County Durham and Darlington NHS
NHS Foundation Trust

Policy Document Control Sheet

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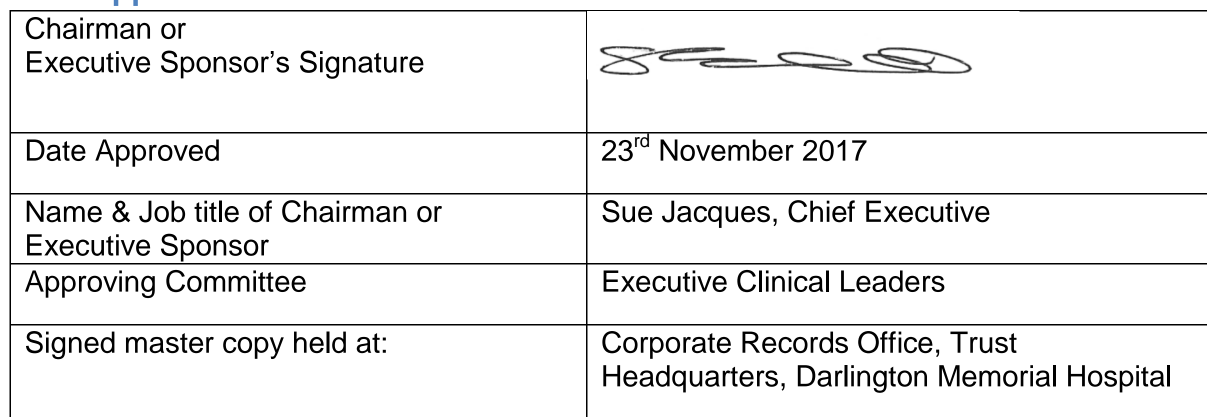

Chairman or Executive Sponsor's Signature	
Date Approved	23rd November 2017
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Version Control Table

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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 re-organisation	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 documented update regarding new structure and job titles within the organisation.	S Perkins, Assoc. Director of Ops & Performance

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Date	Section	Revision	Author
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.	
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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
August 2017	Whole Document	Whole Document changed to reflect National Exempler Policy	S Perkins, Director of Performance

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Contents

Policy Document Control Sheet i
Version Control Table ii
Table of Revisions ii
Contents iv
1 SECTION 1 - GENERAL PRINCIPLES 1
1 Introduction and Overarching Principles 2
1.1 Introduction 2
1.2 Purpose 2
1.3 Roles and Responsibilities 2
1.4 Staff Competency and Compliance 3
1.5 General Elective Access Principles 4
1.6 Individual Patient Rights 4
1.7 Patient Eligibility 4
1.8 Patients Moving Between NHS and Private Care 5
1.9 Commissioner Approved Procedures 5
1.10 Military Veterans 5
1.11 Prisoners 5
1.12 Service Standards 5
1.13 Pathway Milestones 6
1.14 Monitoring 6
1.15 Governance 6
1.16 Reasonableness 6
1.17 Chronological Booking 6
1.18 Communication 7
2 National Referral to Treatment and Diagnostic Standards 8
3 Overview of National Referral to Treatment Rules 9
3.1 Clock Starts 9
3.2 Exclusions 10
3.3 New Clock Starts for the Same Condition 10
3.4 Planned Patients 10
3.5 Clock Stops for First Definitive Treatment 10
3.6 Clock Stops for Non-Treatment 11

with you all the way

3.7 Active Monitoring 11

3.8 Patient Initiated Delays 11

3.9 Patients who are Unfit for Surgery 12

2 SECTION 2 - PATHWAY SPECIFIC PRINCIPLES 13

4 Non-admitted Pathways 14

5 Diagnostics 19

6 Acute Therapy Services 24

7 Non-activity Related RTT Decisions 25

8 Admitted Pathways 26

3 SECTION 3 - CANCER PATHWAYS 30

4 Monitoring 40

4.1 Compliance and Effectiveness Monitoring 40

4.2 Compliance and Effectiveness Monitoring Table.................................. 40

5 Glossary of Terms 41

6 Associated Documentation.. 46

7 Appendices 50

with you all the way

SECTION 1

General Principles

Referral to Treatment

&

Diagnostic Pathways

1 Introduction and Overarching Principles

1.1 Introduction

CDDFT 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 Elective Access Policy was developed following consultation with staff, clinical commissioning groups (CCGs), general practitioners, clinical leads and CCG lay members. The access policy will be reviewed and ratified at least annually or earlier if there are changes to national elective access rules or locally agreed principles.

The Access Policy should be read in full by all applicable staff following successful completion of contextual elective care training. The Policy should not be used in isolation as a training tool.

The Access Policy is underpinned by a comprehensive suite of detailed standard operating procedures (SOPs). 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.

1.2 Purpose

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 Referral to Treatment (RTT) and diagnostic pathway.
- Applies to all clinical and administrative staff and services relating to elective patient access at the Trust.

1.3 Roles and Responsibilities

- ADOS are accountable for implementing, monitoring and ensuring compliance with the Policy within their care groups.
- Head of Information Services is responsible for the timely production of Patient Tracking Lists (PTLs) which support the care groups in managing waiting lists and Referral to Treatment (RTT) standards.
- Waiting List Administrators, including clinic staff, secretaries or booking clerks, are responsible to either their Care Group Admin Manager or the Patient Booking Manager with regard to compliance of all aspects of the Trust's Elective Access Policy.
- Waiting List Administrators for outpatients, diagnostics and elective inpatient or day care services are responsible for the day-to-day management of their lists and are managed by Patient Booking Manager and supported in this function by the General

Managers, ADOS and Clinical Directors who are responsible for achieving access standards.

- General Managers, ADOS and Clinical Directors are responsible for ensuring data is accurate and services are compliant with the Policy.
- General Managers are responsible for ensuring the NHS e-Referral Service Directory of Services (DoS) is accurate and up to-date.
- The Information Team are responsible for producing and maintaining regular reports to enable care groups to accurately manage elective pathways and ensure compliance with this Policy.
- GPs and other referrers play a pivotal role in ensuring patients are fully informed during their consultation and of the need to be contactable and available when referred.
- The CCGs are responsible for ensuring robust communication links are in place to feedback information to GPs. GPs should ensure quality referrals are submitted to the appropriate provider first time.
- The NHS Constitution recommends the following actions patients can take to help in the management of their condition:
    - Patients can make a significant contribution to their own, and their families, good health and wellbeing, and should take personal responsibility for it.
    - Patients should be registered with a GP practice as this is the main point of access to NHS care as commissioned by NHS bodies.
    - Patients should provide accurate information about their health, condition and status.
    - Patients should keep appointments or cancel within a reasonable timeframe.

1.4 Staff Competency and Compliance

Competency

- As a key part of their induction programme, all new starters to the Trust will undergo mandatory contextual elective care training which is applicable to their role.
- All relevant existing staff will undergo contextual elective care training on at least an annual basis.
- Competency tests will be undertaken for all relevant staff and clearly documented to provide evidence that the required level of knowledge and ability has been attained.
- This Policy, along with the supporting suite of SOPs, will form the basis of contextual training programmes.

Compliance

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

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

1.5 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 two headings:

- The individual patient rights (as per the NHS Constitution).
- The standards by which individual providers and commissioners are held accountable by NHS Improvement and NHS England. All patients are to be treated fairly and equitably regardless of race, sex, religion or sexual orientation.

1.6 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 two weeks from a GP referral for urgent referrals where cancer is suspected.

If this is not possible, the Trust 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 (**note that in both of these scenarios the patient's RTT clock continues to tick**).
- If it is clinically appropriate for the patient's condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage.

1.7 Patient Eligibility

CDDFT have an obligation to identify patients who are not eligible for free NHS treatment and specifically to assess liability for charges in accordance with Department of Health Guidance and Rules.

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

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

Citizens of the European Union (EU) that hold a European Health Insurance Card (EHIC) are also entitled to free healthcare, although the Trust may recover the cost of treatment from the country of origin.

All staff have a responsibility to identify patients who are overseas visitors and to refer them to the Overseas Visitor's Office for clarification of status regarding entitlement of NHS treatment before their first appointment is booked or date to come in (TCI) agreed.

1.8 Patients 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.

1.9 Commissioner Approved Procedures

Patients referred for specific treatments where there is limited evidence of clinical effectiveness, or which might be considered cosmetic can only be accepted with the prior approval of the relevant CCG. Link: https://vbcc.necsu.nhs.uk/

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

1.11 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.

1.12 Service Standards

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.

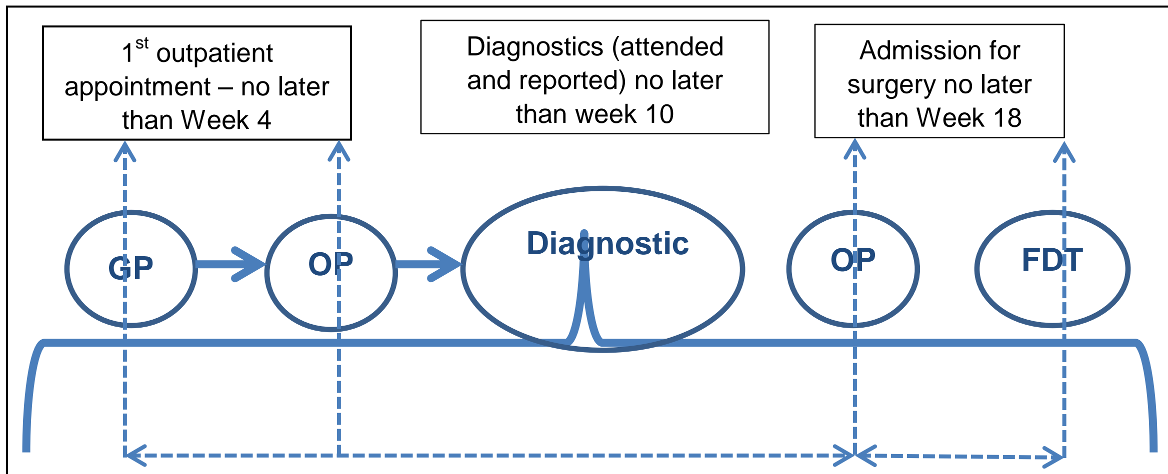
For paper referrals key standards for implementation include the following:

- Referral receipt and registration (within 24 hours).
- Referral vetting and triage (within 48 hours of registration for urgent or 5 days for routine).
- Addition of urgent outpatient referrals to waiting list (within 24 hours).
- Addition of routine outpatient referrals to waiting list (within 24 hours).

The standards above are described in greater detail in the Trust's SOPs.

1.13 Pathway Milestones

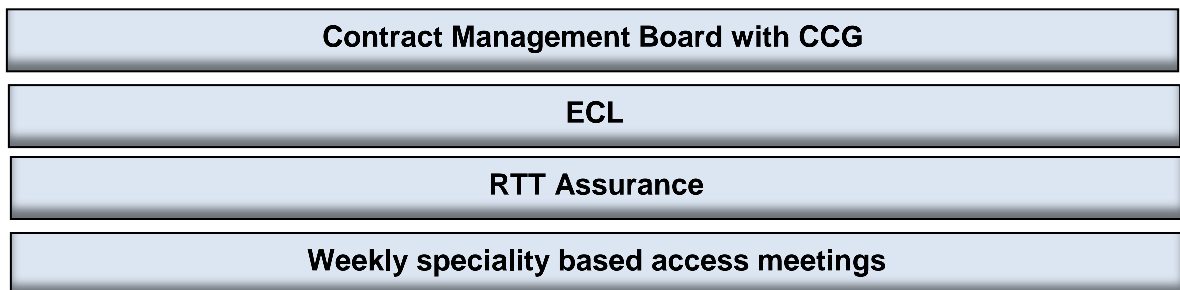
In order to achieve treatment within 18 weeks of receipt of referral, pathways should be designed with key milestones and sufficient capacity agreed with clinicians and commissioners. As an example, a surgical pathway could be broken down into the milestones shown below:



1.14 Monitoring

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

1.15 Governance



1.16 Reasonableness

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

1.17 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 PTLs only. Patients will NOT be selected from any paper based system.

1.18 Communication

All communications with patients and anyone else involved in the patient's care pathway (e.g. general practitioner or a person acting on the patient's behalf), whether verbal or written, must be informative, clear and concise. Copies of all correspondence with the patient must be kept in the patient's clinical notes or stored electronically for auditing purposes.

General practitioners 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/referrer, e.g. when treatment is complete, this must be made clear in any communication.

2 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 126 days).
Diagnostics	
Applicable to diagnostics tests	99% of patients to undergo the relevant diagnostic investigation within five weeks and six days (or 41 days) from the date of decision to refer to appointment date.

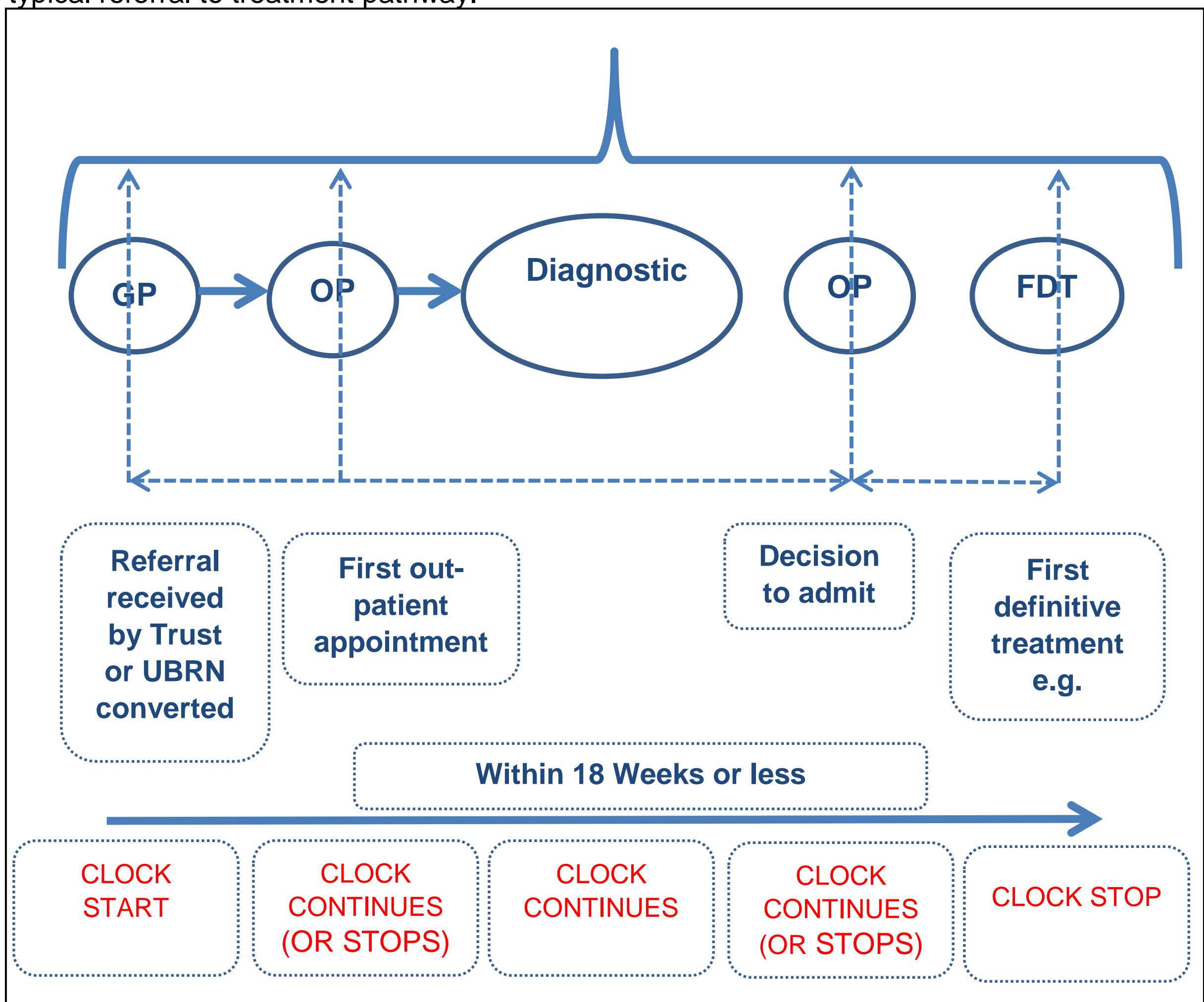
In addition to the elective care standards above, there are separate cancer standards which must be adhered to. The cancer standards are listed in the cancer section on Page 60.

While the aim is to treat all elective patients within 18 weeks, the national elective access standards are set at less than 100% to allow for the following scenarios:

- **Clinical Exceptions** – situations when it is in the patient's best clinical interest to wait more than 18 weeks for their treatment.
- **Choice** – when patients choose to extend their pathway beyond 18 weeks by declining reasonable offers of appointments, or rescheduling previously agreed appointment dates / admission offers, or specifying a future date for appointment / admission.
- **Co-Operation** – when patients do not attend previously agreed appointment dates or admission offers (DNA) and where this prevents the Trust from treating them within 18 weeks.

3 Overview of National Referral to Treatment Rules

The diagram below provides a visual representation of the chronology and key steps of a typical referral to treatment pathway.



3.1 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.

- A referral is received into a Consultant-led service, regardless of setting, with the intention that the patient will be assessed and if appropriate, treated before clinical responsibility is transferred back to the referrer.
- A referral is received into an interface or referral 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-agreed services agreed by providers and commissioners.

3.2 Exclusions

A referral to most Consultant-led services will start an RTT clock. However, the following services and types of patients are excluded from RTT:

- Obstetrics and midwifery.
- Planned patients.
- Referrals to a Non-Consultant-led service.
- Non-English commissioners.
- GUM Services.
- Emergency pathway non-elective follow-up clinic activity.

3.3 New clock starts for the same condition

- **Following active monitoring**

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

- **Following a decision to start a substantively new treatment plan**

  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 second side of a bilateral procedure**

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

- **For a rebooked new outpatient appointment**

  See point 3.1.6 First Appointment DNAs on next page.

3.4 Planned patients

All patients added to the planned list will be given a due date by when their planned procedure/test should take place. Where a patient requiring a planned procedure goes beyond their due date, they should be transferred to an active pathway and a new RTT clock started. The detailed process for management of planned patients is described in the relevant standard operating procedure.

3.5 Clock stops for first definitive treatment

An RTT clock stops when:

- First definitive treatment starts. This could be:
  - Treatment provided by an interface service;
  - Treatment provided by a Consultant-led service;
  - Therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the Consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions.

- A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

3.6 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.

3.7 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 in secondary care. When a decision to commence a period of active monitoring is made and communicated with the patient, the RTT clock stops. Active monitoring may apply at any point in the patient's pathway, but only exceptionally after a decision to treat has been made.

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 patients' 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.

3.8 Patient initiated delays

3.8.1 Non-attendance of appointments / did not attend (DNA)

Other than at first attendance, DNAs have no impact on reported waiting times. Every effort should be made to minimize DNAs, and it is important that a clinician reviews each and every DNA on an individual patient basis.

First appointment DNA

The RTT clock is stopped and nullified in all cases (as long as the Trust can demonstrate the appointment was booked in line with reasonableness criteria). If 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.

Subsequent (follow up) appointment DNA

The RTT 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.

3.8.2 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.

However clinicians will be informed of patient initiated delays to ensure that no harm is likely to result from the patient waiting longer for treatment (clinicians may indicate in advance, for each specialty or pathway, how long it is clinically safe for patients to delay their treatment before their case should be reviewed). Where necessary, clinicians will review each and every patient's case on an individual basis to determine whether:

- The requested delay is clinically acceptable (clock continues).
- The patient should be contacted to review their options – this may result in agreement to the delay (clock continues) or to commence a period of active monitoring (clock stops).
- The patient's best clinical interest would be served by discharging them to the care of their GP (clock stops).
- The requested delay is clinically acceptable but the clinician believes the delay will have a consequential impact (where the treatment may fundamentally change during the period of delay) on the patient's treatment plan-active monitoring (clock stops).

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

3.9 Patients who are unfit for surgery

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

Short Term Illnesses

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

Longer term Illnesses

If the nature of the clinical issue is more serious for which the patient requires optimization and treatment, clinicians should indicate to administration staff:

- It is clinically appropriate for the patient to be removed from the waiting list. This will be a clock stop event via the application of active monitoring.
- If the patient should be optimized/treated within secondary care (active monitoring clock stop) or if they should be discharged back to the care of their GP (clock stop).

SECTION 2

Pathway Specific Principles

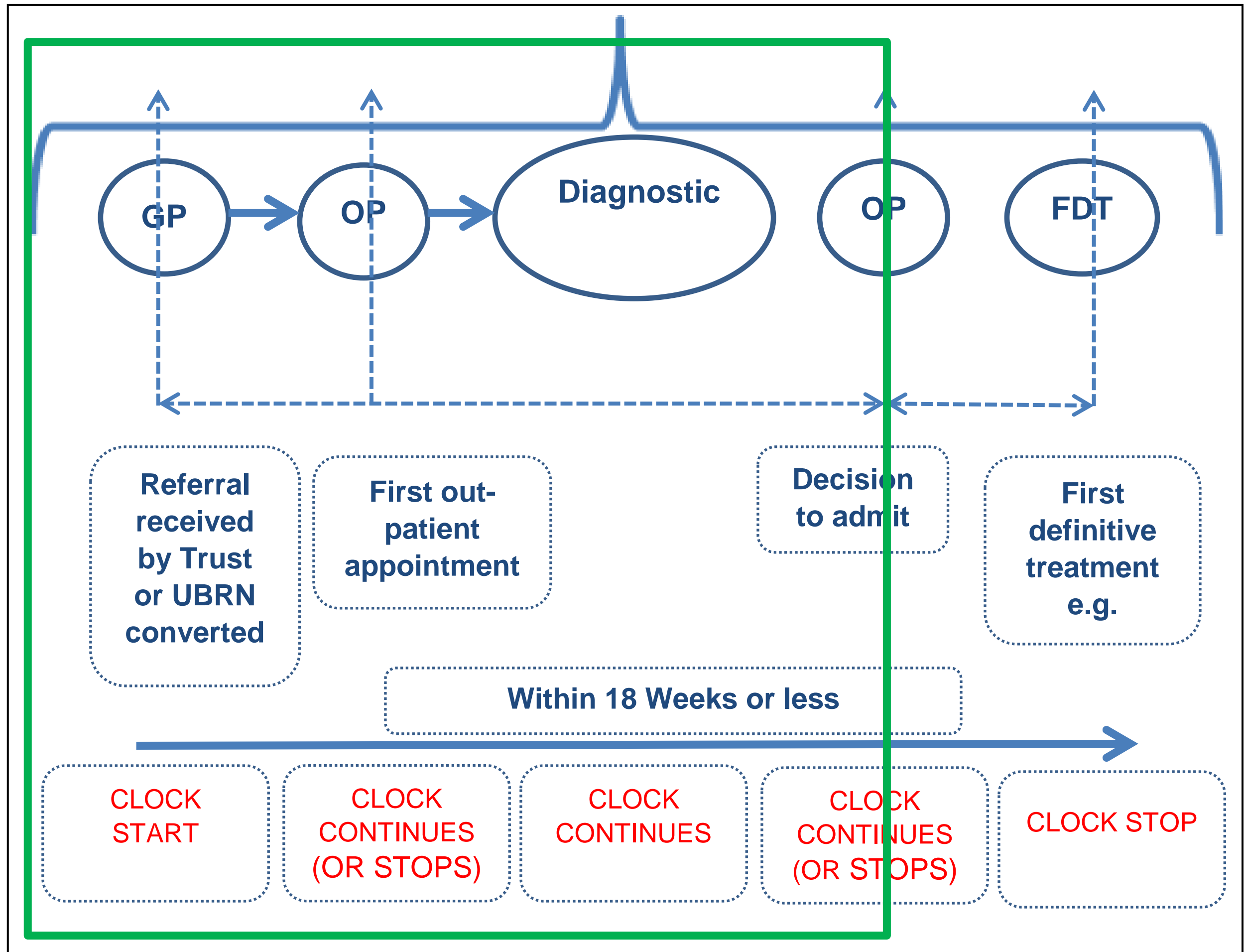
Referral to Treatment

&

Diagnostic Pathways

4. Non-Admitted Pathways

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



Receipt of referral letters

- Paper based referrals are still currently accepted, but CDDFT discourages this route. The NHS e-Referral Service (e-RS) is the preferred method of receiving referrals from GPs and Referral Management Centres (RMCs). Paper-based referrals will be sent to a central point of referral and all referrers will be informed of this requirement and its location.
- Where clinically appropriate, referrals will be made to a service rather than a named clinician unless the patient chooses a named clinician. Services have agreed clinical criteria to support triage and vetting, and patients will then be allocated to the most appropriate clinician, and in consideration of waiting times. Referring to services is in the best interests of patients as pooling referrals promotes equity of waiting times and allows greater flexibility in terms of booking appointments.

Methods of receipt

- **NHS e-Referrals (e-RS)**
    - All NHS e-Referrals must be reviewed and accepted or rejected by clinical teams within two working days for urgent referrals or five working days for routine referrals.
    - Where there is a delay in reviewing e-Referrals this will be escalated to the relevant clinical/management team and actions agreed to address it.
    - GP two week wait referrals will not be triaged.

- **Paper-Based referrals**
    - All routine and urgent pooled and consultant specific referrals letters should be sent to central appointments.
    - Referrals must be date stamped upon receipt at CDDFT. Should a paper based referral be received directly into a specialty, the specialty must date stamp the referral and forward to central appointments within one working day of receipt. For patients referred by paper, the referral received date is the point that the Referral to Treatment (RTT) clock starts.
    - Two week wait referrals will not be triaged.
    - A consultant or clinical team for vetting. This will be undertaken within the number of days specified locally of receipt in order for the referrals to be returned to the central appointments for booking as early as possible in patient's RTT pathway.

REFERRAL TYPES

Rapid Access Chest Pain Clinic (RACPC) Referrals

RACPC patients must be seen by a specialist within 14 days of the Trust receiving the referral. To ensure that this is achieved:

- RACPC referrals should be made via e-RS only.
- GPs should ensure that appropriate information regarding the RACPC referral is provided to the patient.

Transient Ischaemic Clinic (TIA) Referrals

TIA patients must be seen by a specialist within 7 days of the Trust receiving the referral. To ensure that this is achieved:

- TIA referrals should be made via e-RS only.
- GPs should ensure that appropriate information regarding the TIA referral is provided to the patient.

Consultant to Consultant Referrals

- Referrals that are part of the continuation of investigation/treatment of the same condition for which the patient was referred. This includes referrals to pain management where surgical intervention is not intended.
- Urgent referrals for new condition.
- Suspected cancer referral. This will be vetted and dated by the receiving consultant and upgraded if deemed necessary. Once upgraded the patient will be treated within 62 days of the date the referral was received by the consultant.

Clinical Assessment and Triage Services (CATS) and Referral Management Centres (RMCs)

A referral to a CATS or an RMC starts an 18 week RTT clock from the day the referral is received in the CAT/RMC. If the patient is referred on to the Trust having not received any treatment in the service, the Trust inherits the 18 week RTT wait for the patient.

- A Minimum Data Set (MDS) form must be used to transfer 18 week information about the patient to the Trust.

INTER-PROVIDER TRANSFERS (IPTS)

Incoming IPTs

- All IPT referrals are received with the referral letter in central appointments.
- Once the referral is registered and pathway start date entered IPT form is forwarded to information department.
- The Trust expects an accompanying Minimum Data Set (MDS) pro-forma with the IPT, detailing the patient's current RTT status (the Trust will inherit any RTT wait already incurred at the referring Trust if they have not yet been treated) and if the patient has been referred for a new treatment plan for the same condition (where a new RTT clock will start upon receipt at this Trust). The patient's pathway identifier (PPID) should also be provided. If the IPT is for a diagnostic test only, the referring Trust retains responsibility for the RTT pathway.

If any of the above information is missing, the referral should be recorded on PAS and the information actively chased by the information department.

Outgoing IPTs

- The Trust will ensure that outgoing IPTs are processed as quickly as possible to avoid any unnecessary delays in the patient's pathway.
- An accompanying Minimum Data Set (MDS) pro-forma will be sent with the IPT, detailing the patient's current RTT status (the receiving Trust will inherit any RTT wait already incurred if the patient has not yet been treated). If the patient has been referred for a new treatment plan for the same condition, a new RTT clock will start upon receipt at the receiving Trust. The patient's Patient Pathway Identifier (PPID) will also be provided.
- If the IPT is for treatment or a diagnostic test only. If for diagnostic only, this Trust retains responsibility for the RTT pathway.
- The medical secretary requests an IPT form from Information Department and this is forwarded to the receiving Trust.

BOOKING NEW OUTPATIENT APPOINTMENTS

e-Referral Service

- Patients who have been referred via e-RS should be able to choose, book and confirm their appointment prior to the Trust receiving and accepting the referral.
- If there are insufficient slots available for the selected service at the time of attempting to book (or convert their UBRN), the patient will appear on the Appointment Slot Issue (ASI) work list. The RTT clock starts from the point at which the patient attempted to book. Patients on the ASI list must be contacted within two working days by central appointments staff to agree an appointment.

- If a patient's appointment has been incorrectly booked on the NHS e-Referral system into the wrong service at the Trust by the referrer, the referral should be electronically re-directed in the e-Referral system to the correct service. A confirmation letter of the appointment change will be sent to the patient. The patient's RTT clock will continue to tick from the original date when they converted their UBRN.

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's Patient Tracking List (PTL) only.
- Where there is insufficient capacity to offer an appointment within the required milestone, this should be escalated to the relevant service manager.
- Any appointment offers declined by patients should be recorded on PAS. This is important for two reasons: full and accurate record keeping is good practice and the information can be used at a later date to understand the reasons for any delays in the patient's treatment, e.g. hospital or patient initiated.

Clinic Attendance and Outcomes (new and follow-up clinics)

- Every patient, new and follow-up, whether attended or not, will have an attendance status and outcome recorded on PAS at the end of the clinic. Clinics will be fully outcomed or 'cashed up' within one working day of the clinic taking place.
- Clinic outcomes (e.g. discharge, further appointment) and the patient's updated RTT status will be recorded by clinicians on the agreed clinic outcome form (COF) and forwarded to reception staff immediately.
- Upon attendance in clinic, patients may be on an open pathway (i.e. waiting for treatment with an RTT clock running) or they may already have had a clock stop due to receiving treatment or a decision not to treat being agreed. It is possible for patients to be assigned any one of the following RTT statues at the end of their outpatient attendance, depending on the clinical decisions made or treatment given/started during the consultation:

Patients on an Open Pathway

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

Patients Already Treated or with a Decision Not to Treat

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

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

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

Patients Not on an Open Pathway

Patients who have already been treated or who are under active monitoring and require a follow-up appointment should be booked at reception.

Did Not Attends (DNA)

All DNAs (new and follow-up) will be reviewed by the clinician at the end of clinic in order for a clinical decision to be made regarding next steps (see page 41 for the application of RTT rules regarding DNAs). Paediatric and vulnerable patient DNA's should be managed with reference to the Trust's Safeguarding Policy.

Appointment changes and cancellations initiated by the 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 specialty management team. Contact with patient should be made within two 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 consultation. 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.

Appointment Changes Initiated by the Hospital

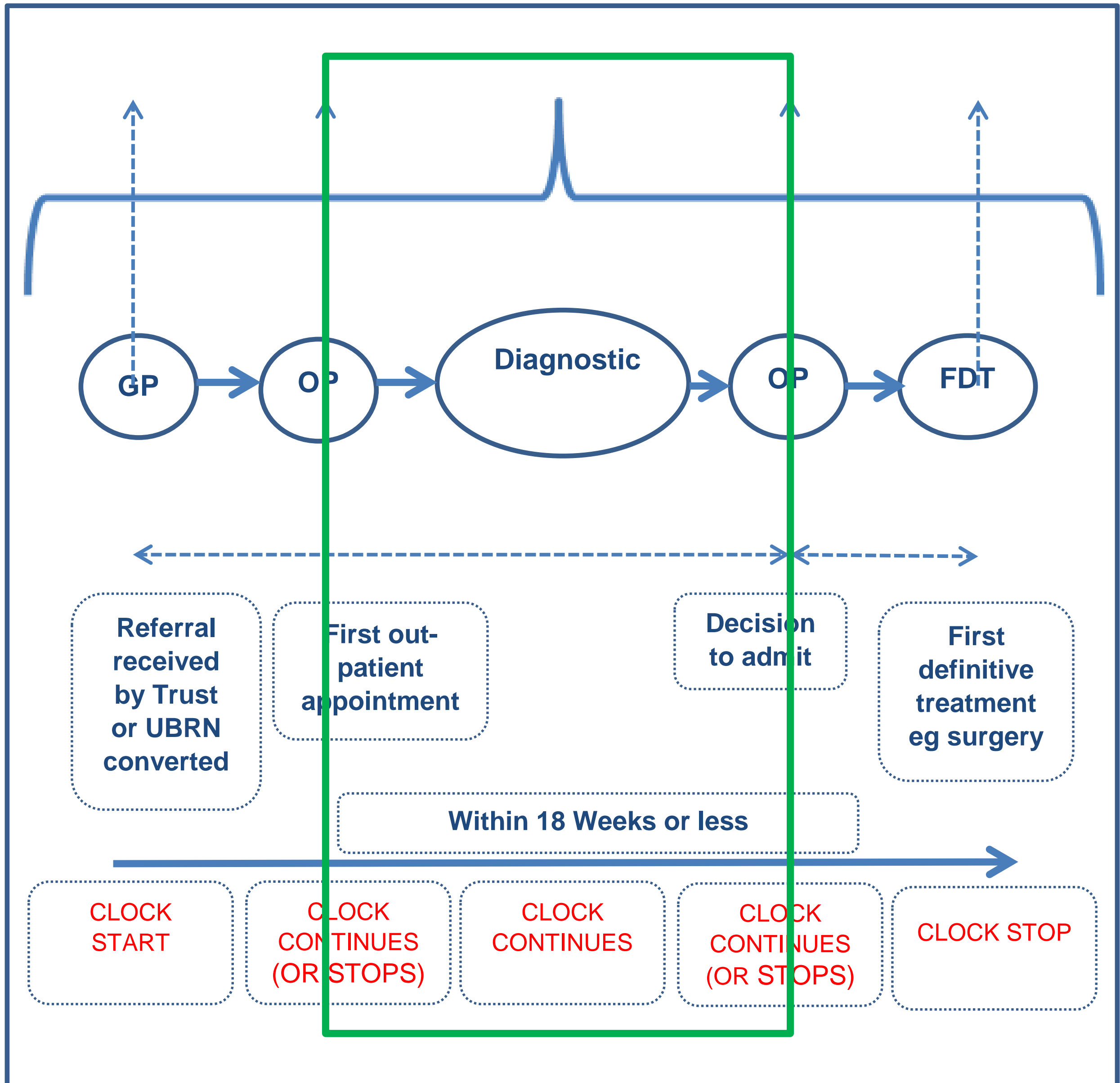
- Hospital initiated changes to appointments will be avoided as far as possible as they are poor practice and cause inconvenience to patients.
- Clinicians are actively encouraged to book annual leave and study leave as early as possible. Clinicians must provide 8 weeks notice if a clinic has to be cancelled 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.

5. Diagnostics

The section within the green border on the diagram below represents the diagnostic stage of the RTT pathway which forms part of the non-admitted pathways. It starts at the point of a decision to refer for a diagnostic test and ends upon the results/report from the diagnostic procedure being available to the requester.

It is important to note however, that patients can also be referred for some diagnostic investigations directly by their GP where they might not be on an 18 week RTT pathway. This will be in circumstances where the GP has requested the test in order to inform future patient management decisions, i.e. has not made a referral to a consultant led service at this time.

The section within the green border on the diagram below represents the admitted stage of the pathway. It starts at the point of a decision to admit and ends upon admission for first definitive treatment.



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) as RTT clocks start on receipt of the referral. These are called straight to test referrals.

- Endoscopy.

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.

- Radiology.

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.

Booking Diagnostic Appointments

Appointments will be booked in line with the locally agreed reasonableness criteria; patients will be offered a choice of two admission dates with two weeks' notice. The appointment will be booked directly with the patient at the point that the decision to refer for a test was made, wherever possible (e.g. the patient should be asked to contact the diagnostic department by telephone 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**.

Diagnostic Cancellations, Declines and/or DNAs for Patients 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**

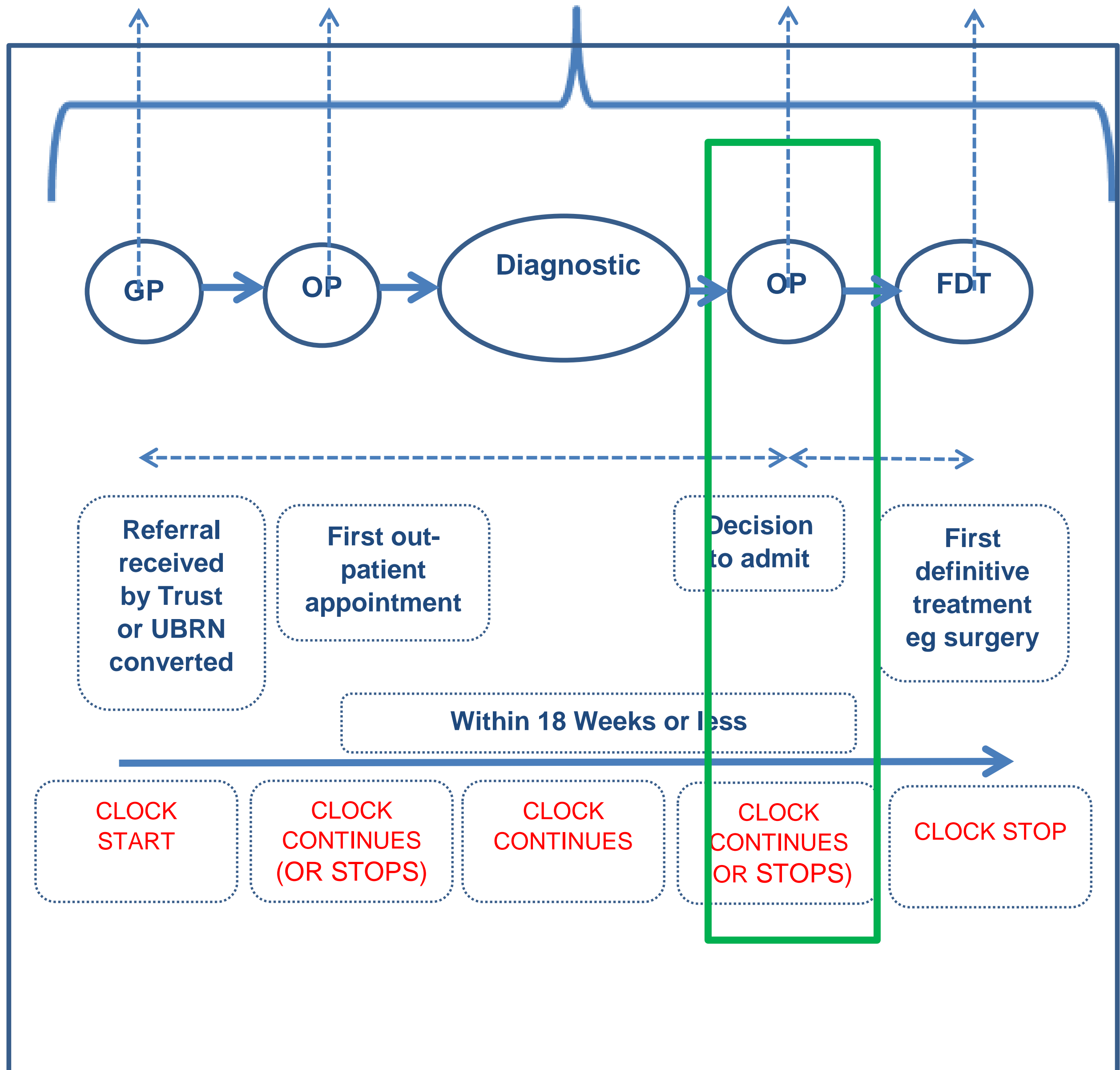
  Patients who require a diagnostic test to be carried out at a specific point in time for clinical reasons are exempt from the diagnostic clock rules and will be held on a planned waiting list with a clinically determined due date identified. However, should patient's wait go beyond the due by date for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

- **Therapeutic procedures**

  Where the patient is solely waiting for a therapeutic procedure, for example in the radiology department, there is no six week diagnostic standard. However, for many patients there is also a diagnostic element to their admission/appointment, and so these patients would still be required to have their procedure within 6 weeks.

Pre-Operative Assessment (POA)

The section within the green border on the diagram below represents the admitted stage of the pathway. It starts at the point of a decision to admit and ends upon admission for first definitive treatment.



- All patients with a decision to admit (DTA) requiring a general anaesthetic should attend a POA clinic on the same day as the decision to admit to assess their fitness for surgery. The vast majority of patients can be assessed by the Trust's dedicated POA nurse specialists.
- For patients with complex health issues requiring a POA appointment with a nurse consultant, the Trust will aim to agree this date with the patient before they leave the clinic. The Trust will aim to agree an appointment no later than seven working days from the decision to admit.
- Patients who DNA their POA appointment will be contacted and a further appointment agreed. Should they DNA again, they will be returned to the responsible consultant. **The RTT clock continues to tick throughout this process.**

- If the patient is identified as unfit for the procedure, the nature and duration of the clinical issue should be ascertained. If the clinical issue is **short term** and has no impact on the original clinical decision to undertake the procedure (e.g. cough, cold, UTI), the RTT clock continues.
- However, if the nature of the clinical issue is more serious for which the patient requires optimization 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 optimization 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.

6. Acute Therapy Services

Acute Therapy Services consist of physiotherapy, psychology, dietetics, Orthotics and surgical appliances. Referrals to these services can 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.

- **Physiotherapy**

  For patients on an orthopaedic pathway referred for physiotherapy as **first definitive treatment** the RTT clock stops when the patient commences physiotherapy.

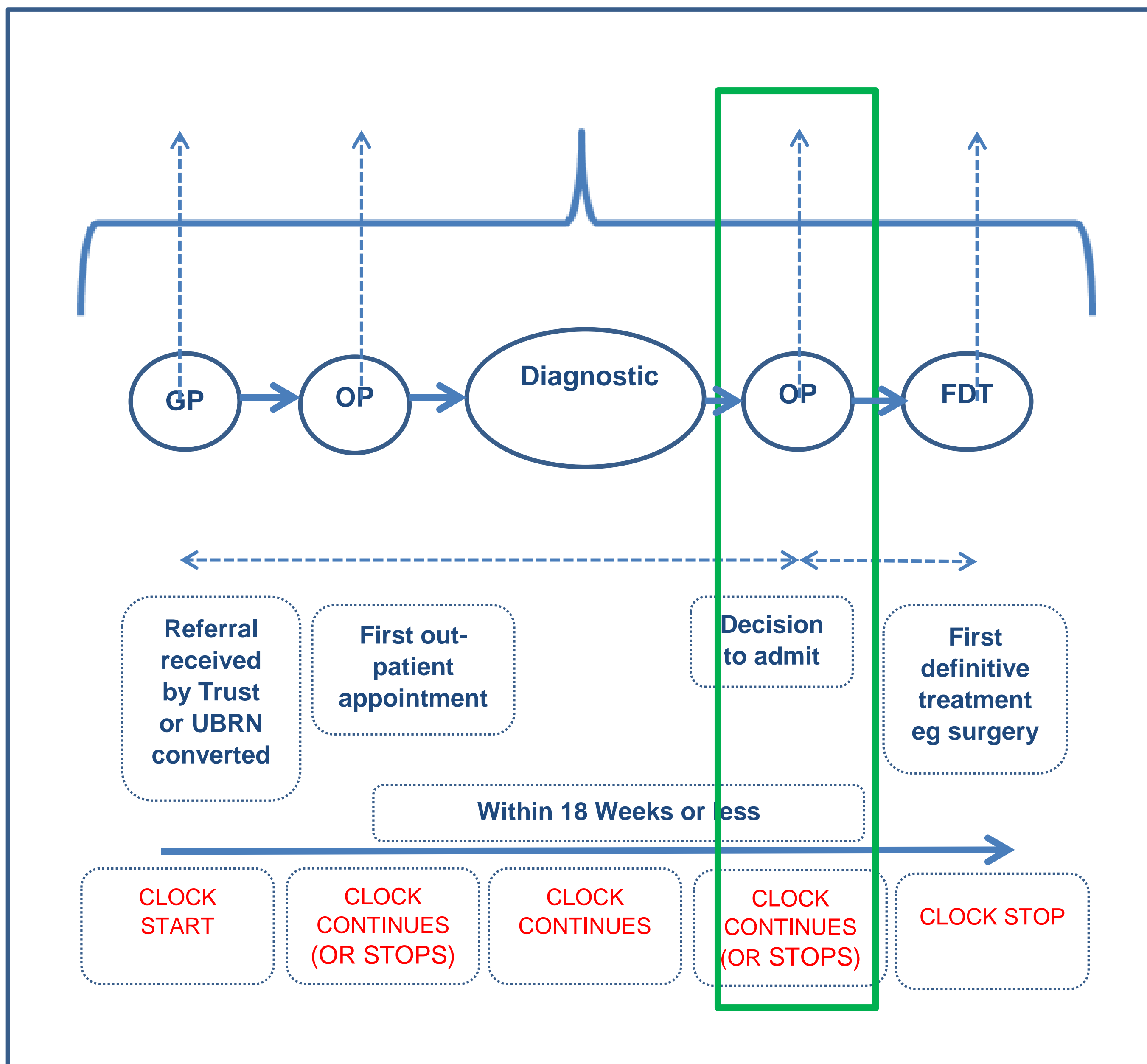
  For patients on an orthopaedic pathway referred for physiotherapy as **interim treatment as surgery will definitely be required** the RTT clock continues when the patient undergoes physiotherapy.
- **Surgical Appliances**

  Patients on an orthopaedic pathway referred for a surgical appliance with no other form of treatment agreed. In this scenario, the fitting of the appliance constitutes first definitive treatment and therefore the RTT clock stops when this occurs.
- **Dietetics**

  If patients are referred to the dietician and receive dietary advice with no other form of treatment, this would constitute an RTT clock stop. Equally, patients could receive dietary advice as an important step of a particular pathway (e.g. bariatric) in this pathway; the clock could continue to tick.

7. Non-Activity Related RTT Decisions

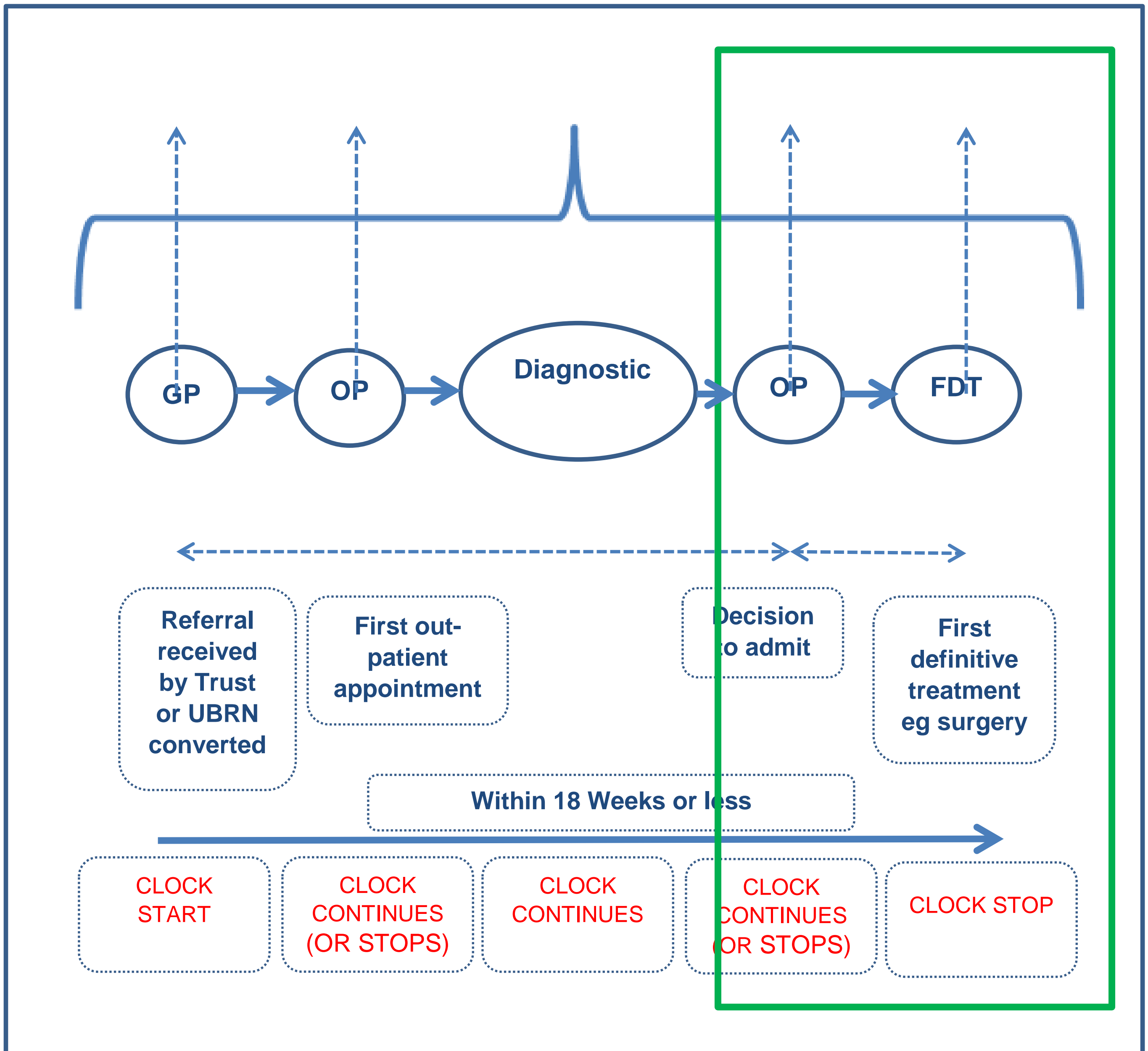
The section within the green border on the diagram below represents the non-activity related RTT decision



- Where clinicians review test results in the office setting and make a clinical decision not to treat, the RTT clock will be stopped on the day this is communicated in writing to the patient.
- Administration staff should update PAS with the clock stop. The date recorded will be the day the decision not to treat is communicated in writing to the patient.

8. Admitted Pathways

The section within the green border on the diagram below represents the admitted stage of the pathway. It starts at the point of a decision to admit and ends upon admission for first definitive treatment.



- **Adding Patients to the Active Inpatient or Day Case Waiting List**

  Ideally patients will be fit, ready and available before being added to the admitted waiting list. However, they will be added to the admitted waiting without delay following a decision to admit, regardless of whether they have undergone pre-operative assessment (*see page 53 – Pre-Operative Assessment*) or whether they have declared a period of unavailability at the point of the decision to admit (*see page 42 – Patient Initiated Delays*).

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

  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, or,
  - 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.

- **Patients Requiring More Than One Procedure**

  If more than one procedure will be performed at one time by the same surgeon, the patient should be added to the waiting list with additional procedures noted. If different surgeons will work together to perform more than one procedure the patient will be added to the waiting list of the consultant surgeon for the priority procedure with additional procedures noted. If a patient requires more than one procedure performed on separate occasions by different (or the same) surgeon(s):

  - The patient will be added to the active waiting list for the primary (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.

- **Patients Requiring Thinking Time**

  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.

- **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. An 'invitation to call' letter will be generated from PAS, asking patients to make contact. Alternatively patients will be given a contact telephone number in clinic to contact waiting list office.

Should the patient not make contact, the demographic details will be confirmed with the GP. Three attempts should then be made to contact the patient, with one being in the evening. If still unsuccessful, a second 'invitation to call' letter will be sent to the patient and a copy sent to their GP.

- Patients will be offered a choice of at least two admission dates with three weeks' notice within the agreed milestone for the specialty concerned. Admission dates can be offered with less than three weeks' notice and if the patient accepts, this can then be defined as 'reasonable'.
- If there is insufficient capacity to offer dates within the required milestone, this issue will be escalated to the relevant service manager. Any admission offers declined by patients will be recorded on PAS. This is important for two reasons:
    - Full and accurate record keeping is good clinical practice;
    - The information can also be used at a later date to understand the reasons for any delays in the patient's treatment, e.g. hospital or patient initiated.

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

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

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 speciality), the patient's pathway will be reviewed by their consultant. Upon clinical review, the patient's consultant will indicate one of the following:

- Clinically safe for the patient to delay – continue progression of pathway. The RTT clock continues;
- Clinically unsafe length of delay – clinician to contact the patient with a view to persuading the patient not to delay. The RTT clock continues. In exceptional circumstances if a patient decides to delay their treatment it may be appropriate to place the patient under active monitoring (clock stop) if the clinician believes the delay will have a consequential impact on the patient's treatment plan, or;
- Clinically unsafe length of delay – in the patient's best clinical interests to return the patient to their GP. The RTT clock stops on the day this is communicated to the patient and their GP. The patient could also be actively monitored within the Trust.

- **Patients Who Decline or Cancel TCI Offers**

Should patients decline TCI offers or contact CDDFT 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 speciality), 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.

- **Patients Who Do Not Attend Admission**

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

- **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 re-arranged 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.

- **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 should be transferred to an active waiting list and a new RTT clock will start. For some patients (e.g. surveillance endoscopies) a diagnostic clock would also start.

SECTION 3

Cancer Pathways

INTRODUCTION AND SCOPE

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

Principles

- As defined in the NHS Constitution, patients have the right to expect to be seen and treated within national operational standards ensuring timely diagnosis and treatment, equity of care and patient choice.
- Patients will, wherever possible, be offered dates for appointment or treatment in chronological order, based on the number of days remaining on their cancer pathway, unless there are clinical exceptions.
- Where ever 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 pre-determined timescales.
- Where patients are at risk of breaching any of the cancer standards it is expected that all staff will follow the Trust Cancer Escalation Policy.

Roles and Responsibilities

- **Chief Executive**

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

- **Director of Operations**

  The Director of Operations is responsible for ensuring that there are robust systems in place for the audit and management of cancer access standards against the criteria set with this Cancer Access Policy and Procedure document.

- **Trust Lead Cancer Clinician**

  Responsible for ensuring high standards of cancer clinical care across the organization in a timely manner, leading the development of the cancer strategy.

- **Trust Cancer Lead Nurse**

  Responsible for development of the cancer nursing strategy with professional line management responsibility for the Trust's cancer clinical nurse specialists. Lead CNS does not directly line manage the Trust's CNS, but provides guidance on cancer strategy/targets and ensures accountability for core nursing cancer standards.

- **Director of Performance**

  Responsible for monitoring of performance in the delivery of the 14, 31 and 62 day standards alongside all cancer screening programmes and for ensuring the clinical directorate delivers the activity required to meets the cancer waiting time standards.

- **Tumour Group Clinical Leads**

  Responsible for ensuring clinical pathways are designed to deliver treatment within 62 days of referral. Responsible for reviewing the outputs of any breach route cause analysis to develop actions to resolve any delays to patients.

- **General Managers**

  Responsible for the monitoring of performance in the delivery of the cancer standards and for ensuring the specialities deliver the activity required to meet the waiting list standards. They are also responsible for ensuring all patients are booked within 14 days by ensuring adequate capacity is available and reviewing daily reports and resolving any breaches. In addition to this they are responsible for evaluating the impact of any process or service changes on 62 or 31 day pathways.

- **Hospital Consultants**

  Consultants have a shared responsibility with their General Managers for managing their patients' waiting times in accordance with the maximum guaranteed waiting time.

- **Clinical Nurse Specialists**

  Clinical Nurse Specialists have a shared responsibility with their Consultants and General Managers for managing their patients' waiting times in accordance with the maximum guaranteed waiting time.

- **Head of Information**

  Responsible for administering data required for managing and reporting cancer waiting times, activity and cancer outcomes. The informatics team ensures there is a robust Standard Operating Procedure for the external reporting of performance.

- **Cancer Services Manager**

  Responsible for monitoring delivery of key tasks by the MDT Coordinators and for running daily audits of all 2ww referrals and highlighting:

  - Overall responsibility for delivery of the Cancer Agenda.
  - Responsible for development of local strategies and plans in line with National, CCG, Cancer Locality and Trust Cancer priorities.
  - Liaising with Clinical Care Groups.
  - IT Agenda for cancer databases, registry and video conferencing.
  - Input into SLA/contracting.
  - Management support to Lead Clinician and Lead Nurse.
  - Patients booked over national standard.
  - Patients with no appointment.
  - Any data entry issues.
  - Producing daily reports for General Managers to resolve potential breaches.
  - Producing daily reports showing compliance with 2ww standard in preceding week for discussion at weekly PTL meeting.

2ww Office Team and those Designated to Make 2ww Outpatient Appointments

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

Booking Clerks

Responsible for ensuring waiting lists are managed to comply with this Policy and Procedure document and in line with their job descriptions.

MDT Coordinators

Responsible for monitoring the cancer pathway for patients following the first attendance, ensuring it is managed in line with this Policy and assisting in the pro-active management of patient pathways on PAS and the cancer management system. Also responsible for facilitation and coordination of MDT meetings and documentation of discussions.

All Staff (for whom this document applies)

- All staff have a duty to comply fully with this Policy and Procedure and are responsible for ensuring they attend all relevant training offered.
- All staff will ensure any data created, edited, used or recorded on the Trust's IT systems within their area of responsibility is accurate and recorded in accordance with this Policy and other Trust policies relating to collection, storage and use of data in order to maintain the highest standards of data quality and maintain patient confidentiality.
- All 2ww patient referrals, diagnostics, treatment episodes and waiting lists must be managed on the Trust's systems. All information relating to patient activity must be recorded accurately and in a timely manner.

TRAINING / COMPETENCY REQUIREMENTS

All staff involved in the cancer pathway will be expected to undertake initial cancer waiting times training within the first three months of appointment within CDDFT. All relevant staff will have annual refresher cancer waiting times training delivered by cancer services management team.

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
Maximum 2ww from urgent GP referral for suspected cancer to first appointments.	93%
Maximum 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 an 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

SUMMARY OF THE CANCER RULES

Clock Start

- **2WW**

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

- **62 Day**

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

  - Urgent two week wait referral for suspected cancer;
  - Urgent two 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).

- **31 Day**

  A 31 day cancer clock will start following:

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

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

Clock Stops

A 62 cancer clock will stop following:

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

Removals from the 62 Day Pathway (not reported)

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

A 31 day cancer clock will stop following:

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

For a more detailed breakdown of the cancer rules please read the latest Cancer Waiting Times Guidance or the Cancer Operational Policy.

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

GP/GDP SUSPECTED CANCER 2 WEEK WAIT (2ww) REFERRALS

- All suspected cancer referrals should be referred by the GP/GDP on the relevant cancer pro-forma provided and submitted via e-Referral.
- 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.

Downgrading Referrals from 2ww

CDDFT 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).

Two Referrals on the Same Day

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

Screening Pathway

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

- Bowel – receipt of referral for an appointment to discuss suitability for colonoscopy with a specialist screening practitioner (SSP);
- Cervical – receipt of referral for an appointment at colposcopy clinic.

Consultant Upgrades

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

Who Can Upgrade Patients onto a 62 day Pathway

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

- Specialist Nurse/Practitioner, either by triaging the referral form/letter or at nurse led initial clinic.
- Specialist Registrar either by triaging the referral form/letter or at initial clinic.
- Radiologist/Histologist/other Trust clinicians on reviewing patients and/or diagnostics.

Responsibilities

- The Consultant or delegated member of the team upgrading the patient is responsible for informing the MDT Coordinator (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.

Subsequent Treatments

If a patient requires any further treatment following their first definitive treatment for cancer (including after a period of active monitoring) they will be monitored against a 31 day subsequent treatment clock. The clock will start following the patient agreeing a treatment plan with their clinician. This will be the decision to treat (DTT) date.

In some circumstances it may be appropriate for the clinician to set an ECAD (Earliest Clinically Available Date) which is when a patient needs to recover following their first definitive treatment. An ECAD can be adjusted but only if the date has not passed. The 31 day clock start date should be the same as the ECAD date for these patients.

- **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.

WAITING TIME ADJUSTMENTS

Pauses

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

- **2ww**

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

- **62/31 Day Pathways**

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

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

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

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

Patient Cancellations

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

- **First Appointment Cancellations**

  2ww referral patients who cancel their first appointment should be offered, where possible, another appointment within the two weeks of the referral being received.

- **Subsequent/Multiple Appointment Cancellations**

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

- **Multiple Cancellations**

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

  Patients can be discharged after multiple (two 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 or breast symptomatic (i.e. outpatient, diagnostic investigation) **an appropriate member of staff will contact the patient to identify any factors that may be stopping the patient attending and another appointment will be offered if the patient agrees.**

- **Patient DNAs**

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

- **First Appointment**
  - All patients referred as suspected cancer including 2ww, screening, 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 DNAs their first appointment for a second time the patient will be escalated to the consultant in clinic for a decision on the next step which may include discharge back to the GP.

- **Subsequent Appointments**

  If a patient DNAs any subsequent appointment the patient should be escalated to the consultant in clinic for a decision on the next step which may include discharge back to the GP.

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

  In the event that the patient remains uncontactable:

    - **For first appointments**

      An appointment will be sent to the patient offering an appointment within the 2ww standard, stating the Trust has attempted to offer a choice of appointments and that the patient should contact the 2ww wait office to rearrange the appointment if it is inconvenient.

    - **Appointments (other than first) on 62/31 day clinical pathway**

      Attempts to contact patient will be made as outlined above. In the event that contact cannot be made, the consultant should decide:

        - To send a 'no choice' appointment by letter, or
        - To discharge the patient back to the GP and remove from the cancer pathway.

- **Patients Who Are Unavailable**

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

DIAGNOSTICS

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

- **Refusal of a Diagnostic Test**

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

- **Managing the Transfer of Private Patients**

  If a patient decides to have any appointment in a private setting they will remove themselves from the cancer pathway.

  If a patient transfers from a private provider onto a 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.

- **Tertiary Referrals**

  Process

  Inter Provider Transfer (IPT) forms will be used for all outbound referrals for patients on a cancer pathway.

  - Where possible information will be transferred between Trusts electronically. Transfers will be completed via a named NHS contact.
  - A minimum data set and all relevant diagnostic test results and images will be provided when the patient is referred.

- **Entering Patients on the Tracking Pathway**

  Suspected cancers – 2ww GP/GDP referrals

  - On receipt of a 2ww referral from a GP/GDP, the 2ww wait office will record the referral (including known adjustments, referring symptoms and first appointment) onto the PAS; an electronic transfer provides this information on the cancer tracking system within 24 working hours of receiving the referral.
  - The Reception staff are responsible for confirming a patient's attendance at the first appointment and recording the outcome.

  Suspected cancers – screening patients

  - The MDT Coordinating 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 Office will be responsible for entering patient details onto the PAS and allocating the patient an appointment within the 2ww wait guidelines.
  - For upgrades at any other point of the pathway the MDT Coordinator will be responsible for updating the cancer management system and will begin tracking of the pathway.

  Suspected/confirmed cancers (31 day patients)

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

  Confirmed cancers

  The MDT Coordinator 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.

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 MDT Coordinator 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.

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

- Comparative audit of data on the cancer management system and PAS.
- Comparative audit of diagnosis code on PAS, cancer management system and healthcare records.
- Comparative audit of cases removed from the 62 day pathway and re-entered as 31 day patients within four weeks of removal.

  This will involve a random selection of healthcare records from each tumour site to be reviewed and will be led by the Cancer Information Team.

The Cancer Information Team will also capture numbers of patients ‘upgraded’ each month and will carry out a quarterly audit to ensure that patients are being ‘upgraded’ at the earliest opportunity.

4 Monitoring

4.1 Compliance and Effectiveness Monitoring

Compliance with this policy will be monitored as outlined in the table below.

4.2 Compliance and Effectiveness Monitoring Table

Monitoring Criterion	Response
Who will perform the monitoring?	
What are you monitoring?	
When will the monitoring be performed?	
How are you going to monitor?	
What will happen if any shortfalls are identified?	
Where will the results of the monitoring be reported?	
How will the resulting action plan be progressed and monitored?	
How will learning take place?	

9 Glossary of Terms

Terms

TERM	DEFINITION
2ww Two Week Wait	The maximum waiting time for a patient's first outpatient appointment or 'straight to test' appointment if they are referred as a 62 day pathway patient.
31 Day Pathway	The starting point for 31 day standard is the date that a patient agrees a plan for their treatment or the date that an Earliest Clinically Appropriate Date (ECAD) is effected for subsequent treatments.
62 Day Pathway	Any patient referred by a GP with a suspected cancer on a two week wait referral pro-forma, referral from a screening service, a referral from any healthcare professional, if for breast symptoms, and also where a routine referral has been upgraded by a hospital clinician, must begin treatment within 62 days from receipt of referral.
Active Monitoring	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures.
Active Waiting List	The list of elective patients who are fit, ready and able to be seen or treated at that point in time. Applicable to any stage of the RTT pathway where patients are waiting for hospital resource reasons.
Bilateral Procedures	Where a procedure is required on the same anatomical sides of the body.
Breach	A pathway which ends when a patient is seen/receives their first treatment outside the 14 day first seen, 62 day referral to treatment and/or 31 day decision to treat to treatment target times.
Chronological Booking	Refers to the process of booking patients for appointments, diagnostic procedures and admission within date order of their clock start date.
Consultant-Led Service	A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse-led clinics which come under the umbrella of consultant-led services.
Day Case	Patients who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight.
Decision to Admit	When a clinical decision is made to admit the patient for either day case or inpatient treatment.
Direct Access	Where GPs refer patients to hospital for diagnostic tests only. These patients will not be on an open RTT pathway.

TERM	DEFINITION
Elective Care	Any pre-schedule care which does come under the scope of emergency care.
First Definitive Treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgment in consultation with the patient.
Fixed Appointments	Where an appointment or admission date is sent in the post to the patient without the opportunity to agree a date.
Full Booking	Where an appointment or admission date is agreed either with the patient at the time of the decision or within 24 hours of the decision.
Incomplete Pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage.
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night.
Notified	Where the RTT clock is discounted from any reporting of RTT performance.
Oncology	The branch of science that deals with tumours and cancers.
Partial Booking	Where an appointment or admission date is agreed with the patient near to the time it is due.
Patient Initiated Delay	Where the patient cancels, declines offers or does not attend appointments or admission. This in itself does not stop the RTT clock. A clinical review must always take place.
Planned Waiting List	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18 week RTT pathway.
Reasonable Offers	A choice of two appointment or admission dates with three weeks' notice.
Straight to Test	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an RTT pathway.

ACRONYMS

TERM	DEFINITION
ASis	Appointment Slot Issues (list). A list of patients who have attempted to book their appointment through the national e-referral service but have been unable to due to lack of clinic slots.
CATS	Clinical Assessment and Treatment Service.
CCGs	Clinical Commissioning Groups. Commission local services and acute care.
CNS	Clinical Nurse Specialists. Use their own knowledge of cancer and treatment to co-ordinate the patient's care plan and act as the patient's 'keyworker'.
COF	Clinic Outcome Form.
COSD	Cancer Outcomes and Services Dataset. Is the key dataset which is designed to define and deliver consistency in data recording, data submission and analysis across cancer in the NHS, including diagnostics, staging, treatment and demographic information. Data is submitted to the cancer registry and used for national reporting.
DNA	Did Not Attend. Patients who have been informed of their appointment date and who, without notifying the hospital fail to attend their appointment.
DNA	Did Not Attend. Patients who give no prior notice of their non-attendance.
DTT	Date of Decision to Treat. The date on which the clinician communicates the treatment options to the patient and the patient agrees to a treatment.
ECAD	Earliest Clinically Appropriate Date. Date that is clinically appropriate for an activity to take place. ECAD is only applicable to subsequent treatments.
E-RS	(National) e-Referral Service.
FOBT	Faecal Occult Blood Test. This test, which is part of the Bowel Screening Pathway, checks for hidden (occult) blood in the stool (faeces).
GDP	General Dental Practitioner (GDP). Typically leads a team made up of dental care professionals (DCPs) and treats a wide range of patients, from children to the elderly.

TERM	DEFINITION
GP	General Practitioner. A physician whose practice consists of providing ongoing care covering a variety of medical problems in patients of all ages, often including referral to appropriate specialists.
The Cancer Management System	A database system used to record all information related to patient cancer pathway by MDT coordinators, clinical nurse specialist and clinicians.
IOG	Improving Outcomes Guidance. This is NICE Guidance on the configuration of cancer services.
IPT	Inter-Provider Transfer.
MDM	Multi-Disciplinary Team Meeting where individual patients care plans are discussed and agreed.
MDS	Minimum Data Set. Minimum information required to be able to process a referral either into the cancer pathway or for referral out to other Trusts.
MDT	Multi-Disciplinary Team. A group of doctors and other health professionals with expertise in a specific cancer, who together discuss and manage an individual patient's care.
MDT Coordinator Multidisciplinary Team Coordinator	Person with responsibility for tracking patients, liaising with clinical and CAU staff to ensure progress on the cancer pathway, attends the weekly Patient Tracking List (PTL) meeting, updates the Trust's database for cancer pathway patients and assists with pathway reviews and changes. Also co-ordinate the MDT meeting and records the decision for onward progress along the cancer pathway.
NCWTDB	National Cancer Waiting Times Database. All cancer waiting times general standards are monitored through the national
PAS	Patient Administration System. Records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient.
PPID	Patient Pathway Identifier.
PTL	Patient Tracking List. A complex spreadsheet used to ensure that cancer waiting times standards are met by identifying all patients on 62 day pathways and by tracking their progress towards the 62 or 31 day standards.

TERM	DEFINITION
PTL	Patient Tracking List. A tool used for monitoring, scheduling and reporting on patients on elective pathways.
RACPC	Rapid Access Chest Pain Clinic.
RCA	Root Cause Analysis. This defines steps on a patient's pathway and identifies breach reasons. In the context of this Policy, this is not the same as the level of investigation involved in an RCA for, for example, a Serious Incident (SI).
RMC	Referral Management Centre.
RTT	Referral To Treatment.
SMDT	Specialist Multi-Disciplinary Team. Meeting where individual patients care plans are discussed and agreement takes place across multiple organisations and involves support from a centre that is deemed to specialise in treating a particular tumour type.
TCI	To Come In.
TIA	Trans Ischaemic.
TSSG	Tumour Site Specific Group.
UBRN	Unique Booking Reference Number.

10 Associated Documentation

No.	Reference Title	Published By	Publication Date	Link
1	Referral to treatment consultant led waiting times Rules Suite.	Department of Health	October 2015	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464956/RTT_Rules_Suite_October_2015.pdf
2	Recording and reporting Referral To Treatment (RTT) waiting times for consultant led elective care.	NHS England	October 2015	https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/recording-and-reporting-RTT-guidance/v24-2-PDF-703K.pdf
3	Recording and reporting Referral To Treatment (RTT) waiting times for consultant led elective care: Frequently Asked Questions	NHS England	October 2015	https://england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/accompanying-FAQs-v7.2.pdf
4	The NHS Constitution.	Department of Health	July 2015	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf
5	Diagnostics waiting times and activity. Guidance on completing the 'diagnostic waiting times and activity' monthly data collection.	NHS England	March 2015	https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/
6	Diagnostics Frequently Asked Questions on completing the 'diagnostic waiting times and activity' monthly data collection.	NHS England	February 2015	https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/
7	Equality Act 2010.	Department of Health	June 2015	https://www.gov.uk/guidance/equality-act-2010-guidance
8	Overseas Visitor Guidance.	Department of Health	April 2016	https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations
9	Cancer Waiting Times Guidance Version 9.			
10	Armed Forces Covenant.	Ministry of Defence	July 2015	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/49469/the_armed_forces_covenant.pdf

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

11 Appendices

Equality Impact Assessment

EAIA Assessment Form **v3/2013**

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.