Liverpool Women's
NHS Foundation Trust

Patient Access Policy

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The Trust is committed to a duty of candour by ensuring that all interactions with patients, relatives, carers, the general public, commissioners, governors, staff and regulators are honest, open, transparent and appropriate and conducted in a timely manner. These interactions be they verbal, written or electronic will be conducted in line with the NPSA, 'Being Open' alert, (NPSA/2009/PSA003 available at www.nrls.npsa.nhs.uk/beingopen and other relevant regulatory standards and prevailing legislation and NHS constitution)

It is essential in communications with patients that when mistakes are made and/or patients have a poor experience that this is explained in a plain language manner making a clear apology for any harm or distress caused.

The Trust will monitor compliance with the principles of both the duty of candour and being open NPSA alert through analysis of claims, complaints and serious untoward incidents recorded within the Ulysses Risk Management System.

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1 Executive Summary

1.1 Policy Scope

i. The purpose of this policy is to ensure all patients requiring access to outpatient appointments, diagnostics and elective inpatient or day case treatment are managed equitably and consistently, in line with national waiting time standards and the NHS Constitution. The policy:

- Is designed to ensure the management of elective and cancer patient access to services is transparent, fair, equitable, and managed according to clinical priorities.
- Sets out the principles and rules for managing patients through their Referral to Treatment (RTT) and diagnostic pathway.
- Applies to all clinical and administrative staff and services relating to elective patient access at the Trust.

1.2 Policy Scope during Covid-19 pandemic

- Patient access has been impacted by the Covid-19 pandemic. This has led to an increase in waiting times across most patient pathways. Elective activity has been stood down for long periods creating an increase in the number of breaches of RTT 18 week pathways and 52 week pathways.
- The significant increase in patient waiting times has the potential to increase the risk of patient harm. The Clinical Validation Programme has been set up to allow prioritisation of patients and maximise oversight of patient pathways
- Patients being added to the in-patient Patient Tracker List (PTL) are allocated a prioritisation code (P1-P6) to indicate the appointment urgency.
- Patients who do not want to attend for appointments/procedures/surgery due to Covid-19 pandemic cannot be removed from the patient waiting lists.

2 Introduction

i. The Trust is committed to delivering high quality and timely elective care to patients. This policy:

   i. Sets out the rules and principles under which the Trust manages elective access to outpatient appointments, diagnostics and elective inpatient or day case treatment.
   ii. Gives staff clear direction on the application of the NHS Constitution in relation to elective waiting times.
   iii. Demonstrates how elective access rules should be applied consistently, fairly and equitably.

iv. The Trust's patient access policy was developed originally following consultation with staff, clinical commissioning groups (CCGs), general practitioners, clinical leads and CCG lay members.

v. The access policy will be reviewed and ratified at least annually or earlier if there are changes to national elective access rules or locally agreed principles. The access policy should be read in full by all appropriate staff who have involvement in RTT/patient pathways.

vi. The Policy should not be used in isolation as a training tool. The access policy is underpinned by a comprehensive suite of detailed standard operating procedures (SOPs).

vii. All clinical and non-clinical staff must ensure they comply with both the principles within this policy and the specific instructions within SOPs. The Trust is committed to promoting and providing services which meet the needs of individuals and does not discriminate against any employee, patient or visitor.

3 Policy Objectives

i. This section of the policy should detail the purpose of the policy, including the rationale for development. This section should include the objectives and intended outcomes of the policy once implemented.

ii. This policies objective is to ensure all patients are given appropriate access to our services, and that our patients a delivered the same standard of care by all employees' of Liverpool Women's Hospital Foundation Trust by implementation of the access rules as laid out within this document.

4 Duties / Responsibilities

i. Whilst responsibility for achieving standards lies with the Divisional Managers and ultimately the Trust Board, all staff with access to and a duty to maintain elective care information systems are accountable for their accurate upkeep. For example:

- Divisional Managers are accountable for implementing, monitoring and ensuring compliance with the policy within their service.
- The Head of Information is responsible for the timely production of patient tracking lists (PTLs) which support the divisions in managing waiting lists and RTT standards.
- Admissions Co-Ordinators, Appointment Co-Ordinators and Booking Clerks, Secretaries and Ward Clerks are responsible to the Patient Access Manager and/or Operational Managers with regard to compliance of all aspects of the Trust's Patient Access Policy.

- Admissions Co-Ordinators, Appointment Co-Ordinators and Booking Clerks are responsible for the day-to-day management of their lists for outpatients, diagnostics and elective inpatient or day-case services and are supported in this function by Line Managers and Operational managers who are responsible for achieving access standards.
- Patient Access Manager, Departmental Managers and Operational managers are responsible for ensuring data is accurate and services are compliant with the policy.
- Heads of Service are responsible for ensuring the NHS e-Referral Service Directory of Services (DoS) is accurate and up to date.
- The Information Team are responsible for producing and maintaining regular reports to enable Services to accurately manage elective pathways, and ensure compliance with this policy.
- GPs and other referrers play a pivotal role in ensuring patients are fully informed during their consultation of the likely waiting times for a new outpatient consultation and of the need to be contactable and available when referred.
- The CCGs are responsible for ensuring robust communication links are in place to feedback information to GPs. GPs should ensure quality referrals are submitted to the appropriate provider first time.
- The NHS Constitution recommends the following actions patients can take to help in the management of their condition:
    - Patients can make a significant contribution to their own, and their families, good health and wellbeing, and should take personal responsibility for it.
    - Patients should be registered with a GP practice as this is the main point of access to NHS care as commissioned by NHS bodies.
    - Patients should provide accurate information about their health, condition and status.
    - Patients should keep appointments, or cancel within a reasonable timeframe.

4.1 Staff Competency & Compliance

4.1.1 Competency

i. As a key part of their induction programme, all new starters to the Trust will undergo mandatory training which is applicable to their role.

ii. All existing staff will undergo mandatory training on at least an annual basis.

iii. Competency tests will be undertaken for all staff and clearly documented to provide evidence that the required level of knowledge and ability has been attained.

iv. This policy, along with the supporting suite of SOPs, will form the basis of training

programmes (refer to the Trust's Training Strategy for more information).

4.1.2 Compliance

i. Functional teams, specialties and staff will be performance managed against key performance indicators (KPIs) applicable to their role. Role specific KPIs are based upon the principles within this policy and specific aspects contained within the Trust's standard operating procedures.

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

4.2 General Elective Access Principles

i. The NHS has set maximum waiting time standards for elective access to healthcare. In England, waiting time standards for elective care (including cancer) come under two headings:
   - The individual patient rights (as per the NHS Constitution).
   - The standards by which individual providers and commissioners are held accountable by NHS Improvement and NHS England. All patients are to be treated fairly and equitably regardless of race, sex, religion or sexual orientation.

4.3 Individual Patient Rights

i. The NHS constitution clearly sets out a series of pledges and rights stating what patients, the public and staff can expect from the NHS. A patient has the right to the following:
   - The choice of hospital and consultant.
   - To commence their treatment for routine conditions following a referral into a consultant-led service, within a maximum waiting time of 18 weeks to treatment.
   - To be seen by a cancer specialist within a maximum of two weeks from a GP referral for urgent referrals where cancer is suspected.

ii. If this is not possible, the NHS has to take all reasonable steps to offer a range of alternatives.

iii. The right to be seen within the maximum waiting times does not apply:
   - If the patient chooses to wait longer.
   - If delaying the start of the treatment is in the best clinical interests of the patient
   - (note that in both of these scenarios the patient's RTT clock continues to tick)
   - If it is clinically appropriate for the patient's condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage.

4.4 Patient Eligibility

i. All Trusts have an obligation to identify patients who are not eligible for free NHS treatment and specifically to assess liability for charges in accordance with Department of Health guidance / rules.

ii. The Trust will check every patient's eligibility for treatment. Therefore, at the first point of entry, patients will be asked questions which will assist the Trust in assessing 'ordinarily resident status'. Some visitors from abroad, who are not ordinarily resident, may receive free healthcare such as those that:

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

iii. Citizens of the European Union (EU) that hold a European Health Insurance Card (EHIC) are also entitled to free healthcare, although the Trust may recover the cost of treatment from the country of origin. All staff have a responsibility to identify patients who are overseas visitors and to refer them to the Overseas Visitor's Officer for clarification of status regarding entitlement to NHS Treatment before their first appointment is booked or date to come in (TCI) agreed.

4.5 Patients Moving Between NHS & Private Care

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

ii. The RTT pathways of patients who notify the Trust of their decision to seek private care will be closed with a clock stop applied on the date of this being disclosed by the patient.

4.6 Commissioner Approved Procedures

i. Patients referred for specific treatments where there is limited evidence of clinical effectiveness, or which might be considered cosmetic can only be accepted with the prior approval of the relevant CCG. NHS Liverpool CCG Commissioning Policy

4.7 Military Veterans

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

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

4.8 Prisoners

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

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

4.9 Service Standards

i. Key business processes that support access to care will have clearly defined service standards, which will be monitored by the Trust. Compliance with each service standard will support effective and efficient service provision, and the achievement of referral to treatment standards.

ii. Key standards for implementation include the following:

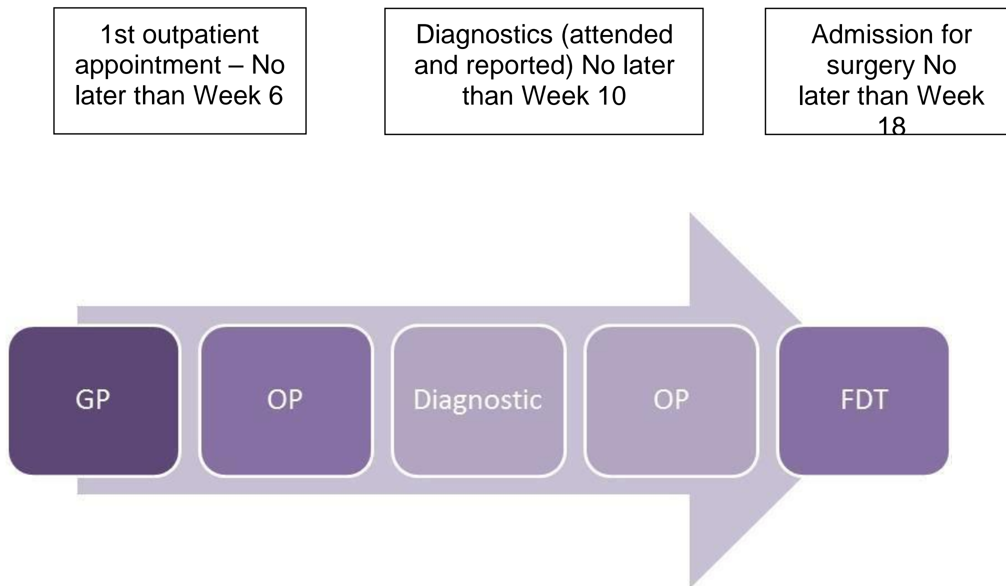
- Referral receipt and registration (within 24 hours)
- Referral vetting and triage (within 48 hours of registration)
- Addition of urgent outpatient referrals to waiting list (within 48 hours of registration)
- Addition of routine outpatient referrals to waiting list (within 5 days of registration)
- Urgent patient contacted by the Trust after addition to waiting list (within 48 hours)
- Routine patient contacted by the Trust after addition to waiting list (within 2 weeks)
- Urgent diagnostic reporting (within 24 hours)
- Routine diagnostic reporting (within 48 hours)

iii. Standard Operating Procedures are held within the patient administration department and are available on Trust intranet to ensure all the above key standards are followed accordingly.

4.10

4.11 Pathway Milestones

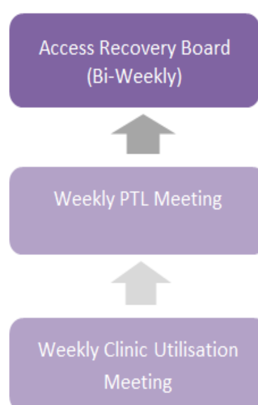
i. In order to achieve treatment within 18 weeks of receipt of referral, pathways should be designed with key milestones and sufficient capacity agreed with clinicians and commissioners. As an example, a surgical pathway could be broken down into the milestones shown below.



4.12 Monitoring

i. Operational teams will regularly, and continuously, monitor levels of capacity for each pathway milestone to ensure any shortfalls are addressed in advance, thus avoiding a poor patient experience, resource intensive administrative workarounds and ultimately breaches of the RTT standard.

4.13 Governance



4.14 Reasonableness

i. 'Reasonableness' is a term applicable to all stages of the elective pathway. Reasonableness refers to specific criteria which should be adhered to when offering routine appointments and admission dates to patients to demonstrate that they have been given sufficient notice and a choice of dates. A reasonable offer is defined as a choice of two dates with at least three weeks' notice.

ii. If the patient has been offered a choice of two or more appointments, each with over three weeks' notice, and they wish to defer again, the clinician will be informed to ensure any delay caused to the patient's pathway is safe.

iii. If the clinician confirms it is safe for the patient to delay their care a further appointment will be made and communicated to the patient.

iv. The clinician may decide it is in the patient's best interest to be discharged from secondary care, and return to the care of their GP until they are ready to attend. If the clinician decides to discharge the patient back to Primary Care, a new referral will need to be made to the Trust if a further appointment is required.

4.15 Chronological booking

i. Patients will be selected for booking appointments or admission dates according to clinical priority. Patients of the same clinical priority will be appointed / treated in RTT chronological order i.e. the longest waiting patients will be seen first. Patients

will be selected using the Trust's PTLs or e-Referral only. Patients will NOT be selected from any paper-based systems.

4.16 Communication

i. All communications with patients and anyone else involved in the patient's care pathway (e.g. GP or a person acting on the patient's behalf), whether verbal or written, must be informative, clear and concise. Copies of all correspondence with the patient must be kept in the patient's clinical notes or stored electronically for auditing purposes. GPs or the relevant referrer must be kept informed of the patient's progress in writing. The patient is receives a copy of their clinical correspondence following attendance and the GP/other referrer is copied in. When clinical responsibility is being transferred back to the GP/ referrer, e.g. when treatment is complete, this must be made clear in any communication.

5 Main Body of Policy

5.1 National Referral to Treatment and Diagnostic Standards

Referral to Treatment	
Incomplete	92% of patients on an incomplete pathway (i.e. still waiting for treatment) to be waiting no more than 18 weeks (or 127 days)
Diagnostics	
Applicable to diagnostics tests	99% of patients to undergo the relevant diagnostic investigation within 5 weeks and 6 days (or 41 days) from the date of decision to refer to appointment date

i. In addition to the elective care standards above, there are separate cancer standards which must be adhered to. The cancer standards are listed in the cancer section. While the aim is to treat all elective patients within 18 weeks, the national elective access standards are set at less than 100% to allow for the following scenarios:
   - Clinical exceptions - situations when it is in the patient's best clinical interest to wait more than 18 weeks for their treatment.
   - Choice - when patients choose to extend their pathway beyond 18 weeks by declining reasonable offers of appointments, or rescheduling previously agreed appointment dates / admission offers, or specifying a future date for appointment/admission.
   - Co-operation - when patients do not attend previously agreed appointment dates or admission offers (DNA) and where this prevents the Trust from treating them within 18 weeks.

5.2 Overview of National Referral to Treatment Rules

5.2.1 Clock Starts

i. The RTT clock starts when any healthcare professional (or service permitted by an English NHS Commissioner to make such referrals) refers to a consultant-led service. The RTT clock start date is the date that the Trust receives the referral. For referrals received through NHS e-Referral, the RTT clock starts on the day Referral Assessment Service request is received. For e-Referral Advice & Guidance requests the clock will start on the date the clinician converts the Advice & Guidance request to a referral.
   - A referral is received into a consultant led service, regardless of setting, with the intention that the patient will be assessed and if appropriate, treated before clinical responsibility is transferred back to the referrer.
   - A referral is received into an interface or Referral Assessment Service (RAS) which

may result in an onward referral to a consultant led service before clinical responsibility is transferred back to the referrer.

- A patient self refers into a consultant led service for pre-agreed services agreed by providers and commissioners.

5.2.2 Exclusions

i. A referral to most consultant-led services will start an RTT clock. However, the following services and types of patients are excluded from RTT:
   - Obstetrics and midwifery
   - Planned patients
   - Referrals to a non-consultant led service
   - Non-English commissioners
   - GUM services
   - Emergency pathway non-elective follow-up clinic activity.

5.2.3 New Clock Starts for same Condition

5.2.3.1 Following active monitoring

i. Some clinical pathways require patients to undergo regular monitoring / review diagnostics as part of an agreed programme of care. These events would not of themselves indicate a decision to treat or a new clock start. If a decision is made to treat after a period of active monitoring / watchful waiting, a new RTT clock would start on the date of decision to treat (DTT).

5.2.3.2 Following a decision to start a substantively new treatment plan

i. If a decision is made to start a substantively new or different treatment that does not already form part of that patient's agreed care plan this will start a new RTT pathway clock and the patient shall receive their first definitive treatment within a maximum of 18 weeks from that date.

5.2.3.3 For second side of a bilateral procedure

i. A new RTT clock should be started when a patient becomes fit and ready for the second of a consultant-led bilateral procedure.

5.2.3.4 For a rebooked new outpatient appointment

i. See point 3.6 First Appointment DNAs on the next page.

5.2.4 Planned Patients

i. All patients added to the planned list will be given a due date by when their planned procedure/test should take place. Where a patient requiring a planned procedure goes beyond their due date, they will be transferred to an active pathway and a new RTT clock

started. The detailed process for management of planned patients is described in the relevant standard operating procedure.

5.2.5 Clock Stops for first definitive treatment

i. An RTT clock stops when:

- First definitive treatment starts. This could be:
    - Treatment provided by an interface service;
    - Treatment provided by a consultant-led service;
    - Therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions
- A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

5.2.6 Clock Stops for Non-Treatment

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

- It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care
- A clinical decision is made not to treat
- A patient DNA which results in the patient being discharged
- A decision is made to start the patient on a period of active monitoring
- A patient declines treatment having been offered it.

5.2.7 Active Monitoring

i. Active monitoring is where a decision is made that the patient does not require any form of treatment currently, but should be monitored in secondary care. When a decision to commence a period of active monitoring is made and communicated with the patient, the RTT clock stops. Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made.

ii. It is not appropriate to stop a clock for a period of active monitoring if some form of diagnostic or clinical intervention is required in a couple of days' time, but it is appropriate if a longer period of active monitoring is required before further action is needed. Stopping a patient's clock for a period of active monitoring requires careful consideration on a case by case basis and its use needs to be consistent with the patient's perception of their wait.

5.2.8 Patient Initiated Delays

5.2.8.1 Non-attendance of appointments / DNAs

i. Other than at first attendance, DNAs have no impact on reported waiting times. Every effort should be made to minimise DNAs, and it is important that a clinician reviews each and every DNA on an individual patient basis at the time of the non-attended activity and documented on an electronic outcome form (E-Outcome) using the In-Touch system.

5.2.8.2 First appointment DNAs

i. The RTT clock is stopped and nullified in all cases (as long as the Trust can demonstrate the appointment was booked in line with reasonableness criteria). If clinician indicates that another first appointment should be offered, a new RTT will be started on the day the new appointment is agreed with the patient. The RTT clock stops if the clinician indicates that it is in the patient's best clinical interests to be discharged back to their GP / referrer.

5.2.8.3 Subsequent (follow up) appointment DNA

i. The RTT clock continues if the clinician indicates that a further appointment should be offered. If patients wait more than 18 weeks as a result of such delays, the 8% tolerance is in place to account for this. The RTT clock stops if the clinician indicates that it is in the patient's best clinical interests to be discharged back to their GP / referrer.

5.2.9 Cancelling, declining or delaying appointment and admission offers

i. Patients can choose to postpone or amend their appointment or treatment if they wish, regardless of the resulting waiting time. Such cancellations or delays have no impact on reported RTT waiting times. However, clinicians will be informed of patient initiated delays to ensure that no harm is likely to result from the patient waiting longer for treatment (clinicians may indicate in advance, for each specialty or pathway, how long it is clinically safe for patients to delay their treatment before their case should be reviewed). Where necessary, clinicians will review each and every patient's case on an individual basis to determine whether:
   - The requested delay is clinically acceptable (clock continues)
   - The patient should be contacted to review their options – this may result in agreement to the delay (clock continues) or to commence a period of active monitoring (clock stops)
   - The patient's best clinical interest would be served by discharging them to the care of their GP (clock stops)
   - The requested delay is clinically acceptable but the clinician believes the delay will have a consequential impact (where the treatment may fundamentally change during the period of delay) on the patient's treatment plan-active monitoring (clock stops).

ii. The general principle of acting in the patient's best clinical interest at all times is paramount. It is generally not in a patient's best interest to be left on a waiting list for an extended period, and so where long delays (i.e. of many months) are requested by patients then a clinical review should be undertaken, and preferably the treating clinician should speak with the patient to discuss and agree the best course of action. Patients should not be discharged to their GP, or otherwise removed from the waiting list, unless it is for clinical reasons.

Patients Who Are Unfit for Surgery

i. If the patient is identified as unfit for the procedure, the nature and duration of the clinical issue should be ascertained.

Short-Term Illnesses

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

Longer Term Illnesses

i. If the nature of the clinical issue is more serious for which the patient requires optimisation and / treatment, clinicians should indicate to administration staff

ii. If it is clinically appropriate for the patient to be removed from the waiting list. This will be a clock stop event via the application of active monitoring.

iii. If the patient should be optimised / treated within secondary care (active monitoring clock stop) or if they should be discharged back to the care of their GP (clock stop).

5.3 Pathway Specific Principles

5.3.1 Non-Admitted Pathways

i. The non-admitted stages of the patient's pathway comprise both outpatients and the diagnostic stages, as highlighted by the section with the green border around it in the diagram below. It starts from the clock start date (i.e. the date the referral is received) and ends when either a clock stop happens in outpatients (this could be the first, second or a further appointment) or when a decision to admit is made and the patient transfers to the admitted pathway.

5.3.1.1 Receipt of Referral Letters

i. Since the October 2018 Paper Switch Off (PSO) all referrals from GPs must be received electronically via NHS e-Referral service (e-RS).

ii. In the event paper referrals are received from GPs, referrers are contacted and informed of the requirement to refer through e-RS

iii. Paper-based referrals are still currently accepted from other Hospital providers.

iv. NHS e-Referral (e-RS) is the preferred method of receiving referrals from GPs and Referral Management Centres (RMCs).
v. Paper-based referrals from other hospital providers will be sent to a central point of referral and all referrers will be informed of this requirement and its location.
vi. Where clinically appropriate, referrals will be made to a service rather than a named clinician. Services have agreed clinical criteria to support triage and vetting, and patients will then be allocated to the most appropriate clinician, clinic media type (ie. Face to Face, Telephone or Virtual attendance) and consideration of waiting times. Referring to services is in the best interests of patients as pooling referrals promotes equity of waiting times and allows greater flexibility in terms of booking appointments.

5.3.2 Methods of Receipt

NHS e-Referrals

i. All NHS e-referrals must be reviewed and accepted or rejected by clinical teams within one working day for urgent referrals or two working days for routine referrals.
ii. Where there is a delay in reviewing e-referrals this will be escalated to the relevant clinical / management team and actions agreed to address it.
iii. If an NHS e-Referral is received for a service not provided by the Trust, it will be rejected back to the referring GP advising that the patient needs to be referred elsewhere. This will stop the patient's RTT clock.

Advice and Guidance Requests

i. Advice and guidance (A&G) requests can be sent from GPs using e-RS. These requests must be triaged and responded to within 24 hours by appropriate clinician.
ii. Where it is identified that an A&G request should be converted to a referral, this can be actioned by the triaging clinician as part of the triage process, and the GP will be notified via e-Referral.

Paper-Based Referrals

i. All routine and urgent pooled and consultant-specific referral letters should be sent to the Trust's centralised booking office.
ii. Referrals must be date stamped upon receipt at the Trust. Should a paper-based referral be received directly into a specialty, the specialty must date stamp the referral and forward to the centralised booking office within one working day of receipt. For patients referred by paper, the referral received date is the point that the RTT clock starts.
iii. Once paper-based referrals have been recorded on PAS, they will be directed to one of the following:
iv. 2WW sub-specialty appointment co-ordinator in Patient Access Centre for immediate booking of an appointment where the referral is suspected cancer. No vetting is required.

v. A consultant or clinical team for vetting. This will be undertaken within the number of days specified locally of receipt in order for the referrals to be returned to the central booking team for booking as early as possible in patient's RTT pathway.

5.3.2.2 Inter-Provider Transfers (IPTs) IPT Cancer Rules

Incoming IPTs

i. All IPT referrals will be received electronically via the Trust's secure generic NHS net email account in the central booking office.

ii. The Trust expects an accompanying Minimum Data Set (MDS) pro-forma with the IPT, detailing the patient's current RTT status (the Trust will inherit any RTT wait already incurred at the referring Trust if they have not yet been treated) and if the patient has been referred for a new treatment plan for the same condition (where a new RTT clock will start upon receipt at this Trust). The patient's pathway identifier (PPID) should also be provided. If the IPT is for a diagnostic test only, the referring Trust retains responsibility for the RTT pathway. If any of the above information is missing, the referral should be recorded on PAS and the information actively chased by the central booking office.

Outgoing IPTs

i. The Trust will ensure that outgoing IPTs are processed as quickly as possible to avoid any unnecessary delays in the patient's pathway.

ii. An accompanying MDS proforma will be sent with the IPT, detailing the patient's current RTT status (the receiving Trust will inherit any RTT wait already incurred if the patient has not yet been treated). If the patient has been referred for a new treatment plan for the same condition, a new RTT clock will start upon receipt at the receiving Trust. The patient's PPID will also be provided

iii. If the IPT is for treatment or a diagnostic test only. If for diagnostic only, this Trust retains responsibility for the RTT pathway.

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

5.3.2.3 Booking New Outpatient Appointments

E-referral Service

i. All e-Referrals will be sent to the Trust's Referral Assessment Service (RAS), where the referral will be clinically reviewed and accepted, rejected or re-directed to the appropriate service. The clinician will also select the media type of the clinic that is appropriate for the patient to attend (ie. Face to Face, Telephone or Virtual).

ii. If there are insufficient slots available for the selected service at the time of attempting to book the patient will appear on the Appointment Slot Issue (ASI) work list. The RTT clock starts from the point at which the patient attempted to book. Patients on the ASI list must be contacted within two working days by the Patient Access Centre to agree an appointment.

Paper-Based Referrals

iii. Appointments will be booked in order of clinical priority (urgent before routine) and then in chronological order of referral received date.

iv. Patients will be selected for booking from the Trust's Patient Tracking List (PTL) or e-Referral only.

v. Patients will be offered a choice of at least two dates with three weeks' notice within the agreed first appointment milestone for the specialty concerned. Appointment dates can be offered with less than three weeks' notice and if the patient accepts, this can then be defined as 'reasonable'.

vi. Where there is insufficient capacity to offer an appointment within the required milestone, this should be escalated to the relevant Operational Manager.

vii. Any appointment offers declined by patients should be recorded on PAS. This is important for two reasons: full and accurate record keeping is good practice and the information can be used at a later date to understand the reasons for any delays in the patient's treatment, e.g. hospital or patient initiated. All appointment cancellations of two or more (other than those with less than the required three weeks' notice) should be escalated to the clinician to ensure the delay in care is safe for the patient. The clinician may decide it is in the patient's best clinical interest to discharge their care back to the GP.

5.3.2.4 Clinic Attendance & Outcomes (New & Follow-Up Clinics)

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

ii. Clinic outcomes (e.g. discharge, further appointment) and the patient's updated RTT status will be recorded by clinicians using e-outcomes on the in-touch system.

iii. Upon attendance in clinic, patients may be on an open pathway (i.e. waiting for treatment with an RTT clock running) or they may already have had a clock stop due to receiving treatment or a decision not to treat being agreed. It is possible for patients to be assigned any one of the following RTT statuses at the end of their outpatient attendance, depending on the clinical decisions made or treatment given / started during the consultation:

Patients on an Open Pathway

- Clock stop for treatment
- Clock stop for non-treatment
- Clock continues if requiring diagnostics, therapies or being added to the admitted waiting list.

Patients already treated or with a decision not to treat

- New clock start if a decision is made regarding a new treatment plan.
- New clock start if the patient is fit and ready for the second side of a bilateral procedure.
- No RTT clock if the patient is to be reviewed following first definitive treatment.
- No RTT clock if the patient is to continue under active monitoring

i. Accurate and timely recording of these RTT statuses at the end of the clinic are therefore critical to supporting the accurate reporting of RTT performance.

5.3.2.5 Booking Follow-up Appointments

Patients on an Open Pathway

i. Where possible, follow up appointments for such patients should be avoided, by discussing likely treatment plans at first outpatient appointment, and / or use of telephone / written communication where a face to face consultation is not clinically required. Where unavoidable, such appointments must be booked to a timeframe that permits treatment by week 18 (unless the patient choses a later date. All patients who require further attendance within 2 weeks must have their follow up appointment prior to leaving clinic

ii. This provides the best opportunity for patient choice to be accommodated within the required timescale for achievement of the RTT standard. Where insufficient capacity is available, the clinic receptionist will escalate in line with local arrangements to obtain authorisation to overbook.

Did Not Attends

i. All DNAs (new and follow-up) will be reviewed by the clinician at the end of clinic in order for a clinical decision to be made regarding next steps for the application of RTT rules regarding DNAs. Neonatal and vulnerable patient DNAs should be managed with reference to the Trust's Safeguarding policy.

Appointment Changes & Cancellations Initiated by the Patient

i. If the patient gives any prior notice that they cannot attend their appointment (even if this is on the day of clinic), this should be recorded as a cancellation and not DNA.
   - If the patient requires a further appointment, this will be booked with the patient at the time of the cancellation if the appointment is within 6 weeks. For any patients waiting over 6 weeks – they will be added to a queue and scheduled with 6 weeks.
   - If the patient is on an open RTT pathway, the clock continues to tick. If there are insufficient appointment slots within the agreed pathway milestones, the issue must be escalated to the relevant speciality management team.

- If the patient has never been seen and advises they do not wish to progress their pathway, they will be removed from the relevant waiting list and a clock stop and nullification applied. The patient will be informed that their consultant and GP will be informed of this.
- If as a result of the patient cancelling, a delay is incurred which is equal to or greater than a clinically unsafe period of delay (as indicated in advance by consultants for each specialty), the patient's pathway should be reviewed by their consultant. Upon clinical review, the patient's consultant should indicate one of the following:
  - Clinically safe for the patient to delay - continue progression of pathway. The RTT clock continues.
  - Clinically unsafe length of delay – clinician to contact the patient by telephone with a view to persuading the patient not to delay. The RTT clock continues.
  - Clinically unsafe length of delay – in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP.

Appointment Changes Initiated by the Hospital

i. Hospital initiated changes to appointments will be avoided as far as possible as they are poor practice and cause inconvenience to patients.

ii. Clinicians are actively encouraged to book annual leave and study leave as early as possible. Clinicians must provide 6 weeks' notice of a clinic has to be cancelled or reduced.

iii. Patients will be contacted immediately if the need for the cancellation is identified, and offered an alternative date(s) that will allow patients on open RTT pathways to be treated within 18 weeks. Equally, this will allow patients not on open pathways to be reviewed as near to the clinically agreed timeframe as possible.

5.3.3 DIAGNOSTICS

5.3.3.1 Patients with a Diagnostic & RTT Clock

i. The diagnostics section of an RTT pathway is a major pathway milestone. A large proportion of patients referred for a diagnostic test will also be on an open RTT pathway. In these circumstances, the patient will have both types of clock running concurrently:
   - Their RTT clock which started at the point of receipt of the original referral.
   - Their diagnostic clock which starts at the point of the decision to refer for diagnostic test (often at the first outpatient consultation).

5.3.3.2 Straight to Test Arrangements

i. For patients who are referred for a diagnostic test where one of the possible outcomes is review and if appropriate treatment within a consultant led service (without first being reviewed by their GP) an RTT clock will start on receipt of the referral. These are called straight to test referrals.

5.3.3.3 Patients with a Diagnostic Clock Only

i. Patients who are referred directly for a diagnostic test (but not consultant-led treatment) by their GP i.e. clinical responsibility remains with the GP, will have a diagnostic clock running only. These are called Direct Access referrals. Patients may also have a diagnostic clock running only where they have had an RTT clock stop for treatment or non-treatment and their consultant refers them for a diagnostic test with the possibility that this may lead to a new RTT treatment plan.

National diagnostic clock rules

5.3.3.4 Diagnostic clock start

i. The clock starts at the point of the decision to refer for a diagnostic test by either the GP or the consultant.

5.3.3.5 Diagnostic clock stop

The clock stops at the point in which the patient undergoes the test.

5.3.3.6 Booking diagnostic appointments

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

ii. If a patient declines, cancels or does not attend a diagnostic appointment, the diagnostic clock start can be reset to the date the patient provides notification of this. However:
    - The Trust must be able to demonstrate that the patient's original diagnostic appointment fulfilled the reasonableness criteria for the clock start to be reset.
    - Resetting the diagnostic clock start has no effect on the patient's RTT clock. This continues to tick from the original clock start date.

5.3.3.7 Diagnostic Cancellations, Declines and / or DNAs for Patients on Open RTT Pathways

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

5.3.3.8 Active Diagnostic Waiting List

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

5.3.3.9 Planned Diagnostic Appointments

i. Patients who require a diagnostic test to be carried out at a specific point in time for clinical reasons are exempt from the diagnostic clock rules and will be held on a Planned waiting list with a clinically determined due date identified. However, should the patient's wait go beyond the due by date for the test, they will be transferred to an active waiting list and a diagnostic clock and RTT clock will be started.

5.3.3.10

Therapeutic Procedures

i. Where the patient is solely waiting for a therapeutic procedure, for example in the radiology department, there is no six week diagnostic standard. However, for many patients there is also a diagnostic element to their admission / appointment, and so these patients would still be required to have their procedure within six weeks.

5.3.3.11

Pre-operative Assessment (POA)

- All patients with a decision to admit will attend a POA clinic to assess fitness for surgery.
- Patients who DNA their POA appointment will be contacted and a further appointment agreed. Should they DNA again, they will be returned to the responsible consultant. The RTT clock continues to tick throughout this process.
- If the patient is identified as unfit for the procedure, the nature and duration of the clinical issue should be ascertained. If the clinical issue is short-term and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold, UTI), the RTT clock continues.
- However, if the nature of the clinical issue is more serious for which the patient requires optimisation and / treatment, clinicians should indicate to administration staff if it is clinically appropriate for the patient to be removed from the waiting list, and if so whether the patient should be:
  - Optimised / treated within secondary care (active monitoring clock stop for existing pathway and potentially new clock start for optimisation treatment) or
  - Discharged back to the care of their GP (clock stop – discharge).
- When the patient becomes fit and ready to be treated for the original condition, a new RTT clock would start on the day this decision is made and communicated to the patient.

ADMITTED PATHWAYS

5.3.4.1 Adding Patients to the Active Inpatient or Day Case Waiting List

i. Ideally patients will be fit, ready and available before being added to the admitted waiting list. However, they will be added to the admitted waiting without delay following a decision to admit, regardless of whether they have undergone pre-operative assessment (see page 17 – Pre-operative Assessment) or whether they have declared a period of unavailability at the point of the decision to admit (see page 11 – Patient Initiated Delays). The active inpatient or day case waiting lists / PTLs includes all patients who are awaiting elective admission. The only exceptions are planned patients, who are awaiting admission at a specific clinically defined time.

ii. In terms of the patient's RTT clock, adding a patient to the inpatient or day case waiting will either:
   - Continue the RTT clock from the original referral received date
   - Start a new RTT clock if the surgical procedure is a substantively new treatment plan which did not form part of the original treatment package, providing that either another definitive treatment or a period of active monitoring has already occurred. The RTT clock will stop upon admission.

5.3.4.2 Patients Requiring More Than One Procedure

i. If more than one procedure will be performed at one time by the same surgeon, the patient should be added to the waiting list with additional procedures noted. If different surgeons will work together to perform more than one procedure the patient will be added to the waiting list of the consultant surgeon for the priority procedure with additional procedures noted. If a patient requires more than one procedure performed on separate occasions by different (or the same) surgeon(s):
   - The patient will be added to the active waiting list for the primary (1st) procedure.
   - When the first procedure is complete and the patient is fit, ready and able to undergo the second procedure, the patient will be added (as a new waiting list entry) to the waiting list, and a new RTT clock will start.

5.3.4.3 Patients Requiring Thinking Time

i. Patients may wish to spend time thinking about the recommended treatment options before confirming they would like to proceed. It would not be appropriate to stop their RTT clock where this thinking time amounts to only a few days or weeks. Patients should be asked to make contact within an agreed period with their decision.

ii. It may be appropriate for the patient to be entered into active monitoring (and the RTT clock stopped) where they state they do not anticipate making a decision for a matter of months. This decision can only be made by a clinician and on an individual patient basis with their best clinical interests in mind.

iii. In this scenario, a follow-up appointment must be arranged around the time the patient would be in a position to make a decision. A new RTT clock should start from the date of the decision to admit if the patient decides to proceed with surgery.

5.3.4.4 Scheduling Patients to Come In (TCI) for Admission

i. Clinically urgent patients will be scheduled first, followed by routine patients. All patients will be identified from the Trust's PTL, and subject to the clause above about clinical priorities, will be scheduled for admission in chronological order of RTT wait. An 'invitation to call' letter will be generated from PAS, asking patients to make contact.

ii. Should the patient not make contact, the demographic details will be checked via the NHS portal for any demographic changes. Three attempts will then be made to contact the patient, with one being in the evening.
   - Patients will be offered a choice of at least two admission dates with three weeks' notice within the agreed milestone for the specialty concerned. Admission dates can be offered with less than three weeks' notice and if the patient accepts, this can then be defined as 'reasonable'.
   - If there is insufficient capacity to offer dates within the required milestone, this issue will be escalated to the relevant service manager. Any admission offers declined by patients will be recorded on PAS. This is important for two reasons:
     - Full and accurate record keeping is good clinical practice.
     - The information can also be used at a later date to understand the reasons for any delays in the patient's treatment, e.g. hospital or patient initiated.

5.3.4.5 Patients Declaring Periods of Unavailability Whilst on the Inpatient / Day case Waiting List

i. Should patients contact the Trust to communicate periods of unavailability for social reasons (e.g. holidays, exams), this period should be recorded on PAS.

ii. If the length of the period of unavailability is equal to or greater than a clinically unsafe period of delay (as indicated in advance by consultants for each specialty), the patient's pathway will be reviewed by their consultant. Upon clinical review, the patient's consultant will indicate one of the following:
   - Clinically safe for the patient to delay - continue progression of pathway. The RTT clock continues.
   - Clinically unsafe length of delay – clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues. In exceptional circumstances if a patient decides to delay their treatment it may be appropriate to place the patient under active monitoring (clock stop) if the clinician believes the delay will have a consequential impact on the patient's treatment plan or
   - Clinically unsafe length of delay – in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP. The patient could also be actively monitored within the Trust.

5.3.4.6 Patients Who Decline or Cancel TCI Offers

i. Should patients decline TCI offers or contact the Trust to cancel a previously agreed TCI, this will be recorded on PAS. The RTT clock continues to tick. If, as a result of the patient declining or cancelling, a delay is incurred which is equal to or greater than a clinically unsafe period of delay (as indicated in advance by consultants for each specialty), the patient's pathway will be reviewed by their consultant. Upon clinical review, the patient's consultant will indicate one of the following:
   - Clinically safe for the patient to delay - continue progression of pathway. The RTT clock continues.
   - Clinically unsafe length of delay – clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues.
   - Clinically unsafe length of delay – in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP.
   - The requested delay is clinically acceptable but the clinician believes the delay will have a consequential impact (where the treatment may fundamentally change during the period of delay) on the patient's treatment plan-active monitoring.

5.3.4.7 Patients Who Do Not Attend Admission

i. Patients who do not attend for admission will have their pathway reviewed by their consultant. If the patient's consultant decides that they should be offered a further admission date, the RTT clock continues to tick. Should the patient's consultant decide that it is in their best clinical interests to be discharged back to the GP, the RTT clock is stopped.

5.3.4.8 On The Day Cancellations

i. Where a patient is cancelled on the day of admission or day of surgery for non-clinical reasons, they will be rebooked within 28 days of the original admission date and the patient must be given reasonable notice of the rearranged date. The patient may choose not to accept a date within 28 days. If it is not possible to offer the patient a date within 28 days of the cancellation, the Trust will offer to fund the patient's treatment at the time and hospital of the patient's choice where appropriate.

5.3.4.9 Planned Waiting Lists

i. Patients will only be added to an admitted planned waiting list where clinically they need to undergo a procedure at a specific time. The due date for their planned procedure will be included in the planned waiting list entry. Patients on planned waiting lists will be scheduled for admission at the clinically appropriate time and they should not have to wait a further period after this time has elapsed. When patients on planned lists are clinically ready for their care to commence and reach their due date for their planned procedure, they will either be admitted for the procedure or be transferred to an active

waiting list and a new RTT clock will start.

ii. For some patients (e.g. surveillance endoscopies) a diagnostic clock would also start.

6 Cancer Pathways

6.1 Cancer Pathways

6.1.1 Introduction and Scope

This section describes how the Trust manages waiting times for patients with suspected and confirmed cancer, to ensure that such patients are diagnosed and treated as rapidly as possible and within the national waiting times standards. This policy is consistent with the latest version of the Department of Health's Cancer Waiting Times Guide and includes national dataset requirements for both waiting times and clinical datasets.

Principles

- As defined in the NHS constitution, patients have the right to expect to be seen and treated within national operational standards ensuring timely diagnosis and treatment, equity of care and patient choice.
- Patients will wherever possible be offered dates for appointment or treatment in chronological order, based on the number of days remaining on their cancer pathway, unless there are clinical exceptions.
- Wherever possible patients will be given reasonable notice and choice of appointments and TCI dates as defined within the policy.
- Accurate data on the Trust's performance against the National Cancer Waiting Times is recorded in the cancer management system and reported to the National Cancer Waiting Times Database (NCWTDB) within nationally predetermined timescales.
- Where patients are at risk of breaching any of the cancer standards it is expected that all staff will follow the published Cancer Escalation policy.

6.1.2 Roles and responsibilities

- **Chief Executive**
  The Chief Executive has overall responsibility and accountability for delivering access standards as defined in the NHS Constitution and Operating Framework.
- **Chief Operating Officer**
  The Director of Operations is responsible for ensuring that there are robust systems in place for the audit and management of Cancer access standards against the criteria set within this Cancer Access Policy and Procedure document.
- **Trust Lead Cancer Clinician**
  Responsible for ensuring high standards of cancer clinical care across the organisation in a timely manner, leading the development of the cancer strategy
- **Trust Cancer Lead Nurse**
  Responsible for development of the cancer nursing strategy with professional line management responsibility for the Trust's cancer clinical nurse specialists.

- **Tumour Group Clinical Leads**
  Responsible for ensuring clinical pathways are designed to deliver treatment within 62 days of referral. Responsible for reviewing the outputs of any breach route cause analysis to develop actions to resolve any delays to patients.
- **Operational Managers**
  Responsible for the monitoring of performance in the delivery of the cancer standards and for ensuring the specialities deliver the activity required to meet the waiting list standards. They are also responsible for ensuring all patients are booked within 14 days by ensuring adequate capacity is available and reviewing twice weekly reports and resolving any breaches. In addition to this they are responsible for evaluating the impact of any process or service changes on 62 or 31 day pathways
- **Hospital Consultants**
  Consultants have a shared responsibility with their General Managers for managing their patients' waiting times in accordance with the maximum guaranteed waiting time.
- **Clinical Nurse Specialists**
  Clinical Nurse Specialists have a shared responsibility with their Consultants and General Managers for managing their patients' waiting times in accordance with the maximum guaranteed waiting time.
- **Head of Performance and Information**
  Responsible for administering data required for managing and reporting cancer waiting times, activity and cancer outcomes. The Informatics team ensures there is a robust Standard Operating Procedure for the external reporting of performance.

  Responsible for monitoring delivery of key tasks by the MDT Co-ordinators and the Pathway Co-ordinators and highlighting:
    - Patients booked to fail.
    - Patients with no appointment.
    - Any data entry issues.
    - Producing twice weekly reports for General Managers to resolve potential breaches.
    - Producing weekly reports showing compliance with 2ww standard in preceding week for discussion at weekly PTL meeting.

- **Cancer Services Manager**
  The Cancer Services Manager supports the operation delivery of cancer services within the Trust, facilitating the development of improved patient pathways.
  They are required to analyse and investigate breaches of all mandatory targets, to provide RCA reports and updates or trends to the gynaecology management team, access Manager and consultants. The Cancer Services Manager will lead the Trust Cancer Team and will ensure the Trust is compliant with the Cancer Waiting Times Standards.
- **Sub-specialty appointment Co-ordinators and those designated to make 2ww Outpatient**

Appointments Responsible for receiving 2ww outpatient referrals and ensuring they are managed to comply with the Cancer Access Policy and in line with their job descriptions.

- **Admissions Clerks/Booking & Scheduling Clerks.**
  Responsible for ensuring waiting lists are managed to comply with this Policy and Procedure document and in line with their job descriptions.
- **MDT Co-ordinators**
  Responsible for monitoring the cancer pathway for patients following the 1st attendance, ensuring it is managed in line with this Policy and assisting in the pro-active management of patient pathways on PAS and the cancer management system.

- **All staff (for whom this document applies)**
  - All staff have a duty to comply fully with this Policy/Procedure and responsible for ensuring they attend all relevant training offered.
  - All staff are responsible for bringing this policy to the attention of any person not complying with it.
  - All staff will ensure any data created, edited, used, or recorded on the Trust's IT systems within their area of responsibility is accurate and recorded in accordance with this policy and other Trust policies relating to collection, storage and use of data in order to maintain the highest standards of data quality and maintain patient confidentiality.
  - All 2ww patient referrals, diagnostics, treatment episodes, and waiting lists must be managed on the Trust's systems. All information relating to patient activity must be recorded accurately and in a timely manner.

Training / competency requirements

All staff involved in the cancer pathway will be expected to undertake initial cancer waiting times training within the first 3 months of appointment within the Trust. All relevant staff will have annual refresher cancer waiting times training.

6.1.2 Cancer Waiting Times Standards

Cancer waiting times (CWT) measure the NHS' performance against these national NHS Constitution Standards, as well as a number of other metrics. These measures are used by local and national organisations to monitor the timely delivery of services to patients.

Current CWT standards:

Maximum two weeks from:	Operational Standard
Receipt of urgent referral for suspected cancer to first outpatient attendance	93%
Receipt of referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment	93%

Maximum 28 days from:

Receipt of two week wait referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of two week wait referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer	75%

Maximum one month (31 days) from:

Decision to treat to first definitive treatment		96%
Decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is:	surgery	94%
	drug treatment	98%
	radiotherapy	94%

Maximum two months (62 days) from:

Urgent referral for suspected cancer to first treatment (62-day classic)	85%
Urgent referral from a NHS Cancer Screening Programme (breast, cervical or bowel) for suspected cancer to first treatment	90%

6.1.3 Summary of the cancer rules

Clock start

2WW

A two week wait clock starts at the receipt of referral.

62 Day

A 62 day cancer clock can start following the below actions:

- Urgent two week wait referral for suspected cancer
- A consultant upgrade
- Referral from NHS cancer screening programme
- Non NHS Referral (and subsequent consultant upgrade)

31 Day

A 31 day cancer clock will start following:

- A DTT for first definitive treatment
- A DTT for subsequent treatment
- An ECAD following a first definitive treatment for cancer.

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

6.1.4.1 Clock stops

A 62 cancer clock will stop following:

- Delivery of first definitive treatment
- Placing a patient with a confirmed cancer diagnosis onto active monitoring

Removals from the 62 day pathway (not reported)

- Making a decision not to treat
- A patient declining all diagnostic tests
- Confirmation of a non-malignant diagnosis.

A 31 day cancer clock will stop following

- Delivery of first definitive treatment
- Placing a patient with a confirmed cancer diagnosis onto active monitoring
- Confirmation of a non-malignant diagnosis

For a more detailed breakdown of the cancer rules please read the latest Cancer Waiting Times guidance or the Cancer operational policy.

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

6.1.5 GP suspected cancer 2 week wait (2ww) referrals

- All suspected cancer referrals should be referred by the GP/GDP on the relevant cancer pro-forma provided and submitted via E-referral or email via the generic nhs.net email address.
- Day 0 is the date the referral was received.
- The first appointment can be either an outpatient appointment with a Consultant or investigation relevant to the referral, i.e. 'straight to test'.
- All 2ww referrals will be checked for completeness by the Pathway Co-ordinators within 24 working hours of receipt of referral.

- For 2ww referrals received by the Trust without key information the Patient Access Team will contact the relevant GP surgery by phone within 48 hours of receipt of referral to obtain the missing information. The referral process should begin, i.e. OPA booked for patient whilst information is being obtained, to ensure no delay is caused to the patient's pathway.
- Any 2ww referral received by the Trust for a service that the Trust is not commissioned to deliver will be sent electronically to an appropriate local provider with a copy for information sent electronically to the referring GP within 24 hours of receipt.
- Any 2ww referral received inadvertently by the Trust which was meant for another Trust will be sent electronically to the intended provider with a copy for information sent to the referring GP electronically within 24 hours of receipt.

Downgrading referrals from 2ww

The Trust cannot downgrade 2ww referrals, if the Consultant believes that the referral does not meet the criteria for a 2ww referral they must contact the GP to discuss. If it is decided and agreed that the referral does not meet the 2ww criteria the GP can retract it and refer on a non 2ww referral proforma (it is, however, only the GP who can make this decision).

Two referrals on the same day

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

6.1.5.1 Screening Pathways

The clock start is the receipt of the referral (day 0) which for the individual screening programmes is as follows:

- cervical - receipt of referral for an appointment at colposcopy clinic.

6.1.5.2 Consultant Upgrades

- Hospital specialists have the right to ensure that patients who are not referred urgently as suspected cancer referrals or through the screening programmes, but who have symptoms or signs indicating a high suspicion of cancer, are managed on the 62 day pathway. This can be achieved by upgrading the patients onto a 62 day upgrade pathway.
- The 62 day pathway starts (day 0) from the date the patient is upgraded.
- Upgrade must occur before the DTT date. Patients not upgraded at this point will be measured against the 31 day DTT to first definitive treatment.
- An upgrade is intended for suspected new primaries only, not those who may be suspected of a recurrence

Who can upgrade patients onto a 62 day pathway?

The specialist team receiving the referral or reviewing the patient or diagnostic result can delegate the responsibility to upgrade the patient. This could be:

- Specialist Nurse / Practitioner, either by triaging the referral form/letter or at nurse led initial clinic.
- Specialist Registrar either by triaging the referral form/letter or at initial clinic.
- Radiologist / Histopathologist / other Trust clinicians on reviewing patients and/or diagnostics.
- The Consultant or delegated member of the team upgrading the patient is responsible for informing the MDT Co-ordinator (by completing the upgrade pro-forma) that an upgrade has occurred, in order for the patient to be tracked on the correct pathway.
- If a patient has been upgraded to a 62 day pathway this must be communicated with the patient so they understand why they are being upgraded, and the GP should be notified by the upgrading clinician

6.1.5.3 Subsequent treatments

- If a patient requires any further treatment following their first definitive treatment for cancer (including after a period of active monitoring) they will be monitored against a 31 day subsequent treatment clock. The clock will start following the patient agreeing a treatment plan with their clinician. This will be the decision to treat (DTT) date.
- In some circumstances it may be appropriate for the clinician to set an ECAD (earliest clinically available date) which is when a patient needs to recover following their first definitive treatment. An ECAD can be adjusted but only if the date has not passed. The 31 day clock start date should be the same as the ECAD date for these patients

6.1.1 Reasonableness

For patients on a cancer pathway, an offer will be deemed to be reasonable if a patient accepts an appointment regardless of notice provided due to pathway type for appointment/diagnostic test/admission.

6.1.2 Pauses

There are only two adjustments allowed on a cancer pathway, one in the 2ww pathway and the other in the 62/31 day pathway:

2WW

If a patient DNAs their initial (first) outpatient appointment or attendance at diagnostic appointment e.g. endoscopy the clock start date can be reset to the date that the patient rebooks their appointment (the date the patient agrees the new appointment not the new appointment date).

62/31 Day pathways

If a patient declines admission for an inpatient or day case procedure providing that the offer of admission was 'reasonable' the clock can be paused from the date offered to the date the patient

is available.
If the patient during a consultation, or at any other point, whilst being offered an appointment date states that they are unavailable for a set period of time (e.g. due to holiday or work commitments), a pause can be applied from the date that would have been offered to the patient to the date that they are available. This will apply to admit treatments only. (Reference: 7.1.8 Cancer Waiting Times Guidance Version 9)

If a treatment is to be delivered in an outpatient setting such as an outpatient procedure or radiotherapy a pause cannot be applied. No adjustments are permissible for medical illness.

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

6.1.3 Patient cancellations

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

First appointment cancellations: 2ww referral patients who cancel their first appointment should be offered another appointment within the two weeks of the referral being received.

Subsequent/multiple appointment cancellations: Patients who cancel an appointment/investigation date will be offered an alternative date within 7 days of the cancelled appointment (no waiting time adjustment will apply).

Multiple cancellations

- All patients who are referred on either a 62 day GP pathway, who cancel two consecutive appointments (i.e. outpatient, diagnostic investigation) will be contacted by an appropriate member of staff to identify any factors that may be stopping the patient attending. Another appointment will be offered if the patient agrees.
- Patients can be discharged after multiple (2 or more) appointment cancellations if this has been agreed with the patient. However, where a patient has cancelled multiple appointments on either a 62 day GP pathway, 2WW, screening pathway (i.e. outpatient, diagnostic investigation) an appropriate member of staff will contact the patient to identify any factors that may be stopping the patient attending and another appointment will be offered if the patient agrees.

Patient DNAs

- Patients will be recorded as a DNA if they do not turn up to a clinic or diagnostic appointment, turn up late or turn up in a condition where the Trust cannot carry out whatever was planned for them. For example, if they have not taken a preparation they needed to take prior to the appointment (this also includes patients who have not complied with appropriate instructions prior to an investigation).

- First appointment
  - All patients referred as suspected cancer including 2ww, screening or upgrade who DNA their first outpatient appointment should be offered an alternative date within 14 days of the DNA

  - A waiting time adjustment applies from receipt of referral to the date the patient makes contact to rearrange the appointment and all details must be recorded on the Cancer management system.
  - If a patient DNA's their first appointment for a second time the patient will be escalated to the consultant in clinic for a decision on the next step which may include discharge back to the GP.

- Subsequent appointments
  - If a patient DNA's any subsequent appointment the patient should be escalated to the consultant in clinic for a decision on the next step which may include discharge back to the GP.

- Patients who are uncontactable
  - If the patient is uncontactable at any time on their 62/31 day pathway, a record of the time and date of the call to them in the 'additional information' section on PAS should be made at the time of the call.
  - Two further attempts will be made to contact the patient by phone, one of which must be after 5.00pm.
  - Each of these calls must be recorded in real time on PAS. These attempted contacts must be made over a maximum 2 day period.
  - If contact cannot be made by such routes, the GP surgery must be contacted to ask for alternative contact routes.

  In the event that the patient remains uncontactable:
  - For first appointments
  - An appointment will be sent to the patient offering an appointment within the 2ww standard, stating the Trust has attempted to offer a choice of appointment, and that the patient should contact the 2ww wait office to rearrange the appointment if it is inconvenient

- Appointments (other than first) on 62/31 day clinical pathway
  - Attempts to contact patient will be made as outlined above. In the event that contact cannot be made, the Consultant should decide:
  - to send a 'no choice' appointment by letter.
  - to discharge the patient back to the GP.

- Patients who are unavailable

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

6.1.1 Diagnostics

- The Trust will maintain a 2ww for all diagnostic "straight to tests" for patients on a cancer pathway and a 10 day turnaround for all subsequent diagnostic tests on a patient's 31/62 day pathway.

Refusal of a diagnostic test

- If a patient refuses a diagnostic test, the refusal will be escalated to the managing clinician to discuss with the patient. If the patient refuses all diagnostics tests they will be removed from the cancer pathway and will be discharged back to their GP.

6.1.1 Managing the transfer of private patients

- If a patient decides to have any appointment in a private setting, they will remove themselves from the cancer pathway.
- If a patient transfers from a private provider onto an NHS waiting list they will need to be upgraded if they have not made a DTT and the consultant wants them to be managed against the 62 day target. If a DTT has been made in a private setting the 31 day clock will start on the day the referral was received by the NHS Trust.

6.1.1 Tertiary referrals

Process

- Inter Provider Transfer (IPT) Forms will be used for all outbound referrals for patients on a Cancer Pathway.
  - Where possible information will be transferred between Trust's electronically. Transfers will be completed via a named NHS Contact.
  - A minimum data set and all relevant diagnostic test results and images will be provided when the patient is referred.

6.1.2 Entering patients on the tracking pathway

Suspected cancers – 2ww GP referrals

- All 2ww referrals come in via e-Referral and if capacity is available the appointment can be made by the GP or the patient.
- If capacity is not available the electronic referral will be added to the Appointment Slot Issues list within e-Referral. Lack of capacity must be escalated to the Patient Access Manager and/or Operational Manager so capacity can be arranged.
- The Pathway Coordinators will record known adjustments, referring symptoms and first appointment onto the cancer management system within 24 working hours of receiving the referral.
- The Patient Appointment Centre is responsible for confirming a patient's attendance at the first appointment and recording the outcome, checking all dates are correct and that DNAs/breach reasons are entered correctly.

Suspected cancers – screening patients

- The Pathway Co-ordinator is responsible for entering patients referred via the screening programme onto the cancer management system database system within 24 hours of receiving notification of the referral.

Suspected cancers – Consultant Upgrades

- For upgrade prior to initial appointments the Pathway Trackers will be responsible for entering patient details onto the cancer management system database and allocating the patient an appointment within the 2ww wait guidelines.
- For upgrades at any other point of the pathway the MDT Co-ordinator will be responsible for updating the cancer management system and will begin tracking of the pathway.

Suspected / confirmed cancers (31 day patients)

- Patients not referred via a 2ww/screening/Consultant upgrade referral should not be entered onto the cancer management system until they have a confirmed cancer diagnosis. The only exception is patients with suspected cancer who are being discussed at an MDM.
- Once a patient has been diagnosed with either a new cancer or recurrence, a record should be entered, within the cancer management system, selecting the appropriate cancer status (by the MDT Co-ordinator) within 24 hours of being notified.

Confirmed cancers

- The MDT Co-ordinator is responsible for ensuring a patient with a newly diagnosed cancer has a record entered on the Cancer management system, and keeping that record updated.

6.1.1 Monitoring and audit

- It is the responsibility of the Pathway Trackers to run a weekly programme of audits for data completeness and data anomalies.
- Any data anomalies are highlighted to the relevant MDT Co-ordinator for investigations and correction. A response to the Pathway Co-ordinators must occur within 24 hours of the anomaly being raised in order not to delay the audit programme and to ensure accurate performance available at all times.

In addition, a regular data quality programme will be established to review the following:

- Comparative audit of data on the cancer management system and PAS.
- Comparative audit of diagnosis code on PAS, cancer management system and healthcare records.
- Comparative audit of cases removed from the 62 day pathway and re-entered as 31 day patients within 4 weeks of removal. This will involve a random selection of healthcare records from each tumour site to be reviewed and will be led by the Pathway Co-coordinators

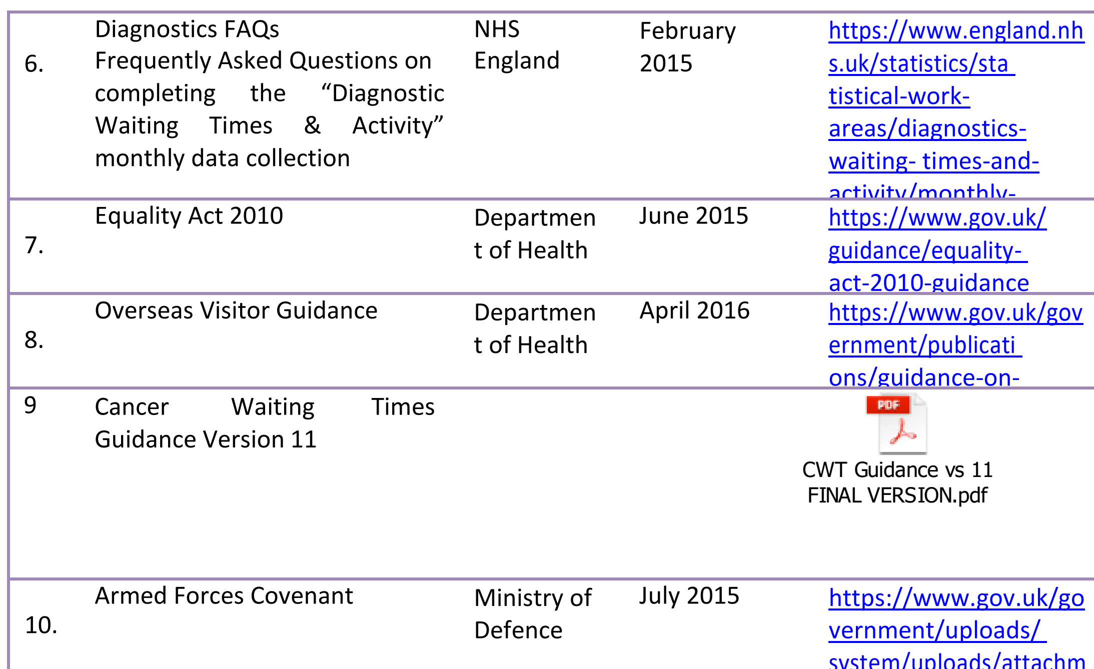
The Pathway Co-ordinators will also capture numbers of patients 'upgraded' each month and will carry out a quarterly audit to ensure that patients are being 'upgraded' at the earliest opportunity.

7 Key Reference

Clinical Prioritisation Categories P2-P6.ppt

National Data Requirements Specific

No	Reference Title	Published by	Publication Date	Link
1.	Referral to treatment consultant-led waiting times Rules Suite	Department of Health	October 2015	https://www.gov.uk/government/uploads/ system/uploads/attachment_data/file/464
2.	Recording and reporting referral to treatment (RTT) waiting times for consultant- led elective care	NHS England	October 2015	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recordi ng-
3.	Recording and reporting referral to treatment (RTT) waiting times for consultant- led elective care: Frequently Asked Questions	NHS England	October 2015	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Accomp anying-FAQs-v7.2.pdf
4.	The NHS Constitution	Department of Health	July 2015	https://www.gov.uk/government/uploads/ system/uploads/attachm
5.	Diagnostics waiting times and activity Guidance on completing the "diagnostic waiting times & activity" monthly data collection	NHS England	March 2015	https://www.england.nhs.uk/statistics/sta tistical-work-areas/diagnostics-waiting- times-and-activity/monthly-



6.	Diagnostics FAQs Frequently Asked Questions on completing the "Diagnostic Waiting Times & Activity" monthly data collection	NHS England	February 2015	https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting- times-and-activity/monthly-
7.	Equality Act 2010	Department of Health	June 2015	https://www.gov.uk/guidance/equality-act-2010-guidance
8.	Overseas Visitor Guidance	Department of Health	April 2016	https://www.gov.uk/government/publications/guidance-on-
9	Cancer Waiting Times Guidance Version 11			CWT Guidance vs 11 FINAL VERSION.pdf
10.	Armed Forces Covenant	Ministry of Defence	July 2015	https://www.gov.uk/government/uploads/system/uploads/attachm

8 Associated Documents

i. Overseas Visitors Policy
ii. Overseas Visitors SOP
iii. Equality and Human Rights Policy

9 Policy Administration

9.1 Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Impact Assessment		PGP April 21	completed
GDPR		PGP April 21	
Have the relevant details of the 2010 Bribery Act been considered in the drafting of this policy to minimise as far as reasonably practicable the potential for bribery?	Yes		
External Stakeholders			
Trust Staff Consultation via Intranet	Start date: March 2021		End Date: March 2021

Describe the Implementation Plan for the Policy (and guideline if impacts upon policy) (Considerations include; launch event, awareness sessions, communication / training via CBU's and other management structures, etc)	By Whom will this be
Policy will be uploaded to staff Intranet and Communicated to staff via the 'Staff Track' newsletter and Meditech Bulletin Board	Policy Officer

Version History

Date	Version	Author Name and Designation	Summary of Main Changes
10/8/17	1	Matthew Taylor – Information & Performance Manager	New Policy, based upon Model access Policy
17/10/17	2	Nicola Murdoch – Business Manager	Policy review and update

15/03/21	3	Debbie Pink – Patient Access Manager	Updated clinic outcome process changed from paper to electronic and included Paper Switch Off (PSO) 2018 information
		Evelyn Rogansky – Cancer Manager	Updated Cancer target information in line with National Guidance
08/11/21	3.1	Debbie Pink – Patient Access	Review date extended to 3 yearly

10 Appendices

10.1 Glossary Terms and Acronyms

10.1.1 Terms

Term	D
2WW Two week wait	The maximum waiting time for a patient's first outpatient appointment or 'straight to test' appointment if they are referred as a 62 day
31 day pathway	The starting point for 31 day standard is the date that a patient agrees a plan for their treatment or the date that an Earliest Clinically Appropriate Date (ECAD) is effected for subsequent treatments
62 day pathway	Any patient referred by a GP with a suspected cancer on a 2 week wait referral pro-forma, referral from a screening service , a referral from any healthcare professional and also where a routine referral has been upgraded by a Hospital clinician must begin
Active Monitoring	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures.
Active waiting list	The list of elective patients who are fit, ready and able to be seen or treated at that point in time. Applicable to any stage of the RTT pathway where
Bilateral procedures	Where a procedure is required on the same anatomical sides of the body.
Breach	A pathway which ends when a patient is seen/receives their first treatment outside the 14 day first seen, 62 day referral to treatment and/or 31
Chronological booking	Refers to the process of booking patients for appointments, diagnostic procedures and admission within date order of their clock start date.
Consultant-led service	A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse-led clinics which come under
Day case	Patients who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.
Decision to admit	Where a clinical decision is made to admit the patient for either day case or inpatient treatment.
Direct access	Where GPs refer patients to hospital for diagnostic tests only. These patients will not be on
Elective care	Any pre-scheduled care which does come under the scope of emergency care.
First definitive treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive

Fixed appointments	Where an appointment or admission date is sent in the post to the patient without the opportunity
Full booking	Where an appointment or admission date is agreed either with the patient at the time of the decision or
Incomplete pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage.
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in
Nullified	Where the RTT clock is discounted from any reporting of RTT performance.
Oncology	The branch of science that deals with tumours and
Partial booking	Where an appointment or admission date is agreed with the patient near to the time it is due.
Patient-Initiated Delay	Where the patient cancels, declines offers or does not attend appointments or admission. This in itself does not the stop the RTT clock. A clinical review
Planned waiting list	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment at the clinically appropriate time
Reasonable offers	A choice of two appointment or admission dates with three weeks' notice.
Straight to test	Arrangements where patients can be referred straight for diagnostics as the first appointment as

10.1.2 Acronyms

Term	Definition
ASIs	Appointment Slot Issues (list). A list of patient who have attempted to book their appointment through the national E-Referral Service but have been unable
CATS	Clinical Assessment and Treatment Service
CCGs	Clinical Commissioning Groups. Commission local services and acute care.
CNS	Clinical Nurse Specialists use their own knowledge of cancer and treatment to co-ordinate the patient's care plan and act as the patient's 'keyworker'.
COF	Clinic Outcome Form
COSD	Cancer Outcomes and Services Dataset is the key dataset which is designed to define and deliver consistency in data recording, data submission and analysis across cancer in the NHS, including diagnostics, staging, treatment and demographic
DNA	Did Not Attend. Patients who have been informed of their appointment date and who, without notifying the hospital fail to attend their appointment.
DNA	Did Not Attend. Patients who give no prior notice of their non- attendance.
DTT	Date of Decision to Treat. The date on which the clinician communicates the treatment options to the patient and the patient agrees to a treatment.
ECAD	Earliest Clinically Appropriate Date that it is clinically appropriate for an activity to take place. ECAD is only applicable to subsequent treatments.
E-RS	(National) E-Referral Service
FOBT	Faecal Occult Blood Test. This test, which is part of the Bowel Screening Pathway, checks for hidden (occult) blood in the stool (faeces).
GP	General Practitioner. A physician whose practice consists of providing ongoing care covering a variety of medical problems in patients of all ages, often including referral to appropriate specialists.
The cancer management system	A database system used to record all information related to patient cancer pathway by MDT co-ordinators, Clinical Nurse Specialist and Clinicians.
IOG	Improving Outcomes Guidance. This is NICE guidance on the configuration of cancer services.
IPT	Inter-Provider Transfer
MDM	A Multi-Disciplinary Team Meeting where individual patients care plans are discussed and
MDS	Minimum Data Set. Minimum information required to be able to process a referral either into the cancer pathway or for referral out to

MDT	A Multi-Disciplinary Team is a group of doctors and other health professionals with expertise in a specific cancer, who together discuss and
MDT Co-ordinator Multidisciplinary Team Co-ordinator	Person with responsibility for tracking patients, liaising with clinical and CAU staff to ensure progress on the cancer pathway, attends the weekly patient tracking list (PTL) meeting, updates the Trust's database for cancer pathway patients and assists with pathway reviews and changes. Also
NCWTDB	National Cancer Waiting Times Database**.** All cancer waiting times General standards are monitored through the national Cancer Waiting
PAS	The Patient Administration System records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with
PAS	Patient Administration System
PPID	Patient Pathway Identifier
PTL	Patient Tracking List. A complex spreadsheet used to ensure that cancer waiting times standards are met by identifying all patients on 62 day pathways and by tracking their progress towards the 62 or
PTL	Patient Tracking List. A tool used for monitoring, scheduling and reporting on patients on elective
RACPC	Rapid Access Chest Pain Clinic
RCA	Root Cause Analysis. This defines steps on a patient's pathway and identifies breach reasons. In the context of this Policy, this is not the same as the level of investigation involved in an RCA
RMC	Referral Management Centre
RTT	Referral to Treatment
SMDT	A Specialist Multi-Disciplinary Team Meeting where individual patients care plans are discussed and agreed takes place across multiple organisations and involves support from a centre
TCI	To Come In

TIA	Trans Ischaemic
TSSG	Tumour Site Specific Group
UBRN	Unique Booking Reference Number

11 Initial Equality Impact Assessment Screening Tool

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Patient Access Policy</td></tr>
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Patients x
Staff
Both</td></tr>
<tr><td>Does the proposal, service or document affect one group more or less favourable than another on the basis of:</td><td>Yes/No</td><td>Justification/evidence and data source</td></tr>
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<tr><td>Gender reassignment</td><td>No</td></tr>
<tr><td>Marriage or civil partnership</td><td>No</td></tr>
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<tr><td>Religion or belief</td><td>No</td></tr>
<tr><td>Sex</td><td>No</td></tr>
<tr><td>Sexual orientation</td><td>No</td></tr>
<tr><td>Human Rights – are there any issues which might affect a person's human rights?</td><td></td><td>Justification/evidence and data source</td></tr>
<tr><td>Right to life</td><td>No</td><td rowspan="4">The Policy protects a service users Human Rights as adherence and monitoring is covered by relevant legislation</td></tr>
<tr><td>Right to freedom from degrading or humiliating treatment</td><td>No</td></tr>
<tr><td>Right to privacy or family life</td><td>No</td></tr>
<tr><td>Any other of the human rights?</td><td>No</td></tr>
<tr><td>EIA carried out by: Nicola Murdoch

Quality assured by: PGP April 21</td><td>Date
March 2021</td><td>Contact details of person carrying out assessment.</td></tr>
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