CDDFT POLICY

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TABLE OF REVISIONS

Date	Section	Revision	Author
June 2009	Whole Document	Review of whole document	S Perkins, Assoc Director of Ops & Performance
October 2011	Section 6	Review of procedure for children who fail to attend	S Perkins, Assoc Director of Ops & Performance
January 2012	Section 10	Update of job titles following reorganization	S Perkins, Assoc Director of Ops & Performance
September 2012	Whole Document	Review of whole document, changes made to: Section 5 – Choose & Book Referrals table Section 6 – Additional information regarding Children with a Gold form Section 9 – Section updated Whole document update regarding new structure and job titles within the organisation	S Perkins, Assoc Director of Ops & Performance
August 2014	Section 3	Update wording under title: Exclusions from the 18 week wait policy	S Perkins, Assoc Director of Ops & Performance

	Section 9	Correction to Primary Target List (PTL) title in document. Paragraph added to include reference to Cancer Tracker	
	Section 10	Divisional Management structure reworded as Care Group management structure.	
	Section 11	Correction to Primary Target List (PTL) title in document.	
February 2016	Whole Document	Whole document reviewed and updated in line with new National Guidelines and to include Cancer Guidelines	S Perkins Director of Performance
September 2016	Whole Document	To incorporate procedures for cancellation and rebooking of review appointments Guidance on management of planned procedures	S Perkins Director of Performance
November 2016	Page 12	Wording changed to accurately reflect our process for managing DNA's	S Perkins Director of Performance

CONTENTS

1 INTRODUCTION

CDDFT's Patient Access Policy has been developed to ensure equity of access to services and the treatment of patients according to clinical need.

Equality, fairness and social inclusion lie at the heart of the Government's plan to modernise the NHS. CDDFT recognises its duties under the legislation/Statutory Duties and Human Rights Act and aims to strengthen, protect and promote human rights for all its patients, service users and staff. It seeks to make a positive difference to the population it serves by delivering fair and equitable services.

This policy sets out the principles and the process for managing patient care at CDDFT from the point of referral to treatment within nationally agreed target timescales. Its purpose is to provide information and assurance to the range of stakeholders in CDDFT that patients are treated in line with national standards of care.

2 PURPOSE

This policy should be used to guide local procedures for administering care pathways and to ensure clear roles and responsibilities in job descriptions, avoiding duplication of effort and ensuring accountability.

2.1 Objectives

The objective of this policy is to ensure that patients are treated in order of clinical priority and in chronological order thereafter. There are national target timescales for delivery of treatment or aspects of treatment, which vary from time to time according to national policy.

This document sets out the standards for CDDFT patients:

- For all **routine referrals** the maximum waiting time is 18 weeks from the point of **Referral** to the onset of **First definitive treatment**
- To ensure delivery of the 18 week RTT the following stage of treatment targets will be adhered to:

  First outpatient appointment 5 weeks from referral
  Diagnostic/Surgery 13 weeks from decision
  Planned procedures will be carried out at their due date

- Patients originally referred by a GP for cancer treatment under the *two week wait* rule must be treated within 62 days of GP referral. This also included those patients upgraded by a consultant to a 62 day pathway.
- All patient diagnosed with cancer must be treated within 31 days of diagnosis.
- All patients who require subsequent treatment for cancer but not first treatment must be treated within 31 days.

Patients waiting for elective treatment must be seen and treated in order of clinical priority; patients with the same clinical priority must be treated in chronological order.

War pensioners should receive priority treatment if the condition is directly attributable to injuries sustained during war periods.

3 SCOPE

This policy applies to all Trust staff members who are involved in the process of administering care pathways.

Key staff groups are:

- Director of Operations, Director of Performance and Associate Directors of Operations
- Consultants
- Medical secretaries and booking office staff
- Reception staff

4 DUTIES

Director of Performance

- The Director of Performance is responsible for the development, ratification and implementation and monitoring of this policy through the care group management structure. The Director of Performance will ensure that this policy is updated in response to changes in national policy and local arrangements agreed with commissioners.
- Will ensure that mechanisms are in place to enable the Trust to capture data accurately, that the reports detailed in Section 8 are compiled and distributed on a regular basis and ensure that all contractual obligations and requests from the Trust's commissioners are met.

Consultants

- Will ensure that clinically urgent patients are treated or seen in clinical priority order and thereafter in strict chronological order within target timescales set out in this policy.
- Authorise the addition of a patient to an RTT pathway e.g. the elective waiting list.
- Ensure all referrals are reviewed as soon as possible by an appropriate individual within three days for urgent referrals and five days for routine referrals of receipt at CDDFT.
- Ensure that all clinical decisions that have an impact on a patient's pathway are properly recorded.
- Do their utmost to avoid clinic cancellation or cancelled procedures by giving a minimum of 8 weeks notice for all leave of absence. Cross cover and team-working arrangements should be put in place to cover clinics so patients are not cancelled. In the event of a late cancellation due to unforeseen circumstances it is imperative that administrative staff are

informed as soon as possible to reduce inconvenience for patients and so that alternative arrangements can be made.

Associate Director of Operations

- Will proactively plan and manage demand, capacity, activity and any backlog to ensure that all patients are treated accordingly to clinical priority and within the target timescales set out in this policy.
- Ensure that all departmental job descriptions and procedures are developed, implemented and monitored to ensure delivery of this policy.
- Ensure that we are working towards PAS being the sole information system used for recording data on patient pathways as CDDFT and that as a consequence PAS is a comprehensive, up to date record of each patients waiting time.
- Monitor departmental progress in delivering this policy, by reviewing and acting on the performance reports listed in this policy and implementing all actions to improve performance that are agreed in reviews with the Associate Director of Operations. Care Group, Directorate and Departmental process standards and performance indicators should be developed, implemented and monitored to support delivery of this policy and related procedures.
- Ensure full compliance with this policy and any related procedures and escalate all problems with the implementation of this policy to the Director of Performance.
- Develop systems to ensure that patients cannot be booked beyond their target treatment date.

Medical Secretaries and Booking Office Staff

- Ensure that all patient pathways are administered in line with this policy and that departmental procedures are followed.
- Anticipate and resolve problems with implementing this policy, escalating to the relevant service manager any capacity or other problems that they cannot resolve.
- Provide clear and transparent explanations of this policy to patients, working proactively to minimise delay and maximise patient convenience and choice of appointment or admission dates.
- Ensure that we are working towards PAS being the sole record of the patient pathway and that all relevant events on the pathway are recorded on PAS in line with this policy and any supporting procedures.

Reception Staff

- Will develop local process performance indicators to ensure that clinic outcome data regarding RTT status or events is recorded on PAS accurately and in a timely fashion.
- Will ensure that all clinic outcomes and patient waiting times are recorded on PAS by the end of the day when the clinic is held.

5 MAIN CONTENT OF POLICY 1

The 18 Week Wait Policy

The 18 week wait ***Referral to Treatment*** (RTT) policy shifts the emphasis away from measuring and managing waiting times for parts of the patient pathway (e.g. waiting lists for outpatient appointments), to measuring and managing the whole patient waiting time form referral to start of first definitive treatment. The purpose of the policy is to better represent the patient experience of waiting and to reduce the overall time it takes from initial referral to the start of treatment to a maximum of 18 weeks. There are strict and complex rules governing what starts and ends a pathway, how to measure the length of a pathway and how waiting times should be managed when patients are referred between hospitals (***Inter Provider Transfers)***. These nationally set rules are summarized in this document**.**

Exclusions from the 18 Week Wait Policy

Patients referred for emergency or maternity (including direct admissions from outpatient clinics) are excluded from the 18 week target. These patients should be treated in a timely manner appropriate to their clinical need.

The 18 week wait standard apples to cancer patients, although the 62 day cancer waiting time standard means that in practice, cancer patients should be treated well within 18 weeks of referral. Breaches of the 62 day cancer standard should be reviewed to asses if these also constitute a breach of the 18 week wait standard.

5.1 Eighteen Week Referral to Treatment (RTT) 'Clock Rules'

Under the 18 week wait RTT target each patient pathway has its own 'clock', recording the length of time between referral and first definitive treatment. Clinical events that impact on the clock can be divided into three broad categories; clock start, clock run and clock stop events.

Clock Starts

An 18 week wait clock starts on the date of receipt of a referral in writing, received by fax, e-mail, post of by **Electronic Referral Service** when the patient converts their **Unique Booking Reference Number.** The clock starts at this point even if the specialty or consultant has a protocol for reviewing the appropriateness of a referral and accepting/rejecting it at a later date.

Clock Runs

The clock continues to run without pause or stop in the following circumstances:

- Awaiting authorization, acceptance or rejection of a referral
- When any diagnostic procedures are ordered or performed
- Upon consultant to consultant referral for the same condition
- Inter Provider Transfer for the same condition
- In the course of multi-organisation pathways

- When the patient **Can Not Attend** (CNA)

It is important to record the above events on the **Patient Administration System** (PAS) as they are important stages in the patient pathway, indicating a patient's progress towards treatment.

Clock Stops

The 18 week wait clock stops under the following circumstances:

- The start of **first definitive treatment**
- The addition of a patient to the transplant waiting list e.g. Corneal graft
- Clinician decision that no treatment is required
- The patient declines treatment
- A patient DNAs a first outpatient appointment

Clock stops mainly occur on admission for the first definitive treatment, or in outpatient consultations. Some patients are admitted for procedures where it is not clear if the procedure will be diagnostic or therapeutic. Under these circumstances the correct RTT status and possible clock stop will need to be documented after the procedure has been completed by the clinician.

Clock also stop on the basis of diagnostic test result reports, as a result of patient or GP communication to the hospital, on a review in an MDT meeting. All of these events must be recorded on a clinical outcome form and sent to data quality at the earliest opportunity.

5.2 Referrals

All referrals to CDDFT must be forwarded to Central Appointments Office and registered on PAS within one working day of receipt.

New Referrals that Start a New 18 Week RTT Pathway

Any referral from a GP to a consultant-led service at CDDFT which may lead to treatment is a new referral and starts a new pathway. If a CDDFT consultant makes a new referral to another CDDFT consultant for a different condition this also counts as a new referral and starts a new pathway. Any referrals for treatment listed on the VBC policy must have a Prior Approval Ticket (PAT).

New Referrals to CDDFT on an Existing 18 Week RTT Pathway

Some referrals to CDDFT are from consultants at other hospitals, from tier 2 service and community based services. These patients are already on an existing 18 Week Pathway and come to CDDFT with an existing Pathway ID and existing 18 week clock start and existing clock pauses. These administrative details must accompany all such referrals on an *Inter Provider Transfers' (IPT)* form.

Electronic Referral Service (ERS)

It is now possible for GPs to use the national ERS system for **direct booking** of GP referrals to CDDFT. The following standards apply for processing ERS referrals:

Priority	Primary Care Attachment of Referrals	Trust Prioritisation of Referrals by Clinicians
Urgent	24 hours	2 days
Routine	3 days	5 days

Accepting or Rejecting a Referral

The waiting time clock runs while a referral is being reviewed by a consultant for acceptance. To avoid unnecessary delays in treating patients, all referral letters to CDDFT must be reviewed and accepted/rejected within 3 days of receipt by the Trust. Inappropriate referrals should be returned to the referrer without delay and the reason for return should be recorded on PAS.

NHS Eligibility

The NHS provides healthcare for people who live in the United Kingdom. People who do not normally live in this country are not automatically entitled to use the NHS free of charge, regardless of their nationality or whether they hold a British passport or have lived and paid National Insurance contributions and taxes in this country in the past.

All Trusts have a legal obligation to:

- Ensure that patients who are not ordinarily resident in the UL are identified
- Assess liability for charges in accordance with the charging Regulations
- Charge those liable to pay in accordance with the Regulations

Anyone who has lived lawfully in the UK for at least 12 months immediately preceding treatment is exempt from charges. All patients should be asked where they have been living for the last 12 months and an Overseas Visitors Form should be completed and filed in the case notes if relevant.

Patients who have not been living in the country for the preceding 12 months should be flagged up as early in the referral process as possible to ensure that eligibility can be established and the patient advised of any financial implications. It should be assumed that is the patient has been attending another hospital or GP that he is automatically eligible.

Transfer of Referrals

In the event of unforeseen circumstances that mean there is no capacity to treat a patient within the target timescale, treatment can be offered to the patient by an alternative consultant. If a patient refuses to transfer then the first available appointment with the original consultant will be offered and the refusal will be recorded on PAS. If a patient is transferred internally from one

consultant to another for the same condition then this is not a new referral and does not start a new 18 week pathway. Referral and clock start date and waiting times are unaffected by transfer of a patient's care form one consultant to another.

Where treatment cannot be provided internally within the target timescale, the Trust has a responsibility for organizing this treatment with another provider. A decision to transfer a patient to an alternative provider must be agreed with the patient and the patient's GP must be informed. Patients who do not wish to be transferred to another provider must still be seen within the target timescale as per the constitutional standard.

Inter Provider Transfers (ITP's)

A specified minimum data set must accompany all IPT's which includes patient demographic data, information about the referral and information about the RTT pathway that the patient is on. The responsibility for the 18 week wait clock transfers to the receiving Trust when the receiving Trust takes clinical responsibility for the patient. At the point of receipt of referral in the receiving Trust, the clock at CDDFT stops. However if the patients pathway exceeds 18 weeks RTT the breach is shared between the referring and accepting Trusts.

5.3 Outpatient and Diagnostic Processes

Booking Appointments

All patients should be offered a choice of date and time for their outpatient appointment at their convenience. This is facilitated through the ERS process.

Electronic Referral Service (ERS)

All patients who are referred through a direct booking service on ERS arrange their own appointment either through their GP, the National Appointment Line (TAL) or on-line.

Non ERS

All patients should be offered a choice of date and time for their outpatient appointment at their convenience, which will be organized through the central appointments office.

Can Not Attend (CAN's)

If a patient cancels an appointment the clock continues to run. The reason for this cancellation must be recorded on the Patient Administration System (PAS).

If an adult CNA's more than 3 times, the patient will be discharged and referred back to their GP.

Filling Short Notice Cancelled Slots

In the event of a cancellation of an outpatient appointment, all efforts should be made to fill the vacant slot to maximise efficiency. Patients will be contacted to offer them an earlier appointment.

Clinic Outcomes

Clinical decisions taken in outpatient settings have important implications for the patient pathway and to ensure patients are treated as soon as possible, the outcome for each clinic appointment must be recorded on a clinic outcome form by the clinician and recorded on PAS by the end of the day when the clinic is held.

Clinic Cancellations

Clinic sessions should be cancelled for all known bank holiday periods a year in advance, along with any other regular events affecting the clinic schedules (e.g. on call and clinical audit).

Any clinics requiring cancellation or reduction should be approved by the Clinical Lead and Service Manager and notified to the clinic administrator 8 weeks prior to the clinic date.

Patients whose appointment is cancelled by the hospital prior to the appointment date should be given an alternative date at the time of cancellation. Please see Appendix 2 for Booking Rules.

Referral and clock start dates and waiting times are unaffected by hospital initiated outpatient appointment cancellations.

New Clinic and Clinic Changes

Changes to clinic templates and requests for new clinics to be set up on PAS should be received by the clinic administrator at least 8 weeks before the expected implementation date. These requests should be submitted on the approved Trust Clinic Changes form.

Does Not Attend and Outpatient Appointment

If a patient fails to attend an outpatient appointment, the patient's notes will be reviewed by the clinician who will decide whether to discharge the patient back to the GP or to re-appoint.

If the patient is discharged both the patient and GP will be informed.

When a review patient DNAs their GP will be given a 20 day window to reinstate the appointment rather than re refer as a new patient.

Exceptions to this will be cancer, diabetic ophthalmology and paediatrics who will always be given a second appointment.

Children who Fail to Attend <u>any</u> Outpatient Appointment

In relation to children who fail to attend an appointment, the respective consultant will be made aware of each instance. Each case will be considered individually and if necessary, support will be sought from staff such as the Specialist Health Visitor for children with chronic and complex needs. Health Visitor, School Nurse, "Looked After" Nurse, Community Paediatric Nurse, Senior Nurse Safeguarding Children and GP as appropriate before a decision not to appoint is made.

Children with 'Gold Form' of CPI Flag who Fail to Attend any Outpatient Appointment

In relation to children who have a 'Gold Form' or CPI flag attached to the notes who fail to attend an appointment the respective Consultant **must** be made aware and follow up appointments made. Notification **must** be sent to the GP, Social Worker and Senior Nurse Safeguarding Children.

Further action must be taken in accordance with Section 3.6 of the NHS Safeguarding Children Procedures and Related Guidance which are available on StaffNet.

Reasonable Offer Dates

For an appointment date offer to be considered reasonable it must be made no less than three weeks in advance and two dates must be offered.

5.4 Inpatient or Day Case Treatment

Adding Patients to the Elective Waiting List

Patients should be added to the CDDFT elective waiting list if they meet the following criteria:

- They are eligible for NHS treatment or consideration in Section 5 above
- They are referred to CDDFT for or consideration for elective treatment and their treatment is not one of the exclusions listed in Section 3 above
- The patient is clinically ready for treatment
- The patient is willing and able to be treated
- The patient has been seen in a private consultation and now wishes to transfer to the NHS, patients must take their place according to clinical priority

Patients should be added to the PAS waiting list module within 24 hours of decision to treat.

Planned Procedures

The patient will transfer to the active waiting list the day following their due date for their procedure.

Thinking Time

In some circumstances a patient requests some thinking time when offered an appointment or treatment date. They are otherwise willing and able to proceed with the appointment but may time to manage their personal circumstances. Under these circumstances, patients have 48 hours to confirm the offer. Failure to confirm the offer within 48 hours will mean the patient is deemed to have cancelled the appointment (CNA).

Can Not Attend (CNAs)

If a patient cancels an admission the reason for this cancellation must be recorded on the Patient Administration System (PAS).

Does Not Attend (DNA)

If a patient fails to attend an admission, the patient will be deemed to have declined the offer of treatment and be discharged from the Trust. The clinician will inform the GP of this decision.

Filling Short Notice Cancellations

In the event of a cancellation of an admission, all efforts should be made to fill the vacant slot to maximise efficiency. Patients will be contacted to offer them an earlier admission.

Prior Approval

Some treatments require authorisation from the CCG before treatment can commence. Once a Prior Approval Ticket is received treatment can commence.

Cancelled Admissions for Non-Medical Reasons

Patients whose admission is cancelled by the hospital prior to admission/appointment date for non-medical reasons should be given an alternative date at the time of cancellation, within the ***target treatment date.***

Patients whose admission has been cancelled once by the hospital should not be cancelled again.

Patients who have their procedure cancelled by the hospital on the day of admission for non-medical reasons must be allocated a new date immediately. Consideration should be given to allocating the next available procedure slot, within 24 hours. If a date cannot be agreed immediately the patient must be reinstated on PAS on the original pathway until a date can be negotiated. All cancelled patients must be treated within 28 days and within the target treatment date, whichever is earlier.

The Trust policy on reasonable offers and clock pauses etc. continue to apply to patients whose operation has been cancelled by the hospital for non-medical reasons.

Referral and clock start dates and waiting times are unaffected by hospital initiated cancellations of an admission for non-medical reasons.

Active Monitoring

Active monitoring of a patient's condition begins when no further assessment or diagnostic intervention is needed, or where the course of treatment is unclear and the consultant decides that the patient's condition should continue to be reviewed. The lock stops at the onset of active monitoring. A new 18 week clock would start when a decision to treat is made following a period of active monitoring.

Decision Not to Treat

A clinical decision not to treat a patient and to refer the patient back to primary care for ongoing management, stops the clock on the date of that decision. If a patient is subsequently referred

back to a consultant led service, then this referral starts a new 18 week clock, even if the referral is for the same condition.

Medical Suspension

A patient should only have a medical suspension entered onto the PAS if is it expected that the patient will be fit for surgery in one month's time. All other patients should be removed from the waiting list and referred back to the GP.

Social Suspension

To support effective management of all patients the maximum time for a social suspension is 6 weeks. All other patients should be removed from waiting list and sent back to the GP.

Management of Elective Waiting List

It is expected that patients should not remain on the waiting list for more than 6 months if they don't have a date for surgery. If a patient has been on the list for 6 months they will be reviewed and if appropriate referred back to their GP.

5.5 General Policy

Removing Patients from the RTT Waiting List

A patient can be removed from the RTT waiting list when:

- The patient is deemed to have declined the offer of treatment
- The patient cancels and does not wish to rebook an appointment or admission
- The patient Does Not Attend a first outpatient appointment
- The patient has cancelled an appointment of admission on two occasions
- The patient receives definitive treatment
- A clinician decides treatment is inappropriate or unnecessary

Removing patients from a CDDFT waiting list stops their RTT pathway and 18 week wait clock. This should always be carried out with the agreement of the consultant. If a patient initiates the removal from the waiting list their consultant should be informed.

Eight Weeks Notice of Annual/Study Leave or Unavailability

Clinicians must give a minimum of 8 weeks notice of any changes to their schedule that may cause a reduction or cancellation of clinic/lab/theatre slots, to ensure that the patients receive adequate notice of changes to their appointment/admissions. All consultants' leave of absence must be requested and granted in accordance with the Trust's Consultant Leave policy.

Information to Patients

Patients should receive appropriate written confirmation when they have been added to a waiting list. The patient should be given contact details to notify the Trust of any changes to

their circumstances or to raise queries about their appointment. Appointment or admission queries should be addressed to the booking offices.

All patients invited to attend the hospital should receive the CDDFT Hospital Information and Location Map.

Communication with patients should be informative, clear and concise and make the process of waiting list management and booking transparent, as set out in this policy.

Training & Competencies

Each Care Group is responsible for assessing and maintaining staff competencies to deliver this policy. Job descriptions should be reviewed and drawn up to make roles and responsibilities for implementing this policy clear and to avoid duplication or overlap. Each department is also responsible for developing and recording procedures to ensure compliance with this policy and for ensuring all staff are trained and competent in the delivery of these procedures.

System Validation

Booking departments carry out weekly validation of the information held on PAS to ensure the data held is accurate.

6 DEFINITIONS

6.1 Glossary of Terms Used

Active Monitoring	An 18 week clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage. A new 18 week clock would start when a decision to treat is made following a period of watchful waiting/active monitoring. Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but refer the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such and also stops an 18 week clock. If a patient is subsequently referred back to a consultant led service, then this referral starts a new 18 week clock.
Booked Admission	According to the National Booking Plan a booked admission is one in which the patient has the opportunity to agree the admission. For full booking, the admission is negotiated within one day of the decision to admit. For partial booking, the

	admission is negotiated at some point greater than one day.
Can Not Attend	Cancellation of an appointment by a patient at any point up to the time of appointment.
Convert UBRN	When an appointment has been booked via ERS, the UBRN is converted. (Please see definition of UBRN)
Day Cases	Patients who are admitted electively who do not require the use of a hospital bed overnight and who return home as scheduled.
Did Not Attend (DNA)	Where a patient fails to attend an appointment/admission without prior notice, up to the start time of their appointment.
Direct Access	Diagnostic tests ordered by a clinician without transfer of care for the patient. Test results are reported to the referring clinician to act on.
Declined the Offer of Treatment	A patient is deemed to have declined the offer of treatment if they DNA. At this point, their 18 week wait clock stops. The patient's consultant must be informed to decide if the patient should be referred back to their GP or if further action is needed to contact the patient. The normal course of action will be to refer back to the GP.
Earliest Reasonable Offer Date	The earliest of any reasonable dates offered to the patient (see Reasonable Offer dates).
Different or New Treatment	A new 18 week RTT pathway and clock starts upon any decision to refer for or start a substantively new or different treatment that does not already form part of that patients' agreed care plan; It is recognized that a patient's care often extends beyond first definitive treatment without a ticking clock.
Electronic Referral Service (ERS)	A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic.
First Definitive Treatment	The first intervention intended to manage a patient's disease, condition or injury and avoid further intervention.
Inter Provider Transfer	The transfer of clinical care for a patient from one service provider to another, where the decision on any care or treatment required tests with a clinician in the receiving organisation.
Outpatients	Patients referred for clinical opinion and potentially for treatment.

Partial Booking	A system where the patient is invited to phone the Trust to arrange an appointment or admission date.
PAS (Patient Administrations System)	The database that holds all administrative data on patients and patient related activity including demographic information, appointments, correspondence, waiting lists and time etc.
Planned Procedures	Procedures that are part of a planned sequence of care, or where a patient has been given a specific date or approximate date at the time a decision to admit was made and where earlier treatment would not be clinically appropriate.
Primary Target List (PTL)	A list of patients in priority order doe appointment, diagnostic tests or admission for treatment.
Reasonable Offer Dates	A reasonable offer is an offer of a time and date 3 or more weeks from the time that the offer is made.
Referral	When any care professional or service permitted by an English NHS Commissioner to make such referral decides to transfer the care of a patient to another service or clinician.
Referral to Treatment (RTT)	RTT if the time from date of receipt of referral at CDDFT to the date of admission or onset of first definitive treatment, whichever is the earliest.
Target Treatment Date	The date by which admission or first definitive treatment must occur to avoid a breach of a local or national standard.
Two Week Wait Rule	Where a patient is referred urgently by a GP with suspected cancer, the patient must be seen within two weeks of the date of referral.
UBRN (Unique Booking Reference Number)	The reference number that a patient receives on their appointment request letter generated by their GP referrer through ERS. The UBRN is used in conjunction with the patient password to make or change an appointment.

7 DISSEMINATION ARRANGEMENTS

All Trust staff are encouraged to make themselves familiar with the Patient Access Policy.

Updates are cascaded to RTT Assurance Group

This policy can be accessed on the Trust intranet site.

8 MONITORING

8.1 Key Performance Indicators

A performance report on this Patient Access Policy should be compiled on a monthly basis by the Information Department in the Trust's balanced scorecard and submitted to the Board of Directors on a regular basis. Key performance indicators compiled on a monthly basis will include:

- Notice period given for consultant leave by consultant
- The number of referrals received without a clock start
- The number of IPTs received without an MDS
- Number and percentage of admitted patients treated within 18 weeks
- Number and percentage of non-admitted patients seen within 18 weeks
- Number of DNAs
- Number of GP and Non GP New referrals
- Number of IPTs and waiting time on receipt of referral to and from CDDFT
- Percentage of incompletes pathways

Primary Target List (PTL)

A ***Primary Target List*** is compiled weekly by the Trust which sets out the patient priority order for clinic appointments, diagnostic tests and admission/treatment as dictated by this policy. This PTL is published for commissioners to ensure transparency and demonstrate that patients will continue to be treated within the target timescale. The PTL is the key management tool for ensuring this access policy is implemented.

In addition to the PTL a daily report is produced to identify all cancer patients who have been added to the Trusts cancer management tracking system. All cancer patients are tracked from first attendance through to diagnosis to treatment.

Escalation

The Trust PTL is distributed weekly to all service managers prior the weekly PTL meeting. Each Care Group will provide an update on their PTL at this meeting highlighting:

- A summary of the PTL
- Demand, activity, and capacity trends that influence the PTL
- Progress in clearing any backlog or implementing plans to address a backlog
- Current and anticipated pressure points
- Plans to address pressure points

Procedures should be put in place in all areas for escalating problems of compliance with this policy. All staff must comply with this policy. All staff must have a clear procedure for reporting problems of compliance with this policy. Service managers are responsible for ensuring a balance between demand and capacity to deliver this policy.

The Director of Performance is accountable for proper implementation of this policy and for the performance management of the process of implementation.

Suspected breaches 40 weeks

A full breach report should be completed within 24hrs and submitted to the Director of Performance or nominated deputy if a breach of the standard is suspected, including the following information:

- Patient ID
- The standard or standards that have been breached
- How and when the suspected breach was discovered and by whom
- The details of the suspected breach including date of clock start, target treatment date and number of days over the target date.
- Reason for the suspected breach
- Action taken to investigate and check the breach
- Plan to avoid recurrence of the suspected breach.

Action should be taken at departmental level to ensure the patient is treated or appointed as soon as possible, but the suspected breach should not be communicated externally until it has been reviewed and confirmed by the Director of Performance or her Deputy. The Director of Performance or nominated deputy alone can confirm if a suspected breach is a genuine breach, and is responsible for ensuring the relevant details are communicated externally.

Key Information

A number of information reports are produced on a regular basis using information covered by this policy or to support delivery of the policy. The contracts and information department has overall responsibility for collating and distributing this information including:

- Performance on delivery of the 31 and 62 day cancer standards
- Primary Target Lists
- Statutory returns including KH07, KH07AR, KH07a, KH06
- The number of referrals received without a clock start
- The number of IPTs received without an MDS
- Number and percentage of admitted patients treated within 18 weeks
- Number and percentage of non-admitted patients seen within 18 weeks
- Number of DNAs
- Number of patients on Active monitoring
- Number of GP and Non GP New referrals
- Number of IPTs and waiting time on receipt of referral to and from CDDFT

8.2 Compliance and Effectiveness Monitoring

Monitoring Criterion	To ensure all patients are treated in accordance with the Department of Health guidance
Who will perform the monitoring?	Director of Performance and RTT Assurance Group
What are you monitoring?	To ensure patients are treated in order of clinical priority and in chronological order
When will the monitoring be performed?	Weekly

How are you going to monitor?	Validation reports
What will happen if any shortfalls are identified?	Escalate to Executive Director of Operations
Where will the results of the monitoring be reported?	Executive Team
How will the resulting action plan be progressed and monitored?	Director of Performance and RTT Assurance Group will implement action plan and Executive Team will monitor
How will learning take place?	New guidance on waiting times is disseminated from Executive Team to Director of Performance and RTT Assurance Group

9 REFERENCES

https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

10 ASSOCIATED DOCUMENTATION

This Policy refers to the following CDDFT Trust policies and procedures:

- Patient Booking Procedures can be located on the Trust Intranet
- Cancer Access Policy February 2016 (see Appendix 1)
- Procedure for Cancellation and Rebooking of Review Appointments

This Policy refers to the following guidance, including national and international standards:

https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

11 APPENDICES

Insert Appendices here; including but not limited to:

- Appendix 1 Cancer Access Policy Feb 2016
- Appendix 2 Procedure for Cancellation and Rebooking of Review Appointments
- Appendix 3 Checklist for Approval of Policies
- Appendix 4 Equality Impact Assessment

County Durham and Darlington NHS
NHS Foundation Trust

Cancer Patient Access Policy
March 2016

Table of Contents

Introduction

Cancer Waiting Times: A Guide (Version 9.0) (CWT V9) U:\Guidance Documents\Cancer Waiting Times A Guide Version 9.pdf was published in October 2015 with an implementation date of the end of the same month. Although the guiding principles remained the same there were a few subtle changes to the guidance, particularly with respect to the number of scenarios relating to allowable adjustments and several places in the guidance make reference to local policy and the need for an agreement on what would constitute a 'reasonable offer'.

Scope

This policy covers patients referred directly to County Durham and Darlington NHS Foundation Trust (CDDFT). This policy is not meant to replace CWT guidance but translates CWT guidance into local operation

Key Dates (taken from CWT V9) – for CWT pathway diagram see Section 10 and local definitions

- Cancer Referral to Treatment Start Date = date of receipt of referral
- Date first Seen = date of first out-patient appointment with relevant specialist or test which meets criteria (see section …)
- Cancer Treatment Period Start Date = Decision to Treat (on either sub or first treatment)
- Treatment Start Date = Treatment Start Date, i.e., date of admission prior to surgery, date of surgery, date of emergency admission where supportive care package commenced, date of start of chemotherapy, date of start of radiotherapy (external shared treatments only)

Inappropriate / Incorrect Referrals

If a consultant identifies that a referral is inappropriate, i.e., doesn't meet 2WW criteria, the booking staff cannot be asked to downgrade a referral. Under CWT V9 (and earlier versions) only a GP can downgrade an inappropriate 2WW referral and it is down to the consultant to discuss this with the GP where applicable. The GP must agree to cancel the referral and re-refer the patient on another pathway if appropriate.

How Referrals/Bookings are Made

NHS e-Referrals Service

The majority of referrals for 2WW Suspected Cancer and 2WW Breast Symptomatic patients are made via the NHS e-Referral Service. Guidance to GPs is that this system should be used where possible (but isn't mandated) and that for suspected cancer referrals the patient should leave the surgery with an appointment. It is an NHS constitutional standard that patients should be offered an appointment within 2 weeks but does not have to accept the appointment. CDDFT Patient Access Team ensure that appointments are loaded onto the e-Referral System and are available for GPs to book with the patient at the time the referral is made. If no appointments are available within 2 weeks then this if 'referred to provider' by the e-Referral Service and the process is as for faxed referrals below.

Faxed Referrals

The remainder of referrals are made by fax to the Cancer Booking Team. One of the team then contacts the patient by telephone to offer an appointment and if no contact can be made then a letter with an offer of appointment is posted to the patient. Where no appointments are available within 2 weeks of receipt of referral then booking team contact the relevant Service Manager to make arrangements for the patient to be seen within the required timescale.

Appointments should only be booked outside of 2 weeks if the patient has either refused all appointments offered or has informed the staff member that they are unavailable for a significant portion of the 2 week period.

Straight to Test Patients

There are three pathways where the GP has indicated that the patient is fit to go straight to endoscopy the patient is booked to have the test in place of a 'first seen' appointment -

a. Suspected Lower GI Cancer (Colorectal)
b. Suspected Upper GI Cancer (OG)
c. Suspected Urological Cancer (Kidney/Bladder)

Under CWT V9 Guidance (11.3.7) these procedures can be counted as 'date first seen'

The appointment that is booked for these patients on the e-Referrals system is a 'dummy' appointment (CASCLIN) which is used to accept the referral. All of these bookings go via the Cancer Booking Team and an out-patient appointment or endoscopy appointment is made according to GPs indication of fitness to go straight to test or by local triage carried out by a member of the specialist team (Lower GI).

Adjustments to a 2WW Pathway for DNA

There are two places in a patient's pathway where adjustments can be made and the first of these applies to the 2WW period.

Where a patient on a 2WW Suspected Cancer, 2WW Breast Symptomatic or National Screening programme does not attend (DNA) their first seen appointment (or straight to test appointment) and fails to give any advance notice, then an adjustment can be applied between the original date of receipt of referral (or URBN conversion date where appointment made via e-Referrals) and the date that the new appointment is booked.

These adjustments are made by the Cancer Services team during Cancer Waiting Times data validation. A report is available in CMIS to facilitate this process. See Appendix 2 for pathway diagram from CWT V9.

Patients who fail to attend / cancer 2WW first seen appointments

Patients who Did not Attend (DNA) appointment/s

CWT V9 defines a DNA as 'Where a patient does not turn up, turns up late, or turns up in a condition where it is not possible to carry out whatever was planned for them, e.g., if they have not taken a preparation they needed to take prior to the appointment. (see section 7 CWT V9)

Patients who fail to attend

If a patient DNA's their appointment then the Cancer Booking Team are notified and the patient is contacted to facilitate rebooking the patient.

CWT V9 (4.11) states that patients should not be referred back to the GP after a single DNA, however, it states that patients can be referred back to GP after multiple DNAs (two or more). The patient's named consultant should write to the consultant to inform them and to discharge the patient back to their care. If the GP re-refers the patient then then this would be the start of a new pathway.

Patient who fail to prepare for 'Straight to Test'

If a straight to test procedure has not been carried out due to failure to undertake adequate preparation, e.g., fasting, bowel preparation etc., this will be recorded as a DNA and the pathway adjusted accordingly. The endoscopy booking officer will use an appropriate outcome code on Waiting List Management in CAMIS to identify these patients.

Adjustments to a 2WW Pathway for DNA

Where a patient on a 2WW Suspected Cancer, 2WW Breast Symptomatic or National Screening programme does not attend (DNA) their first seen appointment (or straight to test appointment) and fails to give any advance notice, then an adjustment can be applied between the original date of receipt of referral (or URBN conversion date where appointment made via e-Referrals) and the date that the new appointment is booked.

These adjustments are made by the Cancer Services team during Cancer Waiting Times data validation. A report is available in CMIS to facilitate this process. See Appendix 2 for pathway diagram from CWT V9.

Patients who cancel appointments

Patients who cancel their appointment cannot be referred back to their GP as they have shown a willingness to engage with the NHS by notifying the trust in advance of their intention not to attend the appointment. A cancellation is when a patient givens any advance notice, even if this is very short.

Adjustments between Decision to Treat to Treatment

This is the second place where an adjustment can be made but is only allowable for admitted care and not for treatments in an out-patient setting.

Adjustments to this part of the pathway are allowable only providing a reasonable offer has been made within target and refused by the patient, or would have been made had the patient not already stated they were unavailable.

Definition of Reasonable Offers in CWT V9

> **2.1.2 What is classed as a reasonable offer for the date of an appointment?**
> For cancer waiting times a 'reasonable' offer of an appointment is defined by local policy and should be an offer for diagnosis or treatment in a cancer pathway.
> **Part of being reasonable means that the patient has been consulted and listened to, taking into account what the patient would find reasonable.**
> In cases of contention (such as treatments offered on the same day) the commissioner decides whether the offered appointment was reasonable.

How Bookings are made for Surgery

Trust Standard Process for booking dates for surgical treatment.

The standard trust process for offering patients a date to come in for a surgical treatment is via the waiting list office, however, some offers are made in clinic by surgeons.

The Waiting List Officer (WLO) will contact the patient by telephone to make an offer of a date To Come In (TCI) for surgery and make appropriate arrangements for pre-assessment etc. At this point the principles of reasonable offer (see below) should be followed.

The process below is followed to ensure that, wherever possible, a date is discussed and agreed with the patient on the telephone.

Process for booking diagnosed / suspected Cancer patients for treatment via Waiting List

Waiting List Officer (WLO) Receives waiting list form from clinic

Patient is added to waiting list on CAMIS and letter printed and sent asking them to contact Waiting List

Pencil provisional date in diary and put TCI in CAMIS with comment 'provisional date, to be confirmed with patient'

Patient contacted (twice) by telephone within working hours and once outside of working hours

If contact made with patient then WLO makes reasonable offer to patient within target and booking is confirmed, any offers/potential offer made or dates patient is unavailable added to CAMIS as a suspension.

If patient has not contacted WLO within one week of 'provisional date' then letter sent to patient informing them of the offer of a date for surgery

Adjustments for Reasonable Offer made of Admission for Surgery

1.1.1. Refusal of a Reasonable Offer made on the telephone

If a reasonable offer of admission is made to the patient (by either the surgeon or the WLO) and the patient refuses this date then an adjustment can be made between the date that was offered and the date that the patient says they were available for surgery. A note of the date the patient was offered will be made by the WLO and a suspension recorded between this date and when the patient can make themselves available.

1.1.2. Refusal of an offer made by letter

If the waiting list offer has been unable to contact the patient (and patient has not responded to letter from WLO) within one week of the date that has been provisionally allocated, this will be booked on CAMIS and a letter sent to the patient to confirm the date for surgery.

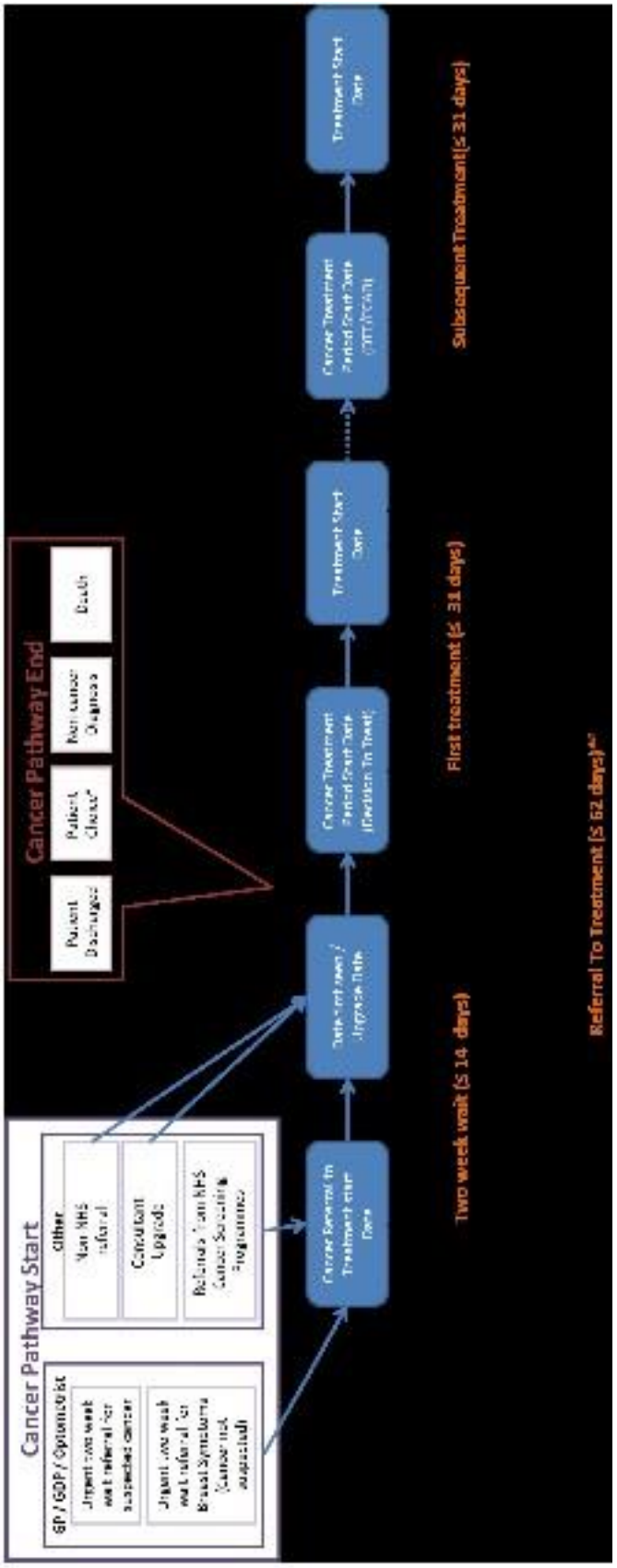
1.1.3. Patient Notifies WLO/Surgeon that they are unavailable for a period of time before an offer can be made

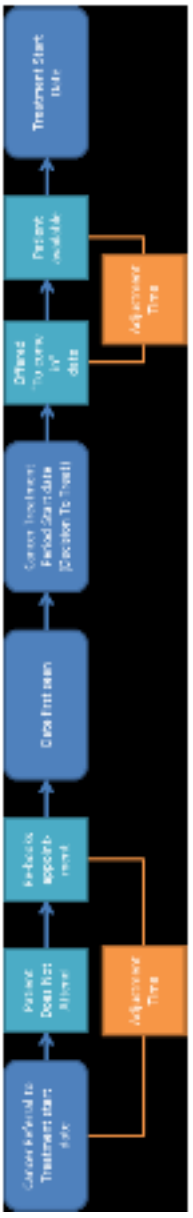
If a patient says that they would be unavailable for a period of time before an offer of admission can be made then it would be inappropriate to make this offer to them. An adjustment would be allowed between this date and when the patient becomes available for treatment. A note of the date that would have been offered to the patient should be made and a suspension recorded between this date and when the patient is available.

1.1.4. Patient Cancels a previously accepted TCI date

If the patient accepts a reasonable offer (which has been made in discussion with them) and subsequently cancels then an adjustment ***cannot*** be made to the pathway. If they then refuse a different date within target in discussion during the rebooking process then the above 9.2.1 to 9.2.3 would apply.

Pathway Diagrams with Key Dates





COUNTY DURHAM AND DARLINGTON
NHS FOUNDATION TRUST

Clinic Management Team - Central Appointments Department

Procedure for Cancellation and Rebooking of Review Appointments Hospital Cancellations

Standard:	All patients from cancelled/reduced clinics must be rebooked within laid down timescale or referred to the Service Manager immediately where no capacity.

On receipt of clinic cancellation request/s:

1. Identify if follow up period is logged on CAMIS and attempt to re-book within specified period.

2. Patients who cannot be re-booked within the specified period to be re-booked to maximum recommended waiting times as follows as per clinical guidance:

   12m – 15m
   6m – 9m
   4m – 6m
   2m – 3m
   1m – 6 weeks

3 Appropriate confirmation will be sent to patients of the changed appointment date/time.

4 For reduced clinics where there is a change of appointment time if the appointments are rescheduled within 15 minutes either prior to or later than the original appointment time, an appointment letter is unnecessary and therefore should not be dispatched

5 Information regarding follow up patients unable to be re-booked to times specified above to be escalated to Service Manager for instruction of how to manage the patients.

6 Manager Lists of outstanding review patients will be kept within the department until instruction received on how to book.

7 This information will be reported to CAD manager for reporting and discussion at weekly PTL meeting.

County Durham and Darlington NHS
NHS Foundation Trust

Checklist for the Approval of Policies

This checklist **MUST** be attached to the Policy when submitted to the appropriate sub-committee for approval. (Please note that for the purposes of this checklist "Policy" includes procedures, protocols, standard operating procedures etc)

Policy Title…Patient Access Policy

Owner: Sarah Perkins

	YES/NO	COMMENTS
Has the correct template been used?	Yes	
Has a unique reference number (consistent with Trust standards) been allocated to the Policy?	Yes	
Is the title of the Policy clear and unambiguous?	**Yes**	
Has the version number been noted on the front sheet and the version control/revision table been updated?	Yes	
Has the Policy type been identified? (Policy/Procedure etc.)	Yes	
Has the date of approval of the original version of the Policy been specified? (e.g. 01/02/2012)	Yes	
Has the date of the sub-committee to which the document is being submitted for approval been specified?		
Has the date the Policy will come into effect been specified? (If this is different from the date of approval, please provide an explanation)	Yes	
Has the Approving Body been correctly identified?	Yes	
Has the Originating Directorate been noted?	Yes	

	YES/NO	COMMENTS
Has the scope of the Policy been identified?	Yes	
Has the date the Policy was last reviewed been noted?	Yes	
Has the date the Policy will next be reviewed been noted? (If less than the standard 3 years, please provide an explanation)	Yes	
Has the Policy been consulted upon? (Please identify stakeholders that have been consulted)	Yes	Waiting List Department and RTT Assurance Group
Has the Policy been reviewed by one of the sub-groups of the relevant Approving Body. (If so, please specify the Reviewing Body on the front sheet)		
Has the Document Owner been identified?	Yes	
Is the Equality Impact Assessment attached? If not, please explain why an EIA is not required.	Yes	
Has the "Date superseded" box been marked "N/A"?	No	This is no longer on the policy template
Has the "Status" box been marked "Approved" in anticipation of the sub-committee decision?	Yes	
Has the Policy been assessed as to whether its circulation should be restricted/unrestricted? If so, the outcome of this assessment should be noted on the front sheet.	Yes	
Has a paper copy of the Policy been submitted for signature by the chairman of the Approving Body?	Yes	
Has the name /job title of the chairman of the Approving Body been correctly identified?	Yes	
Does the Policy identify where signed copies will be held?	Yes	

	YES/NO	COMMENTS
How will the Policy be disseminated? (e.g publication on StaffNet, Trust-wide bulletin etc.)		Publication on StaffNet and Trust Internet

Equality Analysis / Impact Assessment

Division/Department:	Patient Access
Title of policy, procedure, decision, project, function or service:	Patient Access Policy
Lead person responsible:	Director of Performance
People involved with completing this:	Patient Booking Manager/ Director of Performance

Type of policy, procedure, decision, project, function or service:

Existing	☒
New/proposed	☐
Changed	☐

Date Completed:	September 2016

Step 1 – Scoping your analysis

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

To ensure that all patients are treated in accordance with Department of Health guidance.

Who is the policy, procedure, project, decision, function or service going to benefit and how?

All Trust staff who arrange or manage patient attendances.

What barriers are there to achieving these outcomes?

Staff unaware of policy or do not follow the policy

How will you put your policy, procedure, project, decision, function or service into practice?

The policy will be available on the staff intranet and all staff who book patient attendances will be made aware that it is available.

Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

This policy has no direct links with other policies

Step 2 – Collecting your information

What existing information / data do you have?

Current equality data is available on the workforce

Who have you consulted with?

Trust Waiting List Group and RTT Assurance Group

What are the gaps and how do you plan to collect what is missing?

None

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race

No

Sex/Gender

No

Age

No

Disability

No

Religion or Belief

No

Sexual Orientation

No

Marriage and Civil Partnership (applies to workforce issues only)

No

Pregnancy and Maternity

No

Gender Reassignment

No

Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills etc.

No

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

No

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act 2010?

Yes ☐ **No** ☒

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

N/A

Step 5 – Make a decision based on steps 2 - 4

If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.

This is an existing Policy for CDDFT staff, awareness of this policy will be highlighted to directly affected staff groups and the updated policy will be places on the staff intranet for all staff to access.

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:

N/A

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

The policy will be reviewed at least every three years but will be amended before this time if required.

Step 6 – Completion and central collation

Once completed this Equality Analysis form must be forwarded to Jillian Wilkins, Equality and Diversity Lead. jillian.wilkins@cddft.nhs.uk and must be attached to any documentation to which it relates.