represented at this weekly PTL meeting. Providers may want to decide if commissioner representatives attend part or all of the PTL meetings.

Weekly business unit/speciality and Provider PTL meetings

The PTL should be produced on a weekly basis, preferably mid-week to enable discussion of the detail of the PTL. Providers should hold the PTL meetings at the same time each week and, depending upon the size of the organisation, may also wish to hold specialty or local business unit meetings prior to the organisation-wide PTL meeting; local meetings also need to be held on the same day each week.

The business units must be sufficiently prepared for the PTL meeting to:

- have a management plan at an individual patient level;
- have addressed the majority of the key issues;
- have an action plan for those issues to be resolved; and
- escalate any issues that cannot be resolved within the business unit.

The PTL meetings must be action-orientated and focused upon:

- performance management and accountability;
- breaches and prospective management of patients along the 18 week pathway and cancer pathway;
- clearing the backlog of patients waiting more than 18 weeks;
- delivery of the RTT and cancer pathways; and
- monitoring and managing the number of incomplete pathways.

It is important that any agreed actions are followed through and reviewed the following week to ensure they have been addressed. It is advisable to have an audit trail of the actions and when they have been dealt with. In addition, organisations will want to be able to see the impact of the actions in the following week's PTL numbers and profiles. Providers should have clear escalation processes in place to support staff where issues are not resolved between the weekly PTL meetings. The relevant service or general

manager must take the lead in dealing with patient-level issues raised during the PTL meetings.

It is advised that a consistent agenda and reports are reviewed at the local business unit meetings which mirror the requirements of the organisation-wide PTL weekly meeting to ensure the same approach is taken at both levels. This will include a specialty level review with patient level enquiry, actions and follow through.

Suggested Terms of Reference (ToR) and agenda/approach to PTL meetings

The provider should set out clear Terms of Reference for the weekly provider and business unit PTL meetings to clarify expectations and agree a common agenda/approach to these meetings. A suggested ToR and agenda is set out in appendix seven.

iii. Reporting: internal and external

At every stage of the processes described above, both within provider organisations and externally through commissioners, accurate, timely and clearly-presented information and analysis is essential to underpin effective delivery of 18 week RTT pathways.

Some general principles of good information and responsibilities of a good information department are:

- accurate with any sources of bias or inaccuracy explained and understood;
- developed by the information team in close collaboration with representatives from the target audience *for each report;*
- timely as appropriate to the context;
- exception-based in order to highlight areas for attention/concern;
- consistent so that the same Key Performance Indicators (KPIs) are used, where appropriate, throughout the organisation/local health economy;
- secure so that only appropriate staff are able to view information and that patient-identifiable information is only used when absolutely necessary; and
- analysed where appropriate to help non-technical staff to understand the implications of the data they are seeing.

Patient Pathway Management Information

To manage an elective service it is necessary to understand the pathways that patients are expected to take (see section 2.1 above) and, in order to monitor patient waiting times and experience, information is needed for each pathway event for each patient. In detail, the information required to effectively manage patients (via the PTL) should be:

- **live** or as close to live as possible (within 24 hours). Given the short waiting times required to deliver good patient experience, weekly information is insufficient to identify and resolve potential issues in good time; this is particularly true for cancer patients;
- **grouped** into useful cohorts. The number of 'current' patients in a specialty of any size makes it impractical to look at each patient individually even if it were necessary. These should be consistent with **KPIs used across the organisation as much as possible and particularly with those used in the PTL meeting.** Some suggested groups might be, dependent on the needs and configuration of each service:
    - division;
    - specialty/business unit;
    - sub-specialty;
    - consultant;
    - days/weeks waited or days/weeks from target;
    - Weeks waited at the next event e.g. at the next follow-up appointment;
    - Milestone of Treatment (first/follow-up outpatients, diagnostics and decisions to admit etc.) **provided this is expressed using the overall RTT waiting time** and not only using the stage of treatment waiting time; and
    - Staff group (specialty managers, booking staff, validators etc).
- **tailored** to each audience as appropriate, for example it may well be that a divisional manager would not want the same view of the PTL as a booking clerk (although this depends to some extent on the cohorts into which the reports are grouped);
- **patient-level** to the extent that when viewing aggregate information (for example numbers of patients waiting for a particular event) it is possible to 'drill down' to see each patient and accompanying pertinent information. This should incorporate the ability to view the entire patient pathway and not just the current event;
- **exception-based** so that only those patients whose pathways are not 'on track' are highlighted for action – it is unhelpful to list the whole PTL with potentially thousands of patients and unrealistic to think that staff can, or indeed should, review this; and

- **based on milestones** to tie current waiting times back to the agreed clinical pathways. Examples might be patients who have appointment dates which are after key points or who have passed them without appointment milestones such as:

    - **first outpatient appointment;**
    - **key diagnostic test or tests;**
    - **diagnosis;**
    - **decision to treat;**
    - **multi-disciplinary team (MDT) discussion;**
    - **transfer to another provider; and**
    - **treatment itself (or decision not to treat).**

Performance Information

It is common within providers to have internal reports based on the timetable of national returns which are often monthly and quarterly. Whilst it is clearly necessary that this happen so staff at every level know the 'final position' against operational standards, this should be the bare minimum of frequency. It is furthermore vital that 'final' reports are available in advance of national deadlines and that progress towards deadlines is marked. It is also important to show past performance; this is in order to give context to the current position. Analysis and intelligence should also be applied to the information so that non-technical staff can use it to draw useful conclusions and, where necessary, take appropriate and informed decisions.

Most performance information is rendered significantly more useful through the use of past, current and future levels and the graphical display of trends, incorporating features such as:

- actual performance in the week/month to date based on up-to-date activity;
- predicted short-term performance based on forthcoming appointments/TCIs this week/month and in subsequent weeks/months;
- predicted medium-term performance based on figures such as demand (new referrals coming in) and adherence to clinical pathway milestones as well as on 'soft' intelligence such as the confidence of managers, staff leave, capacity fluctuations etc.;
- predicted performance against agreed trajectories and national standards;
- past and current performance in the context of:
    - earlier trends (this year versus last year, this month versus last month, this month versus the same month last year etc.);
    - internal and external trajectories and stretch targets;

  - statistical process control analysis – the assessment of variation and the identification of special causes; and
  - national, regional and/or local comparators and other benchmarking.
- Related metrics which contribute to measured performance, for example:
  - demand and capacity analysis;
  - adherence to Access Policy requirements (length of patient pause, discharge of DNAs etc.);
  - breach reasons/RCA aggregated to show trends; and
  - data quality and, where applicable, the percentage of records validated, again aggregated and trended.

As set out in the section on 'governance' above, each LHE will have a number of monitoring meetings each of which, based on the guidelines above, will require patient pathway management information, performance information or a combination of the two. It is the role of the information team to ensure that the information provided to support each meeting matches as closely as possible the aims of the meeting and the needs of the participants. In addition, where applicable, it captures agreed actions and those responsible for their delivery from previous meetings.

Outpatient, diagnostic, endoscopy and inpatient booking

	Pathway stage	*Information required*
1.	Outpatients	Patient Pathway Management Information, often grouped by weeks waited and separated into new and follow-up appointments. Information about non-RTT patients such as those post-clock stop, non-consultant-led pathways etc
2.	Diagnostic	Patient Pathway Management, often grouped by weeks waited. Six week target and cancer waiting time milestone targets to be shown on same report
3.	Endoscopy	Patient Pathway Management Information, often grouped by weeks waited. Information about planned/surveillance and any other non-RTT patients and six week targets and cancer waiting time milestone targets to be shown on same report
4.	**Inpatient/Waiting List**	Patient Pathway Management Information will

	Pathway stage	Information required
	booking	be required, often grouped by weeks waited. Information about planned/surveillance, cancer subsequent treatments and any other non-RTT patients and cancer waiting time internal milestone targets to be shown on same report

Specialty / Business Unit PTL Meeting, Provider PTL Meeting and similar

There are usually two elements to these meetings – patient-level management and trend performance. Patient Pathway Management Information is required to identify patients where action is required and who will take that action. Performance Information is required to assess current performance against key metrics both in terms of national standards and related issues such as adherence to access policy, percentage of paused patients and breach reporting may be appropriate at patient and / or specialty / consultant level.

MDTs and other clinical groups

To groups of this nature it is likely that a mixture of Patient Pathway Management Information and Performance Information will be required. The bulk of the information required for such meetings is clinical in nature and the ideal is to incorporate key patient pathway information, target dates and milestone for example, into this existing information. Performance Information is needed to understand current and prospective performance against national standards and clinical pathways, and breach reporting is needed at patient and specialty / tumour site / consultant level.

Specialty / Business Unit Meeting

On the presumption that any patient-level management takes place in a PTL meeting setting, performance information will be required at a detailed, sub-specialty / clinical pathway and consultant level in order to understand the micro issues affecting each service. Detailed breach reporting and demand and capacity analysis is required.

RTT / Cancer / Elective Board

At this higher-level meeting a Performance Information overview is required, highlighting specialties / tumour sites where performance is outside of acceptable levels of variation versus national standards, trajectories or internal targets. Aggregated breach reporting and demand and capacity analysis are required.

Provider Executive, Provider Board

At this very high level an agreed performance dashboard across the whole range of Provider performance measures, including elective care, is required. This balanced scorecard should quickly identify areas in which performance is a concern or where confidence about future sustainability is not high. Some specialty-level information may be appropriate for areas of particular concern. It is advisable to use a dashboard or scorecard which shows trends in performance. It is the board's responsibility to understand and what good performance looks like and challenge the reasons behind it. The board should not assume reported good performance is the reality.

External Statutory Reporting

RTT 18 week performance information is reported to DH monthly via the Unify2 website. Documentation for the upload process can be found on the Unify2 site itself. Once monthly performance information has been uploaded and signed-off by the relevant commissioning organisations a series of data quality checks are run by the DH Knowledge and Information (K&I) team. Updated versions can be found on the DH RTT website:

http://media.dh.gov.uk/network/261/files/2012/06/RTT-Assurance-Data-Checks.pdf

If any of these checks is failed, the K&I team will raise a formal query with the reporting organisation and further scrutiny may be required. Reporting organisations are advised to incorporate these statutory checks into their own pre-upload data quality process.

4. Appendices

Appendix 1: Referral Minimum Data Set

- Full name of patient.
- Patient's date of birth.
- Patient's gender.
- Patient's full address including postcode.
- Patient's up-to-date contact telephone number (preferably including a mobile number).
- Patient's NHS number.
- Referrer details (including telephone and fax number).
- Relevant medical history.
- Specific clinical question and diagnostic examination required.
- Diagnosis (provisional, differential or definitive).
- Qualify the diagnosis by indicating whether this is to be:
  1. confirmed: the diagnosis is strongly clinically suspected;
  2. excluded: the diagnosis is not strongly clinically suspected but needs to be excluded; and
  3. follow-up: the diagnosis is known and this investigation is to follow up progress
- Full clinical details on the reason for the referral in line with clinical referral guidance and locally agreed referral criteria plus other relevant information such as current drug regime, clinical question to be answered and significant past medical history.

Appendix 2: Good Practice Principles Vetting Management

The Provider should confirm:

- agree vetting categories of urgent and routine only;
- agreed service standards for vetting i.e. all referrals should be vetted on the same day/within 24 hours of receipt;
- the frequency of vetting and ensure staffing resources are adequate (i.e. pooling avoids delays when key staff are on leave), and ensure service standards are confirmed.
- identify examinations that can be booked before vetting and ensure booking occurs on the day of receipt of the request. Patients need to be aware that there is a small chance the appointment may be changed after vetting;
- review diagnostic modalities to confirm where vetting may not be required / or where not required prior to attendance, eliminating unnecessary delay in scheduling patients (ie ultrasound), whilst ensuring IRMER requirements are met with regard to exposure to ionising radiation (medical exposure) regulations 2000; and
- the Provider should ensure appropriate mechanisms to monitor vetting of referrals (referral turnaround time – min, average and max, unvetted referrals) and ensure appropriate follow up of referrals that are not vetted within the designated agreed service standard.

Appendix 3: Suggested list of weekly tasks for PTL meetings

Outpatient weekly tasks

- Each business unit must confirm with staff that they understand the daily tasks required to track patients along the pathway.
- Outpatient (OP) booking staff must deal with referrals as they come in and book to the agreed maximum waiting times/polling ranges for both Choose and Book (CAB) and paper referrals.
- OP booking staff must escalate to the operational manager when referrals cannot be booked into slots within the maximum waiting time / polling ranges or internal stretch targets set by the Provider.
- Operational managers must check the numbers booked into OP slots per week (within and outside of the polling ranges).
- Patient trackers must review the non-admitted PTL and check where patients are along the pathway:
    - waiting for a first OP appointment;
    - waiting for a diagnostic;
    - waiting for the results of a diagnostic;
    - waiting for a clinical decision related to a diagnostic;
    - waiting for a follow up appointment; and
    - not known (may need notes review)
- Operational Managers must review compliance with the use of outcome forms by specialty or consultant and take necessary actions.
- General Managers must review the actions with the operational managers and may find it helpful to review a random sample of individual patients on the PTL with the relevant staff.

Inpatient / daycase weekly tasks

- Each business unit or speciality must confirm with staff that they understand the daily tasks required to track patients along the pathway.
- Operational managers must ensure that cards are completed for all Decision To Admit (DTA), preferably after pre-assessment, and agree a time frame for entering onto PAS.
- The admissions staff should have weekly targets in terms of numbers of patients to agree TCIs with and also the number of DTA to add to the PAS system.
- General Managers to confirm with each specialty the target from DTA to admission.
- Admission staff must escalate if they do not have sufficient capacity to book patients into within the target and with reasonable notice i.e. 3 weeks.

- General Managers must check that patients are booked in date order and are being given reasonable notice for admission.
- General Managers must agree process for monitoring the application of pauses.
- Operational Managers should meet with Consultants to share their admitted PTL (those with/without a TCI).
- Each business unit must confirm process for cancellations by hospital.
- General Managers are advised to review a random sample of individual patients with the appropriate staff.

Suggested list of attendees for weekly PTL meetings

- Executive responsible officer.
- General Manager.
- Operational / Service Manager.
- Admissions booking staff.
- Patient Trackers / schedulers.
- OP booking / Choose & Book staff.
- Secretaries (may vary by business Unit).
- Information lead.
- Diagnostic lead.
- Theatre manager / nurse.
- Outpatient manager / lead.

Appendix 4: Good practice appointment confirmation letters

Please see the Department of Health's *Frequently Asked Questions on the Referral to Treatment (RTT) data collection* – for guidance on making appointments in line with the RTT national guidance:

http://www.england.nhs.uk/statistics/rtt-waiting-times/rtt-guidance/

Please note that the NHS Standard Contract for 2013/14 requires appointment letters to include information on the maximum waiting times right. In addition an appointment confirmation letter should be sent to the patient, providing:

- clear and informative details and should include a point of contact and telephone number to call if the patient has any queries;
- confirmation of date and time to attend for the appointment;
- name of the procedure the patient will be having;
- explain clearly the consequences of not attending, turning up late to the appointment or cancelling their appointment;
- confirmation of any preparatory requirements;
- additional information confirming the diagnostic procedure the patient will be undergoing and also transport arrangements should be included as appropriate; and
- confirm an expectation the patient should call to reschedule if they are unable to attend, to enable the appointment to be offered to another patient.

Appendix 5: GP booking proforma, St George's Healthcare NHS Trust

Patient Name:

St George's Healthcare NHS
NHS Trust

Outpatients GP/GDP Referral Proforma

Please do not use this form for 2 week target cancer referrals

All referrals to services at St George's Healthcare NHS Trust should be sent directly to:

Central Booking Service
Knightsbridge Wing
St George's Hospital
Blackshaw Road
London SW17 0QT

Please note that if any * starred items are not completed the referral cannot be processed until the completed information is obtained.

*Today's date:	*Speciality:	Consultant:
PATIENT PERSONAL DETAILS		
NHS number	Hospital No.	
*Title	*Surname	*Forenames(s)
*D.O.B	*Male	*Female
*Address		
*Postcode		
Telephone (Home)	Telephone (Work)	
Telephone (Mobile)	*Please give at least one contact number – mobile preferable*	
Details of next of kin (*if referring a patient under 18 years)		

*Patient has been resident in the UK for the last 12 months?	Yes	No	N/k
*Interpreter required?	Yes	No	*If yes, which language?*
Special/Mobility needs			

If your patient requires hospital transport, they should contact the Transport Assessment and Booking (TAB) Team as soon as their appointment has been arranged on 020 8725 0808

*GP/GDP DETAILS	*ETHNIC BACKGROUND
*REFERRING GP/GDP	*Please tick one*
*Practice name	White British o; White – Irish o; Any Other White Background o; Mixed – White and Black Caribbean o; Mixed – White and Black African o; Mixed – White and Asian o; Any Other Mixed Background o; Indian o; Pakistani o; Bangladeshi o; Any Other Asian Background o; Black Caribbean o; Black African o; Any Other Black Background o; Chinese o; Any other Ethnic Group o
*Address	
*Postcode	
*Telephone	
*Fax	

1/2

Patient Name:

St George's Healthcare NHS
NHS Trust

CLINICAL DETAILS
*Comprehensive clinical details and reasons for referral
*Details of any tests requested/awaited/enclosed with the referral e.g. bloods etc.
*Medication/Allergies
FOR OFFICE USE ONLY
ORE'ing/Prioritisation Stamp

Appendix 6: Elective care access policy development guidelines

These guidelines aim to support teams to produce an Elective Care Access Policy (ECAP) highlighting key themes to be included within such a document and provide a starting point for productive conversations across local health economies (LHE). A clear introduction to the policy advising of the remit and rationale of the document is required.

An ECAP should be developed in conjunction with all participants of the LHE and include patient / client representative participation and their observations. Draft policies will need to be reviewed through the internal verification procedures of both commissioner and provider partners. Copies of the completed policy should be available for the general public via the trust website. Consideration should be given as to how this information may be reviewed by those without access to, or the skills to use, web-based information; such as making hard copies available, potentially considering in which languages these should be produced, for outpatient clinics, Patient Liaison Advisory and complaints / customer care services etc. A resume of the completed policy may also be beneficial for patients.

The ECAP should be supported by a series of Standard Operating Procedures (SOPs), which can be adapted and amended as policy changes occur, locally or nationally. SOPs should include clear escalation practices to deal with issues, concerns and problems and include, wherever possible, timescales for both action and response. The SOPs provide staff with a single reference point, allowing individuals throughout the organisation to understand their role in ensuring the ECAP is robustly and universally applied. These should be referenced, as appropriate, throughout the ECAP. The SOPs may be provided as an appendix to the ECAP.

The ECAP should reference those other local policies with which it links, such as ‘Overseas Visitors’; ‘Prior / Commissioner Approval’ etc.

Statement of intent

Policy

The purpose of an ECAP is to ensure patients are treated with equity and efficiency and it should be expressly focused around patient care ensuring the best interests of the patients are foremost. The document needs to reflect the current iteration of the Operating Framework and its stated standards; it also needs to ensure compliance with the NHS Constitution.

SOP

The standards applicable at the time of writing should be clearly indicated and modified when these standards are updated. Any locally agreed additional rules or processes should also be clearly expounded.

Sign off

Policy

The ECAP should be agreed and signed off by LHE representatives. A review date should be clear and the individual(s) / group(s) responsible for the review stated.

Choose & Book (C&B)

Policy

The ECAP should describe the C&B management system.

SOP

The standards should advise staff on how to process C&B referrals and where to escalate any problems or concerns.

Access Standards

Policy

The ECAP should clearly indicate locally and nationally agreed standards for access to care, including details of those patients excluded from the national Referral to Treatment (RTT) standards. Key performance will be outlined in the policy. Details of reasonable notice should be included for inpatient, outpatient, cancer and diagnostic pathways. The importance of treating patient in chronological order, making allowances only for clinical urgency and patient choice.

SOP

The SOP will give details of patient pathways and indicate milestones and trigger points (time to first outpatient appointment (OPA), time to decision to admit, time to admission etc) where escalation may be required.

Definitions

Policy

Key definitions will be included to guide staff in understanding the rules and their application. Any local anomalies or 'special' situations may be usefully described in supporting SOPs. The ECAP should include a section which informs users on the processes which apply to war veterans. The definitions, which may be presented in the format of a glossary for ease of use, should include:

> 'clock start', 'clock stop', 'social pause', 'entitlement to NHS treatment', 'commissioner approval', 'planned lists', 'active monitoring', 'reasonable notice',

‘standards for changing , amending or cancelling appointments by the provider’, ‘patient cancellations’, ‘did not attend (DNA) events’ and ‘interprovider transfers’.

Please note this list should not be considered exhaustive and should be developed for the LHE.

Referral pathways

Policy

Details of the processes required prior to referral, including any pre-referral work up and diagnostic processes should be outlined in the policy. The process for managing inappropriate referrals must be referenced. Any triage which is performed as part of the internal referral management process should be included. The expectations associated with the content of patient letters (outpatient, diagnostic, preadmission and assessment) should be included.

SOP

Details of the patient pathways and actions to be taken if these are not adhered to should be linked to the pathways (see Access Standards above), including individuals to be contacted in the case inappropriate referrals. Pathways scenarios / examples may be provided within the SOPs as illustrations of good / best practice.

Cancer referrals

Policy

Cancer patients fall under elective care and the associated standards should be acknowledged within the ECAP. Individual trusts should determine if they wish to have this patient group included fully within the ECAP or a more detailed cancer policy referenced in the ECAP but produced as a separate document. The development of supporting SOPs will be determined by the integration or otherwise of cancer. The management of patients upgraded following a referral from another route, should be described within the ECAP.

Patient information

Policy

The ECAP should advise of the written information available to patients and when they may expect to receive such information.

SOP

Details of the information offered to patients at key stages of their pathways can be detailed in the SOPs associated with patient pathways (see Access Standards above).

Did not attend (DNAs) & Cancellations

Policy

The policy must note DNA and cancellations as separate events and indicate the action to be taken when each occurs. The policy should also indicate the action to be taken if / when the Trust is the source of any cancellation. Any groups exempt from action related to DNA or cancellation should be specified.

Processes associated with both the planned and short notice cancellation of operations / procedures should be incorporated as well as processes associated with planned and short notice clinic cancellations.

SOP

The SOP should offer details of the individuals to be notified of actions taken following patient cancellations and / or DNAs and the escalation process associated with the management of vulnerable patient groups.

Training and role clarity

Policy

The role of training as an on-going aspect of staff development as well as an integral aspect of induction should be outlined in the policy, identifying those individuals responsible for both delivery and assessing competence post training. The frequency of refresher training should be included and measures to be taken when staff fail to adhere to the policy noted. Clear links to local disciplinary / competency policies should be included.

Reporting suites

Policy

Details of the Trust reporting suites, including the links between specific information and the report to which it will be aligned. There should also be links to inform users of which reports are available to them and the information each should encompass.

SOP

Any audit processes indicating where problems arise and where appropriate action was not taken, should be specified within the SOPs. The feedback methods, based on this information, should be outlined, including reports to Trust Boards.

Low priority procedures

Policy

Identification of low priority procedures and time scales for prior approval to be achieved.

SOP

Details of the action required to manage these patients (link to Referral Pathways).

Inter-provider transfers (IPTs)

Policy

Details of how to manage IPTs and the minimum data set required to be completed.

Appendix 7: Suggested terms of reference for a trust wide patient tracking list (PTL) meeting (can be adapted for business unit PTL meetings)

The trust should set out clear terms of reference for the weekly Trust and business unit PTL meetings to clarify expectations and agree a common agenda/approach to PTL meetings both at a business unit and Trust level.

Introduction

The group will act as an internal forum, ensuring all elective pathway activity is accurately recorded and reviewed. Under the direction of the executive lead or general manager the group will monitor and ensure the national operational standards for elective and cancer waiting times are achieved and improvements in patient flow and discharge performance are delivered to ensure sustainability.

The primary aim of the group is to improve the access to patients by identifying key delays along the pathway in particular with the assessment and admission process and enabling staff throughout the business units and across the wider operational groups to work in a coordinated way to address and remove delays.

The forum will ensure the correct application of rules (for both cancer waiting times and referral to treatment (RTT)), plan and manage patient pathways within the specialty and ensure patients are dated in correct order to deliver the national operational standards.

Scope

In order to achieve robust elective performance the group must ensure that:

- All elective activity and cancer performance is reviewed on a weekly basis.
- Patient flows are analysed for all of their pathways.
- All delays in the care pathway are identified and addressed.
- Coding is accurate and recorded in all admission / diagnostic / outpatient (OP) areas.
- Admitted, non admitted and incomplete pathway performances are reviewed to ensure national standards are achieved.
- Robust planning is in place for known and identifiable events e.g. Bank holidays, Junior Doctors changeover.
- Capacity is planned to ensure appropriate access for all patients

Core Membership

- Executive responsible officer
- General Manager
- Operational Manager
- Patient Tracker (Pathway Co Coordinator)
- Admissions booking

- Outpatient Booking staff / Choose And Book
- Data Quality Clerk
- Secretaries

Note: The group may co-opt additional expertise/representation as necessary

Meeting Arrangements

- Meetings will be arranged at weekly intervals; e.g. on a Wednesday
- The meeting will be chaired by the appropriate executive responsible for delivering the operational standards for cancer waiting times and RTT
- Minutes and action points will be circulated after each meeting
- The administrative support for the meeting will be provided within the core membership

Suggested agenda

The weekly agenda should cover the following key items:

i. RTT Performance (managed to exact date 126 days):

- Trend data review of previous weeks performance by speciality – admitted, non-admitted and incomplete Performance, numbers booked (against ready reckoner / plan numbers), number of incomplete pathways and numbers in the backlog (already breached 18 weeks)
- Trend analysis of breaches - of previous week's breaches, reasons and actions taken to prevent the same happening

ii. Admitted Performance (prospective management by breach date:

- Those patients without a TCI (to come in) already breaching 18 weeks – action required – validation, TCI given to prevent breach where possible.
- Patients new to the admitted PTL that have "dropped in" from the non-admitted PTL / or completely new to the PTL
- Patients that have moved from 17 to 18 weeks
- Those patients with a TCI already breaching– require validation (are they actually breaches) and actions to prevent breach where possible
- Patients new to the admitted PTL that have "dropped in" from the non-admitted PTL / or completely new to the PTL
- Those patients 15 – 18 weeks without a TCI – same as above
- Those patients 15 – 18 weeks with a TCI – validate to determine correct waiting time. Check operational delivery / risks
- Percentage of patients with a DTA at X weeks (an internal milestone set by the Trust), e.g. 10 weeks

iii. Non-Admitted Performance (prospective management by breach date:

- Those patients already breaching 18 weeks – action required – validation, checking if an outpatient appointment or diagnostic test is booked.

- Those patients 15 – 18 weeks – action required – validation, checking if an outpatient appointment or diagnostic test is booked. Establish if the patient has a care plan - action taken to prevent breach where possible.
- Those patients waiting more than X weeks (an internal milestone set by the Trust), with no outcome or clock stop - action required – validation, checking if an outpatient appointment or diagnostic test is booked or if a clock stop/treatment status has been missed.

iv. Outpatient booking:

- By specialty, percentage (or numbers) booked within the agreed Trust milestones for referral to first OP appointment e.g. six weeks
- Choose And Book slot issues (above four percent)
- Follow up capacity issues
- Percentage of attendances that had an outcome
- Total waiting list sizes (both dated and undated)

v. Diagnostics:

- Review of any potential six weeks breaches and actions to resolve them
- Review of any patients waiting more than the internal stretch standards set by the Trust e.g. two weeks to accommodate for an overall 18 week pathway
- Establish the RTT status of any potential six weeks breaches and actions to resolve them

vi. Cancer:

- Two week GP referral to first outpatient
- Two week GP referral to first outpatient - breast symptoms
- 31 day second or subsequent treatment – surgery
- 31 day second or subsequent treatment – drug
- 31 day diagnosis to treatment for all cancers
- Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)
- 62 day referral to treatment from screening
- 62 days urgent GP referral to treatment of all cancers

Information Requirements

- Updated and refreshed PTL
- Cancer PTL
- Information support to attend PTL meetings and assist in analysis of data

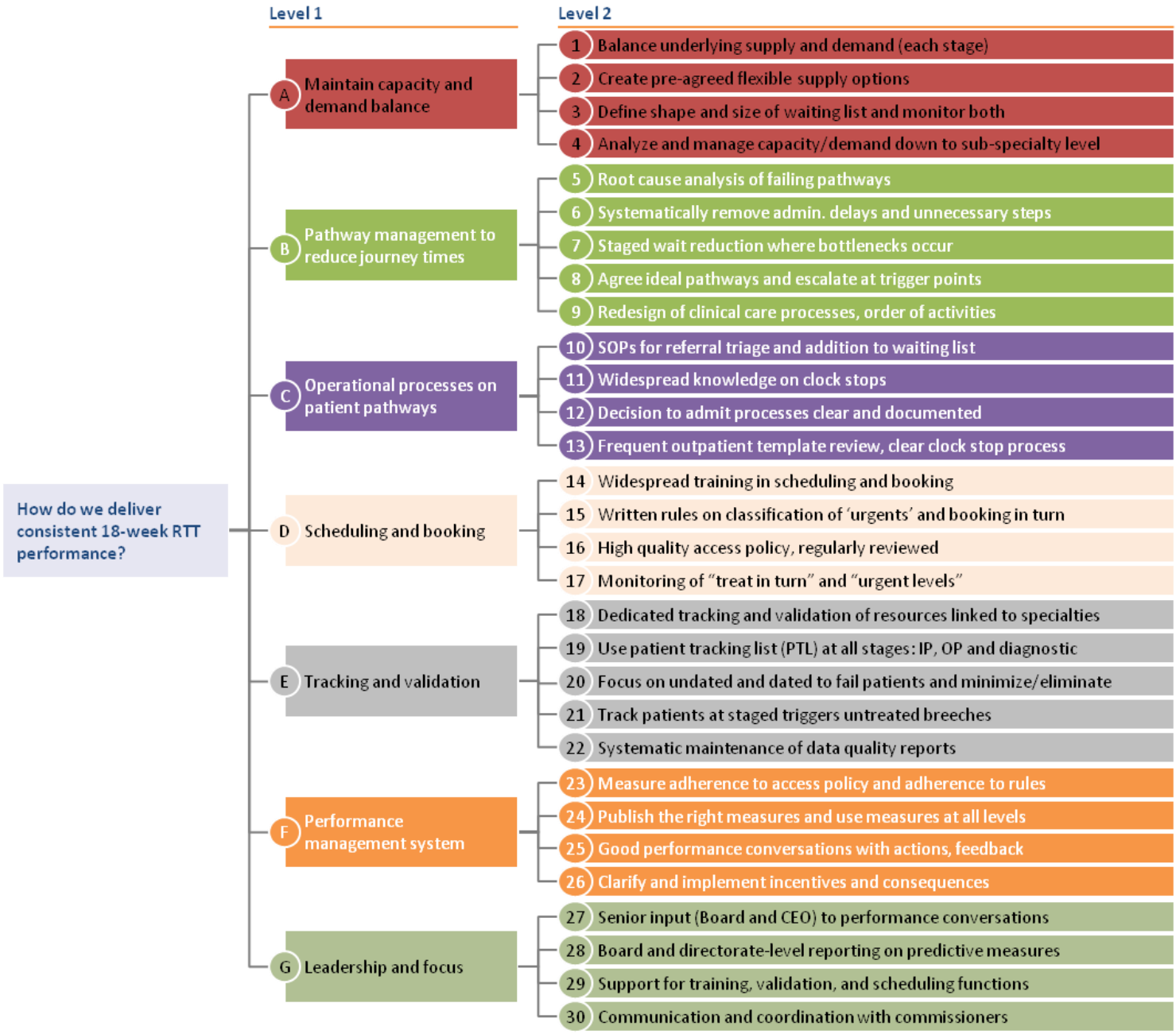
Reporting Arrangements:

- Each Business unit or speciality PTL meeting reports / at the trust wide Weekly PTL meeting chaired by the Director of Operations.
- All minutes and reports agreed by the group will be submitted as requested to the weekly PTL meeting and any other performance meeting.

RTT update

- Review of the actions that were required in the previous week (e.g. additional clinics to be set up (consultant agreed, space agreed, support staff agreed, and template on the system).

Appendix 8: Driver Tree developed jointly with McKinsey Hospitals Institute



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6. Revisions Process

Each month the IST will collect feedback from stakeholders on the use and contents of the guide. This feedback will be used to make any changes or updates the following month.

Feedback can be provided to the IST by email on, *nhsimas.ist@nhs.net*
