Policy

Patient Access

Authors Name & Title: Wyn Taylor, Head of Information Governance and Administration	
Scope: Trust Wide	**Classification: Non-Clinical**
Replaces: Access and Administration Process Policy v3.0	
To be read in conjunction with the following documents: Data Quality Policy	
Document for public display? Yes	

Unique Identifier: TR39(12)	**Review Date: 27th March 2019**	
Issue Status: Approved	**Version No: 4.0**	**Issue Date: 23rd May 2018**
Authorised By: Operational Board	**Authorisation Date: 27th April 2018**	
After this document is withdrawn from use it must be kept in archive for the lifetime of the Trust, plus 6 years		
Archive: Document Control	**Date added to Archive:**	
Officer responsible for archive: Document Control Co-ordinator		

Has the document undergone Equality Analysis?	**No**
Has Endorsement been completed?	**Yes**

Table of Contents

Policy Statement

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

- sets out the rules and principles under which the Trust manages elective access to outpatient appointments, diagnostics and elective inpatient or day case treatment
- gives staff clear direction on the application of the NHS Constitution in relation to elective waiting times
- demonstrates how elective access rules should be applied consistently, fairly and equitably

The Trust's Patient Access Policy has been developed following consultation with staff, Clinical Commissioning Groups [CCGs], clinical leads and lay members. The Policy will be reviewed and ratified at least annually or earlier if there are changes to National rules or locally agreed principles.

The Policy should be read in full by all applicable staff, supported by completion of contextual Referral to Treatment [RTT] training. The Policy should not be used in isolation as a training tool.

The Policy is underpinned by a suite of Standard Operating Procedures [SOPs]. 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.

1. Roles and Responsibilities

All staff involved in the administration of patient activities and healthcare professionals involved in the delivery of that healthcare need to understand and ensure that their practices are consistent with the content of this Policy; and that systems are in place to support effective schedule management.

This section outlines the key responsibilities of key groups of staff within the Trust in relation to this Policy. This list is not exhaustive and each group will have other roles and responsibilities that are not listed here.

Chief Executive has overall responsibility for the strategic and operational management of the Trust, including ensuring that the Trust policies comply with all legal, statutory and good practice guidance requirements.

Chief Operating Officer will performance manage the implementation of the Policy providing assurance directly to the Trust Board. The Chief Operating Officer will ensure the Trust is maximising its clinic and theatre capacity whilst adhering to the NHS Executive guidelines regarding the following:

- total number of patient on the waiting list cancelled
- operations / clinics
- waiting times targets suspended
- Waiting Lists

The Chief Operating Officer will ensure robust and timely information is produced and is made available to Trust management as appropriate.

Divisional Head of Operations will be responsible for ensuring adequate capacity is available to meet the demand for each service. The Deputy Head of Operations will be responsible for monitoring the following:

- cancelled operations
- cancelled, reduced, re-scheduled clinics

Also responsible to act upon any capacity issues within relevant service lines, and ensure adequate capacity is available to meet demand in line with annual business planning processes.

Consultants are responsible for and must decide which patients require listing and assigning clinical priority. Consultants will be responsible for the care of all patients listed on their waiting list including those suspended within National and locally agreed targets.

Consultants and their clinical teams are required to provide at least 6 weeks' notice before the date for commencement of their leave period, and to submit the relevant form to the relevant Clinical Lead or Divisional Head of Operations for approval.

Consultants will be responsible for reviewing patient records for those requiring re-scheduling following a hospital cancellation to ensure patient care is not compromised.

Consultants and their clinical teams will be responsible for ensuring all referrals are reviewed in line with Key Performance Indicator [KPI] targets once received into the Trust.

Consultants are responsible for ensuring that they are aware of the key issues relating to the Policy, including:

- observing the guidance provided within this Policy
- ensuring junior medical staff are aware of their responsibilities in line with this Policy

Hospital Co-ordinators are responsible for obtaining clinical information about patients being transferred from other trusts.

Data Quality Team will ensure data entry is accurate and complies with National and Local data standards.

Information Team will ensure consistent waiting time reporting is achieved both internally and externally and will produce data quality reports to monitor Trust performance and compliance with this Policy.

IT Department will ensure system changes are actioned in liaison with suppliers and that software and process changes are implemented in liaison with users.

Education and Learning will provide Hospital PAS trainers to work with users to ensure that training needs are met and underpinned with effective training documentation.

Outpatient Clerks will be responsible for preparation of documentation prior to the clinic taking place within the department remit. They are also responsible for running the Outpatient Department and making Follow Up appointments for patients.

Patient Access and Administration Manager will be responsible for ensuring robust processes are in place for patients to receive treatment within National and Locally agreed targets and that all staff adhere to the Policy and associated procedures. The Patient Access and Administration Manager will be responsible for monitoring the following:

- Waiting Time Targets
- suspended waiting lists
- Activity Monitoring lists
- updating the Patient Access Policy
- nominating staff to attend training / update sessions
- ensuring clinical staff receive update training on patient access standards

Administration Team Leaders will be responsible for implementing processes in line with this Policy to ensure patients receive treatment within National and Locally agreed targets and that staff adhere to the Policy and associated procedures. Also responsible for escalation of any operational issues, capacity issues or waiting list issues to the Operational Manager or Divisional Head of Operations once all options, in accordance with the escalation procedure, have been exhausted to allow for a resolution to be sought.

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.

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 Trust appropriately and include the required minimum dataset as not to delay referral processes.

Patients can make a significant contribution to their own, and their families, good health and wellbeing, and should take personal responsibility for it. The NHS Constitution recommends the following actions patients can take to help in the management of their condition:

- be registered with a GP practice as this is the main point of access to NHS care as commissioned by NHS bodies
- provide accurate information about their health, condition and status
- keep appointments, or cancel within a reasonable timeframe

Medical Secretariat and Central Booking Team are responsible for the administration of patients and ensuring they are added to the outpatient and inpatient waiting lists on the PAS. The Medical Secretariat must ensure that all patient / GP correspondence is typed and made available in accordance with Local and National standards, ensuring the PAS is updated accordingly.

The Medical Secretariat and Central Booking Team must ensure that all patients are booked within National and Local targets:

- **English patients** – 18 weeks, from referral to treatment
- **Welsh patients** – 26 weeks, from referral to treatment
- **English and Welsh patients** – 6 weeks, for diagnostic tests
- **Rapid Access** – 14 calendar days from date of receipt of referral to appointment

Wards and Departments must ensure patients are admitted and discharged on the PAS, recording all outpatients against admissions if patients do not attend. The Wards and Departments must ensure all purple folders are available for admission and all patient movements are accurately recorded on the PAS i.e. ward transfers, hospital

transfers, consultant changes and discharge details and book relevant follow up appointments.

Theatre / Cath Lab / Ward Manager must contact the Head of Operations before cancelling patients due to lack of bed availability, advising on the patient's length of wait and relevant circumstances. The Theatre / Cath Lab / Ward Manager must inform the Medical Secretariat / Waiting List Team of the hospital cancellation in order to facilitate a new admission date that is within 28 days. Any major problems should be escalated to Divisional Head of Operations or relevant Executive Director in accordance with the Trust's escalation procedure.

2. Procedure

2.1 General Principles RTT and Diagnostic Pathways

2.1.1 Purpose

The aim of the Policy is to ensure that National guidance and good practice is followed to ensure that patients are treated promptly, efficiently and consistently.

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 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 RTT and diagnostic pathway
- applies to all clinical and administrative staff and services relating to elective patient access at the Trust

2.1.2 Staff Competency and Compliance

Competency

As a key part of Local Induction processes, all new starters to the Trust involved in patient booking processes or managing patient pathways should undertake contextual elective care training which is applicable to their role. All existing staff should undertake contextual training on at least an annual basis, or where standards or processes are updated. 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. This Policy, along with the supporting SOPs, will form the basis of contextual training.

Compliance

Staff will be performance managed against KPIs applicable to their role. Role specific KPIs are based upon the principles within this Policy and specific aspects contained within the Trust's SOPs. In the event of non-compliance, a resolution should initially be sought by the individual's team, specialty or line manager. The matter should then be dealt with via the Trust's disciplinary or capability procedure.

2.1.3 General Elective Access Principles

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 2 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

2.1.4 Individual Patient Rights

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 2 weeks from a GP referral for urgent referrals where Cancer is suspected
- if this is not possible, the NHS has to take all reasonable steps to offer a range of alternatives

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

(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

2.1.5 Patient Eligibility

The Trust has 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.

The Trust will check every patient's eligibility for treatment. Therefore, at the first point of entry, patients must be asked questions which will assist the Trust in assessing 'ordinarily resident status'.

If the patient is not eligible for free NHS treatment and it is non-urgent, payment must be taken in advance of any services being provided.

Some visitors from abroad, who are not ordinarily residents, 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

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 and Private Patient Manager for clarification of status regarding entitlement to NHS treatment before their first appointment is booked or date To Come In [TCI] agreed.

If it is identified that a patient is not eligible for free NHS treatment, the following individuals should be informed:

- Lead Clinician
- Overseas and Private Patient Manager
- Finance Lead

2.1.6 Patient Moving Between NHS and Private Care

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.

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.

2.1.7 Military Veterans

In line with the Armed Forces Covenant (published in 2015), all veterans and war pensioners should receive priority access to NHS care for any conditions 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.

GPs should 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.

The status of the patient should be recorded to ensure appropriate priority is assigned.

2.1.8 Prisoners

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

The Trust will work with staff 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.

Once the Trust is aware of a prisoner attending, the Trust's Safeguarding Lead and Risk Management Lead must be notified.

2.1.9 Service Standards and KPI's

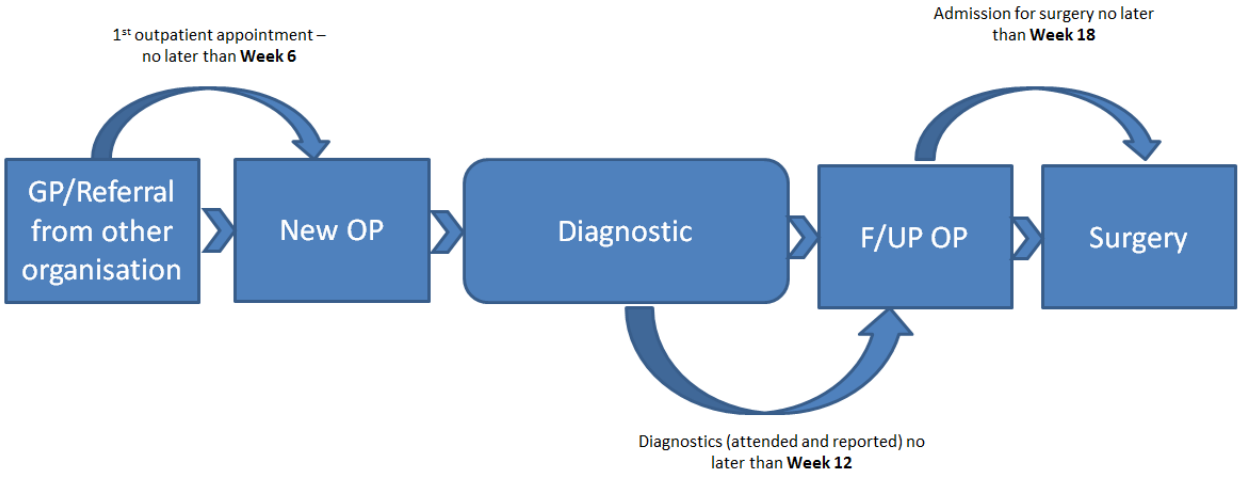
Key business processes that support access to care will have clearly defined service standards, which will be monitored by the Trust. Compliance with each service standard will support effective and efficient service provision, and the achievement of referral to treatment standards. Key standards for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

KPI Description	Target
Referral receipt and registration within 48 hours / 2 working days	95%
Addition of urgent referrals to waiting list within 12 hours	100%
Discharge summaries from in-patient admissions and day cases received in GP practices within 24 hours (TTO)	95%
Consultant dictation timeframe from OPD appointment (2 working days)	95%
Discharge letters to be received by patients GP within 2 weeks of discharge	98%
Consultant dictation timeframe from Inpatient Discharge (5 working days)	95%
Outpatient clinic letter to be sent to referrer no later than 7 days post appointment	100%
Number of outpatient appointments cancelled by provider broken down by specialty including evidence of clinical involvement in re-allocation of appointments	6%
All referrals received to be registered on PAS and uploaded to referral workflow within 48 hours of receipt	95%
Outpatient clinic outcomes to be completed for all outpatient appointments on same day of clinic	95%
Referral to Diagnostic within 6 week period	100%
Diagnostic Reporting to be completed within 5 working days	100%

2.1.10 Pathway Milestones

In order to achieve treatment within 18 weeks of receipt of referral, key milestones and sufficient capacity to meet demand must be planned by the clinical divisions agreed with Consultants. The following is an example of a surgery pathway with key milestones as an indication of optimal patient pathway at LHCH:

Surgery Pathway:



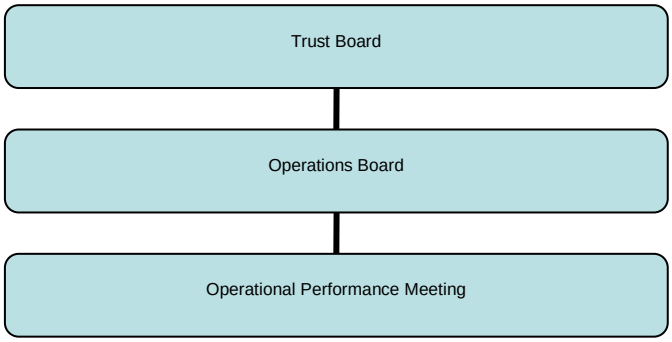
2.1.11 Monitoring

Operational monitoring of compliance, patient pathways and capacity levels will be managed by operational teams and management, to ensure any shortfalls or in poor patient experience, resource intensive administrative processes, or breaches of the RTT standard are avoided. Operational leads will meet to review performance data and compliance at the weekly operational performance meeting.

Operational reports will be constructed and ownership assigned to ensure the Policy and processes are being applied, and to identify any risks or deficiencies in performance delivery.

2.1.12 Governance Process

The Trust has governance structures in place to monitor performance and provide assurance with regard to targets and performance.



Operational performance and delivery against activity plan is also reported and monitored with commissioners of the Trust's services.

2.1.13 Reasonableness

As a matter of routine, the Trust will offer patients sufficient notice to attend routine appointments and admissions dates. A reasonable offer is defined as a choice of 2 dates with at least 3 weeks' notice. If an offer is to be made within this timeframe, patients must be

contacted by phone to agree the date. Reasonable efforts must be made to contact the patient prior to confirming the date in writing.

2.1.14 Chronological Booking

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 Patient Tracking List [PTL]. Patients will NOT be selected from any paper-based systems, therefore all planned activity and booking processes must be linked to PAS which in turn will populate the PTL.

2.1.15 Communication

All communications with patients and anyone else involved in the patient's care pathway (e.g. GP, referring Trust, or a person acting on the patient's behalf), whether verbal or written, must be informative, clear and concise. Copies of all written correspondence relating to the patient must be kept in the patient's Health Records which is stored within the Electronic Document Management System [EDMS] for auditing purposes. The exception to this is copies of appointment letters sent to patients; however an audit trail is retained in PAS of when appointment letters have been generated and printed.

GP or the relevant referrer must be kept informed of the patient's progress in writing. When clinical responsibility is being transferred back to the GP or referrer, e.g. when treatment is complete, this must be made clear in any communication.

2.1.16 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 diagnostic 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

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 of this Policy.

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 and where this prevents the Trust from treating them within 18 weeks

2.1.17 Overview of National Referral to Treatment Rules

The chronology and key steps in a typical referral to treatment pathway are as follows:

- referral received from GP, E-Referrals, or another care provider – CLOCK START
- First Outpatient Appointment – CLOCK CONTINUES OR STOPS
- Diagnostic – CLOCK CONTINUES
- Decision to Admit – CLOCK CONTINUES OR STOPS
- First Definitive Treatment e.g. Surgery – CLOCK STOP

The above is to be achieved within 18 weeks for English patients and 26 weeks for Welsh patients.

2.1.18 Clock Starts

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 the patient converts their unique booking reference. The following scenarios initiate a clock start:

- 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 in to an interface or referral management assessment centre 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-arranged services agreed by providers and commissioners

2.1.19 Exclusions

A referral to consultant led services will start an RTT clock. The following activity is excluded from RTT with regard to this Policy:

- referrals to a non-consultant led service
- emergency pathway non-elective follow-up clinic activity
- non English commissioner activity

2.1.20 New Clock Starts for Same Condition

<u>Following Active Monitoring</u>

Some clinical pathways require patients to undergo regular monitoring or a review of diagnostics as part of an agreed programme of care. These events would not of themselves indicate a Decision To Treat [DTT] 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 DTT.

<u>Following a Decision to Start a Substantively New Treatment Plan</u>

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.

For a Second Element of a Bilateral Procedure

A new RTT clock should be started when a patient becomes fit and ready for the second element of a consultant-led bilateral procedure. For instance, patients with two cancers will have them operated on one at a time often separated by several weeks. Patients will often be managed via the Multi-Disciplinary Team (MDT) process. The Trust in this instance works towards a 31 day target.

For a Re-Booked New Outpatient Appointment

Refer to Section 2.1.25.1 – First Appointment DNA's.

2.1.21 Clock Stops for First Definitive Treatment

An RTT clock stops when first definitive treatment commences, for instance:
- treatment provided by a consultant-led service
- treatment provided by an interface service

2.1.22 Clock Stops for Non-Treatment

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 Did Not Attend [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

It is important that any decision made to stop a patient's clock for non-treatment is clearly documented within the patient's Health Records, particularly where treatment is declined.

2.1.23 Active Monitoring

Active monitoring is where a decision is made that the patient does not require any form of treatment currently, but should be monitored. 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 DTT has been made.

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.

The Trust will have processes in place to ensure patients placed on active monitoring are subject to regular review, to ensure that no undue delay to any further treatment is caused.

2.1.24 Patient Initiated Delays

It is important that such delays are founded on individual patient best clinical interests. Where a patient initiates a delay to treatment, the relevant consultant must assess the clinical impact of the delay and ensure that patient is aware of any subsequent risks. It is important that such delays are clearly recorded in the patient's Health Record for audit trail purposes.

2.1.24.1 Non-Attendance of Appointments / DNA's

Other than at first attendance, DNAs have no impact on reported waiting times. Every effort should be made to minimise DNAs by identifying trends in activity, improving communication processes with patients, and innovation to support patient engagement. It is important that a clinician reviews each and every DNA on an individual patient basis to inform what action is necessary.

<u>First Appointment DNA's</u>

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 i.e. a choice of 2 dates with at least 3 weeks' notice provided to the patient. If the 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.

<u>Subsequent (Follow Up) Appointment DNA's</u>

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.

It is essential for audit trail purposes that a clinical review is undertaken to ensure it is clinically safe to discharge the patient from the care of the Trust. All such decisions should be documented within the patient's Health Record, with the decision clearly communicated back to the referrer.

2.1.24.2 Cancelling, Declining, OR Delaying Appointment and Admission Offers

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.

Cancellations or delays should be communicated to the relevant clinician to ensure that no harm is likely to result from the patient waiting longer for treatment, and an assessment made how long it is clinically safe for the patient to postpone treatment for, and when their case should be reviewed.
Consultants must review on a case by case basis the patient's heath record to determine whether:

- the requested delay is clinically acceptable (clock continues)

- the patient should be contacted to review their options – this may result in an agreement to delay (clock continues) or to commence a period of Active Monitoring (clock stops)
- the patients best clinical interest would be served by discharging the patient back to the care of the GP or referrer (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).

The 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, or where long delays (i.e. a period 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 and the decision documented within the patient's Health Record.

2.1.25 Patients Who Are Unfit for Surgery

If a patient is identified as unfit for a procedure, the nature and the duration of the clinical issue must be ascertained and an assessment made regarding appropriate course of action as follows:

Short-Term Illness

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

Longer Term Illness

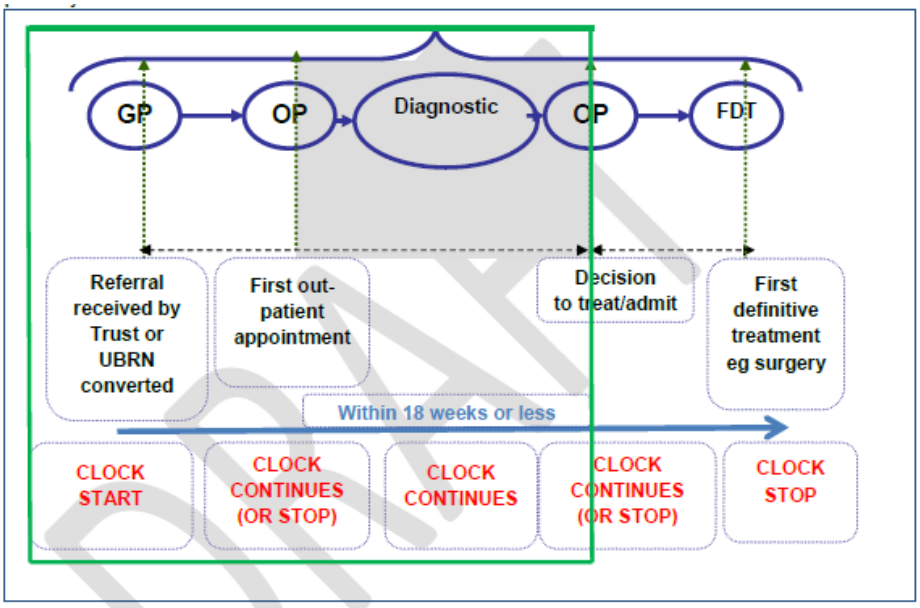
If the nature of the clinical issue is more serious for which the patient requires treatment, the clinician must clearly indicate the required course of action and decision as follows:

- if it is clinically appropriate for the patient to be removed from the waiting list. This will be a clock stop via the application of Active Monitoring
- if the patient should be treated within secondary care (Active Monitoring clock stop) or if they should be discharged back to the care of the GP (clock stop)

2.2 Pathway Specific Principles RTT and Diagnostic Pathways

2.2.1 Non-Admitted Pathways

The non-admitted stages of a patient's pathway comprise both the 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.



2.2.1.1 Receipt of Referral

Paper based referrals are currently accepted by the Trust, however the ambition is to move to a 'digital referrals' service utilising NHS e-Referral Service [ERS] and the Trust developed web referrals portal.

ERS is the preferred method of receiving referrals from English GP's which will become standardised practice from May 2018 in line with the Trust paper switch off programme for GP referrals to first consultant led outpatient appointments.

Referrals are managed centrally for main hospital outpatient activity with the optimal standard of referrals being registered within 2 working days of receipt in to the Trust. Referrals should be directed to the Central Access Booking Team to ensure referral management is standardised and allow monitoring of compliance.

Where clinically appropriate, referrals should be made to a service rather than a named clinician. This will allow referrals to be assessed and assigned to the most appropriate consultant or service, also supporting the chronological booking of patients in line with waiting times. Referrals made to a service supports the best interests of the patient as it promotes equity of waiting times and allows greater flexibility for appointment booking.

2.2.1.2 Methods of Receipt

NHS e-Referrals

All NHS e-referrals must be reviewed and accepted or rejected. Currently, to maintain standardisation in practice, referrals are taken from ERS and placed in to the Trust standard referral management system (Hyland Onbase) to allow consultants to review all referrals in 1 system.

Where there are delays in reviewing referrals, this will be escalated initially to the Patient Access and Administration Manager for review. If required the issue should be escalated to the respective clinical division management team with agreed actions to address the issue.

If an NHS e-Referral is received for a service not provided by the Trust, it will be rejected back to the referrer advising that the patient needs to be referred elsewhere. This will result in the patient's clock stop.

Where the GP has failed to attach a referral letter to ERS, the Trust will contact the referrer once to inform that the referral requires to be uploaded. If a referral is not attached within 3 days of this notification to the referrer, the referral will be rejected.

Paper Based Referrals

All routine and urgent referrals received should be directed to the Central Access Booking Team.

All referrals must be date stamped upon receipt in to the Trust. If the referral is received in to another area of the Trust, the referral should be date stamped and forwarded immediately to the Central Access Booking Team. For patients referred by paper, the referral received date is the point that the RTT clock starts.

All referrals must be registered on the Trust PAS and will then be directed to the relevant consultant or service using the Trust standard referral management system (Hyland Onbase). This ensures the process is auditable and allows for electronic notification of the referral direct to the consultants email inbox.

Urgent 2 week wait referrals for suspected Cancer will be flagged accordingly in the referral management system to ensure this is alerted to the reviewing consultant.

This process must be done as soon as possible to support RTT pathway compliance and outpatient clinic utilisation.

Secure nhs.net Email Referrals

A number of referrers such as the Isle of Man will send referrals to designated nhs.net email accounts. This is to ensure secure transfer, auditability and to reduce waiting times for the patient. Any such referrals are uploaded in to the Trust standard referral management system (Hyland Onbase) for consultant review and acceptance.

2.2.1.3 Referral Types

Rapid Access Referrals

Rapid access patients must be seen by a specialist within 14 days of the Trust receiving the referral. The referrer should ensure that appropriate information is included in the referral and ensure that the patient also receives relevant information.

Consultant to Consultant Referrals

Consultant to consultant referrals may be made for one of the following reasons:

- part of the continuation of investigation / treatment for the same condition
- urgent referrals for new condition
- suspected Cancer referrals

2.2.1.4 Inter-Provider Referrals

The Trust expects an accompanying Minimum Data Set [MDS] for all inter-provider referrals which should clearly detail the patient's current RTT status.

The Trust will inherit any RTT wait already incurred by the referring Trust 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 start will be upon receipt to the Trust.

The patient's unique pathway identifier should also be provided and updated accordingly on the Trust PAS. If any of the required information is missing, the referral should still be recorded on PAS and the missing data chased up by the Central Access Booking Team and PAS updated once received.

2.2.1.5 Booking New Outpatient Appointments (ERS and Paper)

E-Referral Service

Patients who have been referred via ERS should be able to choose, book and confirm their appointment prior to the Trust receiving the referral.

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 GP or patient attempted to book the appointment. Patients on the ASI list will be reviewed by the Central Access Booking Team and an appropriate appointment made. It is preferable that the patient is contacted by phone to agree the appointment date and time to support patient choice.

If an appointment has been incorrectly booked on ERS or to the incorrect service by the referrer, the referral should be appropriately redirected within ERS to the correct service. A confirmation of change letter should be generated and sent to the patient. The patients RTT clock will continue to tick from the date that the Unique Booking Reference Number [UBRN] was converted.

Paper Based Referrals

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

Patients will be selected for booking from the Trust PTL.

An appointment will be generated for the patient and confirmation of the date sent in an appointment letter generated from the PAS. Appointment dates booked within 2 weeks will be deemed as reasonable subject to the patient agreeing to the appointment. It is therefore required that short notice booking are confirmed with the patient.

Where there is insufficient capacity to offer or book and appointment for a patient within the required milestone, the issue must be escalated to the Patient Access and Administration Manager and respective Service Line Manager.

A record of any declined appointment offers made to patients must be recorded. This is important for the following reasons:

- full and accurate record keeping is best practice
- it allows for an auditable trail of actions which can be used at a later date to understand the reasons for any delays in the patients treatment or RTT compliance

The Trust is committed to reviewing processes that will enhance patient choice and support reduction in new patient DNA's or cancellations. Any changes to processes will be proposed to divisional leads for approval prior to implementing change, to ensure divisional and clinical engagement.

2.2.1.6 Clinic Attendance and Outcomes (New and F/UP)

All patients, new and follow up, whether they attend the appointment or not, must have an attendance outcome recorded on PAS at the end of the clinic. Clinics must be cashed up on the same day of the clinic taking place. The Outpatient Reception Team is responsible for ensuring all outcomes are collected and recorded. Any missing outcomes will be monitored and escalated accordingly for action.

Clinic outcomes e.g. discharge, further follow up, and the patients RTT status will be recorded by clinicians on the Trust clinic outcome form held with the Trust EPR system. The Outpatient Reception Team must review this and ensure the outcome is updated accordingly in PAS.

Upon attendance in clinic, patients may be on an open pathway, may already have had a clock stop due to receiving treatment, or a decision not to treat being agreed. Patients may be assigned 1 of the following RTT statuses at the end of their outpatient attendance, depending on the clinical decision made or treatment given during the outpatient 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 inpatient waiting list for admission

- **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 e.g. bilateral lung cancers
  - 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

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

Due to current process, Community Services outcomes incur a slight delay being reported on PAS; however outcome completeness must be monitored and acted upon accordingly within the service.

Booking Follow-Up Appointments

Patients on an Open Pathway

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).

Follow-up appointments should be agreed with the patient prior to leaving the Outpatient Department. 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 must escalate in line with Local arrangements to obtain authorisation to overbook, with overbooks to be approved by the relevant clinician i.e. clinic owner.

Patients NOT on an Open Pathway

Patients who have already been treated or who are on active monitoring and require a further follow up appointment to be booked should have the appointment arranged prior to leaving the Outpatient Department. The consultant must indicate the required timeframe for the appointment in order this can be arranged by the Outpatient Reception Team.

DNA's

All DNA's (New and Follow Up) should be reviewed by the clinician at the end of clinic in order for a clinical decision to be made regarding the next steps to be taken with the patient. Vulnerable patients or high risk patients should be managed in line with the Trust Safeguarding Policy or advice sought from the Trust's Safeguarding Lead.

2.2.1.7 Appointment Changes and Cancellations Initiated by Patient

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 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. Contact with patient must be made within 2 working days to agree an alternative date.

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 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

2.2.1.8 Appointment Changes Initiated by Hospital

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

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.

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.

2.2.2 Diagnostics

2.2.2.1 Patients with a Diagnostic and RTT Clock

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)

Straight to Test Arrangements

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 clocks will start on receipt of the referral. These are called straight to test referrals.

2.2.2.2 Patients with a Diagnostic Clock Only

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.

2.2.2.3 National Diagnostic Clock Rules

Diagnostic Clock Start

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

Diagnostic Clock Stop

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

2.2.2.4 Booking Diagnostic Appointments

Appointments will be booked in line with the Locally agreed reasonableness criteria. The appointment will be booked 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).

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**

2.2.2.5 Diagnostic Cancellations, Declines, and or DNA's on Open RTT Pathways

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.

Active Diagnostic Waiting List

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).

Planned Diagnostic Appointments

Patients who require a diagnostic test to be carried out at a specific point in time for clinical reasons are exempt from the diagnostic clock rules and will be held on a planned waiting list with a clinically determined due date identified. 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.

2.2.3 Pre-Operative Assessment

All patients should be offered an appointment to pre-admission clinic which should be at least 42 days (6 weeks maximum) prior to the attendance procedure depending on the type of referral.

If a patient DNA's a pre-admission appointment, the Clinic Nurse Practitioner will contact the relevant secretary and consultant to identify the reason for DNA and make an informed decision whether a further appointment is to be offered. If the patient declines the upcoming procedure, the patient should be suspended from the waiting list. If the patient declines another appointment to attend pre-admission but wishes to keep the procedure / surgery date, the patient will be clerked on admission by the SHO / Registrar / Advanced Nurse Practitioner.

Patients with a decision to admit will attend a pre-operative assessment clinic to assess their fitness for surgery. The vast majority of patients can be assessed by the Trust's dedicated Clinical Nurse Practitioners / Nurse Specialists.

Patients should be made aware in advance that they may need stay longer on the day of their appointment for attendance in pre-operative assessment clinics if multiple tests and diagnostics are required.

For patients with complex health issues requiring a pre-operative assessment appointment, the Trust will aim to agree this date with the patient before they leave an outpatient clinic.

Patients who DNA their pre-operative assessment appointment will be contacted and a further appointment agreed. Should the patient DNA the second appointment, 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), 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.

2.2.4 Acute Therapy Services

Patients may be referred to acute therapy services e.g. physiotherapy. Referrals made to these services may be:

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

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

2.2.5 Non-Activity Related RTT Decisions

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

PAS must be updated by the administration team with the clock stop. The date recorded will be the day the decision not to treat is communicated in writing to the patient.

2.2.6 Admitted Pathways

2.2.6.1 Adding Patients to Active Inpatient or Day Case Waiting List

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

The active inpatient or day case waiting lists / PTLs will include all patients who are awaiting elective admission. The only exceptions are planned patients, who are awaiting admission at a specific clinically defined time.

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

2.2.6.2 Patients Requiring More Than One Procedure

If more than 1 procedure will be performed at any 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 1 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 1 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 (first) 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

2.2.6.3 Patients Requiring Time to Consider Treatment

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.

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.

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.

2.2.6.4 Scheduling Patients To Come In (TCI) for Admission

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.

Patients will be offered a choice of at least 2 admission dates with 3 weeks' notice within the agreed milestone for the specialty concerned. Admission dates can be offered with less than 3 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 must be recorded on PAS. This audit trail can be used at a later date to

understand the reasons for any delays in treatment, either patient or hospital initiated.

2.2.6.5 Patients Declaring Periods of Unavailability Whilst on the Inpatient / Day Case Waiting List

If a patient contact the Trust to inform of periods of unavailability for social reasons e.g. holidays, this period of unavailability must be recorded on PAS and included on the PTL / Waiting List.

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 during this period
- 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
- 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

2.2.6.6 Patients Who Decline or Cancel TCI Offers

Should the patient decline their 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

2.2.6.7 Patients Who Do Not Attend Admission

Patients who do not attend for admission must have their pathway reviewed by the 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 it is in the patient best clinical interest to be discharged back to the GP, the RTT clock is stopped. Any decision must be documented clearly to support audit trail and decision making process.

2.2.6.7.1 On the Day Cancellations

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.

If the hospital is required to cancel surgery for non-clinical reasons to the patient, the consultant with overall responsibility for the patient must make arrangements for the decision to be communicated to the patient in person, either via the Hospital Co-ordinators or Ward Staff. It would however be preferable that the consultant visits the patient on the ward if possible.

2.2.6.7.2 Planned Waiting Lists

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.

2.3 Cancer Pathways

2.3.1 Introduction and Overarching Principles

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. This section of the policy should be read in conjunction with the National Cancer Waiting Times monitoring and guidance documentation published via NHS Digital: https://digital.nhs.uk/cancer-waiting-times

2.3.2 Purpose

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 any suspected or actual breach is escalated immediately to the Cancer Lead and Divisional Head of Operations.

2.3.3 Roles and Responsibilities

Chief Executive has overall responsibility and accountability for delivering access standards as defined in the NHS Constitution and Operating Framework.

Chief Operating Officer 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 section of the Patient Access Policy.

Trust Lead Cancer Clinician is responsible for ensuring high standards of Cancer clinical care across the Trust in a timely manner, leading the development of the Cancer strategy.

Divisional Head of Operations is responsible for the monitoring of performance in the delivery of the Cancer standards and for ensuring the specialties 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.

Consultants have a shared responsibility with their Divisional Head of Operations for managing their patients' waiting times in accordance with the maximum guaranteed waiting time.

Information and Performance Manager is responsible for administering data required for managing and reporting Cancer waiting times, activity and Cancer outcomes. The Informatics Team ensures there is a robust SOP for the external reporting of performance.

Cancer Performance Lead is responsible for monitoring delivery of key tasks and delivery of 2 week waits, were required highlighting:

- patients booked to fail
- patients with no appointment
- any data entry issues
- producing reports for Divisional Head of Operations to support and resolve potential breaches
- producing reports showing compliance with 2 Week Wait [2WW] Standard in preceding week for discussion at the weekly operational performance meeting

Patient Administration Clerks / Medical Secretaries are responsible for ensuring waiting lists are managed to comply with this Policy and procedures.

All staff (for whom this Policy applies to) have a duty to comply fully with this Policy 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.

2.3.4 Staff Competency and Compliance

All staff involved in Cancer pathway management should undertake Cancer waiting times training and refresher training adequate to roles and responsibility. Local or National training will be made available to staff in roles requiring this specific training.

2.3.5 Cancer Waiting Times Standards

The following table outlines the key Cancer Waiting Times Standards that the Trust must be compliant with.

Service standard	Operational standard
Max 2ww from urgent GP referral for suspected cancer to first appointments	93%
Max 2ww from referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment	93%
Maximum of 31 days from decision to treat to first definitive treatment	96%
Maximum of 31 days from decision to treat/ECAD to start of subsequent treatment(s) where the subsequent treatment is surgery	94%
Maximum of 31 days from decision to treat/ECAD to start of subsequent treatment(s) where the subsequent treatment is drug treatment	98%
Maximum of 31 days from decision to treat/ECAD to start of subsequent treatment(s) where the subsequent treatment is radiotherapy	94%
Maximum 62 days from urgent GP referral for suspected cancer to first treatment	85%
Maximum 62 days from urgent referral from a NHS Cancer Screening Programme for suspected cancer to first treatment	90%
Maximum 62 days from consultant upgrade of urgency of a referral to first treatment	No operational standard as yet
Maximum 31 days from urgent GP referral to first treatment for acute leukemia, testicular cancer and children's cancers	No separate standard, monitored as part of 62 days from urgent GP referral.

2.3.6 Summary of Cancer Rules

2.3.6.1 Clock Start

A 2WW clock starts at the receipt of referral.

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

- urgent 2 week wait referral for suspected Cancer
- urgent 2 week wait referral for breast symptoms (where Cancer is not suspected)
- a consultant upgrade
- referral from NHS Cancer screening programme

- non NHS Referral (and subsequent consultant upgrade)

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.

2.3.6.2 Clock Stop

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: https://digital.nhs.uk/cancer-waiting-times

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

2.3.7 GP/GDP Suspected Cancer 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 2WW Team within 24 working hours of receipt of referral.

For 2WW referrals received by the Trust without key information the 2WW 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.

2.3.8 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 pro forma (it is, however, only the GP who can make this decision).

2.3.9 2 Referrals on the Same Day

If 2 referrals are received on the same day, both referrals must be seen within 14 days and, if 2 primary Cancers are diagnosed, treatment for both Cancers must start within 62 days of receipt of referral if clinically appropriate.

2.3.10 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.

2.3.10.1 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 / Histologist / other Trust clinicians on reviewing patients and/or diagnostics

2.3.10.2 Responsibilities

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.

2.3.11 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 DTT date.

In some circumstances it may be appropriate for the clinician to set an Earliest Clinically Available Date [ECAD] 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.

2.3.12 Reasonableness

For patients on a Cancer pathway, an offer will be deemed to be reasonable if 48 hours' notice of an appointment/diagnostic test/admission is given.

2.3.13 Waiting Time Adjustments

2.3.13.1 Pauses

There are only 2 adjustments allowed on a Cancer pathway, 1 in the 2WW pathway and the other in the 62/31 day pathway:

<u>2WW</u>

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).

<u>62/31 Day Pathways</u>

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 admitted treatments only.

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.

2.3.14 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:

2.3.14.1 First Appointment Cancellations

2WW referral patients who cancel their first appointment should be offered another appointment within the 2 weeks of the referral being received.

2.3.14.2 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).

2.3.14.3 Multiple Cancellations

All patients who are referred on either a 62 day GP pathway, screening pathway or breast symptomatic referral who cancel 2 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, screening pathway (i.e. outpatient, diagnostic investigation) an appropriate member of staff should contact the patient to identify any factors that may be stopping the patient attending and another appointment will be offered if the patient agrees.

2.3.15 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).

2.3.16 First Appointment

All patients referred as suspected Cancer including 2WW, screening, upgrade and breast symptomatic 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.

2.3.17 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.

2.3.18 Patients Who Are Unable To Be Contacted

If the patient cannot be contacted at any time on their 62 or 31 day pathway, a record of the time and date of the call to them must be recorded so the process is auditable, including date and time of attempted contact.

2 further attempts will be made to contact the patient by phone, 1 of which must be after 5pm.

Each of these calls must be recorded in real time on PAS. The 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 can still not be contacted:

<u>For First Appointments</u>

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.

<u>Appointments (Other Than First) on 62/31 Day Clinical Pathway</u>

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

2.3.19 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 to discuss if they can make themselves available. Patients will not be discharged if they make themselves unavailable.

2.3.20 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.

2.3.21 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.

2.3.22 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 patients 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.

2.3.23 Tertiary Referrals

2.3.23.1 Process

<u>Entering Patients on the Tracking Pathway</u>

Suspected Cancers – 2WW GP/GDP referrals

On receipt of a 2WW referral from a GP/GDP, the Cancer trackers will record the referral (including known adjustments, referring symptoms and first appointment) onto the Cancer management system within 24 working hours of receiving the referral.

The Cancer trackers are 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 Cancer Team will be 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 2WW Team 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 a Multi-Disciplinary Meeting [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 Cancer tracker 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.

2.3.24 Monitoring and Audit

It is the responsibility of the Cancer Information Team to run a weekly programme of audits for data completeness and data anomalies.

Any data anomalies are highlighted to the relevant Tumour Site Co-ordinator for investigations and correction. Response to the Cancer Information Team 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.

Regular data quality reports will be established to review the following:

- comparative audit of data on the Cancer management system and PA
- comparative audit of diagnosis code on PAS, Cancer management system and Health Records
- comparative audit of cases removed from the 62 day pathway and re- entered as 31 day patients within 4 weeks of removal

3. Policy Implementation Plan

The Patient Access and Administration Manager will be responsible for implementation of this Policy, maintaining and coordinating an implementation plan.

The Operations Board will be responsible for reviewing implementation progress of the plan.

Policy implementation will be supported by:

- publication on the Trust Intranet site and communicated by corporate communications to all staff
- publication on the Trust Internet site allowing access to patients, CCG's, and GP's
- a programme of training will be delivered to key staff which will incorporate a knowledge test to demonstrate appropriate levels of competence

4. Monitoring of Compliance

Compliance will be measured and monitored against the Policy standards and KPIs, through automated reports and manual audit to ensure standards are being adhered to.

KPI data will be made available to weekly operational performance meetings, and fed up to assurance committee level.

5. References

Model Elective Access Policy, NHS Improvement, June 2017

The Interface between primary and secondary care, Key messages for NHS clinicians and managers, July 2017, Gateway publication reference: 06935

6. Endorsed By:-

Name of Lead Clinician/ Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date
Jane Tomkinson, CEO	Operational Board	27/04/2018

7. Record of Changes

Section Number	Version Number	Date of Change	Description of Amendment	Description of Deletion	Description of Addition	Reason