NHS Improvement

Elective care guide

Referral to treatment pathways: A guide to managing efficient elective care, third edition

May 2017

Delivering better healthcare by inspiring and supporting everyone we work with, and challenging ourselves and others to help improve outcomes for all.

Contents

1. What is new in this third edition?

The *Elective care guide* has been revised to reflect the updated referral to treatment (RTT) guidance published by NHS England in October 2015.

We have included additional guidance on:

- individual patient rights under the NHS Constitution
- balancing underlying supply and demand
- sustainable capacity to accommodate variation
- creating pre-agreed flexible supply options
- achieving and maintaining sustainable waiting list size
- subspecialty level analysis of capacity and demand.

We have given greater emphasis to managing pathways to improve access to treatment including guidance on root cause analysis of delayed pathways; the importance of systematically removing administrative delays and unnecessary steps; the benefit of agreeing pathway timelines and escalation trigger points; and the importance and value of care pathway redesign.

We have widened the guidance on supporting processes (such as trust access policies, patient tracking list (PTL) meetings, and internal and external reporting) to cover:

- patient pathway management information
- performance information
- information requirements
- booking and scheduling
- specialty/business unit PTL meeting, trust-wide PTL meeting
- multidisciplinary teams (MDTs) and other clinical groups
- RTT/cancer/elective board
- provider[1] executive and provider board
- external statutory reporting.

[1] The term 'provider' in this guide refers to both NHS trusts and NHS foundation trusts.

2. How the guide works and who it is for

The guide walks you through the RTT pathway; from pre-referral advice and outpatients, to diagnostics to patient admissions. It covers those areas which support the operational delivery of an effective RTT pathway, including demand and capacity planning, elective access policies, performance management and reporting.

The guide gives advice on the management of the RTT pathway, derived from what the Elective Care Intensive Support Team (IST) (as of April 2016 part of NHS Improvement) has learned from helping NHS organisations across the country to deliver and sustain short waiting times for treatment.

It is for NHS staff involved in any aspect of the delivery of acute elective care who want to understand how best to manage and deliver RTT pathways and standards. This includes staff in acute providers, arm's length bodies, national bodies, clinical commissioning groups (CCGs) and commissioning support units (CSUs).

3. Revisions process

We welcome feedback on the contents and suggestions for inclusion in future editions. We use your feedback to inform changes or updates.

Please send feedback to the IST at nhsi.electiveist@nhs.net.

4. Principles and rules: RTT and cancer rules, maximising efficiency, productivity and experience

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

- individual patient rights as defined in the NHS Constitution
- operational standards against which the performance of providers and commissioners is held to account. These are listed in, for example, the NHS standard contract.

It is important to distinguish between individual patient rights and the method the NHS uses to assess organisational performance. They are not the same.

4.1. Individual patient rights under the NHS Constitution

For patients in England the maximum waiting times for elective care are set out in the NHS Constitution and *The handbook to the NHS Constitution*.

The NHS Constitution sets out the following patient rights:

- to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible
- to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions
- to be seen by a cancer specialist within a maximum of two weeks from urgent GP referral where cancer is suspected.

The handbook lists the specific circumstances where these rights do not apply and those services not covered by the rights.

4.2. Assessment of NHS performance – the operational standards

In addition to the rights of individual patients, NHS providers are held to account against waiting time performance measures.

From October 2016, providers have been held to account through NHS Improvement's Single Oversight Framework.

4.3. Rules and definitions

To ensure reported performance is consistent and comparable across providers, the measurement and reporting of waiting times is governed by:

- consultant-led RTT rules and guidance
- cancer waiting times.

The rules and guidance allow some local interpretation in their application 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 reported waiting times reflect 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 patients' waiting time experience?

5. Maintaining balance between capacity and demand

5.1. Guiding principles

The successful delivery of any maximum waiting time standard (for example, 18 weeks) is predicated on the following factors:

- patient pathways that can deliver a short wait, and clearly describe what should happen, in what order and when
- a balance between demand and capacity
- a maximum number of patients waiting that is consistent with the level of demand and key pathway milestones – for example, maximum time from referral to first outpatient appointment and decision to admit (DTA)
- patients are treated in order of clinical priority; and for those with the same clinical priority, in the order they were added to the waiting list
- patients are actively managed against the pathway for their condition and the important milestones.

A balance between demand and capacity is essential: if demand exceeds capacity the number of patients waiting will grow and waiting times will lengthen. Equally, if there are too many patients waiting, then it will not be possible to achieve the RTT standard.

The dynamic between demand and capacity is best understood and maximum list sizes calculated using a modelling tool. There are many different modelling tools, both commercial and in-house solutions. The main consideration when choosing a tool is whether or not it will improve understanding and support discussions about how a service can predict demand and plan services accordingly.

Section 5.8 gives details of how to access the models we routinely use when helping organisations understand their particular service.

These models can help you understand issues such as the appropriate capacity to deal with a certain variation in demand.

Dos and don’ts

The following lists of dos and don'ts are based on the practical experience we have gained from helping organisations to develop and use demand and capacity models. These checklists should help you avoid the most common pitfalls.

Do:

- Involve clinicians from the start of the process.
- Adopt a logical and consistent approach to the process.
- Ensure 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 model inputs to avoid multiple ad-hoc information requests.
- Decide what's in and what's out so that you compare like with like in terms of demand, capacity and acuity of patients on the waiting list(s).
- Document important information and decisions about the data and any assumptions you have made, especially when building models at subspecialty or consultant level. We recommend you keep this information in a separate spreadsheet within the model.
- Sense check data with those closest to the operational challenges – for example, 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 – for example, whether the sizes of a waiting list at the beginning and end of the year make sense when you look at how many patients were added to and removed from the list (for any reason) over that year.
- 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, have 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 too 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 some refinement may be required 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 its very nature, a modelled 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.

5.2. Information requirements

Service managers need the help of information colleagues to pull together the data items required to complete the demand and capacity models. The operational management and information teams need to go through the models together to understand the data inputs. When writing queries to extract the data, the information team needs to be clear about what is ‘in’ and what is ‘out’. Experience shows that completing the models can be an iterative process and it is unlikely that a trust will get the data extraction exactly right the first time.

All models are likely to require the most recent 12 months of data on:

- weekly referrals
- weekly DTA/additions to the waiting list
- removal other than treatment (ROTT) rates for both the first outpatient and admitted waiting list
- first outpatient attendances
- first outpatient did not attends (DNAs)
- rebooked first outpatient DNAs
- admissions
- cancelled admissions
- rebooked cancelled admissions.

The following information may also be needed:

- current sizes of the first outpatient and admitted waiting lists (both with and without dates)
- 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
- 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)

- baseline core capacity to treat patients – for example, surgical procedures (again factored down for the elements described above).

Some of the data items (for example, first outpatient ROTT rate, cancelled surgical admissions, where capacity was lost) are not routinely extracted. Robust, clean referral data is often quite challenging to extract. Given that referrals are the driver for initiating most elective care pathways, providers need to understand their demand data.

Agreeing (and testing) initial trawls and extraction of the common data items should help standardise the requests made to the information team. This avoids multiple ad-hoc requests being made in which the specified data item depends on an individual's understanding of what is required.

When working with providers to develop demand and capacity models, we often sense check the initial model inputs by making simple comparisons, such as:

- number of referrals against the number of outpatients first seen in the last 12 months
- number of additions to the admitted waiting list against actual admissions.

We consider whether major differences between the above can be explained by changes in the first outpatient or admitted waiting lists, and 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 (for example, breast surgery for cosmetic reasons)
- high admitted waiting list ROTT driven by patient drop-out at pre-assessment (for example, degenerative spinal surgery).

5.3. Balancing underlying supply and demand

Demand and capacity modelling requires the underlying supply and demand to be balanced at each stage of the patient pathway; for example, first outpatient appointment, diagnostic visit, admission. If they are not, delays in access to treatment and under-utilisation of resources can result, making it difficult to plan capacity requirements at subsequent stages of the pathway.

When modelling supply and demand it is important to consider the implications for supporting services such as diagnostics and admissions. Discussing revisions to pathway timings with all those affected will increase the chances of reducing waiting times for patients.

In some models it is possible both to plan for known reductions in activity (for example, peak holiday periods) and to record ‘actual activity’ as it occurs. This provides metrics against which the delivery of the plan can be measured and service areas can be held accountable for their individual performance. For example, if a modelled waiting list is not of a predicted size at a particular point in time, the base drivers can be reviewed to find out why this might be so. Given that the waiting list size will be largely determined by patient addition and removal (that is, activity), it should be possible to work out whether the actual demand differs from that anticipated or the planned level of activity has not been delivered.

In reviewing demand and capacity dynamics, a capacity shortfall is often found to be having an adverse effect on waiting times. These shortfalls can be addressed by increasing the level/availability of the resource, increasing the quality of the service provided, making the current resource more productive, or a combination of these.

The following links offer useful signposts to resources for increasing productivity:

- quality and service improvement tools
- increasing productivity archive
- performance management
- the productive operating theatre
- improving patient flow.

5.4. Sustainable capacity to accommodate variation

Variation in both demand and capacity can inflate waiting times, even when overall the two are balanced. Put another way, it is not enough for providers to set capacity at the average level of demand: they should calculate the sustainable capacity requirements for each service area, taking account of natural variations in demand.

No one approach works for all services – our capacity and demand models referenced in Section 5.8 can be used to estimate a range of values for sustainable capacity, and include advice on which value to use in any given situation.

Regardless of how capacity requirements are calculated, providers should prospectively monitor available capacity levels to assure sustainable delivery of a service, as well as to provide a trigger for increasing capacity. Regular review of this data (ideally weekly) as part of forward clinic and admissions scheduling (four to six weeks in advance) will enable services to respond to capacity issues in a timely manner and to anticipate and mitigate pressures on them.

5.5. Pre-agreeing flexible capacity options

In some circumstances, capacity and demand analysis may indicate a provider needs more flexibility in its capacity. This would be particularly appropriate where demand and capacity are broadly in balance, but variations in demand may cause significant short-term pressure on capacity: if unmanaged, these pressures will increase waiting list backlogs.

It is good practice to agree flexible capacity options ahead of when they may be needed. Such options may include:

- additional capacity within core hours where available
- additional capacity outside core hours (for example, weekend and evening working)
- swapping or changing clinical sessions to provide additional capacity (for example, undertaking a theatre session in place of an outpatient clinic)
- mobile theatre/diagnostic capacity for fixed days of the week to meet shortfalls in capacity
- outsourcing capacity to the private sector, through formal service-level agreements and mechanisms to ensure independent providers adhere to trust access policy.

5.6. Achieving and maintaining a sustainable waiting list size

Services need to be aware of the impact of total waiting list size on waiting times. They should estimate the maximum number of patients who can be held on each waiting list such that waiting times standards can be achieved. Our capacity and demand models (see Section 5.8) include this functionality, and provide guidance on basing these estimates on demand levels, clinical urgency profiles, and the target waiting time for any given stage of a patient pathway. Providers and specialties should carefully monitor list size to identify potential growth which could adversely affect waiting times. The waiting list profile (that is, the distribution of the waiting times of those yet to be treated) should also be reviewed to identify changes in clinical prioritisation and/or poor booking practices.

5.7. Subspecialty level analysis of capacity and demand

It is good practice to consider what level of analysis will be most useful in managing capacity and demand. Subspecialty analysis is usually necessary, at a site or even a consultant level in some circumstances. However, analysis at these more detailed

levels may be limited by lack of data, particularly where consultants provide treatment for more than one subspecialty.

5.8. Getting help

We have used our experience of working with NHS providers and commissioners to develop demand and capacity models that can help organisations achieve an appropriate balance between demand and capacity, and to ensure waiting lists are of an appropriate size. These models are a helpful starting point for organisations looking to better understand demand and to plan capacity accordingly. They are available free of charge on the NHS Improvement elective care hub.

Organisations that are finding it difficult to meet the maximum waiting time standards and/or that would like external assurance of their demand and capacity planning processes can ask us for help by emailing nhsi.electiveist@nhs.net.

6. Managing pathways to reduce pathway times

6.1. Undertaking root cause analysis of delayed pathways

Root cause analysis can reveal the factors leading to delays. Multiple factors on a single pathway are likely to contribute to delays in treatment, and these may be avoidable or unavoidable. Standardisation of breach categories will enable the consolidation of data from different services and the identification of common themes.

A useful metric is the impact of remedial action plans, measured in terms of the number of days of delay at different points along the pathway. This provides an explicit measurement of improvements in the timeliness of care and treatment.

It is good practice for the treating consultant to sign off a breach analysis. Breach analysis details should be reported at specialty level, and summarised for discussion at the trust board.

The National Patient Safety Agency (NPSA) (as of April 2016 part of NHS Improvement) provides useful information and templates for root cause analysis analysis.

6.2. Systematically remove administrative delays and unnecessary steps

Providers must understand the administrative pathways for patients as well as the clinical ones. Mapping the administrative pathways should reveal where any unnecessary delays in the process are occurring. Action can then be targeted at these and reasonable timescales for each process step agreed. The latter will form the basis for future review and can be included in standard operating procedures.

6.3. Agree pathway timelines and escalation trigger points

Local health systems need to take a pathway approach to managing RTT services. A benefit of introducing the RTT standards was that they helped organisations manage patient care on a pathway basis and to remove 'hidden' waits.[2]

In particular, we recommend organisations understand their pathways at a specialty level, not just in aggregate. Part of this understanding is establishing where and when key milestones should occur. For example, a surgical specialty might state that first outpatient attendances should occur by week 6 of an RTT pathway, or that a DTA should be made by week 10. In contrast, for a specialty that treats most patients and inpatients, such as dermatology, the first milestone might be set at 10 weeks.

Benefits to organisations of a pathway approach to managing RTT services are:

- helps them manage to the RTT standards (at specialty level)
- allows them to track patients correctly
- identifies any specialty-specific issues
- enables remedial action to be targeted at the appropriate step of the pathway
- delivers more sustainable services.

NHS organisations must also consider what information flows are needed to support patient management in a pathway approach, as well as identifying what reporting tools will help identify bottlenecks in RTT pathways.

6.4. Redesigning care pathways

Clinical pathways are a sequence of clinical care processes, with different clinicians delivering processes at different stages along the pathway. Clinical pathways facilitate patient diagnosis or the exclusion of illness and reassurance, and treatment. Their documentation may identify opportunities to redesign care and the order of activities, enabling more timely treatment and assurance.

Clinical indicators along the pathway are recorded at each attendance; these determine the next stage of treatment or diagnostics, and are recorded as clinical outcomes at each attendance.

[2] Hidden waits refer to patients who are between stages of treatment; for example, awaiting results, waiting for decision post diagnostic.

There are many opportunities to expedite clinical pathways, such as:

- Educating referrers about referral criteria and the clinical assessment findings that should prompt the onward referral of patients for diagnosis and treatment. Referrers can then include these assessments in their management of patients before referral, which can accelerate a patient along the secondary care pathway once the patient is referred.
- Making direct access diagnostics available to GPs will potentially allow them to exclude certain clinical conditions; better identify need for secondary care; inform opportunities for ongoing clinical management within primary care; where appropriate clarify the most appropriate secondary care setting for treatment; and provide more timely reassurance to patients regarding their clinical presentations.
- Completing clinical processes in parallel will reduce unnecessary delay. For example, at their first appointment patients may simultaneously be referred for diagnostic imaging and blood tests.
- One-stop clinical services allow several elements in the pathway to be completed at a single attendance. For example, when a patient attends an appointment, they undergo the diagnostic test, results are received and they can start treatment on the same day.
- Document clinical protocols so staff are aware of agreed clinical pathways, diagnostic requirements, follow-up criteria, etc.
- Timely nurse-led or junior doctor or consultant-led clinical review of patient results and feedback to patients where appropriate, expediting the next stage of treatment, and negating unnecessary follow-up appointments.
- Clinical order sets for histopathology ensure the minimum standard set of tests is requested for patients, based on their clinical presentation. These standardise the required tests at the appropriate stage of the pathway (usually the first new attendance), ensuring no test is inadvertently overlooked or requested when unnecessary and, where possible, tests negate the need for further tests later in the pathway. There are benefits for patients too: fewer hospital attendances (and in the case of blood tests – fewer needles) and potentially more timely diagnosis.

7. Operational processes on patient pathways

7.1. Managing patients along their pathways – pre-referral

Patient information

As detailed in Section 4.1, the NHS Constitution gives patients the right to start treatment within 18 weeks of referral to a consultant-led service. Where this is not possible, commissioners are required to take all reasonable steps to offer patients a range of suitable alternative providers. All outpatient letters should include information on the NHS Constitution and this right. The NHS e-Referral Service gives referrers and patients information about likely RTT waiting times for the selected specialty at each provider.

Other examples of patient information that it is good practice to provide are:

- A two-week wait (2WW) information leaflet provided by GPs at the time patients are referred on a two-week pathway. This explains to the patient that they are being referred for timely clinical review to exclude cancer and the maximum waiting times before they are seen. The contact number of the secondary provider to which the patient is being referred should be given and the patient told to call this provider if they do not receive a phone call within a defined period of time.
- Access policy overview for patients, including their rights and responsibilities.

Health systems need to have an agreed access policy. For further guidance see Section 8.1. The agreed policy should be given to primary care colleagues and signed off by commissioners. GPs should make patients aware of their right under the NHS Constitution to be treated within 18 weeks of referral for RTT pathways and of their responsibility to attend appointments, making it clear that cancelling or not attending appointments can affect their right to this.

Prior approval panels

Commissioners must have assessment processes for GP requests for patient access to treatments which require prior approval. Commissioners and providers should both be concerned that decisions are made promptly, both for new referrals and patients already on an RTT pathway, as the clock can only be stopped on a patient's RTT pathway when treatment is given or a decision not to treat is made. Commissioners should hold approval panels to fit with RTT timescales for any

patient referred for assessment or on an existing RTT pathway. No time adjustments or clock stops can be made to a pathway while a panel or approval board is assessing requests.

The *Operating framework for the NHS in England 2012-13* outlined that decisions on the appropriateness of referrals should be made by clinicians in line with best clinical evidence. Commissioners should ensure all patients in clinical need are seen, which means that use of minimum waits (that one or more providers is required to comply with) or 'blanket bans' that do not take account of healthcare needs of individual patients can never be justified.

Shared decision-making and other tools

Patients must be involved in decisions about their care. There are several approaches to shared decision-making, including pre-referral initiatives, tools such as patient decision aids, health investment packs, the NHS Atlas of Variation in Healthcare and programme budgeting.

Helpful information about shared decision-making for patients is also available.

RTT rules and referral interface services

The national RTT rules suite includes clear guidance on the rules relating to interface services/intermediate clinical assessment and treatment services (ICATS).

Local health systems should review all such interface arrangements to ensure there are relevant processes and policies to capture RTT pathways accurately. This includes agreeing if a service falls under the definition of an interface service.

The term 'interface service' describes all arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care. The defining feature of such services is that patients may be referred onward to consultant-led secondary care directly rather than via their GP.

Consultant-led referral to treatment relates to hospital/consultant-led care. Therefore, the definition of the term 'interface service' for the purpose of consultant-led waiting times does not apply to:

- similar 'interface' arrangements established to deliver primary care or community services outside their traditional (practice or community based) setting
- non consultant-led mental health services run by mental health trusts
- referrals to 'practitioners with a special interest' for triage, assessment and possible treatment, except where these practitioners work as part of a wider interface arrangement as described above.

If a service meets the definition of an interface service, relevant staff need to be trained in how the RTT rules apply to patients referred to the service they deliver and on clock starts and stops.

Referral management services or assessment services

A referral management service (RMS) or assessment service is defined as a service that does not provide treatment but does accept GP (or other) referrals and may provide advice on the most appropriate next steps for the patient.

Depending on the nature of the service, the patient may or may not be physically seen or assessed. Referrals to referral management or assessment services should start a new RTT clock. It is important to note that referral management services do not affect the patient's right to start consultant-led treatment within the timeframe stated in the RTT standards.

Table 1: Good practice summary for RMS and assessment services

Good practice	Comments
Commissioners and operational managers must ensure the RMS works to documented and agreed turnaround times so that referrals can be triaged or vetted on receipt.	This ensures referrals are processed in a timely manner and patient care is not delayed unnecessarily. Turnaround times should be regularly performance managed by the commissioners.
Local health communities should analyse demand and capacity to ensure the RMS has enough capacity to manage referrals.	This ensures during peak periods of demand that referrals are processed within the agreed turnaround times and patient care is not delayed.
Local health communities should ensure there are relevant compliant processes for forwarding key patient information from onward referring providers, particularly the patient's clock start date.	Many RMS use inter-provider transfer forms to ensure the correct patient details and clock start dates are recorded accurately and forwarded.
Local health communities should assess the mechanisms for using the NHS e-Referral Service in RMS and ensure the correct clock start dates are captured.	e-Referral patients who are referred to secondary care via an RMS may have two unique booking reference numbers (UBRNs) associated with the same pathway. When a second UBRN is created for the same RTT period, this is linked to the first and the date of conversion of the first UBRN is the start date of the RTT clock.
RMS should provide regular training to staff on RTT rules.	Training helps staff understand their role and responsibility in managing patient pathways within RTT standards for referral to treatment for consultant-led services.

7.2. Managing patients along their outpatient pathways – outpatients, scheduling, booking, templates

These guidelines support teams in the delivery of effective and efficient outpatient services. The sections below describe good/best practice for specific parts of the outpatient pathway. Appropriate allocation of roles and responsibilities is outlined where applicable.

Receipt of referral – central point of receipt

On an RTT pathway, the clock starts as soon as the referral is received or the unique booking reference number (UBRN) is converted. It is therefore essential that there is no delay in the processing of the referral once it is received by an organisation.

e-Referrals

The NHS e-Referral Service should be promoted as the primary method for patient referral. All routine, urgent elective and suspected cancer 2WW services should be published on this service; if they are not, providers should have action plans with clearly defined timescales to implement this.

When a referral is received through the e-Referral Service, the RTT pathway starts on the date the (first) UBRN is converted.

For patients referred and booked through the e-Referral Service, the following steps occur automatically:

- patients are booked into an appropriate appointment, according to the priority of their referral
- patients are registered on the provider's patient administration system (PAS)
- the referral information is available for review on an e-referral worklist by the relevant clinician/team as soon as it is attached by the referrer.

Further information on the NHS e-Referral Service and best practice guidelines for its use can be found on NHS Digital's website.

Paper referrals (note diagnostic bookings are also covered in Section 7.4)

A full electronic referral process is a secure and efficient way of managing outpatient referrals and is considered best practice. Organisations that still accept paper referrals and use paper-based systems should be working towards implementing an electronic system for referral management (see above).

It is good practice to send paper referrals directly from the referrer to a single point of receipt. This has three main benefits:

1. limits risk of referrals being received by offices and departments that are unable to manage the referral process, potentially delaying the first appointment
2. reduces the number of duplicate referrals the provider receives and registers on its PAS
3. ensures no unnecessary ‘hand-offs’ and ‘transport’ of referrals.

Organisations still accepting paper referrals need a clear communications strategy to inform GPs of the contact details for the single point of receipt and for escalating referrals not sent to the single point of referral, and addressing this with the relevant referrer.

Organisations need to make a risk-assessed judgment about whether the same team should manage all types of referrals, such as suspected cancer referrals and other rapid access referrals. As a minimum, there must be a process to quickly identify and process these urgent referrals. If these urgent referrals are to be sent to the same single point of receipt as other referrals, as a minimum there must be a process for their quick identification and processing.

Central administration teams

It is good practice to tighten the referral process by making a central administration team responsible for managing referrals from when they are first received by the organisation, through to booking a patient’s first outpatient appointment. Some central teams are also responsible for the booking of diagnostic appointments such as endoscopy.

Staff responsible for the referral management process, whether working in a devolved structure or a central team, must be trained on a regular basis in the following areas:

- PAS referral registration and appointment booking functions, including processes relating to DNAs and cancellations, and discharge processes
- e-Referral
- elective access policy
- RTT rules
- cancer waiting times rules.

Registration of referrals

All referrals should be registered on the organisation’s PAS. Depending on the type of referral, it may also need to be registered on a separate database (for example, suspected cancer referrals need to be registered on the organisation’s cancer waiting times database). Organisations should set defined turnaround timescales

from receipt of referral to registration on the PAS and other systems. Good practice is a maximum of 24 hours for this task.

Pre-registration checks – the minimum dataset

It is common practice for 2WW suspected referrals to be sent using a standard referral pro forma as this ensures the minimum required information is included. Organisations should consider implementing a standard referral pro forma for routine referrals (see Appendix 5 for an example GP booking pro forma).

Regardless of the format of the referral (pro forma or traditional letter), it is considered best practice that all referrals include a minimum dataset; an example is given in Appendix 1. But organisations should have clear processes to manage referrals which do not contain this minimum dataset so that no patient is unfairly disadvantaged.

Organisations should agree the minimum dataset required for a referral to be valid within the local health community and include it in the commissioner's contract with the provider.

Prioritisation and triage of referrals

2WW suspected cancer referrals and 2WW breast symptomatic referrals do not need a prioritisation process as **all appointments should take place within 14 days of the date of receipt of the referral**. But a process is needed to assess the urgency of non-cancer referrals, to be carried out by an appropriate member of the clinical team and within a set timescale – for example, within 24 hours of registration.

Patients under the care of some specialties or with particular tumour sites (eg lower or upper gastrointestinal tract) may go 'straight to test' in endoscopy. Referring GPs should be encouraged to provide specific patient status information for this group of patients as this helps determine which local diagnostic protocol to use or which clinic to refer the patient to.

Booking appointments

Every appointment should be booked correctly and efficiently. Organisations should adopt processes which are patient focused and geared towards offering patients a choice of appointment within a set period. Referrals should be booked in order of clinical priority and then in order of receipt.

It is good practice for a provider to negotiate the date of the first outpatient appointment with the patient. In some organisations, a 'contact letter' is sent to the patient inviting them to phone the hospital within a set period to agree the date for an appointment. Others phone the patient directly to arrange the appointment rather than relying on the patient making contact. At least three attempts are made to contact the patient at different times of the day over a set period.

A facility for the patient to contact the organisation is needed and/or staff need to be available at times when it is likely patients can be contacted (8.00 to 9.00am or after 5.00pm).

Fixed (non-negotiated) appointments should only be sent to patients after a reasonable attempt has been made to contact them. Organisations should implement a policy and 'script' to help staff leave clear and consistent messages on a patient's phone.

A clearly worded appointment confirmation letter should be sent to patients. This should give a phone number for patients to call if they have any queries. The letter should explain any consequences of not attending, arriving late for the appointment or cancelling it. Information about the clinic a patient is attending or tests they will undergo, as well as transport arrangements, should be included as appropriate. For services on the NHS e-Referral Service, this information should be included in the instructions section of the directory of services template.

In summary, organisations need processes to ensure:

- patients are offered a choice of appointment
- every effort is made to negotiate the date of an appointment with patients rather than sending them a 'fixed' appointment
- patients are booked in order of clinical priority and then in order of the date the referral is received
- patients are booked in a timely way to ensure that RTT, cancer 2WW and/or diagnostics six-week wait standards can be met.

Please refer to Appendix 4: Good practice for appointment confirmation letters.

Outpatient clinic booking 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 – that is, making sure no appointment slots are wasted, DNAs are minimised and new-to-follow-up ratios are reduced where appropriate. Clinics must be templated with consideration for clinic duration, and structured to reflect the needs of patients and the service. Accurate templates support more efficient operational management and capacity and demand planning.

Organisations should be guided by the following principles when reviewing their clinic templates:

- clinic templates across all services in a provider should be regularly reviewed (at least annually to coincide with capacity and demand planning for the year ahead)

- clinic session duration should be consistent and determined by the organisation
- clinic start and finish times should reflect the time the clinician is expected to be in the clinic
- a named consultant should be involved in any discussions about changing clinic templates; other teams, such as the outpatient nursing, phlebotomy, radiology and other diagnostic teams, should be consulted about resource availability.

Clinic outcome forms

The RTT status should be recorded at each stage of the patient pathway to determine the next stage of treatment. Clinic outcome forms are essential for capturing the decisions that determine a patient's progress along their RTT pathway.

The clinic outcome form needs to record what happened during the outpatient attendance (for example, any treatment given in outpatients) and the intended next step on the patient pathway. This should be completed accurately and as soon as the attendance ends. While paper systems are still commonly used across the NHS, electronic collection of clinic outcomes should be considered. Electronic systems can embed algorithms that ensure use of consistent outcome codes.

Clinicians should be involved in the design of the clinic outcome form to ensure the necessary clinical information is captured and to get their support for its use.

Consultant-to-consultant referrals

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

Consultant-to-consultant referrals for the same condition usually result in the patient's RTT clock continuing to run. The exception is where the patient received definitive treatment before being referred.

Where a patient is referred to another consultant for a different condition, a new RTT clock will start. It then needs to be decided if the RTT clock for the original pathway should be stopped, or if the patient is on two RTT pathways concurrently.

The patient's GP needs to be informed about the referral to another team.

Inter-provider transfers

A locally agreed and RTT rules compliant policy is needed for managing inter-provider transfers. As with all types of referral, an inter-provider referral should be received at a central point within the organisation. A minimum referral dataset should be agreed for the local health community. In particular, the referring provider must

inform the receiving provider of the patient's RTT status. If the patient has already been definitively treated, then it is appropriate to start a new clock on receipt of the referral. For patients referred when part way along their pathway, the receiving organisation should retain the original referral date as the clock start date.

Providers should be aware of those pathways where it is likely that patients will be referred to another organisation for diagnostics or treatment, and ensure pathway milestones are appropriately monitored for these. Additionally, good communication channels between providers are needed for the timely sharing of information on a patient's RTT status and progress along the pathway, eg clock stops.

Commissioners have a key role in performance managing organisations that repeatedly refer later than agreed milestone timescales, by using, for example, the relevant contracts process, Commissioning for Quality and Innovation (CQUIN) indicators.

Managing DNAs (refer also to Section 7.4)

All providers should have strategies and actions to reduce the number of patients who do not attend their appointments. DNAs not only delay access to treatment for the patient concerned, but they also waste capacity that could have been used to see and treat other patients. As a minimum, organisations should monitor data such as DNA rates by specialty per month, and make local decisions on what an acceptable DNA rate is for the organisation or specialty to achieve. Ideally, the DNA rate should be monitored on an ongoing basis, which will support the evaluation of initiatives to reduce DNA rates.

High DNA rates are often indicators of poor booking practice – for example, a reliance on fixed appointment letters. Providers should introduce patient-focused booking processes that offer patients a real choice when scheduling appointments.

When speaking to patients to confirm appointment arrangements, it is good practice to ask them to write down the appointment details as this helps commit them to memory. Booking practices should be supported with an agreed script, which can be tailored according to the urgency and sensitivity of discussions. The booking script should confirm the implications of not attending an appointment.

Please refer to the Booking appointments section above for further information regarding patient-focused booking and scripts. Appendix 7 includes an example booking script for 2WW patients.

It is good practice when rebooking patients who have previously not attended for staff to agree and directly book the new appointment with the patient at the time of contact. It is also good practice to let the referrer know if a patient who is in a vulnerable group, or who has an urgent referral or who has suspected cancer does not attend. Providers must ensure there are local policies to manage DNAs and

patient cancellations that reflect the spirit of the national RTT rules, and these should be clearly outlined in the organisation's access policy.

While there will be cases where it is appropriate to discharge a patient who does not attend their appointment, providers must not apply blanket rules in this regard. Patients should only be discharged where this is in their best clinical interest. It follows that all such decisions require the involvement of the treating clinician.

The former NHS Institute of Innovation and Improvement published a resource on reducing did not attends.

Organisations may also wish to benchmark DNA performance against peers.

Patient cancellations and rebookings (refer also to Section 7.4)

Appointments may be cancelled by the patient or by the GP on behalf of the patient – these are both referred to as patient cancellations. There needs to be a clearly agreed process setting out when it is appropriate to reschedule the appointment and when to discharge a patient from the RTT pathway following one or several cancellations.

The same principles apply to management of cancellations as to management of DNAs. There must be no blanket rules, and any decisions to discharge must be clinically determined to be in a patient's best interest. Rebookings should always be discussed with the patient, ideally when an appointment is cancelled.

If the appointment is rescheduled the clock will continue. But 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, particularly at the specialty level as well as cancellation rates for those patients on an RTT pathway who have cancelled previously.

Provider cancellations (refer also to Section 7.4)

Cancellation of appointments by the provider inconveniences the patient and reduces the efficiency of the service. Hospitals should cancel appointments only when all options to cover the clinic have been exhausted.

Providers should consider the following arrangements when developing local clinic/appointment cancellation policies:

- policies that encourage clinicians to book annual leave for the year ahead
- a minimum timescale for requests to cancel clinics – for example, six weeks ahead

- limit ‘acceptable’ clinic cancellation reasons to sickness, immediate family emergency, etc
- implement ‘fire-break’ clinics at six- to eight-week intervals to manage unforeseen circumstances. These are clinics which are left empty in case a fully booked clinic needs to be cancelled and rearranged due to unforeseen reasons. Patient appointments are moved to the fire break clinic, minimising the amount of rebooking/administrative work required.

7.3. Managing patients along their pathways – inpatient and day cases: scheduling, planned patients, booking, theatres

Booking surgical admissions

The efficient booking of patient admissions underpins the delivery of RTT pathways. Table 2 lists the tasks involved in the management of the admitted PTL and admissions processes. Staff need to understand their role in undertaking these, to ensure patients are treated within RTT standards.

Table 2: Management of the admitted patient tracking list and admissions processes

Good practice	Comments	What does good look like?
Operational managers must ensure 'to come in' (TCI) cards are completed for all decisions to admit (DTA) (preferably after pre-assessment) and agree a timeframe for entering them onto the PAS, for example 24 hours.	This ensures that all the correct details – including type of operation, patient's details, any surgical kit requests and co-morbidities – are recorded. It also ensures the admitted PTL is kept up to date.	All patients added to the waiting list within 24 hours of DTA. Use of electronic TCI systems to reduce duplication of effort and errors. Data quality report to reconcile clinic outcome of 'add to waiting list' with actual waiting list entry.
General managers must check patients are booked in order of clinical priority and then chronological date order according to the admitted PTL, and that patients are given reasonable notice (three weeks).	General manager should review a validated PTL where necessary with relevant treating clinicians, and verify the reasons for any non-chronological booking.	Evidence that all patients are booked in clinical priority and chronological order. Evidence that any patients waiting a long time are doing so out of choice, rather than because of poor booking practices.
Timely, clinically-led review and sign off of prospective theatre lists.	Clinical review of theatre lists three to four weeks in advance should ensure lists are full, will not overrun and that patients are given sufficient notice of their admission.	A reduction over time in theatre lists that overrun and improved theatre list productivity.
General managers should confirm with each specialty the internal milestone target from DTA to admission, and this should be in line with the overall RTT pathway.	Setting specialty-level internal milestones from DTA to admission is good practice for managing overall RTT pathways. It is important to do this at specialty level	Each specialty has clear internal milestones which are RTT compliant. Early warning and escalation systems to detect deviations from the specialty-specific milestones.

Good practice	Comments	What does good look like?
	because each specialty (or even subspecialty) will make different demands on the admitted part of the RTT pathway.	
Providers should rebook patient admissions either face to face on the day of the DTA, or later by phone. Patients should be offered a choice of two dates, each at least three weeks' ahead.	Providers can book patients by phoning them directly or by writing to invite them to phone to schedule their admission date. Admission letters without a fixed admission date should not be sent – other than when confirming a phone or face-to-face booking.	All patients are able to negotiate their admission date.
Admissions staff must notify their managers if they do not have the capacity to book patients within the target time (and with reasonable notice – three weeks). Providers should have an agreed escalation process for admissions staff 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 treatment.	Efficient and responsive systems to alert booking staff to unfilled theatre lists to resolve capacity issues. Clear escalation policies and timelines with details of accountable officers to approach when capacity issues are identified.
Operational managers should meet consultants to share their admitted PTL (both dated and undated patients).	This informs consultants about their progress toward meeting the national operational standards and makes them aware of the size of their waiting lists.	Bi-weekly, consultants know exactly the size of their admitted PTLs and casemix.

Good practice	Comments	What does good look like?
Operational managers should implement processes for double-checking TCI lists.	This can pick up errors or issues, for example patients listed as coming in the next day but who have not attended for preoperative assessment (POA). TCI lists should be checked on hard copy and on the PAS.	Electronic booking systems which automatically flag patients with an imminent TCI who have not attended or failed POA who have not confirmed their TCI.
A cut-off time for adding to theatre lists, such as 24 hours before the list starts, should be agreed, with a clear escalation process for when this is breached and details of who is permitted to make any changes.	This avoids last minute reorganisation that can lead to lists over running or starting late.	Booking systems which automatically freeze theatre lists 24 hours before they are due to start, with good control systems to manage any changes.
Admissions staff should regularly validate patients before offering dates for surgery and before the TCI date (five to seven days before is recommended), to check the patient is still fit for surgery and can come in as planned.	This can pick up any issues (social or medical) before they lead to a DNA or cancellation on the day of surgery, and a loss in theatre capacity. It is good practice to phone patients in the evening five to seven days before admission. All conversations with the patient should be summarised and dated in the waiting list entry on the PAS. It is important to check any medical issues found through validation with clinical staff to find out if any action needs to be taken.	Low DNA rates or cancellations on the day of surgery for medical or social reasons.

Good practice	Comments	What does good look like?
All conversations with patients should be summarised clearly with dates and names in the waiting list entry on the PAS.	This includes conversations about choice of admission date, or any requests to delay treatment.	Waiting list systems with detailed, accurate audit trails of contact with patients.
The provider should have a central admissions team to manage all inpatient/day case waiting lists and to make all bookings.	This ensures consistency of practice.	Evidence of compliance with standard operating procedures (SOPs).
Pool surgical waiting lists where possible and clinically appropriate.	This helps give patients more choice, even up waiting lists for surgery and prevent RTTs longer than 18 weeks. Note that patients' right to choose their consultant does not prevent providers from offering treatment on a pooled waiting list.	All specialties have looked at pooling waiting lists and done this where clinically appropriate.
POA should take place on the day of the DTA to identify any medical problems.	This helps to ensure patients are fit for surgery at the time of listing, picking up any co-morbidities which may need to be treated before surgery can take place.	Low cancellation rates due to medical issues on the day of surgery.
Each specialty, or where admissions are centralised the admissions office, must confirm the process for dealing with cancellations made by the provider.	National standards require patients whose operations have been cancelled for non-clinical reasons to be re-dated within 28 days of the scheduled date of admission. The admissions office must	All patients whose admissions are cancelled on the day are re-dated within 28 days and have a new date for their surgery when they leave hospital – or are funded to be treated at the

Good practice	Comments	What does good look like?
	be able to demonstrate its processes for meeting this standard.	time and hospital of their choice.
Agree key performance indicators (KPIs) for theatre productivity and utilisation, and a notional target capacity for each theatre list.	The productive operating theatre toolkit can help with this process.	Regular review of KPIs and theatre activity with corrective actions agreed.
General managers must ensure there are local policies to deal with DNAs and patient cancellations of surgical admissions, which reflect the national RTT rules and the local access policy.	Local policies should include giving patients reasonable notice for offers of admission (three weeks) and clearly outlining how the clinical needs of patients, especially vulnerable patients, will be considered before discharging them following a DNA or cancellation.	Visible and well- documented policies in admission offices for booking staff to use. Policies reflect up-to-date RTT national guidance and are assessed regularly.
General managers are advised to have audit arrangements to ensure good practice admissions processes are being followed.	This helps pick up any training issues as well as keep 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.
General managers should ensure there are clear and detailed SOPs, and that these are readily available to staff. These procedures should be supported by an appropriate training programme.	This will help with cover arrangements for admissions staff, and ensure staff work 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 SOPs with clear timelines and contact numbers. Six-month training programmes.

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 on clinical criteria (eg 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 for managing patients who require planned appointments for assessment, review and/or treatment.

In summary, patients should only be added to a planned waiting list where there is a clinical reason for them to wait a period of time before moving on to the next stage of their pathway. When their appointment is due, they should either receive the care in a timely manner, or be added to an active waiting list (RTT and/or diagnostic clock start).

Providers should have robust and detailed evidence of compliance with these rules. We recommend the following as a minimum:

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

Clock pauses

Clock pauses for admitted pathways were discontinued in June 2015. Note clock pauses have never been permitted for non-admitted and incomplete pathway reporting. However, patients retain the right to delay any aspect of their RTT pathway for social or personal reasons, even where such delays mean they cannot

be treated within the RTT waiting times standard. Such patients should still be reported as waiting, and should be accommodated within the 8% performance tolerance. Providers should however record patient-initiated delays for audit purposes.

Providers should ensure there are adequate processes to support the correct reporting of all RTT pathways; that is, without the clock pauses. We recommend the following as a minimum:

- specific and accurate policies/procedures detailed in the provider and local health community access policy, regarding the management of patient choice of date
- providers locally record patient-initiated delays (choice) to help with possible breach analysis
- patients who have requested a delay are highlighted on the PTL.

7.4. Managing patients along their pathways – diagnostics: endoscopy, imaging

The efficient booking of patients referred for diagnostics underpins the delivery of RTT, cancer and diagnostic waiting time standards.

This section details some areas of good practice in relation to diagnostic management.

Paper referrals

Diagnostic departments should encourage the use of standard request forms to make it clear what information is required and to identify incomplete referrals. Referrer self-vetting criteria should be confirmed to minimise inappropriate referrals. Guidelines sufficient to enable administrative staff to book diagnostics should be provided, reducing the need for clinical input to this process. These should be supported by a clear escalation process for staff needing to raise queries regarding specific diagnostic requirements, or to escalate capacity issues.

In addition to the training described in Section 7.2 above, administration teams require appropriate mandatory training on the six-week diagnostic rules and planned patient scheduling.

Advantages of electronic referrals

Organisations should aim to introduce an electronic referral process as this enables single-point electronic capture of information and its transfer to the diagnostic information system. This has the following benefits:

- 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 RTT and DMO1 returns
- instant availability of the request in the diagnostic department
- reduced administrative time, eliminating referral registration
- reduced delays contributing to shortened inpatient stay and achieving RTT standards
- reduced paper and storage costs.

Registration of referrals

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 can see the true waiting list size. Hard copy referrals should be registered before being forwarded 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 sending on for vetting with limited administrative input.

Pre-registration checks – the minimum dataset

Organisations should identify the minimum dataset required to validate a referral, and consider implementing a standard referral pro forma for routine referrals. Regardless of the format of the referral (pro forma or letter), it is considered good practice for all referrals to contain a minimum dataset (see Appendix 1) and to be accurate and legible.

Organisations should have a clear process for managing incomplete referrals so that patients are not unfairly disadvantaged.

Vetting of referrals

Timely, clinically-led vetting of referrals will ensure referrals are appropriate, help identify if a different diagnostic modality is more suitable for confirming a diagnosis, and ensure Ionizing Radiation (Medical Exposure) Regulations (IRMER) requirements (where applicable) are adhered to. Vetting can be done by an appropriately trained pool of staff,[3] rather than particular individuals vetting specific

[3] Can include nurses, radiographers, technologists, technicians, advanced practitioners and administrative staff.

referrals, to increase the vetting capacity and minimise any delay in vetting referrals. Staff should follow clear protocols and be subject to ongoing monitoring and audit.

Please refer to Appendix 2 for good practice principles.

Electronic vetting of referrals

Diagnostic information systems can enable electronic vetting of referrals, reducing the need to print referrals for review by the clinical team. Electronic vetting also means the referral can be booked as soon as 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 then date of receipt to ensure there are no undue delays. Diagnostic information systems can also help with workload prioritisation and reducing variation between patients in referral vetting times.

Booking protocols

Modalities should follow standardised booking protocols agreed with the diagnostic department. The booking team should have clear principle-based guidelines for the booking of diagnostic examinations. For each examination these should cover:

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

Available timeslots for procedures should be limited to three or fewer to facilitate capacity and demand planning – for example, 10, 20 and 30 minutes.

Demand

Providers should have a robust system for ongoing monitoring of referral demand, by modality, to support capacity and demand planning. We have produced specific capacity and demand tools for diagnostic imaging and endoscopy, with accompanying user guides.

Booking appointments

Every appointment should be booked correctly and efficiently. Organisations should adopt processes which are patient focused and geared towards offering patients a choice of appointments within a set period. Referrals should be booked in order of clinical priority and then in order of receipt across all modalities.

Both the RTT status and the six-week diagnostic target should be visible and patients scheduled accordingly. Administrative staff should book patients according to standard written guidance from the relevant clinician, such as senior radiographer, radiologist and technologist. Administrative cross-cover is essential to ensure all modalities can be booked and the impact of absence for annual leave, sickness, etc is minimised.

Confirming appointments

Providers should facilitate direct booking of diagnostics via an electronic booking system (that is, e-referral) or by enabling patients to contact the department for an appointment following their outpatient attendance.

A diagnostic PTL will ensure patients are prioritised appropriately.

Please refer to Appendix 4: Good practice for appointment confirmation letters.

Patient preparation

Bookings staff should ensure patients receive appropriate guidance or instructions before their diagnostic test – for example, fasting instructions. They should also ensure patients have contact details for the department in case they have questions or want further information. 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 minimises the likelihood of cancellations on the day and the appointment having to be rescheduled.

Providers should ensure paper diaries are removed when an electronic schedule becomes available.

Resource utilisation and scheduling

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

- minimise or eliminate carve out or ring fencing of slots
- ensure booking requirements are based on key criteria (refer to Booking appointments above)

- confirm timeframes for release of equipment capacity ring fenced for particular patient groups (for example, screening) for booking other procedures if the equipment time is not fully booked
- have a system for ongoing monitoring of equipment to ensure its effective utilisation
- have a forward plan of scheduled service and quality assurance activities to minimise the effect of these activities on the capacity required to meet service demand.

See also Section 7.2 for general good practice guidance in establishing booking principles.

The capacity within the schedule should be sufficiently flexible to meet variations in demand from 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.

Radiology reporting

As well as carrying out all diagnostic tests within six weeks, the results must be reported in a timely manner. This is a particular issue for radiology departments: many providers find delays in reporting radiological examinations contribute to longer RTT and cancer waiting times.

Providers should establish maximum reporting turnaround times that take account of clinical urgency and RTT waiting time. These time standards should be monitored and reviewed on a regular basis. Where reporting delays are significant, providers could consider one or more of the following actions:

- consultant rotas designed to allocate session cover to a pool of reporters so sessions are not adversely affected by annual leave
- shorter radiologist/consultant sessions to allow more focused reporting and reduce the impact of annual leave and multidisciplinary meeting attendance on the modality
- radiographer/technologist/technician/advanced practitioner-led reporting under clinical protocols to improve reporting times; this needs the agreement of the team and appropriate training of staff.

Unexpected findings

Providers should ensure there is a protocol for referrer notification of unexpected findings of cancer or other clinically urgent conditions, identified as part of the attendance for diagnostic procedures. This should include a mechanism to notify the relevant tumour site MDT if required to ensure timely RTT. The NPSA Note 16 provides guidelines on communicating unexpected significant findings.

Management of DNAs

Booking staff should explain the DNA policy to patients at the time of booking and remind them of their responsibility to inform the organisation in advance if they are unable to attend.

Provider cancellations (refer also to Section 7.4)

Cancellation of appointments by the provider inconveniences the patient and reduces the efficiency of the service. Such cancellations should be authorised only where there is no option available/appropriate to cover the diagnostic list.

Walk-in services

Providers should evaluate the feasibility of using walk-in diagnostics clinics to reduce RTT time and, potentially, improve convenience for patients already on site for another reason, such as to attend an outpatient appointment.

Direct access diagnostics

Providers and commissioners should consider, where appropriate, the introduction of GP direct access to diagnostics. This can help reduce the length of a patient's non-admitted pathway, as well as enabling more timely access to diagnostic services and reducing the patient pathway. 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 for not deferring patients on a planned care pathway: they should be treated at the right time and in order of clinical priority. A significant proportion of planned activity is associated with surveillance and monitoring of high risk patient groups. All providers need to have robust procedures for reviewing planned lists and to ensure patients are seen in the clinically appropriate timeframe.

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

Utilisation of equipment

Refer to the to National Audit Office's report *Managing high value capital equipment in the NHS in England*.

Useful resources

- *Diagnostics waiting time and activity information*
- *Rapid review of endoscopy services*

8. Supporting processes

8.1. Access policies – elective care and cancer

An elective care access policy (ECAP) should be developed by the local health community and involve all relevant parties including patients and clinicians. Policies need to be agreed in line with the internal governance arrangements of both the commissioner and provider. The policy should be published on the provider's website, but also be available in hard copy in, for example, outpatients or the patient advisory liaison service. The languages in which the ECAP is published need to be considered. A patient-friendly summary of the policy may be helpful in setting out what patients can expect of the provider, as well as the responsibilities of patients in relation to accessing appointments and treatment.

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

The ECAP should also reference other relevant local policies, such as 'overseas visitors', 'prior/commissioner approval', etc.

More detailed guidance in relation to developing an access policy is available on the NHS Improvement elective care hub.

8.2. PTL meetings

A trust-wide elective access meeting should be held weekly, chaired by the executive director (or designated deputy) responsible for the delivery of the RTT and cancer operational standards. Appendix 3 lists suggested tasks for preparation for the weekly PTL meetings.

The meetings need to be attended by those with operational responsibility for delivering the standards (Appendix 6 lists suggested attendees). The function of the meeting should be to provide regular operational oversight of the cancer and RTT standards and to receive escalations from throughout the organisation relating to risks to performance. The meetings should be supported by documented terms of reference and standing agenda. Action notes should be taken at each access meeting. These notes will clarify expectations for staff participating in discussions, both in terms of their preparation ahead of and attendance at the meeting.

Local commissioner representation at these meetings is helpful, but providers may want to decide if this should just be for part of the PTL meetings.

In addition to the trust-wide elective access meeting, specialties should hold their own weekly PTL meeting to discuss their own specialty-level key performance indicators (KPIs) and patient-level information.

We suggest specialty and local business unit meetings are held on the same day each week and, depending on the size of the organisation, before the trust-wide elective access meeting.

Business units must adequately prepare for the PTL meeting to show they have:

- a management plan at the individual patient level
- addressed the majority of key issues arising from the previous meeting, or in relation to pathway delays for patients as a result of capacity issues or inaction by booking and scheduling staff
- an action plan for those issues still to be resolved
- escalated any issues that cannot be resolved within the business unit.

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

- performance management and accountability
- breaches and prospective management of patients along the RTT and cancer pathways
- clearing the backlog of patients waiting longer than the RTT standard
- delivery of the RTT and cancer pathways
- monitoring and managing the number of incomplete pathways.

Any agreed actions must be followed through and reviewed the following week to ensure they are being addressed. An audit trail of dated actions and when they have been dealt with is advised. In addition, organisations will want to see the impact of their actions in the following week's PTL numbers and profiles. For issues not resolved between one PTL meeting and the next, providers need clear escalation processes to support staff. The relevant service or general manager must take the lead in dealing with patient-level issues raised during PTL meetings.

8.3. Reporting: internal and external

At every stage of the processes described above, accurate, timely and clearly-presented information and analysis underpin effective management of RTT pathways; this is the case for both those carried out within providers and those carried out externally through commissioners.

Some general principles of good information management should be applied to all RTT reports. For example:

- 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 to highlight areas for attention/concern
- consistent – so that the same key performance indicators (KPIs) are used, where appropriate, throughout the organisation/local health system
- secure – so that only appropriate staff can view information and patient-identifiable information is only used when absolutely necessary
- checked and analysed where appropriate to help staff understand the implications of the data they are seeing.

8.4. Patient pathway management information

Effective management of an elective service (via the PTL) requires a good understanding of the pathways patients are expected to follow and information about actual patient waiting times along that pathway. The information should be:

- **Live** or as close to live as possible (within 24 hours). Short waiting times are required to deliver a good patient experience, so weekly information is insufficient to identify and resolve potential issues quickly enough; this is particularly true for cancer patients.
- **Grouped** according to useful cohorts. The numbers of patients waiting at any one time makes it impractical to look at each patient individually. Patients should be grouped in a way that is consistent with the **KPIs used across the organisation as far as possible and particularly with those used in the PTL meeting**. Some specific cohorts may be required depending on the needs and configuration of each service; for example:
    - specialty/business unit
    - subspecialty
    - consultant
    - days/weeks waited or days/weeks from target
    - weeks waited at the next event – for example, at the next follow-up appointment

- treatment milestone (first/follow-up outpatients, diagnostics and decisions to admit, etc) provided this is on the overall RTT waiting time and is not a treatment stage.

- **Tailored** to each audience as appropriate; for example, a divisional manager will not need the same view of the PTL as a booking clerk (although this will depend to some extent on the cohorts used to group information).
- **Patient-level** to the extent that when viewing aggregate information (for example, numbers of patients waiting for a particular event) it is possible to identify each patient and accompanying pertinent information. It should be possible 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. As the entire PTL will potentially have thousands of patients on it, it is unrealistic for staff to review this individually.
- **Based on milestones** to link current waiting times back to the agreed clinical pathways. This identifies, for example, patients who have appointment dates that are later than agreed booking windows or who pass these key points without attending an appointment. Key points include:
  - milestone for attendance at first outpatient appointment (for example, six-week milestone for first outpatient appointment, along with percentage seen within that timeframe)
  - key diagnostic test or tests
  - diagnosis
  - decision to treat
  - MDT discussion
  - transfer to another provider
  - treatment (or decision not to treat).
- **Inclusive of service standard information** to support timely patient management. For example:
  - referral vetting (for example, urgent referrals vetted within 24 hours, routine referrals vetted within 48 hours)
  - booking first appointment (for example, urgent referral booked within 48 hours of receipt, routine referrals booked within five days of receipt)
  - outcome attendances (for example, 95% completed on the day, 98% within 48 hours, 100% within five days)
  - clinical letter typing (for example, urgent letters within 48 hours, routine letters within five days, along with the percentage achieving the standard).

8.5. Performance information

It is common for providers to time their internal reports according to the timetables for national returns, which are often monthly and quarterly. This lets staff at every level know the 'final position' against operational standards, but more frequent information is required for operational management purposes.

Furthermore, 'final' reports must be available in advance of national deadlines and progress towards deadlines tracked. It is also important to put the current position in context by including data on past performance. Information should also be processed in such a way that non-technical staff can use it to draw useful conclusions and, where necessary, take appropriate and informed decisions.

When past, current and predicted performance can be compared in a graphical display of trends, it can be useful to incorporate features such as:

- actual performance in the week/month to date
- predicted short-term performance based on forthcoming appointments/TCIs this week/month and in subsequent weeks/months
- predicted medium-term performance based on data on, for example, demand (new referrals coming in) and adherence to clinical pathway milestones, as well as on 'soft' intelligence such as booked staff leave and associated 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 – assessment of variation and identification of special causes
    - national, regional and/or local comparators and other benchmarking
- related metrics which influence measured performance, for example:
    - demand and capacity analysis
    - adherence to access policy
    - breach reasons/route cause analysis (RCA) aggregated to show trends
    - data quality and, where applicable, the percentage of records validated.

Each local health community will hold a number of monitoring meetings and each of these, based on the guidelines above, will require patient pathway management information, performance information or a combination of the two.

The information team must ensure the information provided to support each meeting matches as closely as possible the aims of the meeting and the needs of its participants. Where applicable, the information provided should capture agreed actions from previous meetings and those responsible for their delivery.

8.6. Information requirements

Booking and scheduling

Those responsible for booking patient events will require the patient-level information listed in Table 3.

Table 3: Patient-level information required for booking patients

Pathway stage	Information required
1. Outpatients	Patient pathway management information, grouped by weeks waited, new and follow-up appointments, and clinical urgency. Information about non-RTT patients such as those post-clock stop, non consultant-led pathways, etc.
2. Diagnostics	Patient pathway management information, grouped by weeks waited and clinical urgency. Information about planned/surveillance, due/treat by date, six-week diagnostics, cancer and RTT pathway status, therapeutic procedures, other non-RTT patients, and cancer waiting time milestone targets to be shown on the same report.
3. Inpatient/waiting list booking	Patient pathway management information, grouped by weeks waited and clinical urgency. Information about planned treatment/surveillance, treat by date, subsequent treatment for cancer and any other non-RTT patients, whether patient has had their preoperative assessment (POA), and cancer waiting time internal milestone targets to be shown on the same report.

8.7. Information for PTL meetings

Patient pathway management information is used to identify patients for whom action is required to expedite their pathway. Performance information is used to assess current performance against key metrics in terms of national standards and related issues such as adherence to access policy. Breach reporting is appropriate at patient and/or specialty/consultant level.

Please refer to Section 8.2 PTL meetings.

MDTs and other clinical groups

These groups are likely to need a mixture of patient pathway management information and performance information. Most of the necessary information is clinical in nature – key patient pathway information, waiting time against standard, target dates and milestones.

Performance information is needed to understand current and prospective performance against national standards and clinical pathways. 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, subspecialty/clinical pathway and consultant level to understand the issues affecting each service. Detailed breach reporting and demand and capacity analysis is required.

RTT/cancer/elective board

A performance information overview is required for this higher-level meeting, highlighting specialties/tumour sites where there is unacceptable variation in performance against national standards, trajectories or internal targets. Aggregated breach reporting and demand and capacity analysis are required.

Provider executive and provider board

Reports to the trust board should support delivery of elective care (RTT, diagnostics and cancer standards). They should cover more than performance relating to the national standards and include, for example, breach volumes, clearance times, as well as a narrative on specific pressure points.

At this highest trust level an agreed performance dashboard across all provider performance measures, including elective care, is required. This should quickly identify areas where performance is a concern or confidence about sustainability is not high. Some specialty-level information may be appropriate for areas of particular concern. We advise using a dashboard or scorecard that shows trends in

performance. The board's responsibility is to understand the information presented in the dashboard or scorecard and what good performance looks like, and to challenge the reasons for performance. The board should not assume reported good performance is the reality and instead should seek assurance by asking for data quality measures.

External statutory reporting

RTT performance information is reported monthly via the Unify2 online data collection tool. Guidance on uploading to Unify2 can be found in Section 9 of the RTT recording and reporting guidance, and on the Unify2 website. Once this monthly information has been uploaded, it is reviewed and then signed-off by the relevant commissioning organisations. NHS England also runs monthly central data quality checks. The most up-to-date versions of these checks can be found in Annex B of the RTT recording and reporting guidance.

If the submitted data fails any of these checks, NHS England will raise a 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.

Appendix 1: Example referral minimum dataset

- Patient's full name
- Patient's date of birth
- Patient's gender
- Patient's full address including postcode
- Patient's up-to-date contact telephone number (preferably a mobile number)
- Patient's NHS number
- Referrer details (including email, telephone and fax number)
- Relevant medical history
- Specific clinical question and diagnostic examination required
- 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
    3. follow-up: the diagnosis is known and this investigation is to follow-up progress
- Full clinical details on reason for the referral in line with clinical referral guidance and locally agreed referral criteria, as well as other relevant information such as current drug regime, clinical question to be answered and significant past medical history

Appendix 2: Good practice principles for vetting management

The provider should:

- ensure two vetting categories of urgent and routine only
- ensure agreed service standards for vetting – that is, all referrals should be vetted on the same day as/within 24 hours of receipt, and in line with trust access policy
- confirm vetting frequency and ensure staffing resources are adequate (for example, by pooling to avoid delays when key staff are on leave), and ensure service standards are confirmed
- document examinations that can be booked before vetting and ensure booking occurs on the day the request is received. Patients need to be aware that there is always a small chance their appointment may be changed after vetting
- review diagnostic procedures to confirm where vetting may not be required, making patient scheduling as efficient as possible without compromising Ionizing Radiation (Medical Exposure) Regulations (IRMER) 2000
- ensure appropriate mechanisms to monitor vetting of referrals (referral turnaround time – minimum, average and maximum; unvetted referrals) and appropriate follow-up of referrals that are not vetted within the designated agreed service standard.

Appendix 3: Suggested list of weekly tasks to support PTL meeting preparation

Outpatient weekly tasks

- Each business unit must confirm with staff that they understand the daily tasks required to track patients along the elective care pathway.
- Outpatient booking staff must deal with referrals as they come in and book patients within the agreed maximum waiting times/the number of weeks a GP can book a patient in advance, also referred to as the polling ranges for both e-referrals and paper referrals.
- Outpatient booking staff must escalate to the operational manager referrals that 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 outpatient slots per week (within and outside the polling ranges).
- Patient trackers must review the non-admitted PTL and check where patients are on the pathway:
    - waiting for a first outpatient 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
    - 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. They may find it helpful to review a random sample of individual patients on the PTL with the relevant staff.

Inpatient/day case weekly tasks

- Each business unit or specialty must confirm with staff that they understand the daily tasks required to track patients along the elective care pathway.

- Operational managers must ensure DTA notifications are completed for all DTAs, preferably after pre-assessment, and agree a timeframe for entering them onto the PAS.
- Admissions staff should be set weekly targets – number of patients to agree TCIs with and number of DTAs to add to the PAS.
- General managers to confirm with each specialty the expectation regarding the timeframe from DTA to admission.
- Admissions staff must escalate concerns that they do not have sufficient capacity to book patients within the target and with reasonable notice – that is, three weeks.
- General managers must check patients are booked in date order and are given reasonable notice of admission.
- General managers must agree the process for monitoring the application of pauses.
- Operational managers should meet consultants to share the consultant and specialty admitted PTL (those with/without a TCI).
- Each business unit must confirm the process for hospital cancellations.
- General managers are advised to review a random sample of individual patients with the appropriate staff.
- General managers should confirm which patients have passed their treat by date, been moved to an active waiting list, and been reviewed/treated within the relevant RTT standard – for example, six weeks for a diagnostic.

Appendix 4: Good practice for appointment confirmation letters

Refer to NHS England'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://media.dh.gov.uk/network/261/files/2012/06/RTT-FAQs-v10-Oct-2012.pdf

Appointment letters should include information on the patient's right to receive treatment within maximum waiting times, as per the NHS Constitution.

In addition, an appointment confirmation letter should:

- provide clear and informative details, and a telephone number to call if the patient has any queries
- confirm the date and time of the appointment
- name the procedure the patient will be having
- explain clearly the consequences of the patient not attending, turning up late for or cancelling the appointment
- confirm anything the patient needs to do in preparation
- provide information regarding transport arrangements as appropriate
- confirm the expectation the patient will call to reschedule if they are unable to attend, so that the appointment can be offered to another patient.

Appendix 5: GP pro forma two-week wait referral

NHS

North Trent Cancer Network

Breast

Fast Track Referral – 2 Week Wait

Referring Clinician:

Name: «Sender_name»
Address:
«Sender_address»
Tel No: «Sender_telephone_number»
Fax No: «Sender_fax»

Date of Referral: | **Time:**

Patient Details:

NHS No: «NHS_number»
Name: «Forename» «Surname»
Address: «Patient_address»
Tel no. (home & mobile):
DOB: «Date_of_birth»
Male / Female: «Gender»
Language: **Interpreter required ( )**
Transport required ( )

Please use separate children's pro-forma for patients under 16

For patients over 16:

- Do not use this form to refer asymptomatic women for routine breast screening but contact your local Breast Screening Unit directly on: XXXXX localities to insert.
- In a patient who has previously had histologically confirmed breast cancer, who presents with a further lump or suspicious symptoms, an urgent referral should be made irrespective of age

Dear Colleague

I would be grateful for your opinion on the patient named above who presents with clinical findings I consider suspicious of malignancy.

I have discussed the possibility of cancer with this patient.
Has the patient confirmed that they can be available to attend an appointment within the next two weeks? **Yes ( ) No ( )**

Women

Referrals

Any Age	Tick if present
Fixed and hard lump +/- skin tethering	
Eczema/nipple discharge that is resistant to topical treatment	
Spontaneous unilateral bloody nipple discharge	
Recent onset of nipple distortion	
Persistent mastalgia, no lump	
Other (please state)	

Refer 2WW

Under 30 years	Tick if present
Fixed and hard lump +/- skin tethering	
Enlarging lump	
Lump	
Other (please state)	

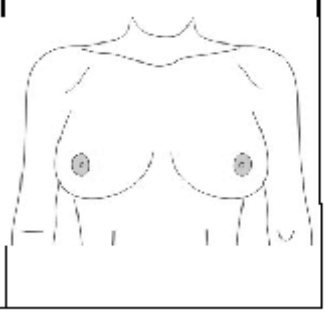
Refer 2WW

30 Years and over	Tick if present
Lump persisting after next period / post menopausal	

Refer 2WW

Exam

Right ☐ Left ☐ Both ☐



Form to be reviewed annually

Page 1 of 3

Revised: 7 Feb 11 FINAL

Appendix 6: Suggested terms of reference for a trust-wide 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 meeting expectations and agree a common agenda/approach for both levels of PTL meeting.

Introduction

The meeting 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 the national operational standards for elective and cancer waiting times to ensure these are achieved, as well as improvements in patient flow and discharge performance to ensure service sustainability.

The primary aim of the group is to improve patient access to care by identifying delays along the pathway, particularly with the assessment and admission processes, and enabling staff throughout the business units and across the wider operational groups to work in a co-ordinated way to overcome delays.

The meeting will ensure rules (for both cancer waiting times and RTT) are correctly applied, patient pathways within the specialty are planned and managed, and patients are dated in the correct order to deliver the national operational standards. The meeting should be supported by clear terms of reference and an attendance list.

Scope

To achieve robust elective performance the group must ensure:

- all patients have a next step/event noted for their pathway
- all elective activity and cancer performance is reviewed on a weekly basis
- patient flows are analysed (including achievement against milestones) for all pathways
- patient pathways are clearly established with key milestones indicated
- delays in the care pathway are identified and addressed
- coding is accurate and recorded in all admission/diagnostic/outpatient areas

- incomplete pathway performances are reviewed to ensure national standards are achieved
- there are policies supported by robust planning for known and identifiable events – for example, bank holidays, junior doctor changeover
- capacity is planned to ensure appropriate access for all patients
- the meeting has authority to take action and/or escalate issues where necessary.

Core membership

- executive responsible officer
- general manager
- operational manager/service managers including diagnostic departments
- lead information manager

Note: attendance at the meeting should be required and representatives sent when regular attendees are not available due to annual leave, etc.

The group may co-opt additional expertise/representation as necessary. Invitations to attend may be extended to commissioners to provide assurance of the processes in place to support delivery of the RTT and cancer standards.

Meeting arrangements

- Meetings will be arranged at weekly intervals, ideally at the same time and in the same location.
- Meetings 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 and followed up at the next meeting to ensure robust accountability.
- Administrative support for the meetings will be provided by its core membership.

Suggested agenda

The weekly agenda should cover the following key items. Note the trust-wide meeting will necessarily cover higher level analysis of data and trends, and high risk areas only. Specialty-level meetings will cover issues in more depth, and to individual patient level.

1. RTT performance:

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

2. Admitted performance (prospective management by breach date):

- patients without a TCI already breaching 18 weeks – action required – validation, TCI given to prevent breach where possible
- patients new to the admitted PTL who have 'dropped in' from the non-admitted PTL and/or are completely new to the PTL
- 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 who have 'dropped in' from the non-admitted PTL and/or are completely new to the PTL
- patients waiting 15 to 18 weeks without a TCI – as above
- patients waiting 15 to 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) – for example, 10 weeks
- planned patients who have passed their treat by date and are transferred to the active waiting list.

3. 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 and if it can be brought forward to prevent breach where possible
- those patients waiting 15 to 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.

4. Outpatient booking:

- by specialty, percentage (or numbers) booked within the agreed trust milestones timeframe for referral to first outpatient appointment – for example, six weeks
- e-referral slot issues (above 4%)
- follow-up capacity issues
- percentage of attendances that have had an outcome
- total waiting list sizes (both dated and undated).

5. Diagnostics:

- review of any potential six-week breaches and actions to resolve them
- review of any patients waiting more than the internal stretch standards set by the trust – for example, two weeks to book patient for an overall 18-week pathway
- establish the RTT status of any potential six-week breaches and actions to resolve them.

Information requirements

- Updated and refreshed PTL (ideally daily refresh).

Reporting arrangements

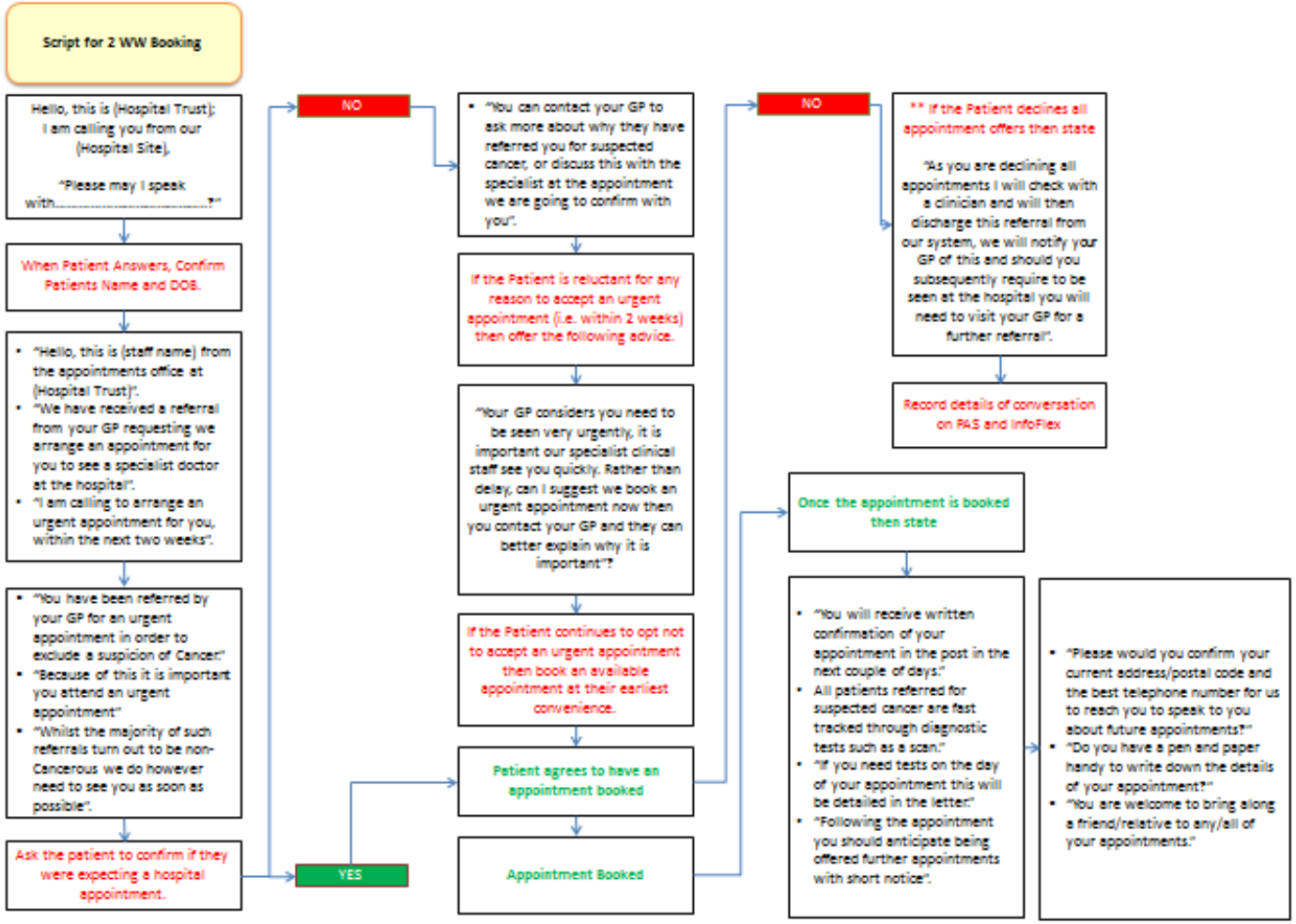
Each business unit or specialty PTL meeting reports at the trust-wide weekly PTL meeting chaired by the executive lead for RTT or director of operations.

All minutes and reports agreed by the group will be submitted as requested to the weekly PTL meeting and any other performance meeting.

Action review

- Review of the actions agreed in the previous week's meeting (for example, additional clinics to be set up – consultant agreed, space agreed, support staff agreed and template for the system).

Appendix 7: Booking script example



Contact us:

NHS Improvement
Wellington House
133-155 Waterloo Road
London
SE1 8UG

0300 123 2257
enquiries@improvement.nhs.uk
improvement.nhs.uk

Follow us on Twitter @NHSImprovement

This publication can be made available in a number of other formats on request.