Sherwood Forest Hospitals NHS
NHS Foundation Trust

Title: **ELECTIVE ACCESS, BOOKING & CHOICE POLICY**			
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Division/Department: Planned Care & Surgery	**Policy Category:** Corporate Information
Author (post-holder): Access, Booking and Choice Manager Head of Information Head of Cancer Services	**Sponsor (Director):** Chief Operating Officer
Consult With: Heads of Service Divisional Nurses Matrons Divisional Managers Service Managers Business Support Access, Booking and Choice Teams Adult Safeguarding Lead Child Safeguarding Lead Learning Disability Lead Information Services Data Quality Team Patient Focus Groups CCG Trust Cancer Lead Trust 18 Week Lead Cancer Team Tumour Site Leads	
Review Date: **Annually from Approval Date**	
Target Audience: All staff groups involved in the management and administration of patient pathways. This policy applies to all elective Trust services including cancer.	

Contents

Section 1: Policy Statement

This document defines the Elective Access, Booking & Choice Policy for Sherwood Forest Hospitals NHS Foundation Trust (hereafter referred to as 'the Trust').

The Trust is committed to providing an excellent standard of patient access and care for elective pathways whilst reducing waiting times and allowing for patient choice.

The purpose of this policy is to outline the Trust's and Commissioner requirements by ensuring that the management of patients is transparent, fair, equitable and managed according to clinical priority whilst maintaining key patient access standards.

- Outpatient, Elective Inpatient/Day-case and Diagnostics Waits
- 2 Week Wait Cancer referrals and subsequent cancer treatment pathways
- Referral to Treatment (RTT) Maximum Waiting Time Standard

This document will clearly set out the responsibilities and accountability of all staff involved in the processes documented within the policy. The policy covers those responsible for referring patients, managing receipt of referrals, booking outpatient activity and maintenance of the elective waiting list for the purpose of taking a patient through their referral to treatment pathway.

The RTT standard for consultant-led elective services is that no patient should wait more than 18 weeks from the time they are referred to the start of their treatment, unless it is clinically appropriate to do so or they choose to wait longer.

This policy defines the principles of pathway management at the Trust and their application along the patient pathway with consideration for patient choice and complex patient pathways. The policy sets out a framework within which the staff responsible for managing patient pathways can develop specific local procedures to ensure consistent application of the principles and arrangements set out within this Elective Access Policy.

The policy is jointly owned by the Chief Operating Officer, Trust Cancer Lead and Trust 18 Week lead who are accountable for the delivery of all key patient access standard. The Chief Operating Officer is the Executive Lead for Cancer

This policy applies to the management of all patient groups, excluding non-elective, maternity/obstetric patients and patients on a suspected or confirmed cancer pathway at the Trust irrespective of who and where the booking and scheduling of patients activity is undertaken. Arrangements for suspected or confirmed cancer patient pathways are set out within the Cancer Access Policy (**Section 11**). Cancer Access Policy

There may be occasions when situations arise which are not covered by this document, if you require further assistance or clarification on any aspects of this policy please contact in the first instance:-

- Your direct line manager for any general issues
- Access, Booking and Choice Manager for specifics (RTT)
- Cancer Management Team for queries relating to the application of cancer waiting times standards

Section 2: Roles and Responsibilities

The Chief Executive has overall responsibility for pathway management in the Trust. As accountable officer the Chief Executive is responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity. Patient pathway management and reporting is key to this as it will ensure appropriate clinical care in compliance with national standards and local requirements.

The Chief Operating Officer is responsible for ensuring patient access through the operational delivery of the waiting times standards described in this policy and responsibility for the governance and performance monitoring processes that underpin the Policy.

The Chief Operating Officer has a responsibility to the Trust to ensure that access standards are delivered. It is however, the Divisional Managers who are directly responsible for achieving these standards. It is the role of the Chief Operating Officer to ensure this is done transparently and without contravening this policy.

The Trust 18 Week Lead is responsible for ensuring that this policy is implemented across Trust services and that operational system and processes are developed, coordinated and monitored.

The Head of Information is responsible for the management of the Medway system on which patient information and waiting lists are held, and is responsible for the provision of operational information to support delivery of patient pathways and for the reporting of information within and external to the organisation.

Divisional Clinical Directors and Divisional Managers have a shared responsibility for implementation of the Elective Access, Booking & Choice Policy within their Division's clinical and management teams and for ensuring compliance with the arrangements set out within this policy. They also have joint responsibility for ensuring clinical teams within their division have awareness of all patients on the Cancer PTL, and for the management of these patients through cancer pathways

Hospital Consultants, Clinical Nurse Specialists along with the Service Managers have a shared responsibility for managing patients waiting times.

The Head of Information, Access, Booking and Choice Manager and the Cancer Management Team are responsible for providing expert guidance and advice in the application of the national pathway management rules, this policy and its application throughout the Trust. The Access, Booking and Choice Manager (and the Cancer Management Team) have a responsibility to provide challenge to the Clinical Divisions and the Booking & Scheduling Service in the management of waiting times across all Trust services.

The Access, Booking and Choice Manager is the Trust's operational lead for management of patient booking and waiting times and will provide operational expertise in applying this policy and developing the supporting operational procedures to ensure compliance within each area in respect of RTT. The Cancer Management Team is responsible for providing operational expertise relating to the application of CWTs guidance and developing supporting operational procedures to ensure compliance in all areas of CWTs standards.

The local Clinical Commissioning Groups play a pivotal role in ensuring patients fully understand their responsibilities on both the RTT and Cancer pathways and GPs refer appropriately for secondary care services.

All staff who book and schedule patient care are responsible for the day-to-day adherence to this policy and for using the supporting standard operating procedures in doing so. Staff are accountable to their management teams for the application of this policy in respect of RTT and Cancer.

All staff are responsible for ensuring that this policy is adhered at all times. A failure to follow the requirements of the policy will result in investigation and management action being taken as considered appropriate. This may include formal action in line with the Trust's disciplinary or capability procedures for Trust employees; and other action in relation to other workers, which may result in the termination of assignment, placement, secondment or honorary arrangement.

Section 3: Pathway Management Principles and General Rules

National Operating Standards

The NHS constitution clearly sets out a series of pledges and rights for 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
- From a GP referral for treatment into a consultant-led service have a maximum waiting time of 18 weeks from referral for elective conditions
- 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 exception to the right to be seen within the maximum waiting times applies:

- If the patient chooses to wait longer.
- If delaying the start of the treatment is in the best clinical interests of the patient, for example where stopping smoking or losing weight is likely to improve the outcome of the treatment.
- 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.
- If the patient fails to attend appointments that they had chosen from a set of reasonable options, or
- If the treatment is no longer necessary.

The following service is not covered by the right:

- Maternity services.

Patients must be treated within the above national waiting time standards. Failure to achieve these standards and thresholds will jeopardise the achievement of an excellent rating by the Care Quality Commission annual assessment, this will put the Trust at risk of breaching its terms of authorisation as a Foundation Trust and will risk financial penalties within the NHS standard acute trust contract.

Referral to Treatment Pathway (RTT)

From 2008 a patients pathway has been managed as a whole rather in stages of treatment (First Outpatient, Elective Waiting List and Diagnostic). The RTT pathway measures the patient's journey from referral received to first definitive treatment or those where no treatment is required.

The RTT pathway applies to elective pathways only that involve consultant-led care. The RTT Rules Suite provides further definition of the RTT maximum waiting time standard and should be read in conjunction with this document. The RTT Rules Suite can be located within the following web address http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting-RTT-guidance-v24-PDF-573K.pdf

RTT Pathway Clock Start

A RTT pathway commences under the following circumstances when any care professional or service permitted by an English NHS commissioner to make such referrals refers to:

- A consultant led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner;
- An interface or referral management or assessment service, which may result in an onward referral to a consultant led service before responsibility is transferred back to the referring health professional or general practitioner.
- A waiting time clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional permitted to do so.

Upon completion of a consultant-led referral to treatment period an RTT pathway recommences under the following circumstances:

- When a patient becomes fit and ready for the second of a consultant-led bilateral procedure, see page xxx;
- Upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan;
- Upon a patient being re-referred in to a consultant-led; interface; or referral management or assessment service as a new referral;
- When a decision to treat is made following a period of active monitoring;
- When a patient rebooks their appointment following a first appointment DNA that stopped and nullified their earlier clock.

RTT Pathway Clock Stop

A RTT pathway stops under the following circumstances for treatment or non-treatment where a clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay.

Clock stops for treatment

- First definitive treatment is defined as being an intervention intended to manage a patient's disease, condition or injury and avoid further intervention. The date where first definitive treatment starts will be the date that stops the clock - this may be either in an interface service or a consultant-led service.
- Clock stops due to the patient being added to the transplant list

Clock stops for 'non-treatment'

- 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 to start a period of active monitoring;

- A patient declines treatment having been offered it;
- A clinical decision is made not to treat;
- A patient DNAs (does not attend) their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient;
- A patient DNAs any other appointment and is subsequently discharged back to the care of their GP, provided that the provider can demonstrate that the appointment was clearly communicated to the patient; discharging the patient is not contrary to their best clinical interests; discharging the patient is carried out according to local, publicly available/published, policies on DNAs; These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g. children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders.

Active Monitoring (RTT)

The concept of active monitoring stops the clock and caters for periods of care without (new) clinical intervention e.g. three monthly routine check-ups for diabetic patients. This is where it is clinically appropriate to monitor the patient in secondary care without clinical intervention or further diagnostic procedures, or where a patient wishes to continue to be reviewed as an outpatient without progressing to more invasive treatment. Active monitoring can be initiated by either the clinician or the patient.

If after a period of active monitoring, the patient or care professional decides treatment is now appropriate, a new pathway and a new clock starts. There is then a new patient pathway in which the patient must receive their first definitive treatment within a maximum of 18 weeks

RTT Pathway Clock Pauses

In line with new national guidance **no clock** may be paused and waiting time adjusted when treatment provided where a decision to admit for treatment has been made. Any patient who chooses to wait longer than18 Weeks should be accommodated without being penalised. The Trust will continue to capture where the patient has declined appointment offers for admission.

The 3 weeks reasonable notice for day case and inpatient appointments rule does not prevent patients from being offered earlier appointments.

If a patient makes themselves unavailable for a set period of time (e.g. due to school holidays or other reasons) then this may mean that offering actual dates which meet the reasonableness criteria would be inappropriate (as the patient would be offered dates that the provider already knew they couldn't make). In this case, the waiting time clock will not be paused but the provider will capture the patient being unavailable for the given period and not penalise the patient.

Key Waiting Time Standards (RTT)

95% of non-admitted patients will not wait longer than 18 Weeks (126 days) for their clock to stop. Non-admitted pathways are those that end in treatment that do not require and elective admission to hospital or where no treatment is required.

90% of admitted patients will not wait longer than 18 Weeks (126 days) for their clock to stop. Admitted pathways are those that end in an elective admission to hospital either as an elective inpatient or day-case for treatment.

92% of patients on an incomplete pathway will be waiting no longer than 18 weeks (126 days) for their clock to stop.

95% of direct access audiology patients will not wait longer than 18 Weeks (126 days) for their clock to stop. Direct Access Audiology pathways are those that end in treatment that do not require and elective admission to hospital or where no treatment is required.

Patients waiting or having a clock stop at 127 days or more will be classed as an RTT pathway breach and reported as such.

Less than 1% of patients will wait longer than 6 weeks for a diagnostic test, investigation or image.

Patients referred on a suspected cancer pathway will be managed as per the **Trust Cancer Access Policy Section 11. The RTT pathway does not replace the Cancer waiting time standards.** Cancer Access Policy

The Trust internal standard for first outpatient attendances for all referral sources is a **patient should wait no longer than 13 weeks.**

All patients waiting for a diagnostic test, investigation or image **will wait no longer than six weeks.**

The Trust internal standard for elective Inpatient or Day-case admissions is that **all patients will be treated within 18 Weeks**.

The RTT pathway does not replace other waiting time standards where these are shorter than 18 weeks. This includes waiting times for patients with suspected cancer or waiting times for Rapid Access Chest Pain clinics.

Patients may have more than one RTT waiting time running simultaneously if they have been referred to and are under the care of more than one clinician at any one time. Each RTT pathway has to be measured and monitored separately and will have a unique patient pathway identifier in MEDWAY.

It should be noted that any patient referred to an obstetric or midwifery service, to fracture clinic following an emergency admission or Emergency Department attendance, all patients seen in the Outpatient Department following an emergency admission are NOT applicable to the RTT waiting time unless a new decision to treat or significant new plan of care is commenced where a new RTT clock would start.

Elective Access Principles (RTT)

As a general principle, the Trust expects before a referral is made for treatment that the patient is both clinically fit for assessment and possible treatment of their condition, and is ready to immediately start their pathway following initial referral. The responsibility lies with the Clinical Commissioning Groups, GPs and other primary care services to ensure patients understand this before beginning an elective pathway.

Patient's entitlement to NHS treatment

The Trust has a legal obligation to identify patients who are not eligible for free NHS treatment. The NHS provides health care for people who live in the United Kingdom. People who do not normally live in this country are not automatically entitled to use the NHS free of charge – regardless of their Nationality or whether they hold a British passport or have lived in and paid National Insurance Contributions and taxes in this country in the past.

All NHS Trusts have ***legal obligation*** to:

- Ensure patients who are not ordinarily resident in the UK are identified

- Assess liability for charges in accordance with Department of Health Overseas Visitors Regulations
- Charge those liable to pay in accordance with Department of Health Overseas Visitors Regulations

The Human Rights Act 1998 prohibits discrimination against a person on any ground such as race, colour, language or religion. The way to avoid accusations of discrimination is to ensure everybody is treated equitably.

The Trust needs to check every patient's eligibility for treatment. An NHS card or number does not give automatic entitlement to free NHS treatment. Therefore, all patients without exception at first Outpatient appointment patients will be asked 'Have you lived in the UK for the past 12 months' and asked to provide evidence of residency in the UK to prove entitlement to free NHS treatment within secondary care for example; a contract of employment is employed, utility bill, tenancy agreement or bank statement along with their Passport or identification card for EU Citizens. If a patient has not lived in the UK for the past 12 months or cannot provide evidence of residency the Overseas Visitors Team must be contacted to interview the patient, before treatment commences (unless this treatment is clinically urgent). Further details of these arrangements are set out in the Trusts Overseas Visitors Policy.

Overseas Visitors Policy - Final - Septen

Patients transferring from the Private sector to the NHS (RTT)

Patients can choose to convert between an NHS and Private status at any point during their treatment without prejudice. All patients wishing to transfer from the private service to the **NHS must be returned to their GP to be offered choice and onwards referral to an NHS provider.** No patient should be referred direct to the Trust from a private service.

Patients who are referred via their GP's from a private service can be added direct to the NHS waiting list on the referral received date. **They do not need an NHS appointment prior to the addition.**

Patients transferring from the NHS to private

NHS patients already on NHS waiting lists opting to have a private procedure must be removed from the NHS waiting list.

A new referral must be created – NHS to private and a waiting list entry as a private must be entered on MEDWAY.

NHS Provider Commissioning Private Sector Service

There may be circumstances where the Trust chooses to commission services provided by the private sector to enable waiting time standards to be met. In this situation the RTT Pathway waiting time would continue with the Trust remaining accountable for the delivery of the RTT pathway standards.

Patients requiring commissioner approval (RTT)

No referral for an excluded procedure should be accepted without an exceptional treatment approval form. If the referral does not have the relevant approval the referral should be rejected and returned to the GP for them to request exceptional treatment funding via the relevant CCG panel.

In some instances it will not be apparent until the Outpatient Consultation that the patient requires an excluded procedure, when it is identified at the Outpatient Consultation, the relevant clinician should discharge/return the patient back to the GP for the GP to progress the exceptional treatment panel approval and re-refer the patient once approval has been granted. The GP must make explicit comment in the re-referral that the patient has panel approval and the patient will expedited.

The documents below are the CCG Commissioning Policy for Individual Funding Requests and Request Form.

CCG 1. Commissioning Policy

CCG 1a. NEW Nottinghamshire Cour

Access to Health Services for Military Veterans

It is the GP's responsibility to inform the Trust that the patient being referred is a Military Veteran and that the condition they are being referred for is service related. In line with December 2007 guidance from the Department of Health, Military veterans should be prioritised over other patients with the same level of clinical need if their condition is service related. An alert must be added to MEDWAY and the patients case notes to identify the patient's status.

Interpreter Requirements

Where a patient requires an interpreter for an appointment or admission this must be highlighted at the top of the referral or request and also must clearly state the type of interpreter required.

Disabilities or Special Needs

The Trust is committed to providing, wherever possible, a booking system to support the requirements of individuals with disabilities; this may involve for example booking an appointment time that is more suitable to the patients needs.

We will continually work towards ensuring that individuals with disabilities are not disadvantaged by this Policy; we will, through the impact assessment process and involvement with local disability groups, identify areas of concern and work to eliminate these issues wherever possible.

Religion and Ethnicity

The Trust is committed to providing, wherever possible, a flexible booking system to support the ethnic or religious requirements of the service user, for example, more suitable appointment times or female interpreter for female service users.

We will continually work towards ensuring that individuals due to their ethnic or religious requirements are not disadvantaged by this Policy; we will, through the impact assessment process identify areas of concern and work to eliminate these issues wherever possible.

Patient Transport

The Trust can no longer book patient transport. Patients that meet the eligibility criteria are required to book transport through NSL for Derbyshire, Lincolnshire and Northamptonshire based GP Practices or Arriva for Nottinghamshire and Leicestershire based GP Practices for their Outpatient Appointment, Diagnostic Appointment or Elective Procedure.

Section 4: Supporting Tools, Monitoring Systems and Application of the Policy

As a provider of services covered by RTTs, the Trust needs to know the clock start date, clock stop date and patient choosing to wait for treatment for all RTT patient pathways. An RTT status should be recorded at each stage of the patient journey at the time of the patient appointment, contact or intervention. The Trust's primary system for administrating patients and their pathways is MEDWAY with Radiology, Endoscopy and Cardio Respiratory systems providing supporting information. Other agreed systems are in place for particular areas of our services, such as our system for tracking and monitoring cancer pathways on ORION which is covered in the **Cancer Access Policy Section 11**. Cancer Access Policy

All waiting lists must be held and managed on the MEDWAY system and/or other agreed Trust systems. Lists that are currently held in books, on cards, on spreadsheets or databases or in any other non-Trust system form are not permitted, and must be transferred to MEDWAY and/or another agreed system.

The Trust will provide patient tracking & booking lists (PTLs) three times a week for the management of patient pathways; these will include non-admitted, admitted, diagnostic and non-RTT PTLs. The PTLs are created from RTT entries made on the MEDWAY system. All activities such as referrals, requests for admission and clinic outcome forms must be entered onto MEDWAY in a timely manner and in accordance with this policy and standard operating action card procedures. Failure to add patient activities to the waiting lists and in a timely manner is a serious matter that can delay patient care unnecessarily and non-compliance with this policy may result in action being taken.

The PTLs will be the central list of patients being seen at the Trust, including those who are no longer on an active RTT pathway, and will be subjected to an audit cycle. The PTLs are distributed by Information Service through the agreed mechanism and are the responsibility of the appropriate operational management and booking teams to access the information they require to book and schedule patients.

The Board, Executive Team and key Committees will receive granular details on the Trust performance for RTT, Cancer and Diagnostics on either a weekly or monthly basis dependent on meeting frequency, along with key Data Quality Indicator reports.

The Trust will provide the necessary training to staff in the use of MEDWAY and specific functions within the system relating to each individual member of staff's job role ensuring a clear understanding of expectations is communicated. RTT training will be available for all staff to ensure accurate and timely data collection is performed which enables the Trust to meet reporting requirements both internally and externally. Each year all relevant staff with undergo compulsory refresher training.

Standard letters of invitation, removal from the list etc should be generated from MEDWAY or other Trust systems. This provides a uniform approach and an audit trail. The Trust standard letters will be used where appropriate.

Any potential current and retrospective breaches of waiting times standards must be notified to the relevant Divisional Manager without delay as soon as they come to light. Any such failures will be regarded as adverse incidents and may result in the declaration of retrospective breaches of waiting times standards. It is the responsibility of the relevant operational manager to raise an adverse incident report and promptly notify the Deputy Chief Operating Officer of the event.

The monitoring of the Trust's Elective Access Policy is an essential part of ensuring patients do not wait unnecessarily for elective care at the Trust and the access to the Trust's services is equal and fair. Information Services will routinely provide reports detailing compliance against key areas within the policy which will be provided to the relevant operational and clinical teams.

Set out below are the key areas of the Elective Access that will be monitored when the policy is implemented.

Overarching Monitoring

- Outcome Form monitoring – unreconciled, unknown and use of 99 and 98 RTT codes
- Outcome Form monitoring – data quality monitoring of outcomes used and RTT code use as consultant and service level
- Capacity Escalation Process
- Reasonable Offer Dates – Outpatient, diagnostic and day case/inpatient
- Multiple hospital cancellations at consultant and service
- Multiple patient cancellations at consultant and service
- Rebooking of DNAs and multiple DNA rebooking at consultant and service level
- Monitoring of Overseas Visitors assessment
- Monitoring of Military Veterans flagging

Section 5: The Referral Process

A referral is a decision made by a Health Care Professional to refer a patient to a particular Health Care Provider and to a particular Service.

It is the referring Care Professionals responsibility to inform the patient of the intention to refer into secondary care and ensure that the patient is both clinically fit and prepared to receive potential treatment and be available within 18 weeks from referral. Where the referring Care Professional knows that the patient is unavailable for example on a tour of duty, extended holiday or has work or study commitments, the referral should not be made until a more appropriate time.

The Trust expects all referrals to be made via the NHS e-Referrals Service System (formerly Choose and Book) unless the referring Care Professional does not currently facilitate the use of NHS e-Referrals Service, and will use email or fax. ***Action Card 2***

NHS e-Referrals Service system is the nationally recommended referral route allowing the patient choice over Provider, date and time of their appointment.

Routine practice will see referrals made to a service rather than an individual. This will ensure that there is improved waiting times across consultants and services to ensure patients are seen in a timely manner. As set out within the NHS Operating framework, the Trust will work to ensure patients see the Consultant of choice where a preference is expressed. ***Action Card 1***

Clock Start Date

The RTT Clock Start Date is defined as the date that the provider receives notice of the referral. This must be recorded so that the RTT Waiting time of the patient is tracked. For NHS e-Referrals Service referrals, this will be the date that the patient converts their UBRN (Unique Booking Reference Number). For referrals not made via the NHS e-Referrals Service, the clock starts on the date that the referral is received by the Trust.

Appointment Slot Issues (ASIs)

When no clinic appointment is available for patients to book in the NHS e-Referrals Service, the referral is deferred (via the professional application) to the provider to enable the provider to book the patient an appointment. When a referral is deferred, it will appear on the provider's 'Appointment Slot Issues' (ASI) work-list.

The date on which the UBRN appears on the work-list is the Consultant-led RTT Clock Start.

For the management of Appointment Slot Issues, it is imperative that patients are contacted within 4 working days of their details appearing on the ASI work-list. In the first instance, where possible, patients will be contacted by telephone to book their appointment. If this is not feasible a contact letter will be sent to the patient advising them of the receipt of the referral and the Trust will contact the patient to arrange a convenient appointment date and time.

The Clinical Assessment Service

Within the Nottinghamshire Health Community a Clinical Assessment Service (CAS) exists. This is classed as an intermediate/interface service. The purpose of the service is to triage referrals so the patient receives the most

appropriate care of their condition. Depending on the nature of the condition the CAS may or may not physically see or assess the patient and may choose to onward refer the patient into a secondary care consultant led service.

In RTT terms the referral into the CAS generates the RTT clock start either by the conversion of the UBRN if booked through NHS e-Referrals Service or on the receipt of the paper referral. The onward referral onto secondary care will be included in the total RTT waiting time and should be supported by an Inter Provider Transfer (IPT).

Direct Access Diagnostics Referrals

The Trust operates a Direct Access Diagnostic Service where the GP can refer the patient for a diagnostic procedure only, with the intention that the responsibility for the patient remains with the GP and there is no intention for the patient to go on to see a consultant or enter a consultant led service at that stage. Trust examples of this type of service include direct access arrhythmia and direct access gastroscopy. This does not start an RTT clock however if the GP chooses to refer the patient on into secondary care to a consultant led service on the basis of the test results the receipt of the **new referral would start an RTT pathway.**

Urgent GP Orthopaedic Referrals

Some patients will present at their GP and will require a referral into a consultant led orthopaedic clinic. This referral will be urgent but not classed as an emergency attendance and therefore will generate an RTT start on the date of the GP telephone referral. A referral letter must also accompany the telephone referral prior to the patient being seen.

Emergency Outpatient Appointments Referrals

The Trust accepts emergency referrals from care professionals for patients needing to be seen same day in an outpatient environment setting. These referrals will be made by telephone and be supported by a paper referral accompanying the patient when they attend. Trust examples of this type of service include **emergency ENT, maxillofacial, ophthalmology and ambulatory clinics.** These patients are classed as **genuine emergencies** and are therefore not applicable to an RTT Pathway.

Consultant to Consultant Referrals

This type of internal referral should only occur where it is for the same condition as the original referral from the GP. Exceptions to this include

- Diagnosis of cancer is confirmed or suspected,
- urgent problems for which delay would be detrimental to the patient's health, this must be clearly documented
- haematology disorders,
- community and acute paediatrics,
- vulnerable and frail adults and falls patients.

Any patient referred consultant to consultant will be managed in line with their RTT waiting time.

All other unrelated conditions must be returned to the GP for the patient to be offered choice of provider. Referrals that are acceptable must be made via the Trust's Web based Interconsultant (ICR) Referral System. Where the referral is for the same condition as the original referral the pathway must be linked, where the referral is for a new condition this would result in the generation of a separate RTT pathway and a clock start. These referrals must be prioritised alongside external referrals. ***Appendix 2***

Interprovider Transfers (IPT's)

Patients may be referred into the Trust from another provider including CAS services, this is classed as an IPT and the referring Trust is mandated to accompany the referral letter with a minimum dataset containing the relevant 18 week information if applicable. Any patient transferred from another provider will be managed in line with their RTT waiting time. If the referral into the Trust is for a new condition this would result in the generation of a new RTT pathway and clock start at the receiving Trust. If the referral into the Trust is for a condition that the patient is already being seen for at the referring provider then the referring Hospital must provide the RTT clock position.

The minimum dataset must include patient:

- Name
- Date of Birth
- NHS No
- Address
- Patient Pathway Identifier (PPI)
- Current 18 week position
- Current RTT start date
- Date decision to refer

Incomplete RTT data is not an acceptable or a reason for delaying the acceptance of an appropriate referral however this information must be obtained from the referring provider and the Trust MEDWAY system updated within 24 hours of receipt of the referral.

Self Referrals

The Trust will only accept a patient self-referral into clinical pathways that have been agreed between the Trust and Clinical Commissioning Group.

Fertility Pathways

There are specific arrangements for the application of RTT principles and rules to fertility patients and their families which can be found within the DH website.

http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting-RTT-guidance-FAQs-v6-PDF-164K.pdf

It is the Trust's responsibility to ensure:

- Accurate, clear and up to date information about Outpatient, Advice and Guidance and Direct Access services provided by the Trust will be included on the NHS e-Referrals Service Directory of Services (DOS) and Trust Website to ensure patients are referred into the most appropriate service reducing the need to redirect referrals.
- Named clinician services are available on NHS e-Referrals Service for Commissioners to refer into.
- It is the Division's responsibility to monitor slot availability and forward plan for any identified capacity constraints.
- All clinically appropriate referrals made to them are accepted. Patients choosing the Trust must be treated by that provider if this is clinically appropriate and in accordance with the patient's wishes.

It is the Care Professional's Responsibility to:

- Refer and book the patient into the most appropriate clinical service by utilising the information contained within the DOS.
- Ensure that all elective referral letters, whether paper based or sent via the NHS e-Referrals Service System are clear and concise, stating the clinical priority and reason for the referral request.
- To ensure no elective referral letters are hand written.
- To ensure a minimum set of patient information is contained within the referral
    I. The GP Practice
    II. NHS Number
    III. Ethnicity
    IV. Full patient Demographics including evening or daytime and/or mobile telephone number
    V. Current drug regime and significant past medical history
- Generate and attach (C&B) or send (Paper) urgent referral letter within one working day and a routine referral letter within three working days of the date decision to refer.
- Ensure a Unique Booking Reference Number (UBRN) is generated for all NHS e-Referrals Service referrals and where possible an appointment booked before the patient leaves the GP surgery. At the point the UBRN is converted into an appointment date and time this will electronically generate an RTT clock start.

Any paper referrals should be kept to an absolute minimum. If it is necessary to send a paper referral i.e. the care professional does not have access to NHS e-Referrals Service then these must be addressed to either:

- KINGS MILL HOSPITAL – Clinic Admin Department, Office Suite 2.5, King's Mill Hospital, Mansfield Road, Sutton in Ashfield, Nottinghamshire, NG17 4JL

- NEWARK HOSPITAL – Appointments Office, Newark Hospital, Boundary Road, Newark, Nottinghamshire, NG24 4DE

Referral Triage (Grading Process)

For NHS e-Referrals Service the GP initially grades the referral as either Two Week Wait (**please refer to the Cancer Access Policy Section 11**) Cancer Access Policy, Urgent or Routine. The appointment slot is selected by the GP and patient's choice. The consultants should then review their referrals on the NHS e-Referrals Service system to ensure the patient is booked into the correct service and allocated the correct urgency. Consultants or a designated member of the team must review their referrals daily.

If patients are booked into the incorrect service the referral must be re-directed within the NHS e-Referrals Service system to be processed by the e-Referral Booking Team. ***Action Card 1***

Any non NHS e-Referrals Service referrals made to specialities where the clinical agreement is that the referral must be graded by a clinician prior to the new appointment being made will be sent for grading to the required department within 24 working hours of the date request received. ***Action Card 2***

The triage process is to ensure the patient is allocated to the correct clinic within the correct time frame and that any pre-existing referral criteria agreed with the commissioning CCG's are met.

Clinicians should review referrals **within 72 working hours of receipt** to ensure the patient is booked to the appropriate speciality and with the correct urgency.

Any inappropriate referrals will be returned to the referrer by the rejected referral option within NHS e-Referrals Service or paper referrals manually returned with an explanation as to why they were inappropriate. It is the referring Care professional's responsibility to notify the patient of any rejected referrals to ensure the patient does not attend a previously booked appointment. In order for the Trust to understand the volume of rejected referrals a standard monthly operational report will be shared within Service Leads, Operational and DQ Teams.

The Trusts and clinical Commissioning Groups will continue to work together to ensure all referrals are appropriate for the services that the Trust provides

The duty of care rests with the referrer until such time as the referral is accepted by the Trust or by an authorised Clinician within the CAS.

Section 6: Outpatient Booking Processes (Non Admitted Pathways)

This outpatient section applies to all pathways awaiting an outpatient consultation both new and follow-up with the Trust.

Non-admitted patient tracking lists (PTL's) will be managed by the Access, Booking and Choice Team on a day to day basis. Delivery of the Access Standards is the responsibility of the Divisions through the engagement with clinical teams. Capacity management to achieve all waiting time standards is the responsibility of the Division with the support of the Access, Booking and Choice Team.

The utilisation of outpatient clinics must be monitored daily and any empty slots which become available an attempt will made to fill these slots with the 2 Week Waits, urgent or the next longest waiting patients not the next routine.

Every patient must be sent or given a letter confirming that he or she has an outpatient appointment, including instructions on where to attend, bring any medication, any special instructions relating to the appointment and details of how to contact the Trust regarding the outpatient attendance. The 'outpatient' letter should be an agreed template generated from MEDWAY and sent out in the name of the Access, Booking & Choice Manager.

Patient information should be made available or can be made available in a variety of languages and formats such as large print, Braille and audio as required.

New Outpatient Appointments

The Trust is committed to ensuring that any patient referred to the organisation will be seen **within a maximum of 13 weeks of** initial referral irrespective of referral source with consideration given to the overall RTT clock for those patients that are Interconsultant referrals or Interprovider referrals.

If the patient is unable to agree a first appointment at the Trust within 13 weeks of receipt of referral the patient will be discharged back to the GP or other care Professional until such time that they are able to accept an offer of an appointment. This decision must be clearly communicated to the patient and not contrary to their clinical urgency. Patient exceptions apply to this rule cover paediatric patients, those with suspected cancer, vulnerable adults and patients with notifiable diseases.

In this instance the referral back to the GP would stop the RTT clock and any subsequent re-referral would start a new clock. It must be emphasised to patients by their GP's/Care Professionals the importance of being ready willing and able to be seen and treated at the Trust. Responsibility for ensuring that there is sufficient Outpatient capacity to meet these waiting times lies with the Divisions.

Offer of Appointment (New and Follow-up Appointments)

The Trust will offer all patients reasonable offers of appointment. **For New Appointments**, the majority of patients will have chosen their own appointment on NHS e-Referrals Service at a date and time most convenient to their needs.

For outpatient appointments (excluding diagnostic) both New and Follow-up, the Trust deems a reasonable offer for an Outpatient appointment is an offer of at least 2 appointment dates and times with 3 or more weeks from the date that the offer is made. For a diagnostic outpatient appointment a reasonable offer of appointment is at least

three weeks of the date the appointment is being offered as per the national diagnostic guidance. Further details are covered within the diagnostic section of this policy. ***Action Card 5***

The following criteria will determine if the appointment booking was made with reasonable notice or not, utilising the 'Booking Type' data field on MEDWAY.

- **Full Booking** - to be classed as a 'fully booked' appointment a face to face or telephone communication with the patient or the patient's proxy to mutually agree the Outpatient or Outpatient Diagnostic appointment must have taken place. This booking type would be classed as reasonable for any time frame of offer of appointment.

- **Partial Booking** – to be classed as a 'partially booked' appointment the Trust invites the patient to telephone the Trust to book the Outpatient or Outpatient Diagnostic appointment at a mutually agreed appointment date and time. This booking type would be classed as reasonable if the offer of appointment is 2 or more weeks from the date that the offer is made or the patient agrees to an appointment less than 3 weeks notice verbally.

- **No Patient Choice -** to be classed as a 'no patient choice' appointment there will not have been a verbal offer of an appointment or invitation by letter to the patient to contact the Trust to mutually agree an appointment date and time. This appointment booking type will only ever be classed as reasonable if the Outpatient or Outpatient Diagnostic appointment is booked with 3 or more weeks notice from the date that the offer is made.

Inevitably some patients will be unable to accept reasonable appointment offers for a variety of reasons including work commitments or holidays. Refused offers of appointments must be entered onto the MEDWAY System at this point the RTT pathway continues.

Follow-up Appointments following a clinic attendance – All patients on an active RTT pathway MUST be given a fixed appointment irrespective of review period requested. This will be booked by the Outpatient Receptionist at the desk prior to leaving the Outpatient Department. The appointment must be booked before the RTT pathway breach date unless it is clinically appropriate to book beyond the breach date. Any other circumstance or in the instance that there is no clinical capacity at the time frame requested the Receptionist must follow the Trust's Escalation Policy to resolve the issue. Where it is not clinically appropriate to bring the patient back to Outpatient clinic within the breach date BUT the clinical plan is that the patient will receive their 1st definitive treatment and will have a clock stop either by treatment from another clinical specialty or at another Provider prior to the next appointment then it would be acceptable to book a fixed appointment beyond the breach date. A comment to confirm this must be added to the MEDWAY system on the booking of the future appointment. The appointment will be booked on the Trust MEDWAY system and the patient will be given a record of the date either by appointment card or posted letter to follow.

All patients where it is clinically appropriate requiring an appointment within 6 weeks on an inactive RTT pathway should be given a fixed appointment booked by the Outpatient Receptionist at the desk prior to leaving the Outpatient Department. This will be booked on the Trust MEDWAY system and the patient will be given a record of the date either by appointment card or posted letter to follow. In the instance that there is no clinical capacity at the time frame requested the Receptionist must follow the Trust's Escalation Policy to resolve the issue.

Patient appointments requested greater than 6 weeks in advance for those specialities that operate a partial booking review list will be added to the Trusts Review List appropriate to that specialty. No patient should be added to the review list on an active RTT pathway. The Appointments office Team will manage these future partially booked follow-up appointments. The Trust currently uses a variety of methods to contact the patient to book these appointments. The Trust will be moving towards a position of contacting all patients by letter of invitation, to mutually agree an appointment date and time however, currently some patients will be given a fixed 'no patient choice' appointment in the first instance which the patient will be able to change as specified in the section below. ***Action Card 6***

Follow-up Appointments following a Ward Discharge - All patients following a Ward Discharge MUST be given a fixed appointment irrespective of review period requested.

Every effort must be made to book this appointment by the Ward Receptionist by contacting the relevant Patient Pathway Coordinator prior to the patient leaving the ward on discharge. Where this is not feasible then the Ward Receptionist will contact the Patient Pathway Coordinator at the earliest possible time to book the appointment. The follow-up appointment must be booked within the RTT Breach date where this is applicable. In the instance that there is no clinical capacity at the time frame requested the Receptionist must follow the Trust's Escalation Policy to resolve the issue. The appointment will be booked on the Trust MEDWAY system and the patient will be given a record of the date either by appointment card or posted letter to follow.

Patient Cancellations

A patient cancellation is where a patient contacts the Trust in advance of their appointment including on the day cancellations stating that they are unable to attend the appointment. Patients who attend but are unable to wait for their appointment are included in this category.

There will be occasions where the patient will need to rearrange a previously agreed appointment, as a Trust we will make every effort to book a mutually agreeable date and time in the first instance. If the patient contacts the Trust to change this appointment we will endeavour to accommodate this requirement within the arrangements set out below.

- 1st Requested Appointment Change – Accommodate the change
- 2nd Requested Appointment Change within the last 6 months of care episode – Inform the patient that this is their last opportunity to change but accommodate the change. The Trust will monitor NHS e-Referrals patient cancellations via a Business Intelligence Report and contact the patient to ensure the appointment is still required.
- 3rd Requested Appointment Change within the last 6 months of care episode - Patient will be discharged back to the care of their GP unless there is a hospital change within the last 6 months of care episode.
- 4th Requested Appointment Change (only applicable to patients with 3rd Requested Appointment Change and Hospital Change) within the last 6 months of care episode - Patient will be discharged back to the care of their GP

On the discharge of the patient following 3 attempts to change the appointment a letter will be sent to the GP to inform of the discharge. This decision must be clearly communicated to the patient and not contrary to their clinical

urgency. Patient exceptions apply to this rule covering paediatric patients, those with suspected cancer, vulnerable adults, and patients with notifiable diseases. ***Action Card 7***

Hospital Cancellations

No patient should have their appointment cancelled by the Trust. However this may occur in exceptional circumstances but every effort will be made to avoid cancelling patients more than once. As a key principle the Trust will endeavour never to change a patient's appointment more than once in any 6 month episode of care.

Clinic Cancellation – Notice period greater than 6 weeks

In the event of a clinic requiring a reduction or cancellation the requester must have completed the **Over 6 Weeks Cancellation Form** template (Appendix 4) for clinic change requests and authorisation sought from the Division prior to the request being made to the Access, Booking and Choice Team. ***Action Card 13***

The Divisional Business Unit on receipt of the request must speak with the requesting clinician to ensure that appropriate cover has been arranged for the clinic to go ahead without either cancellation or reduction.

If the requesting clinician is unable to comply with this request then the Divisional Business Unit representative must raise this with the Divisional General Manager. The decision will then be taken whether to cancel the clinic or make other arrangements.

The Business Unit Manager, in the decision that a clinic is to be cancelled MUST email confirmation of this change to the appropriate Access, Booking and Choice Team.

Should the clinic need to be rearranged then the clinical risk and the potential effect on waiting time standartds must be taken into consideration and the appointments rearranged appropriately.

Clinic Cancellation – Notice period less than 6 weeks

A short notice cancellation is defined as any cancellation or reduction of any clinic session with less than 6 weeks notice. Cancellations of clinics with less than 6 weeks notice will be made only in exceptional circumstances.

Short term clinic cancellations would be for example in the event of unforeseen sickness or clinician unavailability due to personal circumstances.

The requestor MUST complete the **Under 6 Weeks Cancellation Request Form** template (Appendix 5) and the Divisional Business Unit Representative on receipt of this information will exhaust all options to ensure the clinic session can still go ahead by arranging appropriate cover without either cancellation or reduction taking place. ***Action Card 13***

In circumstances where this is not feasible the Divisional Manager will authorise the cancellation, then email the completed template to the central email account, CentralSupportTeam@sfh-tr.nhs.uk , within the Access, Booking and Choice Team to progress the cancellation of the session and to organise the rearranged appointments.

Should the clinic need to be rearranged then the clinical risk and the potential effect on waiting time standards must be taken into consideration and the appointments rearranged appropriately.

Additional/Adhoc Clinics

A minimum period of not less than 2 weeks' notice must be provided. In exceptional circumstance i.e. 2 week wait patients, 72 hours' notice will be accepted from the date all staffing and other resources are confirmed. The template **Additional / Ad hoc Outpatient Clinic Approval Form** (Appendix 6) must be completed and emailed to the central email account , CentralSupportTeam@sfh-tr.nhs.uk , within the Access, Booking and Choice Team to progress

Failure to Attend an Outpatient Appointment (DNA'S) (RTT)

As a Trust we will make every effort to book a mutually agreeable date and time for all Outpatient Appointments and that the booking has been clearly communicated to the patient. The onus is therefore on the patient to attend their appointment.

Patients should be recorded on MEDWAY as Did not Attend (DNA) when they give no advance warning of not attending. Failure to attend and record the DNA reflects the inability to offer the appointment slot to another patient. If the patient arrives more than 20 minutes after their appointment time it is at the clinician's discretion whether or not they will see the patient. The patient will need to be informed that they may have to wait until the end of the clinic session to be seen. If the patient chooses not to wait they will be classed as a DNA.

The following rules apply to the management of DNAs for both New and Follow-up appointments, patient exceptions apply to this rule covering paediatric patients, those with suspected cancer, vulnerable adults, and patients with notifiable diseases. All patient exceptions must be given a further appointment.

- DNA First Appointment following care professional referral then the RTT clock will be stopped and the patient will be discharged back to the care of the referring care professional, subject to the discretion of the clinician for cases of complexity and acute clinical need. If discharged the patient can be re-referred at the care professional's discretion in which instance a new RTT pathway will start on the date of the new date request received. If a further appointment is given the clock will start from the booking date of the new appointment.
- 1st DNA of a Follow-up Appointment within 6 months of an episode of care the clinician will review the requirement for a further offer of appointment. If the appointment is rebooked the RTT pathway will continue where applicable. If the patient is discharged back to the care professional the RTT clock will stop where applicable. If the patient is re-referred by the care professional then a new RTT pathway will start.
- 2nd DNA of a Follow-up Appointment within 6 months of an episode of care the patient will be returned to the care of the referring care professional and the RTT clock will be stopped. If the patient is re-referred by the care professional then a new RTT pathway will start.

For any patients discharged back to the care professional a letter of communication will be sent to both the patient and care professional informing them that they have been discharged from the Trust and that the patient can be re-referred at the care professionals' discretion at any point. ***Action Card 8***

Failure to Attend a Paediatric Outpatient Appointment (DNA's)

Specific rules apply to the management of paediatrics DNA's and these can be viewed in depth in the **Policy for the Management of Children who Fail to Attend Appointments** via the link below**.** As a general rule it is at the Clinicians discretion whether to request further appointments following a DNA. The Consultant must make the referring Care

Professional aware of the failure to attend. The parent must be contacted to understand the reason for the DNA and required proforma must be completed (see appendix 3) and a further appointment is made. Should there be concerns that the parents be disengaged then refer to the clinician for next action.

If the appointment is rebooked the RTT pathway will continue where applicable. If the patient is discharged back to the care professional the RTT clock will stop where applicable. If the patient is re-referred by the care professional then a new RTT pathway will start.

http://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=14972

Failure to Attend suspected cancer, vulnerable adults, and patients with notifiable diseases

Again as a general rule it is at the Clinicians discretion whether to request further appointments following a DNA for the above set of patients. In most instances patients will be sent a further appointment after the 1st DNA and in special circumstances the Consultant may choose to offer a 3rd appointment for clinical reasons, however the Trust must make every reasonable effort to ensure that the patient attends for their appointment.

If the appointment is rebooked the RTT pathway will continue where applicable. If the patient is discharged back to the care professional the RTT clock will stop where applicable. If the patient is re-referred by the care professional then a new RTT pathway will start.

Outpatient Clinic Processes

Each clinic MUST be fully prepped by the very latest the day prior to the clinic taking place for all but emergency patients, this will include ensuring that the:

- The patient medical notes are available for each consultation
- The patient medical notes are prepared adequately to record the consultation following the prepping SOP
- Any referral letters are available for all new appointments
- Any tests and investigation reports are completed and available for the clinician to view wherever applicable
- Every patient has a relevant reconciliation slip with the current RTT status and Breach Date recorded where applicable to enable the RTT pathway to be managed appropriately

Data Quality

It is essential that accurate patient demographic data is held on MEDWAY at all times, therefore it is paramount that at every opportunity this information is confirmed with the patient to confirm the patient demographic details. This will include

- Patient Name
- Date of Birth
- Patient Address and postcode
- GP details
- Telephone contact details
- Next of Kin

- Religion
- Ethnicity

If any patient details have changed since the patients last attendance this information must be amended on MEDWAY and new medical notes front sheet and labels produced.

Recording Clinical Outcomes

To be able to record a clinical outcome, a reconciliation slip must be completed by the clinician for every patient whether the appointment is a New or Follow-Up this is a mandated process. It is the responsibility of the clinician to complete all relevant information including any outpatient procedures or diagnostics tests and to ensure the reconciliation slip is returned to the clinic receptionist on the Outpatient reception desk prior to the clinical session ending.

Every outpatient attendance must have a defined clinical outcome and RTT status. Outpatient receptionists must ensure that the end of every clinical session that all patients have a clinical outcome and RTT status recorded accurately on MEDWAY. All clinics MUST be outcomed fully within 24 working hours of the clinic taking place. These forms must be completed accurately and on time, if not completed this will delay treatment. A daily un-reconciled clinic report will be circulated to the Operational Managers, Outpatient Clinic Supervisors and Team Leaders for action and escalates where there are delays. This is a mandated process and will be monitored through internal audit processes. It is the responsibility of the Divisional Manager to ensure patient appointments have an outcome.

Clinical Outcome – Consultant Upgrade

Where the consultant decides to upgrade the patient's priority to a 62 Day Cancer Pathway following Outpatient consultant, the consultant will telephone the Cancer Upgrade Line to upgrade the patient and complete the Upgrade Template. For patients upgraded to treatment within 62 days, these patients will have a 62 day starts on the date of the upgrade. Please see the **Cancer Access Policy Section 11** for further details. Cancer Access Policy

Clinical outcome – Awaiting reports

Patients can be classed as awaiting reports where the clinician does not routinely want to see the patient again in the Outpatient Department as a Follow-up but has requested tests or investigations to be completed prior to making a decision on the next course of action.

To indentify these patients the Awaiting Report report is run to aid the further management of the patient's pathway. The Patient Pathway Co-ordinator will monitor the patients on the report to ensure all tests and investigations are completed and the results returned to the department to be viewed by the consultant and a decision made as to further plan of action.

It is the Patient Pathway Co-ordinators responsibility to update the MEDWAY clinical outcome of Awaiting Reports to Previously Awaiting Reports to remove the patients from the report.

It is the Patient Pathway Co-ordinators responsibility to manage the patients RTT pathway and update MEDWAY with the relevant administrative contact where necessary these will be referred to as 'decisions made outside of clinic'.

Clinical outcome – Open Appointment

Currently there is a clinical option to offer a patient an open appointment for a period of 6 months following their last outpatient attendance. This outcome should only be used for paediatric patients and vulnerable adults.

Following the 6 month period the patient will be classed as discharged back to the care professional and if they require further consultation then a new referral must be sought which was start a new RTT pathway and clock.

Clinical outcome – Discharge

The patient has been discharged from the Trust back to the care of the referring care professional and no further consultation is required. If further consultation is required a new referral must be sought from the care professional which will start a new RTT pathway and clock.

Clinical Outcome – Added to Elective Waiting List

Patients can either be added to a diagnostic, therapeutic or planned waiting list as a Day-case or Inpatient Admission. The patient may require a bilateral procedure for example left and right cataract removal. The patient would be added to the waiting list for the first procedure and would only be listed for the second procedure once the initial treatment was completed. Please refer to the Elective Admissions section for further guidance.

Clinical Outcome – Refer Other Consultant this Provider (Inter Consultant Referrals)

During consultation there is a requirement to refer the patient from one clinical specialty to another clinical specialty, for example Trauma and Orthopaedics to Rheumatology. Interconsultant referrals are managed across the four sites within the Trust namely King's Mill Hospital, Newark Hospital, Ashfield Community Hospital and Mansfield Community Hospital. The Trust has a strict Interconsultant protocol agreed with commissioners that patients can only be referred in this manner if the referral is for the same presenting condition or the referral meets the criteria set out in the protocol for new/consequential condition. The exceptions can be found within the **In Provider Consultant – Consultant Referral Protocol in Appendix 2.** The RTT pathway will be managed in-line with the current pathway status for all same condition referrals; consultant to consultant referrals for a new condition will start a new RTT pathway on a new PPI.

Any Interconsultant referrals must be made via the Trust's Web based Interconsultant (ICR) Referral System.

Clinical Outcome – Refer Other Consultant Other Provider

During consultation there is a requirement to refer the patient to a service at another provider e.g. Nottingham University Hospitals. The reason for referral could either be for diagnostic investigation or treatment that will be performed at the other provider; this must be clearly documented within the patient case-notes and included within the clinical letter digital dictation marked as urgent. To ensure monitoring of the RTT pathway continues **it is mandatory that an Inter Provider Transfer Minimum Data Set form is completed** when transferring patients between organisations and that these referrals are sent securely through NHS mail.

All Inter-Provider Transfers must be **completed within 48 working hours** of the decision to refer being made and the relevant administrative event entered onto the MEDWAY system which details the organisation the patient is being referred to and if it is for diagnostics or treatment. The MDS contains the Referral to Treatment (RTT) data items that need to pass between providers including the Patient Pathway Identifier, NHS Number, Organisation Code, RTT

Start Date (where applicable) and RTT Clock Status. Receipt of these RTT data items will allow the receiving provider to measure RTT waiting times and develop an RTT patient tracking system to prospectively manage the delivery of the RTT standards. The Trust's Inter Provider Referral form can be found on the Intranet sites using the link below:

http://sfhnet.nnotts.nhs.uk/18weeks/IPTransfers.aspx

Section 7: DIAGNOSTIC BOOKINGS

Many patients require diagnostics to determine the appropriate diagnosis and their subsequent treatment. Diagnostic tests can be for example in the form of a blood test, an endoscopy procedure or x-ray. Diagnostic tests must be performed within a maximum of 6 weeks of request for the test to ensure delivery of the national waiting time standard. In many instances they will also form part of the patients 18 week RTT journey. The importance of timely access to diagnostics and their reporting is a key element to ensuring that patients are not made to wait unnecessarily for treatment within 18 weeks. Diagnostic patients cannot have their RTT clock paused. In the background to RTT the diagnostic phase of treatment has an absolute maximum waiting time.

No patient should wait more than 6 weeks from the date of a decision to request a diagnostic to having the test undertaken. The measurement of 6 weeks is different to that of RTT measurement. The rules for measuring diagnostic waits are not set out within this Elective Access Policy although will be applied by the Information Team as appropriate. **No patients should be booked later than 6 weeks from a decision to request a diagnostic to having the test undertaken.**

The arrangements for diagnostics remain the same for both RTT, non-18 week pathways and for diagnostics performed as an outpatient, daycase or an inpatient.

Diagnostic Booking and Scheduling

Diagnostic waiting lists and PTLs are managed on a day to day basis by individual services such as Endoscopy, Radiology, and Cardio-Respiratory Investigations that perform diagnostic procedures and by the Waiting List team for those patients being admitted as a day case or inpatient for diagnostics. Clinical ownership and delivery of access standards is the responsibility of the Divisions.

Responsibility for ensuring that there is sufficient capacity to achieve the necessary waiting time lies solely with the Divisions. Where a diagnostic procedure is unable to be booked due to capacity the Trusts Escalation Policy should be followed.

Where a patient is awaiting two diagnostic tests/procedures concurrently the patient should have two independent 6-week diagnostic waiting time clocks.

Every patient must be sent or given a letter confirming that he or she has an appointment for a diagnostic test, including instructions for the appointment and details of how to contact the Trust regarding the admission. The 'appointment/to come in' letter should be an agreed template generated from MEDWAY and sent out in the name of the Access, Booking & Choice Manager.

Patient information should be made available or can be made available in a variety of languages and formats such as large print, Braille and audio as required.

GP Direct Access Diagnostics

Patients referred from the GP for direct access diagnostics where the clinical responsibility for the patient's assessment and management remains with the GP are not part of RTT. An RTT clock will not start for these patients although the patient should not wait more than 6 weeks from decision to request a diagnostic test to having the test

undertaken. An example of this a patient referred into the Cardiac Arrhythmia Clinic or Cardiac Echo Clinic, where the GP will review the results of the test before making the next clinical decision.

GP Straight to Test

This group of referrals is where the GP refers the patient to a consultant-led service and refers for a diagnostic test; this would start an RTT Clock. An example of this is the patient being added directly to the waiting list for a diagnostic procedure within the endoscopy unit before attending for an outpatient appointment first.

Booking Diagnostic Referrals

All referrals for diagnostics should include information on the patient's RTT pathway status where appropriate. Bookings for diagnostics should be undertaken on a chronological basis taking into account RTT breach dates.

On receipt of an appropriate referral the teams that undertake diagnostics booking following any necessary clinical review should contact the patient by telephone in the first instance in order to agree and book the date for the diagnostic procedure.

Patients should be offered reasonable notice for diagnostic appointments which is an appointment at least three weeks of the date the appointment is being offered. Patients should be offered a minimum of two dates with these offers being recorded on the appropriate Trust system. Where patients are offered and accept an appointment that is offered with less than three weeks' notice and accepts this appointment this is considered reasonable.

Where the patient is unable to be contacted by telephone the diagnostics and/or admissions booking team will attempt to contact the patient on the number provided throughout the working day a minimum of three times over two days.

In the event that the diagnostics booking team cannot contact the patient by telephone they will send an 'invite to call letter' requesting the patient contact the department. If no response from the patient is received within seven days a reminder letter is sent and a further telephone call made. This approach is known as partial booking. Should no contact be made after the 14 day period the patient will be discharged from the diagnostic waiting list and sent a letter, copied to the clinical referrer advising them that if they wish to be seen they will need to be re-referred for diagnostics. On discharge from the Trust's care the RTT clock will stop.

All appointments agreed and confirmed with patient on the telephone should be confirmed in writing giving clear details of the date, time and location of the diagnostic appointment along with appropriate information relating to the procedures and any necessary preparations the patient should take. The appointment letter should also set out to the patients the implication for non-attending the appointment and undertaking multiple rearrangements of the appointment.

Patients who require diagnostics to be performed at specific times, such as HSGs at specific days of a menstrual cycle the patient should be given clear instructions for the procedure at both the outpatient clinic and at the point of diagnostic appointment booking.

Failure to Attend Diagnostics (Applies to All Diagnostic Tests)

Patients who do not attend their appointments for diagnostics should be discharged from diagnostics. The diagnostics booking team will update the diagnostic system such as CRIS and send a letter to the referring clinician

within 24 hours. The referring clinician supported by the PPC should review the patient's records and determine if a further request for diagnostic should be made or if the patient should be discharged to the patients GP. The patient should be discharged to the care of the GP unless there are exceptional circumstances for the clinician to request a second appointment. On discharge of the patient to the GP the RTT clock will stop or should a second appointment be requested the RTT clock will continue to tick.

The principle of this procedure is that all patients will be discharged from the Trust and diagnostics waiting list following a DNA (did not attend). The exceptions to this are paediatric patients, those with suspected cancer, vulnerable adults and those with notifiable disease or those deemed to be at high clinical risk by the clinician. Further details on each of these groups are within Appendix A. Patients within these categories will be contacted to arrange another appointment to take place within two weeks of the DNA.

Patient Cancellations

Patients should be given a choice of appointments with reasonable notice. A patient cancellation is where a patient contacts the Trust in advance of their appointment including on the day cancellations stating that they are unable to attend the appointment. Patients who attend but are unable to wait for their appointment are included in this category.

There will be occasions where the patient will need to rearrange a previously agreed appointment, as a Trust we will make every effort to book a mutually agreeable date and time in the first instance. If the patient contacts the Trust to change this appointment we will endeavour to accommodate this requirement, however it should be stressed to the patient that they will only to change the diagnostic appointment once. Should the patient wish to cancel the appointment again the patient should be advised they will be discharged to the clinical referrer.

Patients Unfit for Admitted Diagnostic Procedures

Patients listed for diagnostics procedures should undergo a pre-operative assessment or appropriate level of initial assessment to determine suitability to proceed with the diagnostic procedure. Where a patient is not fit to have the procedure performed the patient should not be added to the diagnostic waiting list and should be referred back to the clinician referring for the diagnostic with advice.

Where following pre-operative and anaesthetic assessment a clinical opinion of suitability for a procedure is required from another clinical speciality such as cardiology the patient continues to wait until a clinical decision is made the patient is not fit to proceed with the diagnostic pending further optimisation of a clinical condition the patient should be removed from the diagnostic waiting list and discharged to the clinicians requesting the diagnostic

The clinician should then determine if it would be appropriate to…

- discharge the patient to the referring GP. The RTT clock would be stopped on discharge.
- decide if an alternative management plan could be made. The RTT treatment status would reflect the management plan.
- await the management of the secondary condition. The RTT clock would be stopped for active monitoring.

Action Card 3

Diagnostic Become Therapeutic

Some procedures are intended as diagnostic up until a point during the procedure, when the healthcare professional makes a decision to undertake a therapeutic treatment at the same time. These procedures should still be reported in Department of Health diagnostic and RTT returns. The treatment will stop the RTT pathway.

Some procedures will include both a diagnostic test and a therapeutic treatment. If the procedure is part-diagnostic or intended to be part-diagnostic, these should be counted as diagnostic procedures.

'Planned' or Sequenced Diagnostics

A planned or 'sequenced' diagnostic test/procedure is a procedure or a series of procedures carried out as part of a treatment plan which is required for clinical reasons to be carries out at pre-defined specific times or repeated at a specific frequency. The clinical reasons for a specified time frame must be explicit and recorded on the diagnostic request.

Examples may include:

- Surveillance Ultra sounds – such as annual ovarian screening;
- Surveillance Dexa; and
- Diagnostics to be carried out within a fixed period of time based on clinical timing such as monitoring scans, repeat endoscopies or echocardiograms.

Planned patients should be booked in for the diagnostic test/procedure at the clinically appropriate time and they should not have to wait a further period after this time has elapsed. For example, a patient due to have a re-test in six months' time should be booked in around six months later and they should not get to six months, then have to wait again for non-clinical reasons.

When patients on planned lists are clinically ready for their test to commence and reach the date for their planned appointment, they should either receive that appointment or **be transferred to an active waiting list and a waiting time clock should start (and be reported in the relevant waiting time return) if waiting beyond the planned interval date.** The key principle is that where patients' tests can be carried out immediately, then they should receive the test or be added to an active waiting list.

Data Recording

Where diagnostic procedures become treatment they must be recorded on the Clinic Outpatient Form by the attending healthcare professionals and entered into MEDWAY as a clock stop on the RTT pathway.

In order to be able to record where the patient is on the RTTs pathway, clinicians are asked to complete the Clinic Outcome Form for patients attending for a diagnostics in agreed modalities. It is the responsibility of the clinician to complete the relevant information and hand it to the relevant receptionist.

Every diagnostic attendance must have a defined RTT status. The RTT status is defined as "the status of an activity (or anticipated activity) for the 18 week referral to treatment period, decided by the lead care professional".

Section 8: ELECTIVE ADMISSIONS

The RTT standard measures a patient journey from referral to treatment with all stages of the journey measured as one complete pathway. In the background to RTT each stage of treatment has an absolute maximum waiting time.

Patients awaiting a diagnostic procedure as an inpatient or a daycase must not wait more than 6 weeks from the date of a decision to request a diagnostic to having the test undertaken. The measurement of 6-weeks is different to that of RTT measurement. **No patients should be booked later than 6-weeks from a decision to request a diagnostic to having the test undertaken either as a daycase or an inpatient.**

The process of selecting patients for admission is a complex activity that is managed within the Access, Booking and Choice Team who process elective admission requests and manage waiting lists, ensuring that patients are offered a reasonable choice of admission date. Specialities within the Divisions that undertake their own scheduling outside of the centralised team are required to follow the centralised processes as detailed in this policy and supporting local procedures until such a time as they may integrate into the central service.

Waiting lists and PTLs are managed by the Access, Booking and Choice Team on a day to day basis. Clinical ownership and delivery of access standards is the responsibility of the Divisions. Responsibility for ensuring that there is sufficient capacity to achieve the necessary waiting time lies solely with the Division's Management Team.

Structure of Waiting Lists

The admitted patient tracking list (PTL) contains patients who are waiting for both definitive treatment and diagnostics including patients who are being investigated or treated for confirmed cancer.

All patients for elective admission must be entered onto the inpatient waiting list on MEDWAY which forms the Trust's admitted PTL. Waiting lists held off MEDWAY are strictly forbidden by the Trust. Where lists are held off MEDWAY these should be identified to the Chief Operating Officer. Arrangements will be made to safely transfer these lists to MEDWAY within agreed timescales.

The use of paper diaries for planning care is a particular risk to the organisation in terms of delivery of waiting time standards and maintaining a complete picture of patients awaiting surgical care at the Trust. Their use is contrary to best practice and should only be authorised by the Chief Operating Officer in discussion with the Divisional Managers and be entered on the Trust's Risk Register.

Low Priority Treatments

Referrals for Low Priority Treatments – Requests for admission for some conditions which are classed as low priority treatments are not generally funded by commissioners. These patients must not be added to the inpatient waiting list unless explicit approval has been received on a named patient basis from the commissioning CCG. Once approval has been obtained, the request for admission can be processed in the normal way. The RTT clock continues to tick whilst approval for treatment is sought.


CCG 1516 PLCV.pdf

Patient Information

Every patient must be sent or given a letter confirming that he or she has been added to the waiting list and confirmation by letter of agreed admission dates, including instructions for admission and details of how to contact the Trust regarding the admission. The 'admission/to come in' letter should be an agreed template generated from MEDWAY and sent out.

Patient information should be made available or can be made available in a variety of languages and formats such as large print, Braille and audio as required.

Selecting Patients for Admission

Inpatient and daycase admissions would usually form part of the patient's RTT pathway. The Waiting List Officers must note the RTT pathway status of each patient. Patients will be selected and booked in chronological order according to their RTT breach date unless clinical urgency dictates otherwise using the PTL. The use of paper diaries in clinics presents a particular risk in the management of patient care. No scheduling should be undertaken using this approach.

The Trust operates a partial booking approach to management of the patients awaiting definitive or diagnostic treatment. These patients should be added to the respective waiting list and advised they will be contacted before their procedure by the Waiting List Team. Relevant information and contact details should be provided to patients at the point of being added to a waiting list. Certain patient groups can be fully booked where there is agreed processes and the patient is clinically urgent or those with suspected cancer. The full details of partial booking for admission are set out within the relevant Waiting List Standard Operating Procedures.

If a patient's RTT status does not allow reasonable offers for admission to be made, and the patient does not wish to accept a date at shorter notice, this must be escalated to the Team Leader or Access, Booking and Choice Manager. A root cause analysis (RCA) must be undertaken to identify the issues and highlight where changes need to be made for the future and a suitable date within the patient's RTT breach date is agreed.

As a teaching hospital, clinicians will need to identify a way of ensuring teaching requirements are met. It is acknowledged that service pressures may conflict with teaching requirements. This must be addressed within the Divisional Management Teams with the involvement of the Clinical Directors and Divisional Managers.

A patient should only be added to the waiting list if they are ready, willing and able for admission within 12 weeks of the day the decision to admit is made.

Patients who do not want treatment, i.e. have not actively consented to the treatment, and/or are unfit for surgery, and will not be available for surgery within 12 weeks, **must not be** added to the waiting list. Such patients must either be reviewed in outpatients and enter a period of active monitoring, if appropriate, or be returned to their GP's care with advice on re-referral. Examples of patients not to be added to the waiting list include those required to lose weight before being ready for their operation, high blood pressure, pregnancy, or undecided about surgery. Such conditions would be determined through early health screening in the outpatients clinics or at the pre-operative assessment clinic. This discharge or start of active monitoring will stop the RTT clock.

Decision to Admit

All inpatient and daycase waiting lists must be coded with the appropriate intended management, procedure and RTT codes, where MEDWAY allows. A decision to admit will add the patient to the Trust's admitted definitive and diagnostic PTL.

Patients who are not ready, willing and able for admission should not be put onto the waiting list and should be referred back to their GP for re-referral at a later date. This discharge will stop the RTT clock. Re-referral can be into the point where they left the Trust's care, ideally into a pre-operative assessment clinic, when they are available for admission. A new RTT pathway will start on receipt of the referral.

If a patient requires further tests, wants to think about whether they want surgery or a consultation with another clinician is needed first, the patient should not be added to the waiting list until these have been confirmed. A patient's decision to admit should not start their pathway unless they have been re-referred into the Trust directly for treatment, are being listed from active monitoring or they have been treated for their first condition and now have a secondary condition.

Referrals from another NHS Organisation for admission should be placed on the waiting list and a copy of their request should be sent to the Trust's RTT Tracking Team for them to chase the relevant RTT data set, if one has not already been received. The RTT status will be amended to reflect the information received from other organisations.

Private Patients Who Transfer into NHS Care

The RTT standard applies to NHS patients; this includes patients being treated in the independent/private sector (NHS Partners) under NHS commissioned care. However, patients who transfer to NHS care following private (non-NHS) assessment, investigation or treatment are subject to the RTT standard from the date of receipt of their referral to the NHS. Any elements of care provided as a private patient before referral to the NHS do not form part of the RTT pathway.

NHS patients seen in the independent/private sector and referred to the NHS should have the RTT minimum data set as set in out in appendix five included with/within their referral.

'Planned' or 'Sequenced' Procedures

Where patients may require two-part treatment or a bilateral procedure they will be placed on the waiting list for the first procedure, treatment of which stops the clock. The decision to treat for the second procedure is likely to be made during follow up. A new RTT clock commences on the decision to admit for the second procedure.

Patients on the 'planned' waiting list are outside the scope of RTT, as they are not actively awaiting treatment. Planned procedures are part of an agreed programme of care which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Patients must only be included on a planned waiting list if there are clinical reasons why the patient cannot have treatment until a specified time, for example the second stage of a two-part treatment. Planned activity is also sometimes known as "surveillance".

Patients on the planned list will be reviewed administratively by the Waiting List Team on a routine basis to check patient's availability for treatment (fortnightly) and offered subsequently a date of admission in line with good clinical practice for their condition and specialty guidelines. Once the patient is clinically ready for the second (or

subsequent) treatment the patient must be removed from the planned list and added to the active waiting list with a new RTT clock commencing.

Pre-Operative Assessment

Pre-operative assessment is used to determine a patient's fitness for surgery and anaesthesia. If a patient is found to be unfit the steps in **medically unfit patients section** apply. Pre-operative assessments should be carried out as soon as possible after the decision to admit preferably on the day of the decision to admit.

Should the pre-operative assessment not occur within outpatients at the decision to admit the offering of reasonable pre-operative appointments follows the same principles as reasonableness for outpatients appointments i.e. an offer of an at least two appointments with two weeks' notice. Should the patient accept the offer of a pre-operative assessment appointment with less than two weeks notice, this will be deemed reasonable.

If a patient DNAs their pre-operative assessment appointment without prior notice they will be reviewed by the responsible clinician to determine clinical risk and exclusions to the DNA arrangements set out in Action Card 10. Patients would usually be discharged back to their GP and their RTT clock will be stopped. The patient will be deemed to have declined treatment. A letter will be sent to the patient with a copy to their GP informing them of this. ***Action Card 10***

Medically Unfit Patients

Patients who are not clinically fit to have their procedure should not be added to the waiting list.

Patients listed for inpatient and day case diagnostics and procedures should undergo a pre-operative assessment or appropriate level of initial assessment to determine suitability to proceed with the procedure. Where a patient is not fit to have the procedure performed the patient should not be added to the waiting list and should be referred back to the clinician referring with advice.

Where following pre-operative and anaesthetic assessment a clinical opinion of suitability for a procedure is required from another clinical speciality such as cardiology the patient continues to wait until a clinical decision is made. If the patient is not fit to proceed with the procedure pending further optimisation of a clinical condition the patient should be removed from the diagnostic waiting list and discharged to the clinician requesting the procedure.

If the nature of the condition means that the patient will not be ready for treatment within four weeks the clinician should then determine if it would be appropriate to:

- discharge the patient to the referring GP. The RTT clock would be stopped on discharge.
- decide if an alternative management plan could be made. The RTT treatment status would reflect the management plan.
- remove the patients from the waiting list and await the management of the secondary condition. The RTT clock would be stopped for active monitoring.

Re-referral can be into the point where they left the Trust's care, when they are available for admission. A new RTT pathway will start on receipt of the referral. Patients who develop conditions which can be expected to resolve within four weeks will remain on the waiting list and will be managed as part of the RTT tolerance. Their clocks will continue to tick and their waiting time will not be reset or adjusted.

No patients can be medically suspended on the RTT pathway. ***Action Card 12***

Offer of 'To Come in' (TCI) Date

All patients should be offered a date for admission in chronological order in relation to their RTT breach date from the PTL. Patients for inpatient or day case diagnostics must be admitted within 6-week of decision to admit. This is both a local and national standard.

Patients should be offered a choice of at least two different admission dates each with at least three weeks' notice before their RTT breach date. Earlier admission dates can be offered, if the patient accepts this offer this becomes a reasonable offer for admission. The two reasonable offer dates should be recorded on MEDWAY for audit purposes and RTT measurement.

Offers may be by telephone or face to face and should be recorded on MEDWAY for audit purposes. The Trust will attempt to contact patients by telephone at least three times over two consecutive days, at different times. If the patient is unable to be contacted then a letter should be sent requesting the patient to contact the Waiting List Team.

If after seven days the patient has not contacted the Trust a reminder letter is sent out. If after seven days the patient has not been in contact, the patient should be removed from the waiting list and discharged back to the care of the GP indicating the reason for the discharge. A letter will be sent to the patient, Consultant and GP confirming this. This applies equally to cases where more than one clinician is required to undertake the case ('joint cases').

The admission date and pre-operative assessment details will be confirmed in writing along with information for the patient on their responsibilities with regard to non-attendance or cancellation.

Scheduling 'Joint Cases'

The Trust undertakes 'joint case' procedures that may require two or more specialist surgeons from within the Trust or surgeons from another Trust such as urology or colorectal specialists. The responsibility for coordinating admission and surgery dates for these cases falls with the Access, Booking and Choice Team. In light that these are complex patients the Waiting List Team Leader and/or Access, Booking and Choice Manager should undertake liaison on dates working with the relevant division/business manager within the other provider. The relevant Divisional Business Support Unit Manager may be able to provide assistance as the contract lead for these externally contracted services.

Clock Pauses for Patient Choice

In line with new national guidance no clock may be paused or waiting time adjusted when treatment is provided where a decision to admit for treatment has been made. Any patient who chooses to wait longer than 18 Weeks should be accommodated without being penalised. The Trust will continue to capture where the patient has declined appointment offers for admission and choosing to wait.

http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Recording-and-reporting-RTT-guidance-v24-PDF-573K.pdf

The 3 weeks reasonable notice for day case and inpatient appointments rule does not prevent patients from being offered earlier appointments.

If a patient makes themselves unavailable for a set period of time (e.g. due to school holidays or other reasons) then this may mean that offering actual dates which meet the reasonableness criteria would be inappropriate (as the patient would be offered dates that the provider already knew they couldn't make). In this case, the waiting time clock will not be paused but the provider will capture the patient being unavailable for the given period and not penalise the patient.

Patients who for personal reasons are unable to come in within 12 weeks of decision to admit will be discharged from the waiting list and referred back either to the care of either their consultant or GP, as appropriate.

Patient Cancellations of Agreed TCI Dates

Should a patient contact the Trust to cancel their admission and does not wish to have a further admission date, they will be discharged to the care of their GP and the GP informed of the reason for the discharge. Their RTT clock will stop and their GP and/or Consultant will receive a letter stating the reason for the discharge. Should the GP re-refer a new RTT pathway will begin.

Where a patient calls to cancel and rearrange their admission date they can do so only once as long as they have given at least seven days' notice. If seven days notice has not been given the patient will be removed from the waiting list and discharged back to their GP except in exceptional circumstances, e.g. family bereavement, emergency admission to hospital. These arrangements must be made clear to the patient in their admission letter.

A rescheduled date should be offered, where possible at the time of the cancellation that is within the RTT breach date. The offers for a rescheduled date must be reasonable and be recorded on MEDWAY. Should a patient accept a date with less than three weeks notice this becomes a reasonable offer. **If a date cannot be accommodated within the patient's RTT pathway the Divisional Management Team MUST be notified**.

Patients who call requesting to cancel and rearrange their appointment for a second time will be informed that this is not possible and will be discharged to the care of their GP or consultant as appropriate. ***Action Card 9***

Patients Who Fail to Attend (DNA) their Admission

Patients who DNA their admission will be removed from the waiting list and discharged to the care of their GP or Consultant, as appropriate following clinical review. A letter will be sent to the patient, Consultant and GP confirming this. Their RTT clock will stop. ***Action Card 11***

The principle of this procedure is that all patients will be discharged from the Trust and from the waiting list following a DNA (did not attend). The exceptions to this are paediatric patients, those with suspected cancer, vulnerable adults and those with notifiable disease or those deemed to be at high clinical risk by the clinician. Further details on each of these groups of patients are detailed in Appendix 1.

Patients that fall into the exception groups set out below must be contacted to arrange another admission date to take place as soon as possible and prior to their RTT breach date. **If a date cannot be accommodated within the patient's RTT pathway the Divisional Management Teams should be notified**.

Hospital Cancellations of a TCI Date

Patients should only have their agreed admission cancelled under exceptional circumstances. Pre-Operative assessment must ensure that everything that needs to be done before the patient's operation has been done (kit ordered, bloods taken, post-op arrangements discussed, etc.). If an admission is cancelled at short notice, telephone calls and first class mail should be used to ensure the patient is given as much notice as possible.

All cancellations at the last minute for non-clinical reasons should be escalated within the organisation, to ensure every effort is made to avoid cancellation. Escalation for last minute non-clinical cancellations must be escalated to the Divisional Business Support Unit Manager.

The individual taking the decision to cancel the patient's admission is responsible for informing the Waiting List Team. Please follow the hospital cancellation policy and SOP for last minute cancellations for non-clinical reasons.

Any patient who has had an admission cancelled by the Trust should not be cancelled a second time. The Waiting List Team should indicate on MEDWAY and on admission lists whether a patient has been previously cancelled and their waiting status, to identify long waiters. Prior to any repeat cancellations, Divisional Business Support Unit Manager must authorise the cancellation.

Where cancellations are initiated by the Trust, patients should be contacted and offered a choice of at least two different TCI dates with reasonable notice before their RTT breach date and within 28 days of their cancellation.

Analysis of Cancellations

No patient should have their scheduled admissions cancelled. However, this may occur in exceptional circumstances. The RTT clock will continue to tick while the patient's appointment is rescheduled.

A short-notice cancellation is defined as any cancellation or reduction of any theatre session with less than six weeks' notice. In the event of a short-notice cancellation request, the Access, Booking and Choice Manager will escalate initially to the relevant Divisional Business Support Unit Manager.

The Divisional Business Support Unit Manager will speak with the requesting clinician who will be expected to cancel leave, or ensure that appropriate clinical cover is arranged for the theatre session to go ahead without either cancellation or reduction.

If the requesting clinician is unable to comply, the Divisional Business Support Unit Manager will escalate directly to the Clinical Director and Divisional Manager.

The Clinical Director and Divisional Manager will review the position and make a recommendation as to whether the theatre session should be cancelled or not.

The Information Team will monitor and distribute cancelled appointments with less than six weeks' notice report on a monthly basis. This will be reported as part of the Divisional Performance Review.

Validation of Waiting Lists

Appropriate validation exercises will be undertaken to ensure that data held on patients is accurate and up to date and to ensure that they still require the appointment or procedure they are waiting for.

Managers should undertake a validation exercise of the inpatient and day case waiting list on a weekly rolling basis. Divisional Managers are responsible for ensuring that the rolling validation and manual cross checks are carried out for all waiting lists, including planned waiting lists and PTLs.

All patients who have been on a waiting list for six weeks should be sent a letter asking them to confirm if they still require surgery. Patients will be given a maximum of three weeks to respond to a validation before being removed from the waiting list. The first waiting list validation letter should be sent, allowing the patient a week to respond. Should the patient not respond a further letter should be sent requesting the patient contact the Trust to confirm they still wish to be treated. The Trust will allow the patients two weeks after the second letter to respond and should the patient not respond they should be removed from the waiting list. The removal should be recorded on MEDWAY with the date and reason for removal.

There may be instances where the clinician decides it is in the patients best interest to not proceed with elective surgery therefore removing the patient from the waiting list, and will review the patient within an outpatient clinic to advise on further appropriate management in discussion with the patient.

Appendix 1 – Failure to Attend Exceptions

The principle of the Elective Access, Booking & Choice policy is that all patients will be discharged from the Trust and from the waiting list following a single DNA (did not attend).

The exceptions to this broad policy are set out below. It is extremely important that the DNA requirements of this policy are adhered to in order for the Trust to maintain access to services in a fair and consistent way and adequately ensure delivery of national access standards.

The reappointment of patients following DNA's will be subject to clinical audit to ensure we are offering access in line with the requirements of this policy.

- Cancer patients (diagnosed or suspected) – these patients should be referred to the Trust on identified two-week wait cancer pathway, be upgraded to a cancer pathway should the cancer not be identified as part of the referral and later detected in the Trust or are transferred to the Trust from another provider as part of their cancer pathway. Further details are set out within the **Cancer Access Policy Section 11**. Cancer Access Policy

- Paediatric patients as per the Policy for the Management of Children who Fail to Attend Appointments.

- Patients with notifiable diseases (diagnosed or suspected) – the following Diseases are notifiable (to Local Authority Proper Officers) under the Public Health (Infectious Diseases) Regulations 1988. Further details can be found on the Health Protection Agency Website www.hpa.org.uk

Acute encephalitis	Opthalmia neonatorum
Acute poliomyelitis	Paratypoid fever
Anthrax	Plague
Cholera	Rabies
Diptheria	Relapsing fever
Dysentery	Rubella
Food poisoning	Scarlet fever
Leprosy	Smallpox
Leptospirosis	Tetanus
Malaria	Tuberculosis
Measles	Typoid fever
Meningitis – meningococcal, Pneumoccal, haemophilis influenza, viral.	Viral haemorrhagic fever
Meningococcal septicaemia (without Meningitis)	Viral hepatitis – A, B, C, other
Mumps	Whooping cough
	Yellow fever

- Vulnerable patients – it is essential that patients who are vulnerable for whatever reason have their needs as part of the referral process to the Trust or at the point of requesting diagnostics or requesting an admission, with the patients consent. This group of patients includes;
    - Patients with learning disabilities or mental health problems
    - Patients with significant physical or mobility difficulties
    - Patients who require an interpreter
    - Patients who pose an increased anaesthetic risk (uncontrolled epilepsy, congenital heart disease); and
    - Elderly patients who require community care.

- Patients deemed to be at high clinical risk by the clinician – as with all DNA reappointments a clinical decision may be made that in the best interests, the patient should be offered a further appointment.

Appendix 2 Inter Provider Consultant – Consultant Referral Protocol

Guidance for the Management of the Inter Consultant Referral System

Following patient review by a Consultant in the Outpatient setting or on the review of tests and investigations following awaiting reports, **it may be necessary to refer the patient on to another Consultant under a different main specialty code.**

Consultant to Consultant referrals **MUST meet set criteria** as agreed during contracting negotiations and are described in the following guidance.

The rationale for limiting the number of onward internal referrals is to primarily ensure that all patients are offered choice for each different episode of care and to ensure that they are provided care as close to home wherever possible.

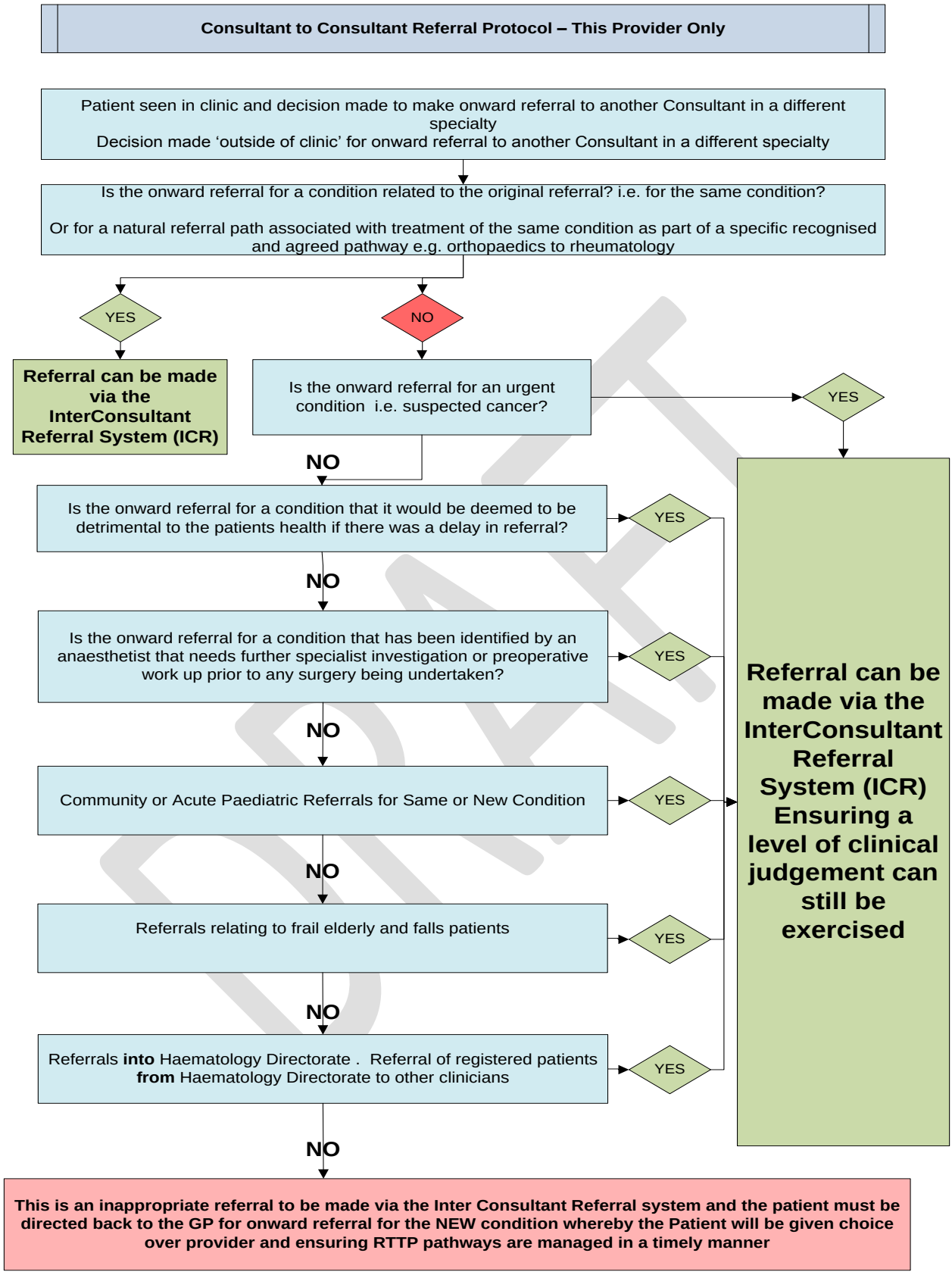
It may be possible to provide care in the Primary Care setting which is beneficial to many patients and to free up access to secondary care for patients genuinely requiring the Trusts services in a timely manner. Genuine onward referrals must be made with minimal delays in the patients RTTP pathway.

Permissible inter specialty Consultant to Consultant Referrals

- Consultants **MAY** refer patients onto another specialty for a condition unrelated to the original referral **if the referral is deemed to be of an urgent nature, for which to delay the referral would be detrimental to the patients health** (for example patients needing to be seen urgently i.e. suspected cancers **(New condition referral)**
- Patients in which an anaesthetic opinion has been sought and further investigation by a specialist is required prior to elective surgery taking place. **(New condition referral)**
- Patients who remain under the original specialty referred to but require simultaneous input from another specialism directly associated with their current condition. **(Same condition referral)**
- Referrals associated with treatment of the same condition whereby the patient is passed to the other specialism who takes over the patients care for the same condition on referral. **(Same condition referral)**
- **Community or Acute Paediatric referrals to any specialism for new or same condition**
- Referrals into **Haematology Directorate for diagnosis and management issues related to inherited and acquired bleeding disorders.**
- **Referral of registered patients from Haematology Directorate to other clinicians** for medical, surgical and obstetric issues.
- **Referrals relating to frail elderly and falls patients**

All consultant to consultant referrals should be made on the agreed Trust wide web based Inter Consultant Referral System so a record of the referral can be kept and monitored to prevent any delays in the patients 18 week pathway. **All new condition onward referrals should be copied to the patients GP for their information.**

The diagram attached explains the process further and **allows that level of clinical judgement can still be exercised.**


Consultant to Consultant Referral Protocol – This Provider Only
Patient seen in clinic and decision made to make onward referral to another Consultant in a different specialty
Decision made 'outside of clinic' for onward referral to another Consultant in a different specialty
Is the onward referral for a condition related to the original referral? i.e. for the same condition?
Or for a natural referral path associated with treatment of the same condition as part of a specific recognised and agreed pathway e.g. orthopaedics to rheumatology
YES
NO
Referral can be made via the InterConsultant Referral System (ICR)
Is the onward referral for an urgent condition i.e. suspected cancer?
YES
NO
Is the onward referral for a condition that it would be deemed to be detrimental to the patients health if there was a delay in referral?
YES
NO
Is the onward referral for a condition that has been identified by an anaesthetist that needs further specialist investigation or preoperative work up prior to any surgery being undertaken?
YES
NO
Community or Acute Paediatric Referrals for Same or New Condition
YES
NO
Referrals relating to frail elderly and falls patients
YES
NO
Referrals into Haematology Directorate . Referral of registered patients from Haematology Directorate to other clinicians
YES
NO
Referral can be made via the InterConsultant Referral System (ICR) Ensuring a level of clinical judgement can still be exercised
This is an inappropriate referral to be made via the Inter Consultant Referral system and the patient must be directed back to the GP for onward referral for the NEW condition whereby the Patient will be given choice over provider and ensuring RTTP pathways are managed in a timely manner

Appendix 3 **Paediatric DNA Proforma**

Sample DNA Sticker

Did not attend record (DNA) for under 18s

Date: __/__/__ **Tick as appropriate**

Child or Young person <18 years? Yes □ No □
Safeguarding Concerns evident? Yes □ No □

Outcome: Send further appointment □
Open appointment □
Discharge □

Liaison: GP/health visitor/school nurse/other (please state)_____

Signed:…… **Designation:**……

Print name:…… **Date:** __/__/__
Version:

Appendix 4 - Over 6 Weeks Clinic Cancellation Form

Over 6 weeks cancellation form 250

OVER 6 WEEKS CANCELLATION FORM

A minimum of 6 weeks must be given in line with the AccessPolicy/Annual Leave Policy, re-instatment 4 weeks notice (in line with Patient choice and reasonable notice).

INSTRUCTION TO CANCEL/REDUCE/REINSTATE CLINIC							
Date of clinic	**Clinic code**	**Name of Doctor**	**Please indicate if a Nurse led clinic is affected Clinic Code and Actual Numbers**	**Grade of Doctor**	**Reason i.e. A/L, S/L, O/C Mtg.**	**Action Required i.e Cancel/Reduce or reinstate Actual Numbers New & F/ups**	**SPECIAL INSTRUCTIONS e.g. do not remove certain patient, add message to corresponding specialist nurse list etc.**

Form completed by: Ext number: Date:

· **Please ensure that if this doctor works for more than one firm, that this is identified and taken account of for cancellations. If the leave dates involve a cross over when the doctor moves to another firm, please reflect this on the cancellation form and notify the appropriate secretarial colleague.**

● **Please be advised if there are any conflicting messages already on the clinics to be changed the Clinic Changes team will contact you for confirmation/clarification.**

Request for cancellations/reductions under 6 weeks must be authorised by Divisional Mangers/Asst Divisional Mangers, an Under 6 weeks cancellation form completed. Consideration taken into covering the clinic or additional clinic arranged prior to clinic cancelleation

Appendix 5 - Under 6 Weeks Clinic Cancellation Form

Under 6 weeks cancellation form 250

UNDER 6 WEEKS CANCELLATION REQEST FORM

A minimum of 6 weeks must be given in line with Access Policy/Annual Leave Policy, RE-INSTATMENT 4 weeks notice (in line with Patient Choice and reasonable notice).

INSTRUCTION TO CANCEL/REDUCE/REINSTATE CLINIC							
Date of clinic	Clinic code	Name of Doctor	Please indicate if a Nurse led clinic is affected Clinic Code and Actual Numbers	Grade of Doctor	Reason i.e. A/L, S/L, O/C/ Mtg/ Admin Error	Action Required i.e Cancel/Reduce or reinstate Actual Numbers New & F/ups	SPECIAL INSTRUCTIONS e.g. do not remove certain patient, add message to corresponding specialist nurse list etc.

Form completed by: Ext number: Date:

· Please ensure that if this doctor works for more than one firm, that this is identified and taken account of for cancellations. If the leave dates involve a cross over when the doctor moves to another firm, please reflect this on the cancellation form and notify the appropriate secretarial colleague.

• Please be advised if there are any conflicting messages already on the clinics to be changed the Clinic Changes team will contact you for confirmation/clarification.

Request for cancellations/reductions must be authorised by Divisional Mangers/Asst Divisional Mangers. Consideration taken into covering the clinic or additional clinic arranged prior to clinic cancelleation

AUTHORISATION	
NAME	
DATE	

Appendix 6 – Additional/Adhoc Outpatient Clinic Approval Form

Additional / Ad hoc Outpatient Clinic Approval Form

Date

1. Details of requestor:

Full Name/job title	Signature	Specialty	Consultant name

2. Details of the proposed additional session (at least 2 weeks' notice to be provided): in exceptional circumstances ie 2ww 72hrs notice will be accepted from the date all staffing is confirmed

Date	Day	Start	Finish	Total Hrs.

3. What is the reason for additional session?

Capacity Issues	
2 Week Wait	

4. Clinic detail

Clinic type	Number of Patients	Slot Duration		
			Has staff cover been arranged?	
New			Is this clinic an additional cost?	
Follow-Up			Clinic Code/Doctor code	
Procedure				
Other			Other comments:	
Total				

5. Resources required:

	Name/s	Yes	No
Central Support	Lesley Humber Teresa Ilyk Lisa Arrowsmith		
Clinic Prep	Karen Wetton Shirley Timson		
Booking Team	Rebecca Robinson Relevant Booking Team		
Case Note	Lisa Widdowson Case Note Store		
Receptionist	Jill Hinks Sarah Chinery		
Nursing staff	Mandy Topliss Sue Dyson Sam Lambert		
Consultant			
Other			

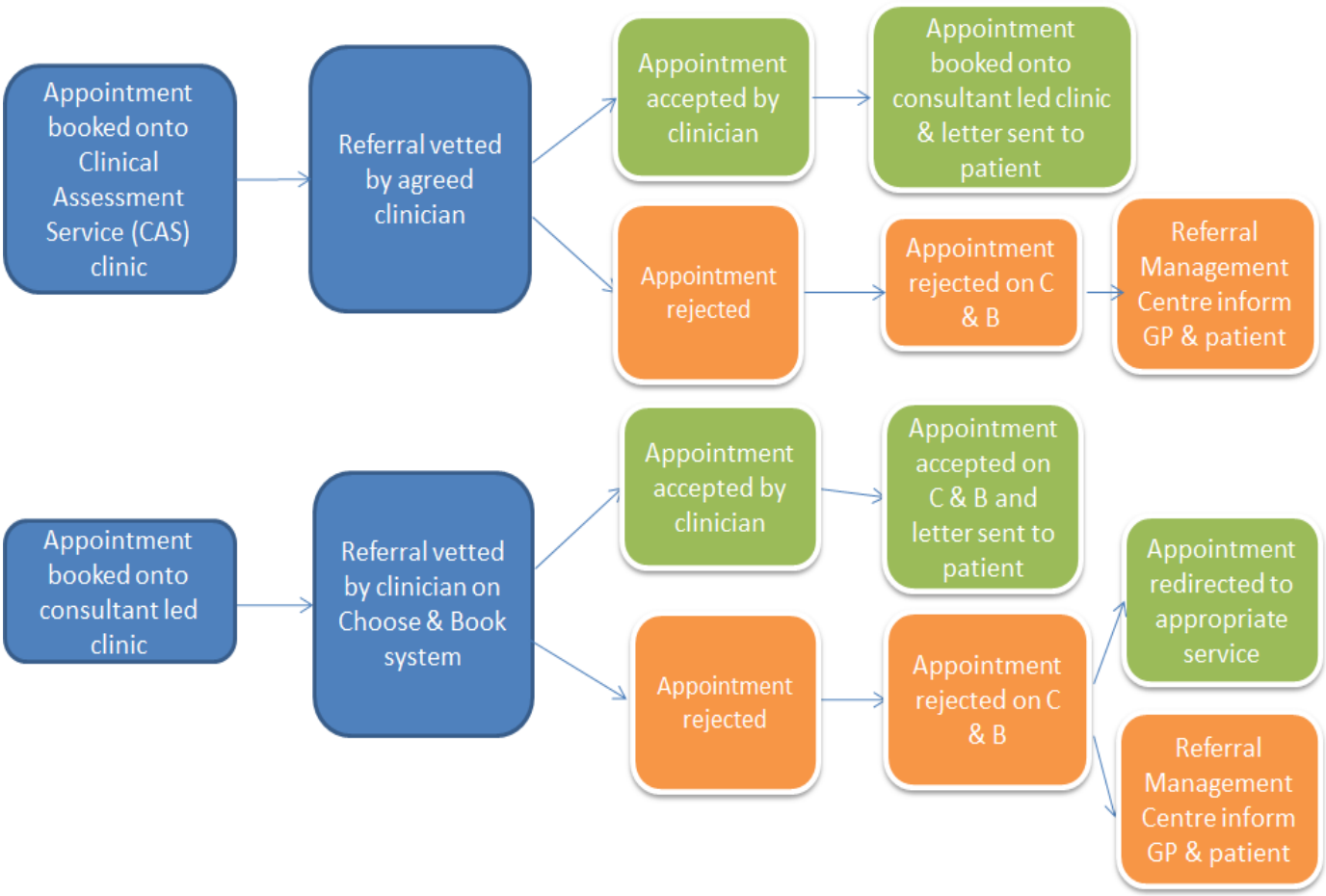
NB Please note that this request form must be completed in full prior to submission electronically (email central account name TBC)

6. Review approval and confirmation by relevant Divisional Team:

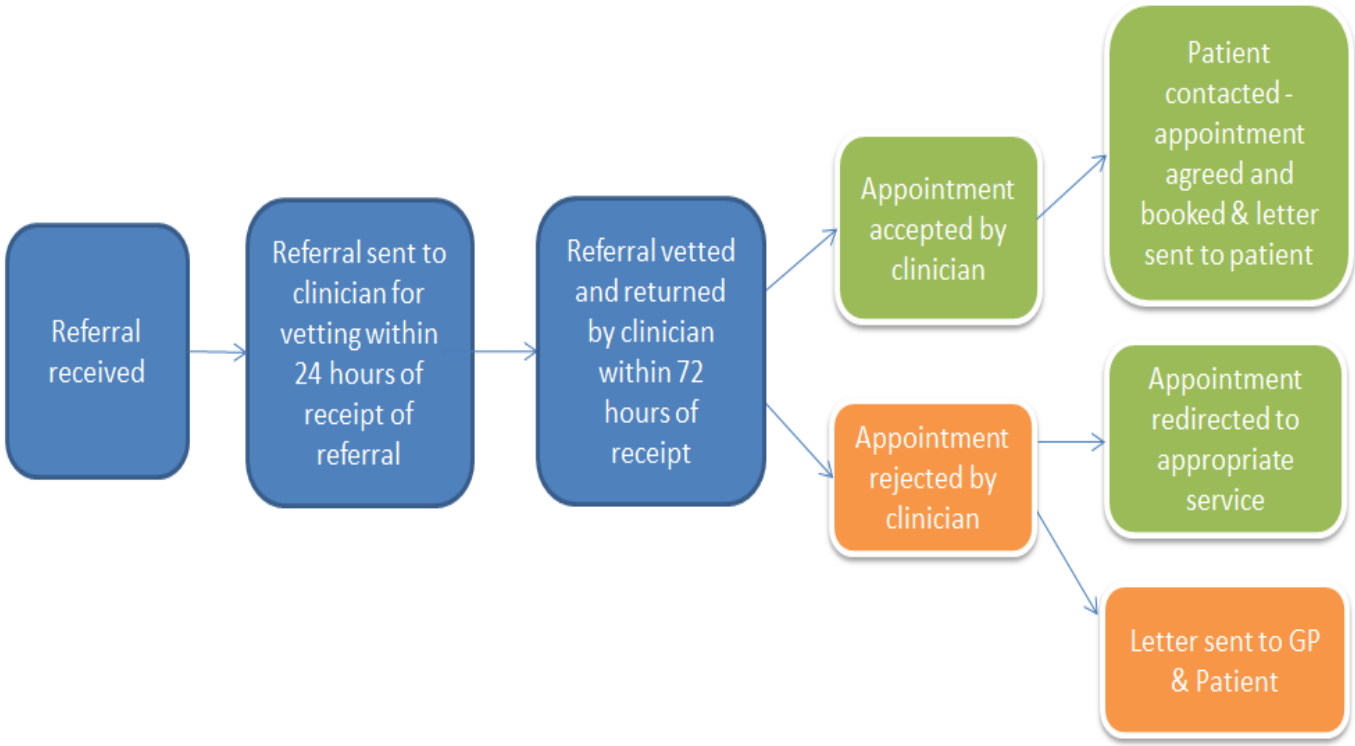
Divisional Manager/Deputy Manager/Asst General Manager:

…….. Date:……..

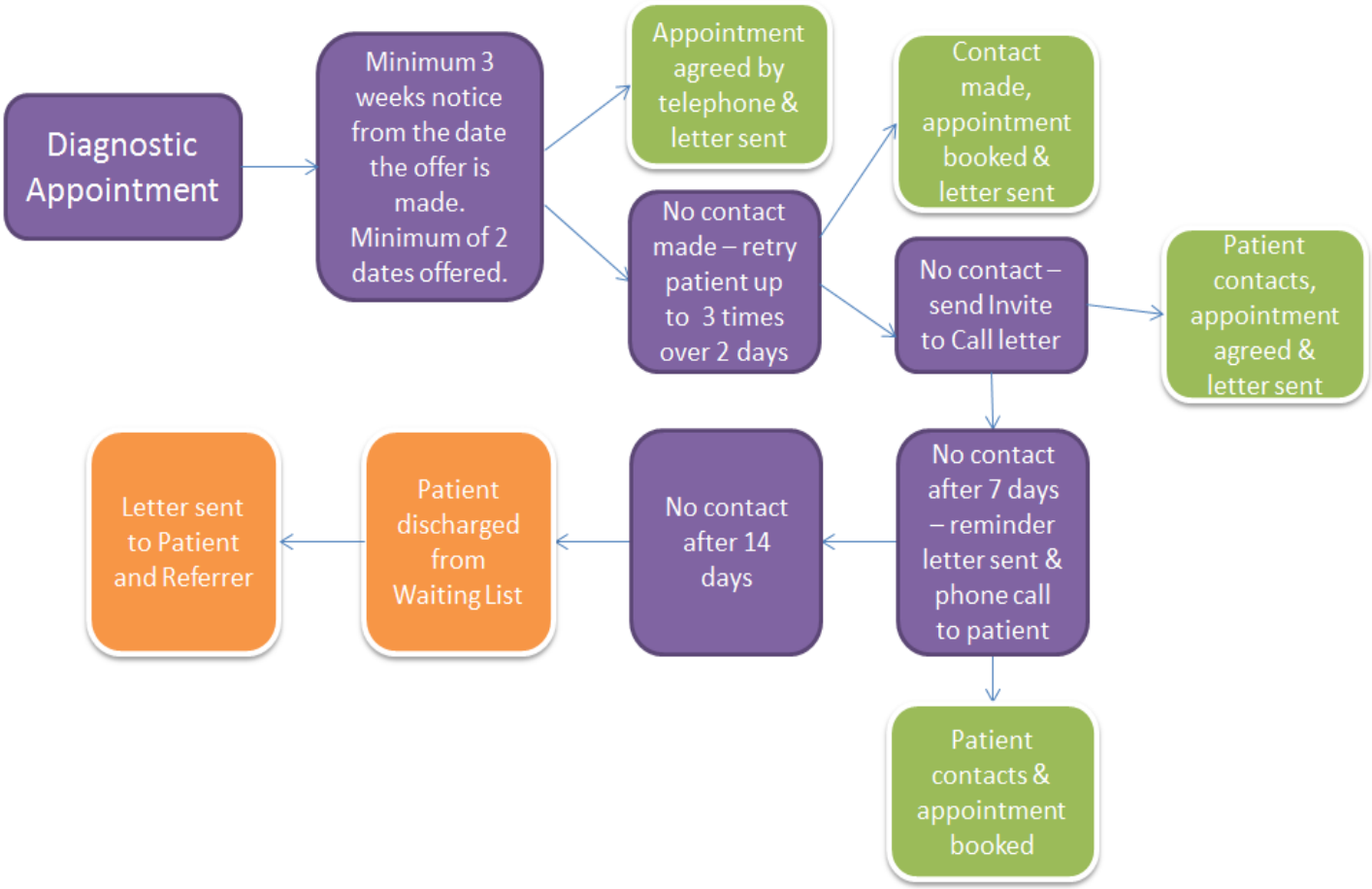
Action Card 1: New Appointment Booking Process for NHS e-Referrals Service Referrals



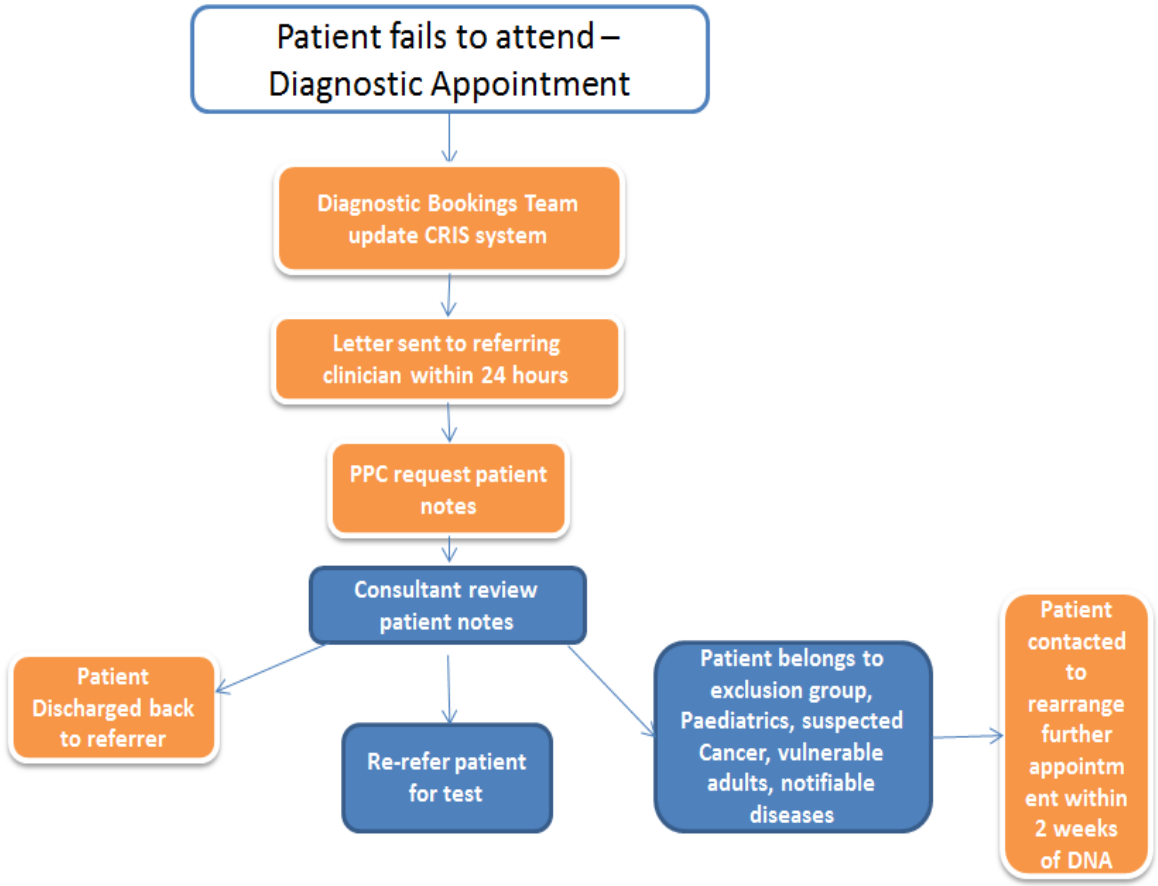
Action Card 2: New Appointment Booking Process for Non e-Referrals Service Referrals



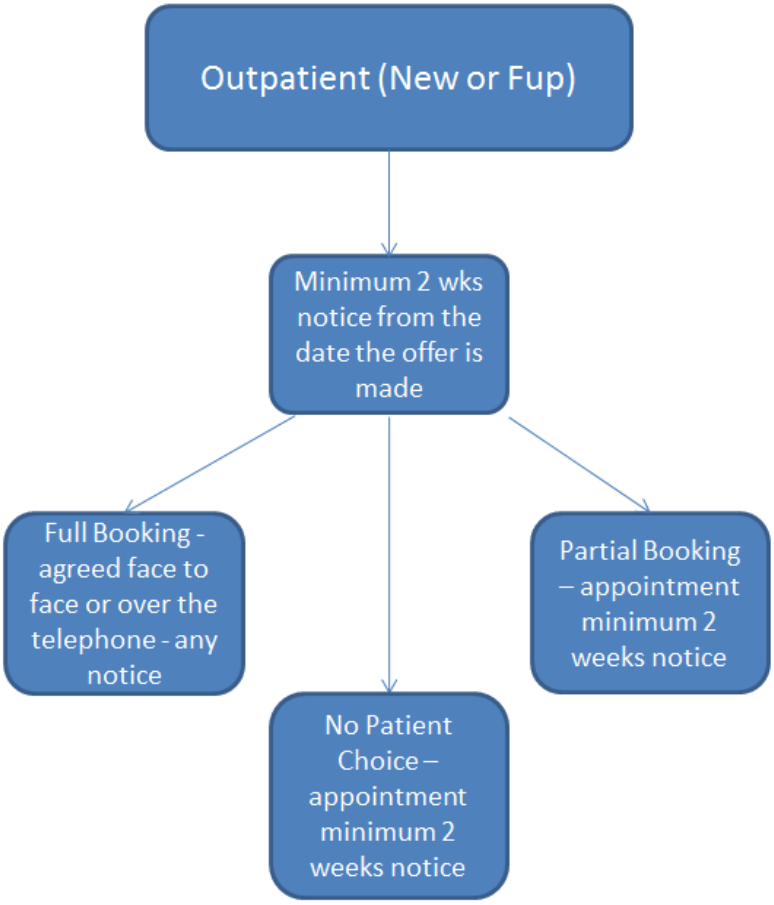
Action Card 3: Diagnostic Appointment Booking Process



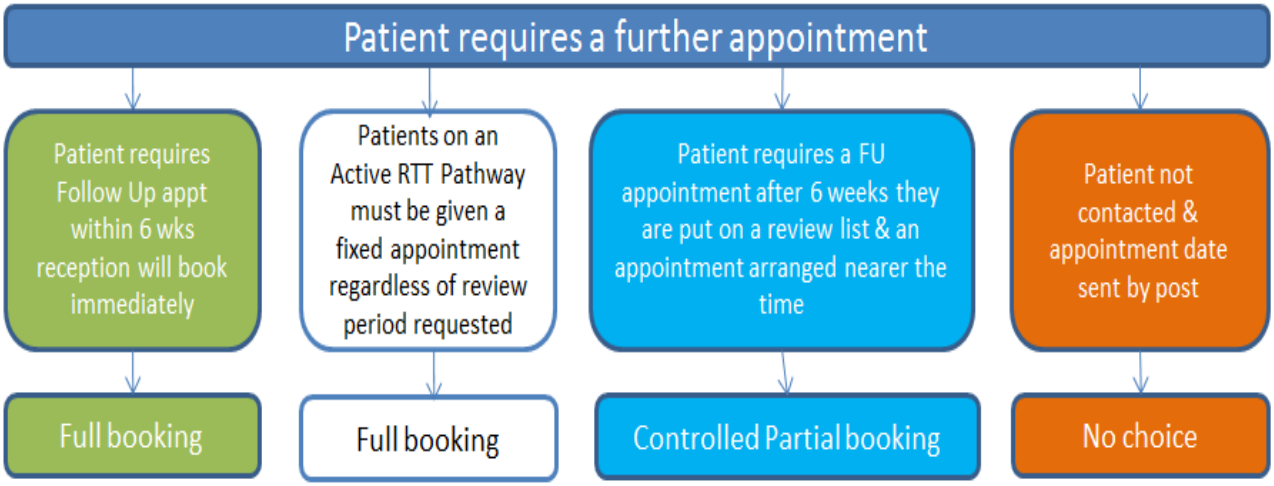
Action Card 4: DNA Process for Diagnostic Patients



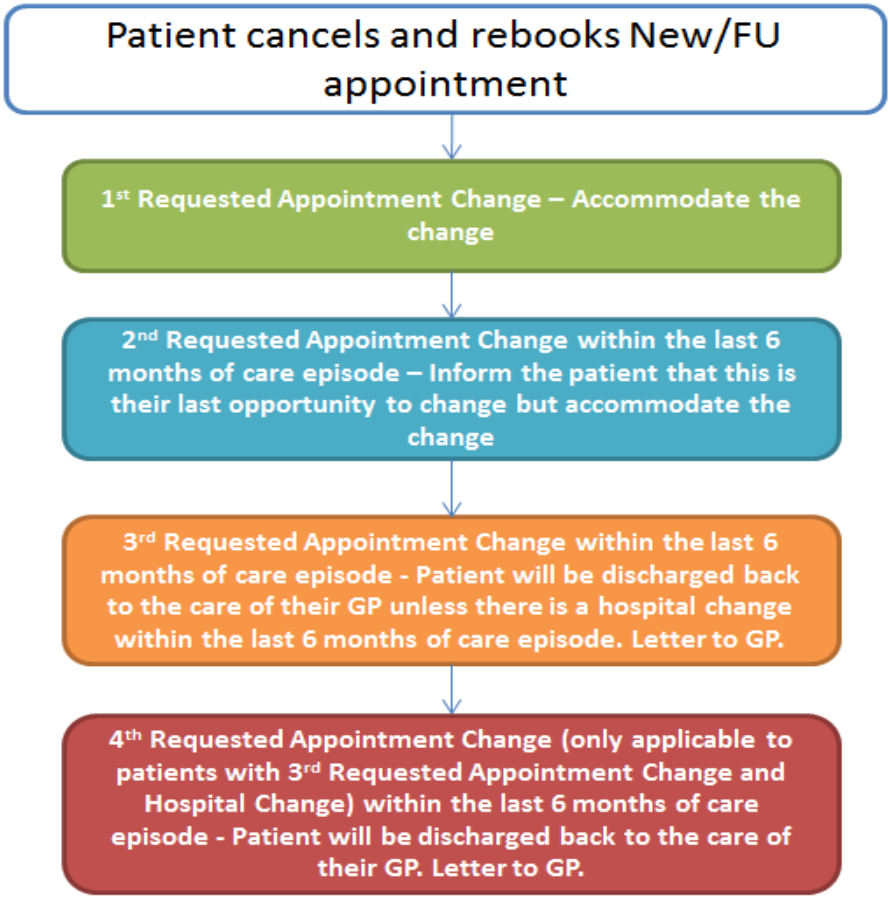
Action Card 5: Reasonable notice



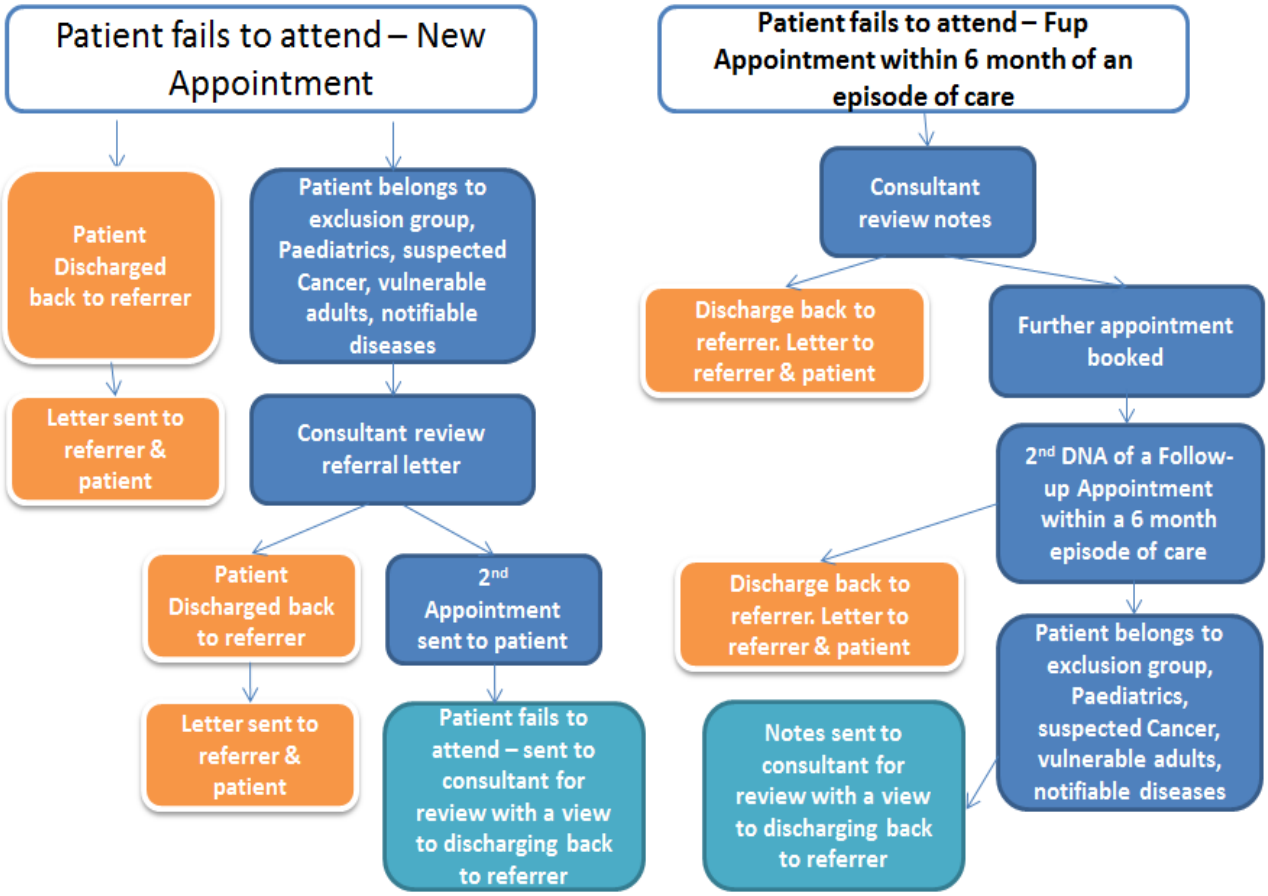
Action Card 6: Booking Follow Up Appointments



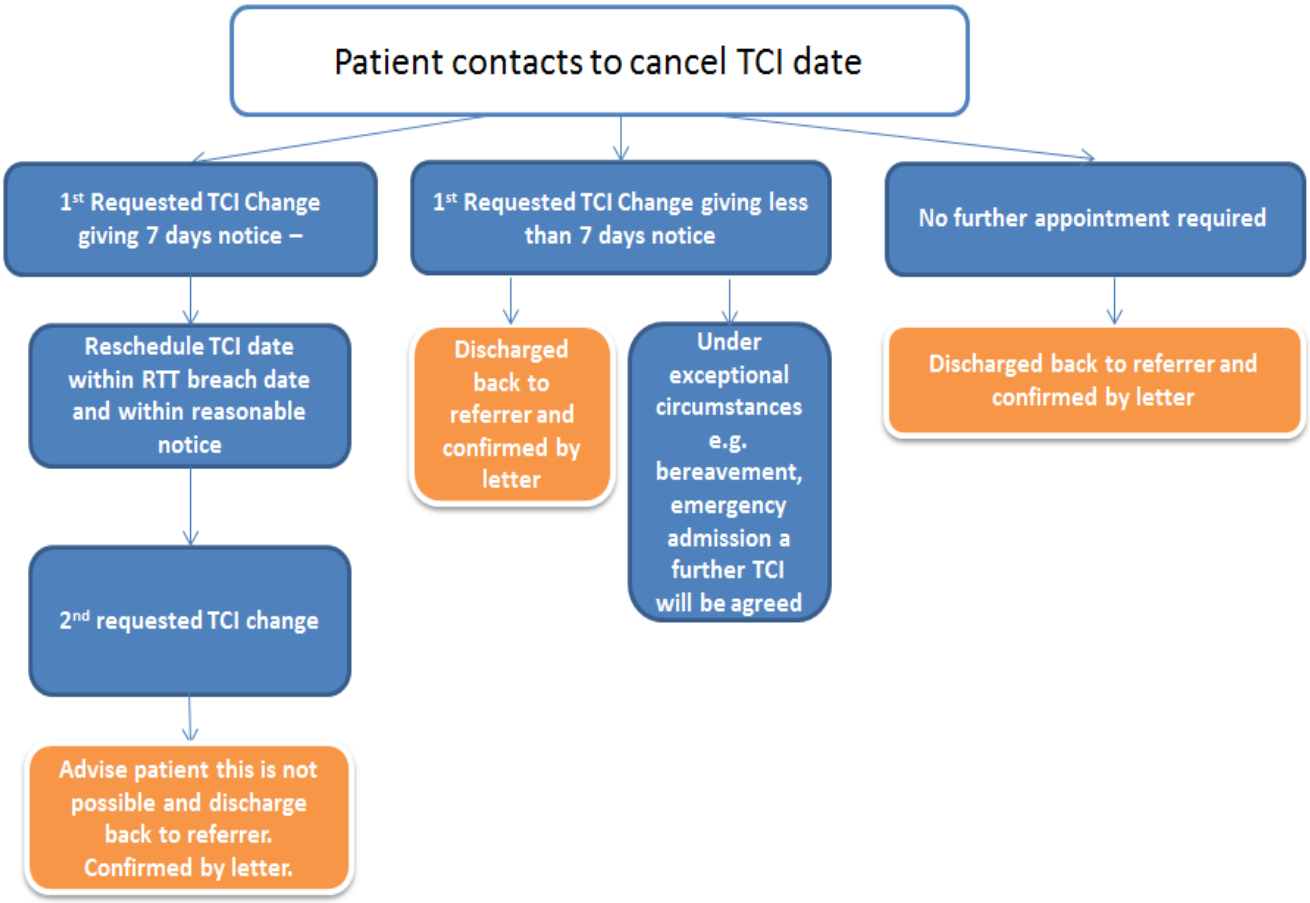
Action Card 7: Patient Cancellations (New & Fup)



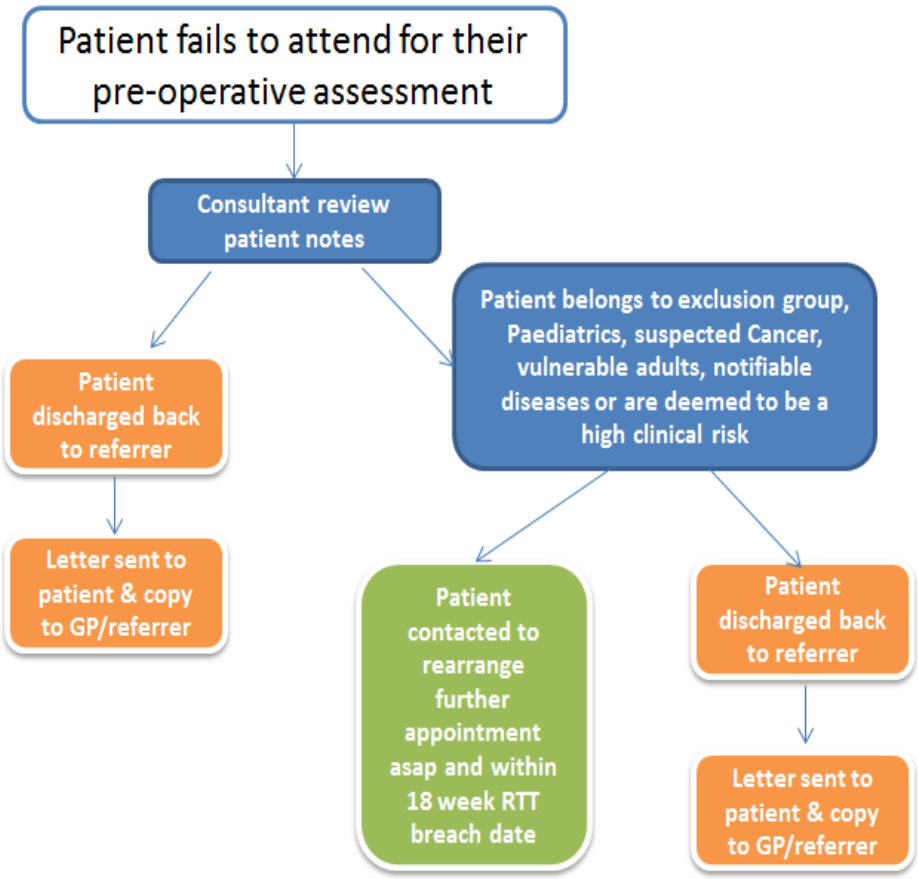
Action Card 8: DNA Process for New & Fup Patients



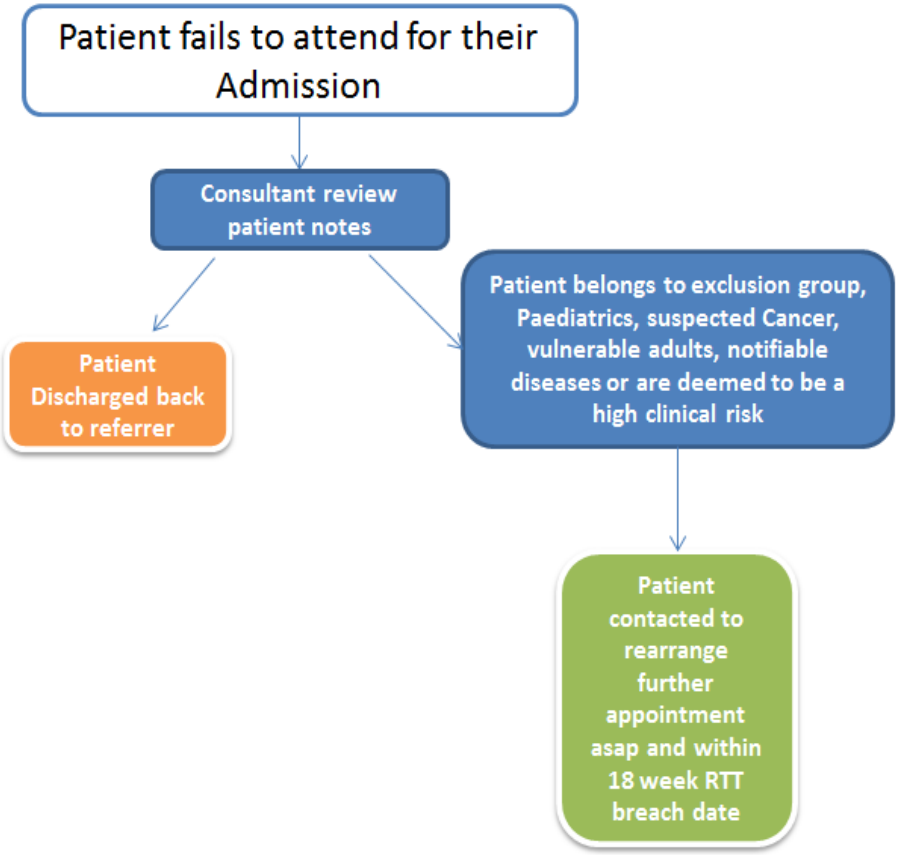
Action Card 9: Patient Cancellations TCI Date



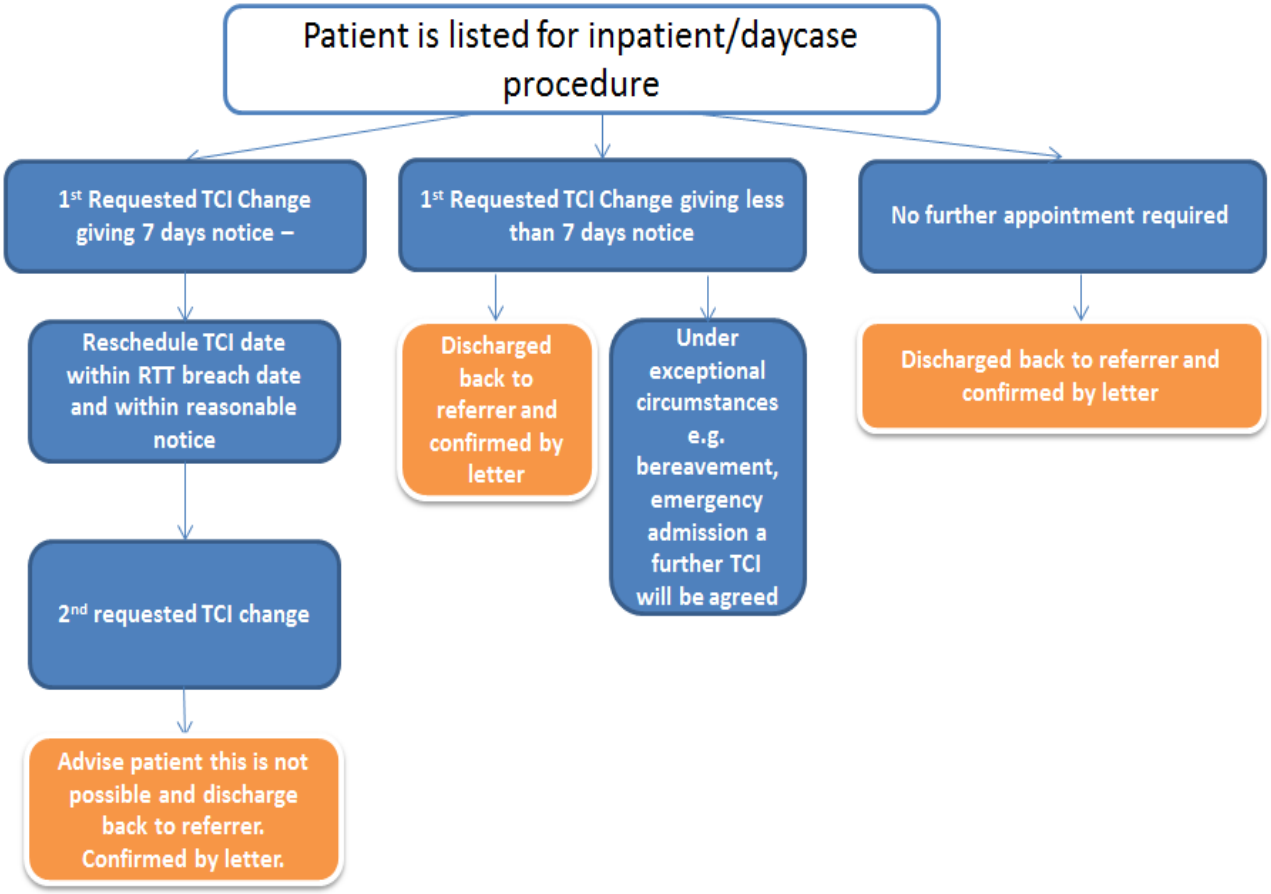
Action Card 10: DNA Process for Pre-operative Assessments



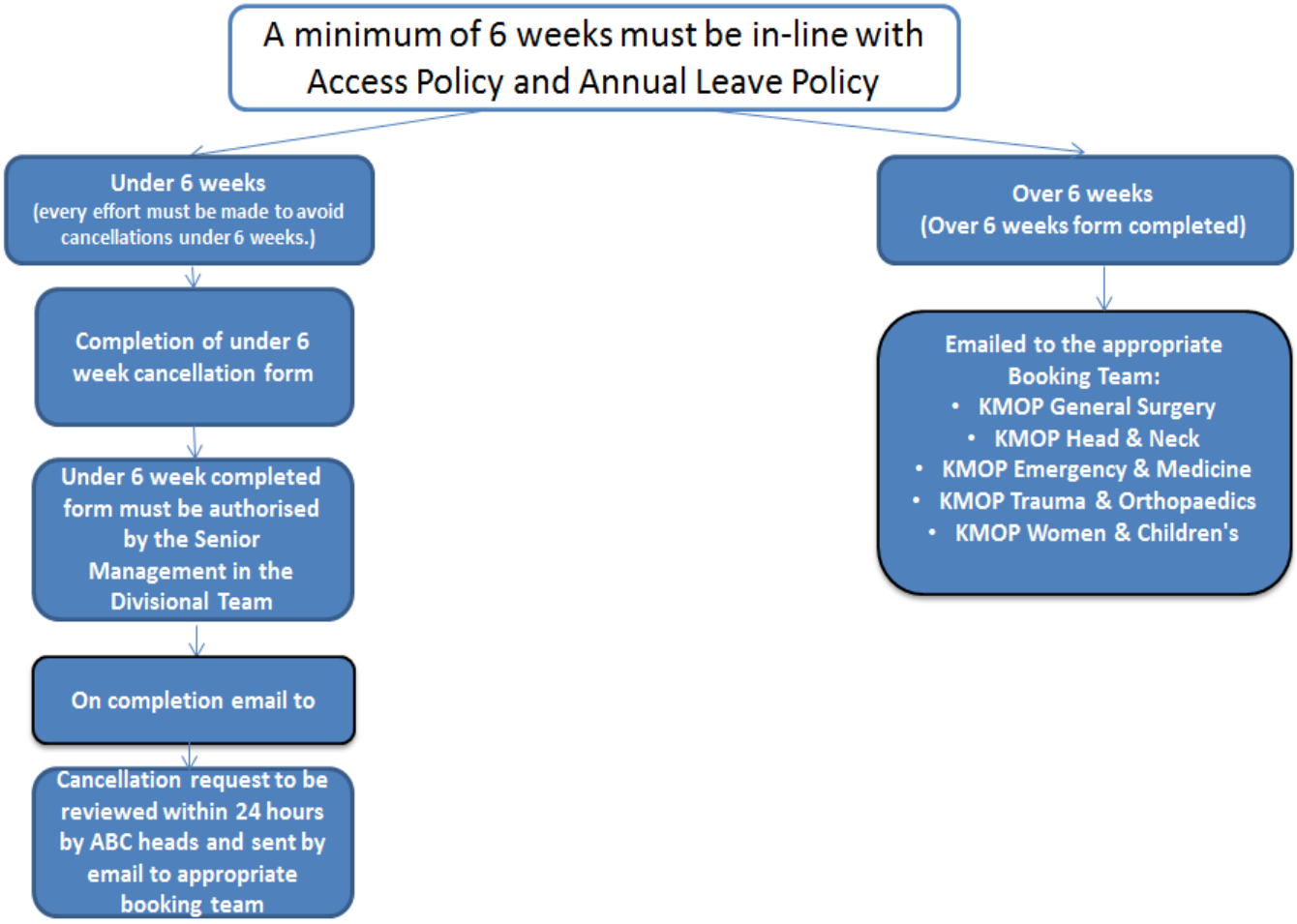
Action Card 11: DNA Process for Admitted Patients



Action Card 12: Medically Unfit Patients



Action Card 13: Cancellation/Reduction of OPD Clinics



Section 11: Cancer Access Policy

Title: Cancer Access Policy				
Date Approved: 16/10/2014	**Approved by:** Clinical Quality & Governance Committee	**Date of review:** October 2015	**Policy Ref:**	**Issue:** 1
Division/Department: Planned Care & Surgery/ Cancer Services		**Policy Category:** Governance		
Author (post-holder): Head of Cancer Services Head of Information		**Sponsor (Director):** Director of Operations		

CONTENT

1 INTRODUCTION

This policy is issued and maintained by the Director of Operations on behalf of the trust, at the issue defined on the front sheet, which supersedes and replaces all previous versions.

2 POLICY STATEMENT

This Cancer Access Policy complements Elective Access, Booking & Choice Policy and should be read in conjunction with the general principles set out in that document for the Trust's duty of care to patients, and of the patient's rights and responsibilities.

The Trust is committed to ensuring all patients referred with suspected or diagnosed cancers are treated efficiently, equitably, in line with National Access standards and Cancer Waiting Times Guidance, and with due care and compassion. The best interests of the patient are at the forefront of the Trusts guidelines.

Equality Impact Assessment

The Trust is committed to ensuring that none of its policies, procedures and guidelines discriminate against individuals directly or indirectly on the basis of gender, colour, race, nationality, ethnic or national origins, age, sexual orientation, marital status, disability, religion, beliefs, political affiliation, trade union membership, and social and employment status. An EIA of this policy/guideline has been conducted by the author using the EIA tool developed by the Diversity and Inclusivity Committee. (01-10-2014).

Related Trust policies/ guidelines and other trust documents:

- Consultant Cancer Upgrade Policy

3 DEFINITIONS

Definitions for specific terms used in the policy or procedure should be clarified e.g.

'The Trust': means the Sherwood Forest Hospitals NHS foundation trust.

'Staff ': means all employees of the trust including those managed by a third party organisation on behalf of the Trust.

'2ww'. means a GP 2 Week Wait referral for suspected cancer

'VSA' Vital Sign Application (National Cancer Waiting Time Standard)

'Hospital Consultant' means any Trust Hospital Consultant

'Nurse Specialist' means any Trust Nurse Specialist

'Core MDT Members' means the Hospital staff agreed as core members of a Cancer Multi-Disciplinary Team by the Tumour Site Cancer Lead Clinician

'MDT Team' means the Tumour Site Multi-Disciplinary Cancer teams who are responsible for managing patients care

'VSA 13b' means the new National Cancer Waiting Time standard, Consultant Upgrade

4 ROLE AND RESPONSIBILITIES

See roles and responsibilities defined in the Elective Access Policy. In addition:

- The Head of Cancer Services the Trust's operational lead for management of cancer service provision, pathways and waiting times and will provide operational expertise in applying this policy and developing the supporting operational procedures to ensure compliance within each area.
- The Cancer MDT Co-ordinator Lead is line manager of the Cancer Pathway Co-ordinator Team who are responsible for tracking and reporting on patients against National Cancer Waiting Times standards and facilitating Cancer Multi-Disciplinary Team meetings.

5 SCOPE OF POLICY

This policy applies to the management of all suspected and confirmed cancer patients at the Trust irrespective of who and where the booking and scheduling of patients activity is undertaken.

6 CONSULTATION

This policy has been discussed and agreed in partnership with the Trust's Cancer Management Board.

The following group(s)/ committee(s) have been consulted in the development of this document:

Contributors:	**Communication Channel: e.g.** • **Email** • **1:1 meeting/ phone** • **Group/ committee meeting**	**Date:**
Newark & Sherwood CCG	Exec Team meeting	
Mansfield & Ashfield CCG	Exec Team meeting	

7 CANCER ACCESS POLICY

Adjustments to cancer pathways are allowed in two places:

1) If a patient DNAs their initial out-patient appointment – this would allow the clock to be re-set from the receipt of the referral to the date upon which the patient rebooks their appointment. This adjustment is relevant to the cancer two week wait and the 62-day standard.

2) If a patient declines an offer of admission for treatment in an in-patient (ordinary admission or day case) setting provided the offer of admission was "reasonable".

NB: For cancer patients under the 31 or 62 day standard 'reasonable' is classed as any offered

appointment between the start and end point of 31 or 62 day standards .The adjustment would be the time between the date of the declined appointment (the offered To Come In date) to the point when the patient could make themselves available for an alternative appointment:

7.1 Cancer Pathways: Two Week Waits

Pathway Definitions

In accordance with national standards and guidelines, the Trust is committed to ensuring patients referred urgently with suspected cancers will be seen at the earliest opportunity, within a maximum of 14 days subject to exceptions listed below.

All patients with

a) suspected cancer .

b) Symptomatic breast referrals (cancer not suspected) should be offered an appointment by the Trust within 14 days of the referral received date.

Patients should not be booked beyond the 14 day period without escalation to the Head of Cancer Services

Two week wait referrals can only be 'downgraded' by the GP - if a consultant thinks the two week wait referral is inappropriate this should be discussed with the GP and the GP asked to withdraw the two week wait referral status;

7.2 Management of 2WW pathways

The rules for cancer pathways apply a strict gateway control to ensure patients are seen quickly and cancers diagnosed at the earliest opportunity. Patients have the right to be seen by a cancer specialist within a maximum of two weeks from

a) GP referral for urgent referrals where cancer is suspected (detailed below), and if this is not possible, the Trust has to take all reasonable steps to offer a range of alternatives.

b) symptomatic breast referral (cancer not suspected)

The exception to the right to be seen within the maximum waiting times applies:

- Some patients will choose to wait longer and others will not be clinically able to be seen within these time frames. If the patient fails to attend appointments that they had chosen from a set of reasonable options

Any patient who contacts the Trust to change their appointment should be offered another appointment date within 14 days of receipt of the referral and not the next available slot. If dates cannot be offered within this time period due to capacity, the Access, Booking & Choice Team should escalate to the Cancer MDT Co-ordinator Lead and the Business Manager(s).

7.3 Direct booking

The Trust has a directly bookable service for the following tumour sites: ENT, Maxillofacial, Ophthalmology, Brain, Breast, Gynaecology, Lung, Skin, Lower GI and Urology. The Central Support Team will advise the appropriate Divisional Business Unit/Service Director regarding capacity issues on a daily basis and action taken without delay in the best interests of patients.

7.4 Clinical Assessment Service

For the tumour sites of Haematology and Upper GI a Clinical Assessment Service (CAS) is in place. Therefore, patients will be booked into an Internal CAS slot. When the referral has been through the CAS, the Trust will contact the patient to agree a two week wait appointment slot. Some Upper GI referrals are suitable for 'straight to test' within Endoscopy and are therefore vetted for clinical suitability prior to offering a clinic/straight to test appointment. Vetting takes place within 24 hours of receipt within the Upper GI service.

7.5 Patient inability to attend

Should the patient not be able to attend an appointment within this two-week period then alternative appointments should be offered outside of the two-week period.

Patients should not be referred back to the GP because they are unable to accept an appointment within the two-week wait standard period due to, for example, a social commitment, ill health or logistical issues. It is expected that a certain proportion of patients will choose to wait longer and the operational standard now takes this into account.

7.6 GP referral within 24 hours of the decision to refer

A GP should refer the patient even if a patient cannot make themselves available for an appointment within the two week period since receipt of this referral flags to the receiving organisation that there is a potential cancer case on its way. The patient's availability should be included on the 2-Week Wait Referral Proforma, including dates not available.

7.7 Patient Information

Patients will be given information about why they are being referred on a 2ww 'suspected cancer' or 'symptomatic breast referral' by their General Practitioner, in accordance with NICE guidelines (updated and published June 2015) to replace NICE guideline CG27 (published June, 2005) Patients should be informed by their GP of the importance of being seen quickly and the importance of patients keeping appointments. The information provided to the patient by the GP will be supplemented with a patient leaflet, approved by the Nottinghamshire Patient & Carer Groups. These leaflets are available for GPs to give to patients during their primary care consultation.

GPs should identify urgent suspected cancer referrals by completing the standard proforma (agreed with CCG), which should be attached and sent via Choose & Book within 24 hours of the decision to refer.

7.8 Two Week Rule Referrals sent to the wrong provider:

If the Trust receives a referral for a patient for a service we do not provide, that referral should be forwarded immediately to an appropriate provider together with the minimum dataset. The date of receipt is when the referral was originally received, not the day it was forwarded, and this does not constitute a reason for making a pause in the

pathway. The GP should be contacted and advised to enable a change in future practice. If the referral has been sent to another provider and forwarded to SFH for initial appointment it is the responsibility of that provider to ensure the patient is referred without delay, and to provide the minimum dataset.

7.9 Two Week Rule Referrals not containing the required information (minimum dataset):

If a referral is received not containing information needed to process it, then the referring GP should be contacted immediately by telephone, thereby minimising the delay to the patient. This does not constitute a reason for making a pause to the pathway and patients should not be referred back to their GP to stop a pathway.

7.10 Management of 1st Appointment DNAs

Patients must be offered and have accepted at least two appointments at the first outpatient consultation which they subsequently DNA prior to being considered for referral back to their GP.

Patients **should not** be referred back to their GP after **first DNA** (Did Not Attend) of their first appointment;

Patients can be referred back to their GP after multiple (two or more) DNAs;

Where patients have not attended their initial outpatient appointment the appropriate Consultant must review the referral details of the patient prior to referring the patient back to the GP and the patient must be informed of the action which is being taken.

A patient must not be referred back to their GP if they cancel once and DNA once. GPs must have proactive arrangements in place to ensure that patients referred back to them are consulted with to establish the reasons for the DNAs.

Any patient who does not attend (DNA) their 1st appointment will be offered another appointment within 7 days. If patient does not accept appointment within this timescale a further appointment will be offered up to a maximum of 14 days from the date of the DNA appointment.

If the patient DNAs a second appointment they may be referred back to GP care, subject to the discretion of the clinician and in accordance with clinical priorities and patient needs. The interests of the patient must be central to all clinical decision making.

A third DNA will trigger a mandatory discharge back to GP, unless the patient has an urgent condition and/or specific circumstances that demand individual management.

If the Trust cannot provide evidence that the patient has received and accepted the appointment, DNA rules will not apply. If there is any doubt over the appointment having been received, the Trust should offer another appointment without delay.

For any patients discharged back to their care professional, they will be contacted by telephone to inform them that they have been discharged from the Trust and those booked via the Choose & Book system will also be discharged through the electronic system.

7.11 Management of 1st Appointment Cancellations

Patients must be offered and have accepted at least two appointments at the first outpatient consultation which they subsequently cancel prior to consideration for referral back to the GP.

Patients **should not** be referred back to their GP after **a single appointment cancellation**;

Patients should not be referred back to their GP after multiple (two or more) appointment cancellations unless this has been agreed with the patient – by cancelling an appointment a patient has shown a willingness to engage with the NHS.

The Provider organisation must ensure that referral back to the GP is acceptable to the Consultant and must also discuss and agree this action with the patient. The interests of the patient must be central to all clinical decision making.

GPs must have proactive arrangements in place to ensure that patients referred back to them are consulted to establish the reasons for the cancellations and take action in the patient's best interests.

. Two week wait referrals can only be 'downgraded' by the GP - if a consultant thinks the two week wait referral is inappropriate this should be discussed with the GP and the GP asked to withdraw the two week wait referral status

If this request is authorised by the GP then the two-week wait referral must be withdrawn by the GP and then re-submitted as an 18 week referral. If the request is not authorised by the GP then the patient will remain on the two-week pathway.

7.12 Pathway Definitions

Diagnostic and Treatment Pathways (31 & 62 DAY)

Any patient referred as a suspected cancer or breast symptomatic (two week wait referral), must be treated within the national waiting time standard of 62 days from receipt of referral.

Patients diagnosed with cancer will be given their first definitive treatment within 62 days of referral; subject to patient choice (i.e. the right to be treated within the maximum waiting times does not apply if the patient chooses to wait longer). The pause of the pathway would be the time between the date of the declined appointment (the offered To Come In date) to the point when the patient could make themselves available for an alternative appointment for treatment in an in-patient (ordinary admission or day case) setting. If a patient chooses to wait longer, and the first offered treatment date is outside of the 62 day standard, there is no application of a pathway pause for patient choice.

The following exceptions could be applied:

- If delaying the start of the treatment is in the best clinical interests of the patient, for example where stopping smoking or losing weight is likely to improve the outcome of the treatment (pause of pathway is not applicable – national operational standard of 85% has been set to take account of this scenario)
- 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.
- If the treatment is no longer necessary.

7.13 Management of 31 & 62 day Pathways

Consultant Upgrades

When routine referrals (i.e. those not on a 62 day pathway) are upgraded onto the 62-day pathway via the Consultant Upgrade process. This should be communicated back to the referring clinician (GP) by letter so that they are aware of the elevated priority of the referral. The date of upgrade is the date the Consultant notifies the Cancer Pathway Co-ordinator team.

The Trust has a Cancer Consultant Upgrade policy which provides clear and documented instructions about who can upgrade and how to upgrade patients; the policy can be accessed by the following link **http://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?ContentId=20284**.

7.14 **Management of patients who DNA or cancel diagnostic test and/or staging appointments at any point in the pathway** (after 1st appointment).

Patients should not be referred back to their GP after first DNA (Did Not Attend) of any appointment/treatment (TCI).

Patients can be referred back to their GP after multiple (two or more) DNAs

Where patients have attended their initial outpatient appointment the appropriate Consultant must review the details of the patient prior to referring the patient back to the GP and the patient must be informed of the action which is being taken. GPs must have proactive arrangements in place to ensure that patients referred back to them are consulted with to establish the reasons for the DNAs or cancellation of appointments.

There is no pause/adjustment in the pathway if a patient DNAs or cancels appointments at any point in the pathway after the 1st appointment. .

7.15 Screening patients:

Screening patients are not two week wait referrals. Such referrals from the screening programmes are automatically on a 62 day pathway until cancer is ruled out so a consultant upgrade is not necessary.

There are 3 national screening programmes:

- Breast
- Cervical (Gynaecology)
- Bowel
- For screening referrals there is no national standard on time to DATE FIRST SEEN (they are not subject to the 14 day standard). There are, however, internal waits standards within the NHS cancer

Screening programmes. The relevant internal screening service standards are as follows:

- breast – a minimum standard of >=90% of women attending an assessment centre within three weeks of attendance for the screening mammogram;
- bowel – a specialist screening practitioner appointment should be offered within two weeks (14 calendar days) from the date that the FOBT (faecal occult blood test) kit was read;

- cervical – at least 90% of women referred for colposcopy after one test reported as possible invasion or after one test reported as possible glandular neoplasia should be seen urgently within two weeks of referral;
- cervical – at least 90% of women referred for colposcopy with a test result of moderate or severe dyskaryosis should be seen in a colposcopy clinic within four weeks of referral.

If a patient comes from the cervical screening programme (referral for low risk cervical cytology) and cancer was then suspected they could be upgraded.

3.4.6. When does the 62 day standard start for the three cancer screening programmes?

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

means as follows:

- breast - receipt of referral for further assessment (i.e. not back to routine recall);
- bowel - receipt of referral for appointment to discuss suitability for colonoscopy with a
- specialist screening practitioner (SSP);
- cervical - receipt of referral for appointment at colposcopy clinic.

7.16 Where Patients are not immediately fit for diagnostics/treatment needed:

If it is known that a patient is clinically unfit for diagnostic/treatments needed within the timeframe scheduled for their appointment, or a first appointment straight to diagnostic test, patients should not be given appointments when it is known by the provider that they cannot attend owing to ill health in order to prompt a series of DNAs or cancellations resulting in referral back to the GP (NB. Medical suspensions are no longer applied to these patients.)

The operational standard for the 14, 31 and 62 day standards now takes this into account and therefore patients are required to remain on their cancer pathways and not be referred back to the GP, placed on a pending list, moved between cancer pathways or moved solely onto an 18 week pathway.

7.17 Subsequent Cancer Treatments

a) Subsequent Drug Treatments

All patients that require subsequent cancer drug treatments will be treated within 31 days of the decision to treat or 'Earliest Clinically Appropriate Date'.

b) Subsequent Cancer Treatments - Surgery

All patients that require subsequent cancer surgery will be treated within 31 days of the decision to treat or 'Earliest Clinically Appropriate Date'.

c) **Subsequent Cancer Treatments - Other**

All patients that require other subsequent cancer treatments will be treated within 31 days of the decision to treat or 'Earliest Clinically Appropriate Date'.

d) Recurrence of Cancer

All patients with a confirmed recurrence of cancer in the same tumour site will be treated within 31days of the Decision to Treat, even if they have been referred on a two week wait suspected cancer referral.

e) Rare Cancers

Rare cancers (children's, testicular and acute leukaemias) are treated within 31 days of an urgent GP referral for suspected cancer

Urgent GP referrals for suspected cancer should result in a 31 day period (rather than 62 day period) from receipt of referral if a patient is diagnosed with one of these 3 types of cancer. If a patient is not urgently referred but a consultant suspects one of these cancers they can upgrade the patient onto the relevant 31 day pathway.

7.18 Reasonable Notice (CWTs)

All offers of inpatient treatment are considered reasonable if they are between the start and end of the relevant cancer pathway (i.e. within the 31 or 62 day standards), but offers should account for the preparations and planning that patients (and carers) often need to take, plus the clinical priority of the patient.

A minimum of three days' notice should be provided for all offers of appointments and treatments, subject to agreement between the local Commissioner and the Trust that this is appropriate and desirable for their local population. This does not preclude the Provider organisation from offering an earlier appointment, with the consent of the patient. Provider organisations must not offer inpatient treatment dates which they know a patient cannot attend, so as to induce a pause to the patient pathway, or to induce a series of DNAs and subsequent referral back to the patient GP.

7.19 Contacting Patients to make Appointments

Where possible "Choose and Book" will be used to book appointments. Where referrals come in through any other source, the Trust will make all reasonable efforts to contact the patient to book appointments. Appointment letters must not be sent before either a date has been agreed, or at least two attempts to contact the patient, on different days and at different times, have been made. Local protocols must be documented. If a patient is not contactable then the Provider should liaise initially with the GP to establish why. However if an appointment letter is sent, with reasonable notice, then a subsequent cancellation or DNA may be counted. An appointment letter must not be sent to a patient in circumstances where it is known that they will be unavailable to attend thus to induce a series of DNAs or cancellations resulting in referral back to the GP.

7.20 Patient Choice

The operational standard now takes into account that more breaches are likely owing to patients choosing to wait longer. In addition, a pause is allowed if a patient declines a reasonable offer for admitted treatment (see Section 7.16 above) if the date is offered within the 31/62 day timescale. No pause is allowed if the date offered is outside of these timescales. Patients must not be moved between cancer pathways (i.e. 62 day to 31 day or solely onto an 18-week pathway or placed on pending lists for non-admitted treatment) because they cannot guarantee attendance.

7.21 'Thinking Time' – when a patient decides between treatment options.

No pathway pauses to the waiting time can be applied where a patient requires thinking time. "Thinking time" is one component of patient choice. Clinical teams should agree a period of appropriate thinking time with patients and Clinical Nurse Specialists should follow up if the patient fails to make contact with the Trust to confirm the treatment the patient wishes to proceed with.

7.22 Trust Response to Patient choice

If the patient cannot guarantee attendance for tests or treatment or are unavailable for non-admitted care within a certain timescale they will remain on their referred pathway, unless the patient declines all further treatments or investigations. Decisions by patients (including dates/times/conversations) to decline treatment or investigation must be recorded in the patient notes and/or on the Medway system.

The Trust is required to provide proactive arrangements to ensure that patients referred back to their GP/GDP are consulted with in a primary care setting about the obstacles that prevented them from attending their appointment(s).

A treatment status of "Active Monitoring‟ (also known as "Watch and Wait‟) must not be used incorrectly to stop a patient pathway in the time when a patient has exercised choice or is deciding between treatment options.

Active monitoring is not a substitute for patient 'thinking time'. It is where a diagnosis has been reached but it is not appropriate to give any active treatment at that point in time but an active treatment is still intended/ may be required at a future date. The patient is therefore monitored until a point in time when they are fit to receive, or it is appropriate to give, an active treatment. The patient would have to agree that they were choosing to be actively monitored for a period of time rather than receive alternative treatment. This treatment type may be used for any tumour site if appropriate and it would start on the date of the consultation where this plan of care was agreed with the patient.

It is not acceptable to use this option as a means to end a 62 day period if the initial choice of first definitive treatment is not available within the standard time due to capacity problems, patient choice or fitness.

8 EVIDENCE BASE

This policy supports the delivery of Cancer Waiting Times as set out by the Department of Health. Further information can be found at **http://www.performance.doh.gov.uk/cancerwaits/**

9 MONITORING COMPLIANCE

The following approaches will be utilised to monitor compliance:

- audit of visibility of posters in clinical areas
- issues and observation raised by staff
- audit the 31 day cancer waiting times pathway

10 TRAINING REQUIREMENTS

No specific training is required for the application of this policy. It is accessible to the users via the intranet. Any person recording information relating to cancer pathways should be familiar with the Cancer Access Policy and the rules of Cancer Waiting Times Guidance (v8.0) and its application.

11 DISTRIBUTION

This policy will be available to employees within the trust's suite of governance policies, accessible via the Corporate Information intranet site.

12 COMMUNICATION

The policy will be advised through staff bulletin and team brief. It will also be displayed in the MDT room and other areas where doctors or nurses congregate.

13 AUTHOR AND REVIEW DETAILS

Date issued:	
Date to be reviewed by:	October 2015
To be reviewed by:	Head of Information/Head of Cancer Services
Executive Sponsor**:**	Chief Operating Officer

Section 12 Cancer Flows and Action Cards

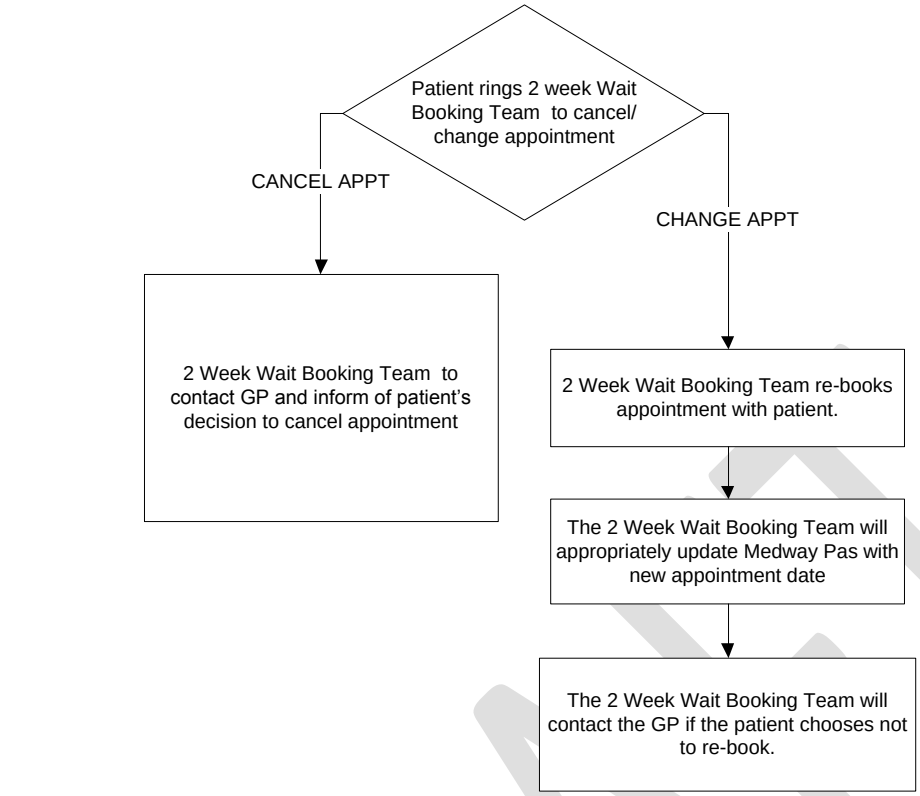
Section A: 2 Week Wait Referrals from GP/GDP

National Standard: 1st Outpatient appointment or test appointment to be booked within 14 days of receipt of referral.

NB: Excludes Sarcoma – SFHFT does not receive 2ww for Sarcoma as it is not a diagnostic centre for this type of tumour.

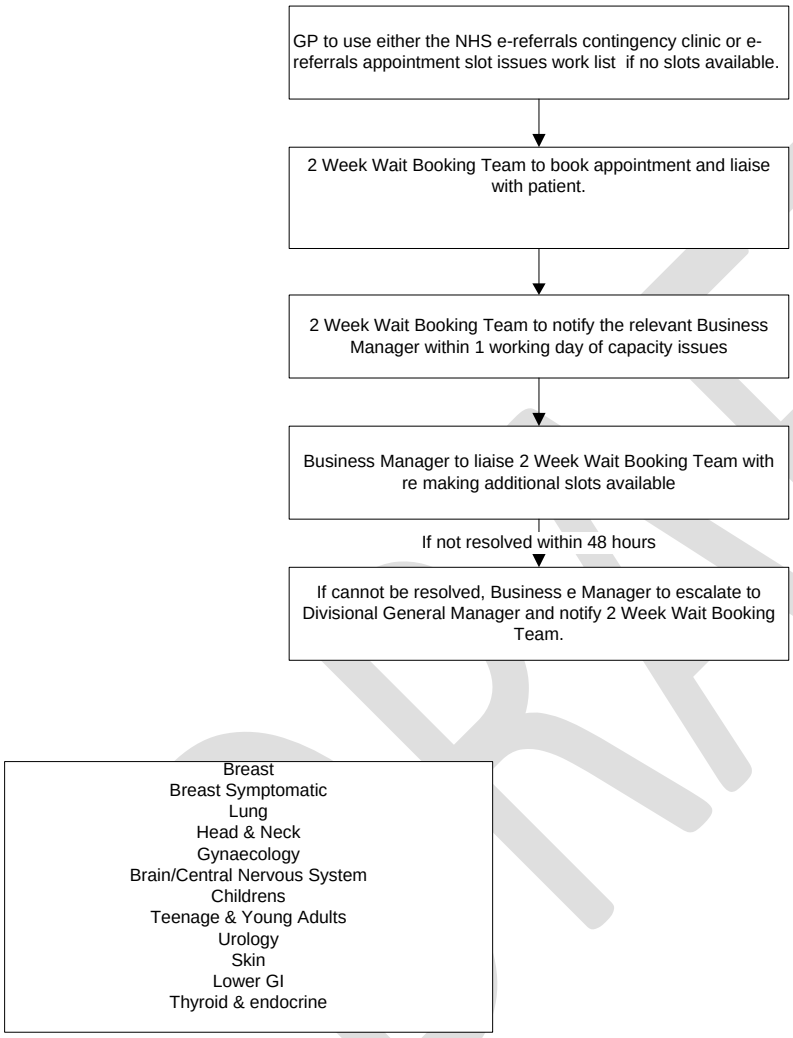
Scenario	Action
Tumour sites where 1st OPA is always booked - 62 day pathway ***See Appendix A 1- 4 flowcharts*** Breast Breast Symptomatic Lung Head & Neck Gynaecology Brain/Central Nervous System Children's Teenage & Young Adults Urology – PSA clinics, Testes, Penile, Renal, Haematuria Lower GI Skin Thyroid/Endocrine	• GP to book appointment and attach referral letter via NHS e-referrals. • GP must attach referral letter within 24 hours of appointment booking. • GP to agree date/time with the patient
No slot availability	• GP to use either the NHS e-referrals contingency clinic or e-referrals appointment slot issues work list. • 2 Week Wait Booking Team to book appointment and liaise with patient. • 2 Week Wait Booking Team to notify the relevant Business Manager within 1 working day of capacity issues • Business Manager to liaise 2 Week Wait Booking Team with re making additional slots available • If cannot be resolved Business Manager to escalate to Divisional General Manager and notify 2 Week Wait Booking Team within 48hours of initial request.
Appointment cancelled/changed by Patient	• Patient rings 2 Week Wait Booking Team to cancel/change appointment. • 2 Week Wait Booking Team re-books appointment with patient. • GP contacted if the patient cancels appointment and does not wish to re-book.
Patient DNAs	• 2 Week Wait Booking Team will utilise the NHS e-referrals rebooking work list to contact the patient and rebook the 1st OPA. • For non e–referral 2 Week Wait appointments the Business Intelligence 2 Week Wait DNA report will be used. • GP contacted if the patient DNAs appointment and does not wish to re-book • Consultant informed if the patient DNAs more than twice or more for next steps.

Section A: Appendix A1 – 2ww appointment cancelled or changed by patient

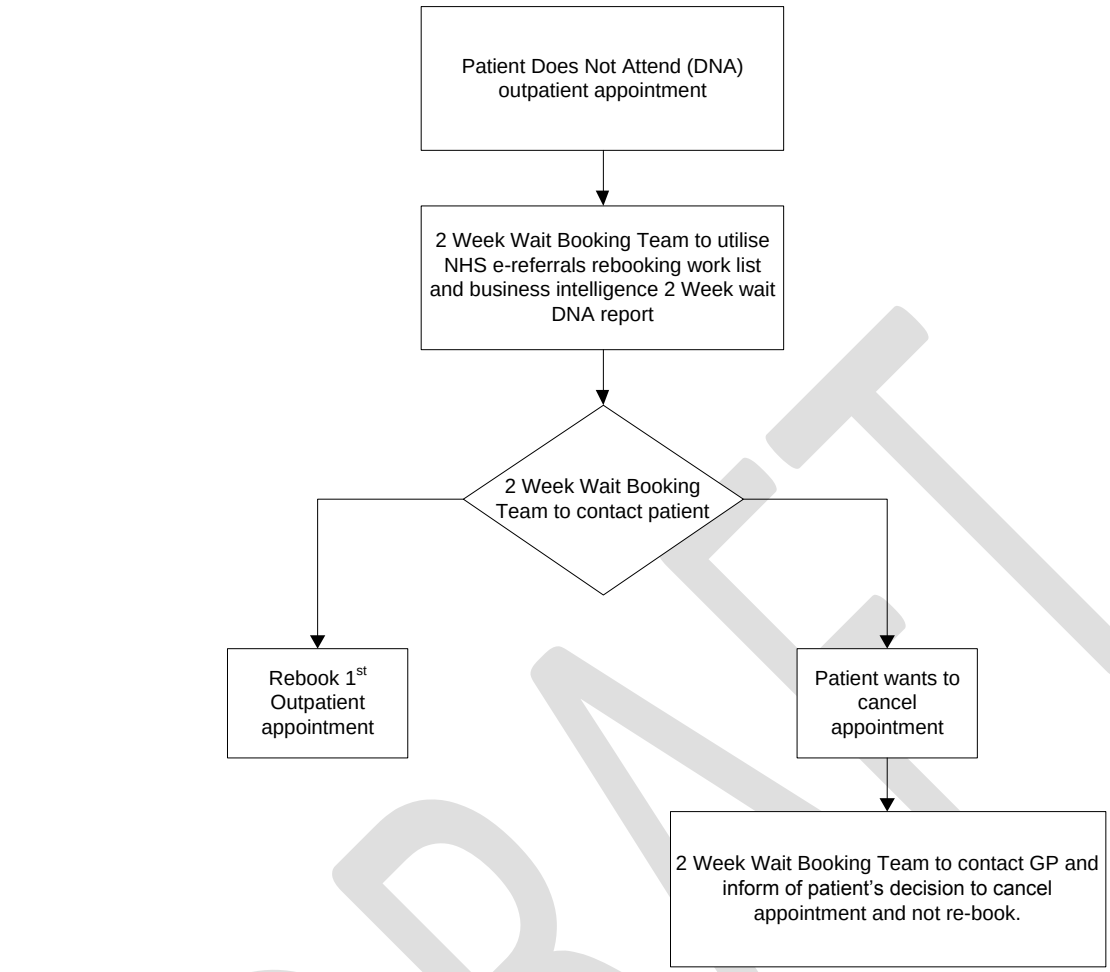


Breast
Breast Symptomatic
Lung
Head & Neck
Gynaecology
Urology
Skin
Thyroid & Endocrine
Lower GI
Brain/Central Nervous System
Childrens
Teenage & Young Adults

Section A: Appendix A2 – 2ww No slot availability on NHS e-Referrals System

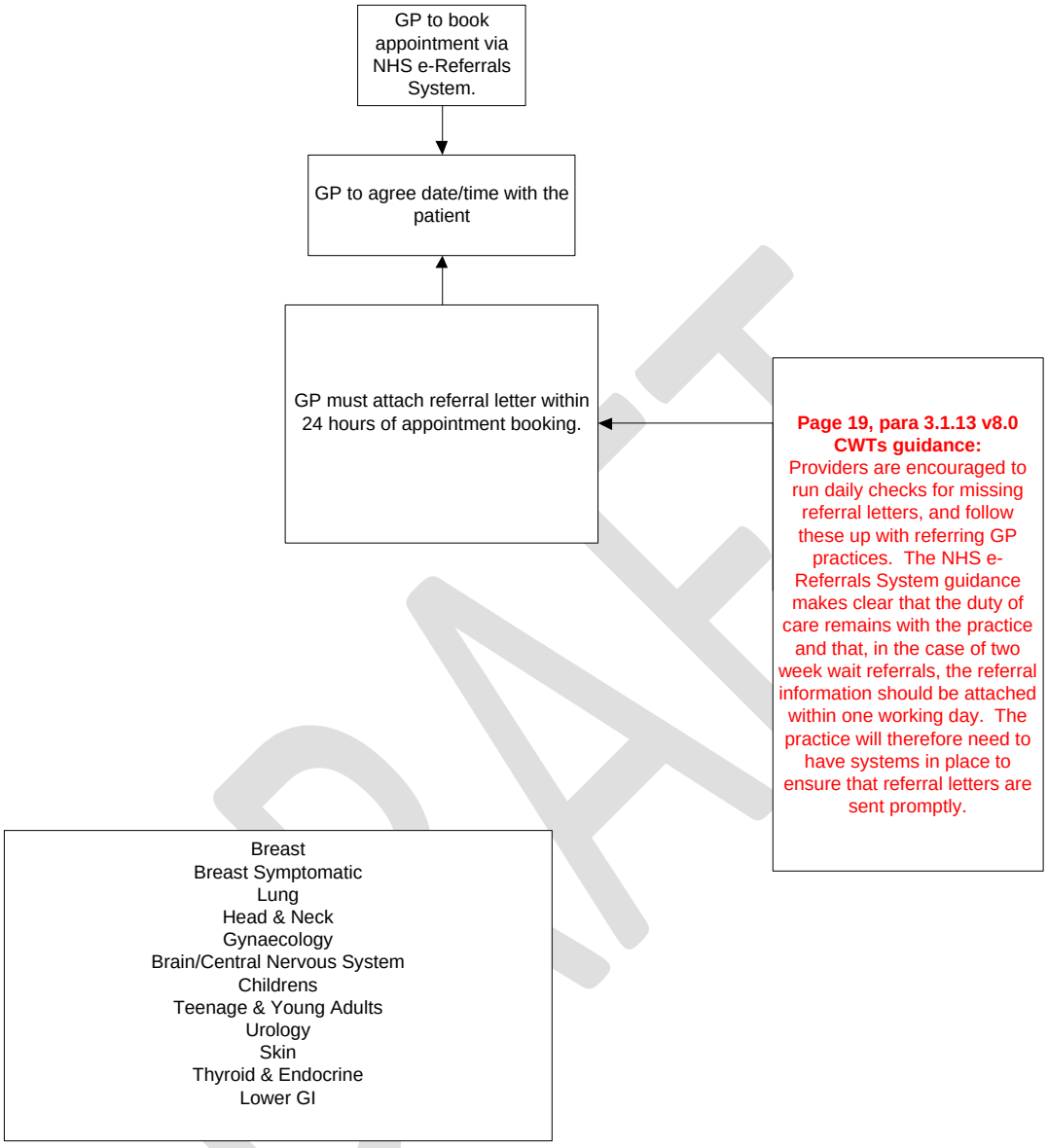


Section A: Appendix A3 – 2ww patient does not attend outpatient appointment (DNA)



Breast
Breast Symptomatic
Lung
Head & Neck
Gynaecology
Brain/Central Nervous System
Childrens
Teenage & Young Adults
Urology
Skin
Lower GI
Thyroid & Endocrine

Section A: Appendix A4 – 2ww tumour sites where 1st OPA is always booked



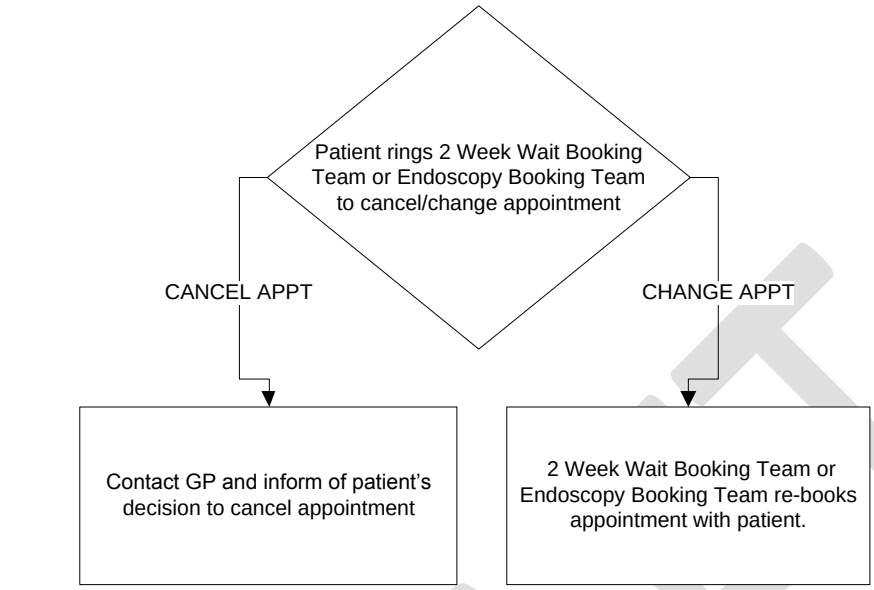
Section B: Tumour sites where clinical team triages to either 1st OPA or straight to test.

Scenario	Action
Tumour sites where clinical team triages to either 1st OPA or straight to test. ***See Appendix B 1- 4 flowchart*** Upper GI - Endoscopy Haematology	• GP to send 2ww referral form electronically into the Upper GI or Haematology Review Work list on NHS e-referrals with extract of Medical History, Medication and Allergy History from GP system • For Upper GI the 2 Week Wait Booking Team accept the referral and print off the referral letter on a daily basis for the consultant to vet. • Each referral is logged on the Upper GI Target spread sheet for monitoring. • After clinical review the referral letters requiring a 1st OPA booking are collected on a daily basis and transacted within 24 hours. • For patients requiring a diagnostic test these are added to the Waiting List by the Endoscopy Team. • The Upper GI Target spread sheet is updated by the 2 Week wait Booking Team to reflect the clinical decision. • The GP is informed of the clinical decision of OPA or diagnostic Test. • For Haematology the referral letter is emailed to the Haematology PPCs for the clinician to vet. • The 2WW Booking Team is notified by the Haematology PPC regarding the appointment and the patient is contacted to confirm the date. • The 2WW Booking Team informs the GP of the appointment date.
No slot availability for 1st OPA or diagnostic test	• 2 Week Wait Booking Team or Endoscopy Booking Team to book appointment and liaise with patient. • 2 Week Wait Booking Team or Endoscopy Booking Team to notify the relevant Business Manager within 1 working day of capacity issues • Business Manager to liaise 2 Week Wait Booking Team or Endoscopy Booking Team with re making additional slots available • If cannot be resolved Business Manager to escalate to Divisional General Manager and notify 2 Week Wait Booking Team within 48hours of initial request.
Appointment cancelled/changed by Patient	• Patient rings 2 Week Wait Booking Team or Endoscopy Booking Team to cancel/change appointment. • 2 Week Wait Booking Team or Endoscopy Booking Team re-books appointment with patient. • GP contacted if the patient cancels appointment and does not wish to re-book.
Patient DNAs	• 2 Week Wait Booking Team will utilise the NHS e-referrals rebooking work list to contact the patient

	and rebook the 1st OPA. • The Endoscopy Booking Team will re-book a further TCI after 1st DNA. • For non e–referral 2 Week Wait appointments the Business Intelligence 2 Week Wait DNA report will be used. • GP contacted if the patient DNAs appointment and does not wish to re-book • Consultant informed if the patient DNAs more than twice or more for next steps.

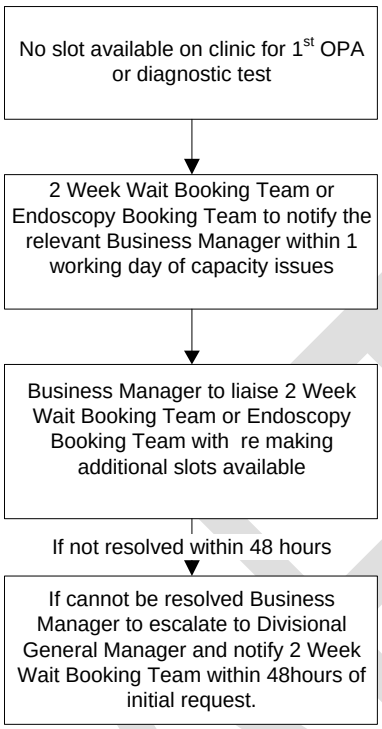
NHS e-Referrals System guidance makes it clear that the duty of care remains with the practice and in the case of 2ww referrals, the referral information should be attached within one working day.

Section B: Appendix B1- appointment cancelled or changed by patient



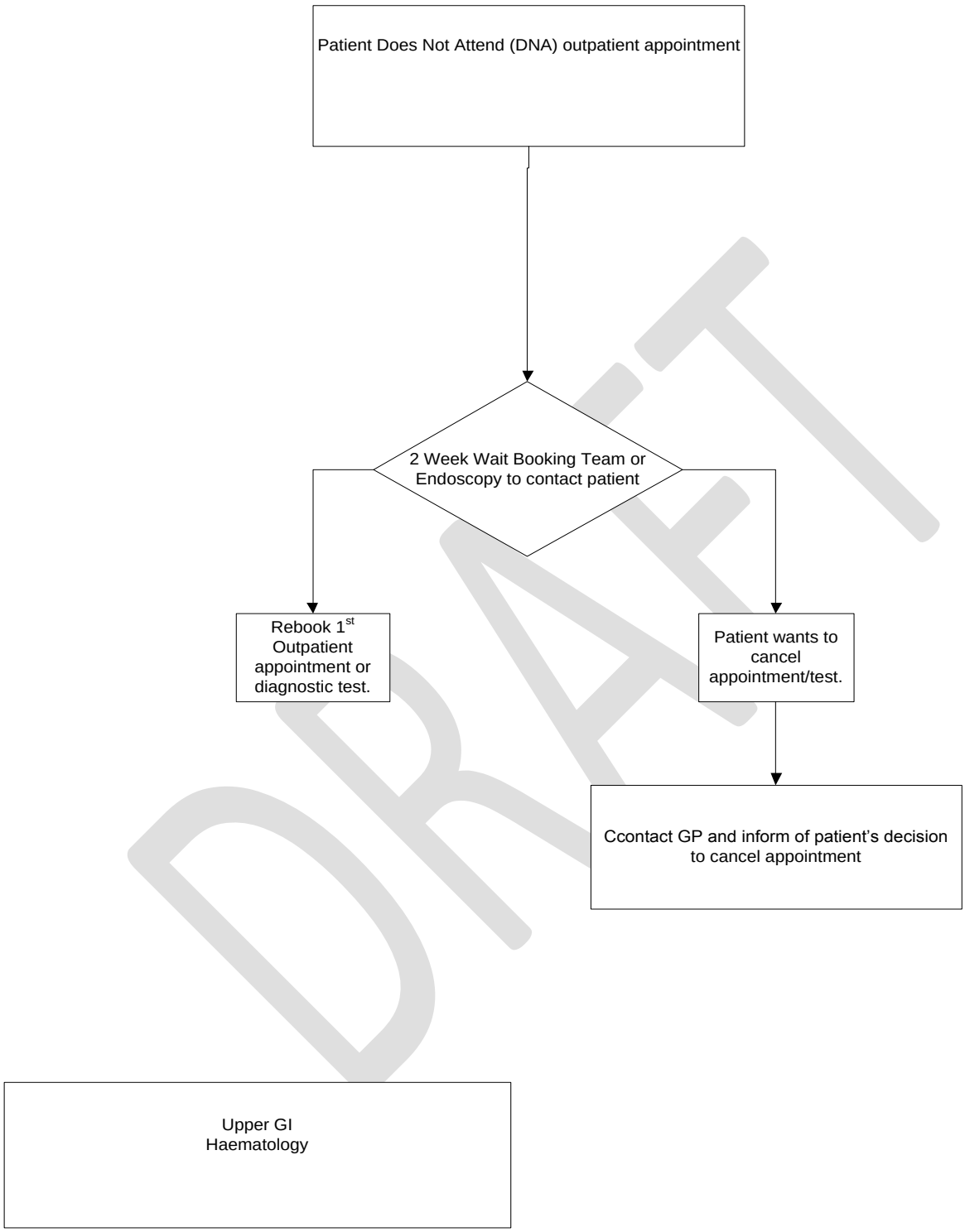
Upper GI
Haematology

Section B: Appendix B2 - No slot availability for 1st OPA or diagnostic test

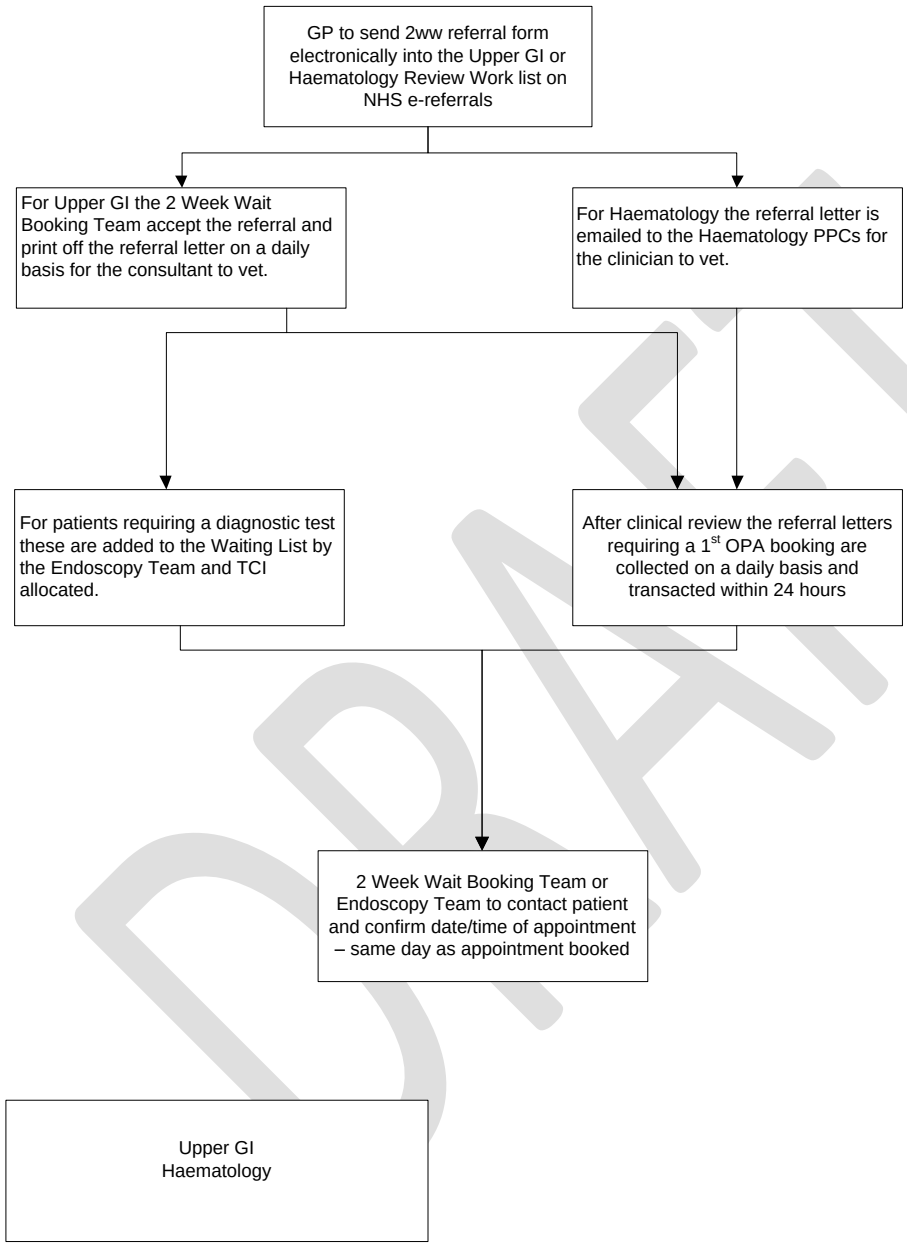


Upper GI
Haematology

Section B: Appendix B3 - Patient does not attend outpatient appointment or diagnostic test



Section B: Appendix B4 - Tumour sites where clinical team triages to either 1st OPA or straight to test



Section C : Inter MDT Referrals

Local (SFHFT) Standard: Accurate (100%) recording of referrals between MDTs and to ensure no patient can be 'lost' between MDTs.

Scenario	Action
Transfer of referrals between MDTs (irrespective of route of referral) Continues on existing pathway ***Appendix C1 – Inter-MDT referral forms***	• For Inter-MDT referrals the individualised Tumour Site Specific forms should be utilised which are located electronically on the SFH Trust Intranet. Hard copies are also located in the MDT Meeting Room. • Clinical teams to populate the forms with the patient information and clinical details • The forms then should be emailed or sent to the appropriate clinical MDT Lead (and copied to the Cancer Pathway Coordinator). • The receiving MDT should ensure the patient is added for discussion at the next scheduled MDT meeting. • Post MDT meeting discussion an update should be provided to the referring MDT and the next steps for the patient documented and actioned in a timely manner.

Section C: Appendix C1 Inter-MDT referral forms

Located on the Sherwood Forest Trust Intranet Site at:

http://sfhnet.nnotts.nhs.uk/departments/cancerservices/deptbrowse.aspx?recid=5321&mode=new

Cancer of Unknown Primary (CUP) Referral Forms are only currently available in hard copy in the MDT Meeting Room or via the Cancer Pathway Team.

Section D: Incoming Tertiary Referrals

Local (SFHFT) Standard:

a) **100% incoming tertiary referrals to be received via Cancer Pathway Team (central email address)**
b) **All incoming tertiary referrals are received by Day 42 of the 62 day pathway**
c) **All incoming tertiary referrals to be recorded on Orion**

Scenario	Action
All incoming tertiary referrals to be received by the Cancer Pathway Team (single point of referral).	• Tertiary referrer centres to send information via the Network agreed tertiary spread sheet to the Cancer Pathway Team central email address (sfh-tr.SFHFT-CancerPathwayTeam@nhs.net). • Cancer Pathway Team to record all incoming tertiary referrals on Orion as appropriate and day of pathway received • Any missing CWT information to be notified back to originating Trust by Cancer Pathway Team • Clinical team to notify Cancer Pathway Team of next steps for each patient • Tumour site pathway to be followed from this point.

Section E: Outgoing Tertiary Referrals

Local (SFHFT) Standard :

d) 100% outgoing tertiary referrals to be recorded on the Orion system and sent via Cancer Pathway Team(central email address)

e) All outgoing tertiary referrals to be sent by Day 42 of the 62 day pathway

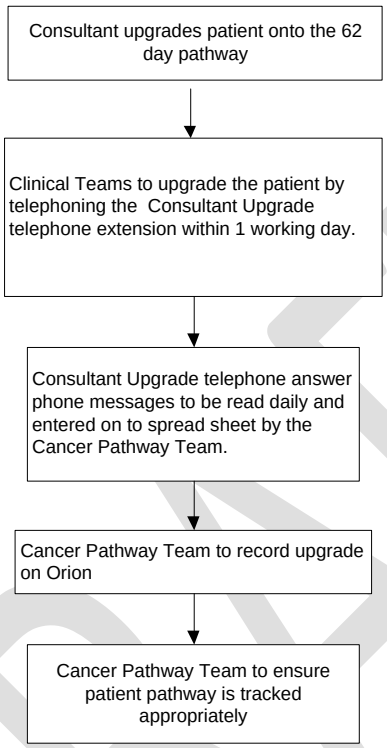
Scenario	Action
All outgoing tertiary referrals to be recorded and sent through the Cancer Pathway Team (single point of referral).	• Trust to confirm to all tertiary referrer centres of the central email address for the Cancer Pathway Team and that all tertiary referrals will be sent by this route. • Cancer Pathway Team to record all outgoing tertiary referrals on Orion database • Cancer Pathway Team to record day of pathway outgoing tertiary referrals sent • Cancer Pathway Team to send all tertiary referrals on the tertiary spread sheet via the Cancer Pathway Team central email address. • Receiving provider to notify SFHFT Cancer Pathway Team of receipt of referral (within 1 working day) • Any missing CWT information to be notified back to SFHFT MDT Cancer Pathway Team by receiving provider Cancer team. • Specialist tumour site pathway to be followed from this point.

Section F: Consultant Upgrades

Local SFHFT Standard: 100% Consultant upgrades are recorded on the Orion system by the Cancer Pathway Team and are tracked appropriately through the 62 day pathway.

Scenario	Action
100% of Consultant upgrades are recorded on the Orion System and are tracked appropriately through the 62 day pathway. ***See Appendix F 1 – flowchart***	• Clinical Teams to upgrade the patient by telephoning the Consultant Upgrade telephone extension within 1 working day, and providing the information required to enable the patient to be tracked on the 62 day pathway • Consultant Upgrade telephone answer phone messages to be read daily and entered on to spread sheet by the Cancer Pathway Team. • Cancer Pathway Team to record upgrade on Orion. • Cancer Pathway Team to ensure patient pathway is tracked appropriately.

Section F: Appendix F1 – 100% of consultant upgrades are recorded on Orion and tracked appropriately through the 62 day pathway



ALL TUMOUR SITES

Section G: Imaging department policy for the rapid notification of a new or unsuspected imaging diagnosis of cancer or serious unexpected findings

Scenario	Action
A new or unsuspected imaging diagnosis of cancer could arise from the following : • GP requested tests (e.g. x-ray, CT, or MRI) • Consultant requested tests (e.g. from routine 18 week referrals) **Appendix G1 - tumour sites are informed of cases of probable suspected malignancy identified in Radiology**  Unsuspected Cancer Policy - version 9 (2).	What is a new or unsuspected imaging diagnosis of cancer? This is defined as those suspicious lesions identified by radiology following G.P direct access tests, identified on the radiology report as UUUUs. process to be followed by SFHFT when a UUUU has been identified • Radiology will return the report to the original referrer (G.P/clinician) highlighting that a suspicion of cancer may be present. It remains the responsibility of the doctor who requested this examination to ensure appropriate and prompt onward referral. • If the original referrer is the G.P then it is their responsibility to inform the patient they are referring the patient to SFHFT on a 2ww suspected cancer pathway (and to give the patient the CCG 2ww leaflet). • Once the 2ww referral (and medical history) has been received from the GP, the patient will be recorded on Medway and Orion and tracked on the 62 day pathway.

Section G: Appendix G1: Which tumour sites are informed of cases of probable suspected malignancy identified in Radiology

	Email to:	Hard copy to:
Specialty	Person	
Gynae	Mr Gie's Secretary, Pam Radzki, Karen Purnell	Mr Gie
UGI	Dr Sharat Misra, Sarah Swain (now including liver mets of unknown primary)	Dr Misra
CRC (Specialist Nurses)	Joint email - Sue Godber, Louise Smith, Sharon Hudson	CR Specialist Nurses
Lung	Dr Giles Cox's Secretary, Sarah Chappell, Alison Machin and Thomas Reid	Dr Cox
ENT	Sue Stringer, Specialist Nurse	Sue Stringer, Specialist Nurse
Urology	Mr Ashok Bhojwani, Janet Parkin** see below	Mr Bhojwani
Haematology	Dr Steve Jones (cc: Rosalind Bunting/Jackie Rhodes)	Dr Jones
Breast	Joint email – Gillian Clark,	Breast Care Nurses
Sarcoma	Joint email – Nicola Wilshaw, (@**nuh.nhs.uk**)	Sarcoma specialist nurse, Cancer Centre, NCH
Unknown primary/bone metastases	Lara Hardy and Karen Shaw, acute oncology service nurse specialists	Lara Hardy, acute oncology nurse specialist

Section 13: GLOSSARY

Referral to treatment period	The part of a patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other clock stop.
A	
Active monitoring	A patient's RTT clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage. A new clock would start when a decision to treat is made following a period of active monitoring (in previous guidance also known as watchful waiting) Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to refer the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such and also stops a clock. If a patient is subsequently referred back to a consultant-led service, then this referral starts a new clock.
Admission	The act of admitting a patient for a day case or inpatient procedure
Admitted pathway	A pathway that ends in a clock stop for admission (day case or inpatient)
B	
Bilateral (procedure)	A procedure that is performed on both sides of the body, at matching anatomical sites. For example, removal of cataracts from both eyes.
C	
Care Professional	A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
e-Referrals (Choose and Book)	A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic
Clinical decision	A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements
Consultant	A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. The operating standards for referral to

	treatment exclude non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.
Consultant-led	A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.
Convert(s) their UBRN	When an appointment has been booked via Choose and Book, the UBRN is converted. (Please see definition of UBRN).
D	
DNA – Did Not Attend	DNA (sometimes known as an FTA – Failed to attend). In the context of the operating standards, this is defined as where a patient fails to attend an appointment/admission without prior notice
Decision to admit	Where a clinical decision is taken to admit the patient for either a day case or inpatient treatment
Decision to treat	Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatments performed in other settings e.g. as an outpatient
F	
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 for clinical judgement, in consultation with others as appropriate, including the patient.
Fit (and ready)	A new patient pathway and clock should start once the patient is fit and ready for a subsequent bilateral procedure. In this context, fit and ready means that the clock should start from the date that it is clinically appropriate for the patient to undergo that procedure, and from when the patient says they are available.
H	
Healthcare science intervention	See *Therapy or Healthcare science intervention*
I	
Interface service (non consultant-led interface service)	All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care. The operating standard/right relates to hospital/consultant-led care. Therefore, the definition of the term 'interface service' within the context of the operating standards does not apply to similar 'interface' arrangements established to deliver traditionally primary care or community provided services, outside of their traditional (practice or community based) setting.

	The definition of the term does not also apply to: • Non consultant-led mental health services run by Mental Health Trusts. • referrals to 'practitioners with a special interest' for triage, assessment and possible treatment, except where they are working as part of a wider interface service type arrangements as described above.
N	
Non-admitted pathway	A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment'
Non consultant-led	Where a consultant does not take overall clinical responsibility for the patient.
Non consultant-led Interface service	See *interface service*
O	
Operational Standards	We will define success by what our patients tell us, but patients' views need to be underpinned by measures of delivery that organisations can report and monitor progress on operationally. We will continue to measure performance against the minimum operational standards of 90 per cent (admitted patients) and 95 per cent (non-admitted patients). These operational standards allow for patient initiated delays (patients who choose to wait longer than the maximum 18 weeks period) and clinical exceptions (patients for whom treatment in 18 weeks is not in their best clinical interests) on referral to treatment pathways.
R	
Reasonable offer	Where a decision to admit, as either a day case or inpatient has been made, many patients will choose to be admitted at the earliest opportunity. *A reasonable offer* is an offer of a time and date three or more weeks from the time that the offer was made. If patients decline these offers and decide to wait longer for their treatment they will not be penalised and or their waiting time adjusted.
Referral Management or assessment Service	Referral management or assessment services are those that do not provide treatment, but accept GP (or other) referrals and provide advice on the most appropriate next steps for the place or treatment of the patient. Depending on the nature of the service they may, or may

	not, physically see or assess the patient. Referral Management and Assessment Services should only be in place where they carry clinical support and abide by clear protocols that provide benefits to patients. They must not be devices either to delay treatment or to avoid having clinical discussions with GP practices about good referral practice. In the context of the operational standards, a clock only starts on referral to a referral management and assessment service where that service may onward-refer the patient to a surgical or medical consultant-led service before responsibility is transferred back to the referring health professional.
S	
Straight to test	A specific type of direct access diagnostic service whereby a patient will be assessed and might, if appropriate, be treated by a medical or surgical consultant-led service before responsibility is transferred back to the referring health professional.
Substantively new or different treatment	Upon completion of a referral to treatment period, a new pathway and clock starts upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan; It is recognised that a patients' care often extends beyond the 18-week maximum referral to treatment period, and that there may be a number of planned treatments beyond first definitive treatment. However, where further treatment is required that was not already planned, a new pathway and clock should start at the point the decision to treat is made. Scenarios where this might apply include: • where less 'invasive/intensive' forms of treatment have been unsuccessful and more 'aggressive/intensive' treatment is required (e.g. where Intra Uterine Insemination (IUI) has been unsuccessful and a decision is made to refer for IVF treatment); • Patients attending regular follow up outpatient appointments, where a decision is made to try a substantively new or different treatment. In this context, a change to the dosage of existing medication may not count as substantively new or different treatment, whereas a change to

	medication combined with a decision to refer the patient for therapy might. Ultimately, the decision about whether the treatment is substantively new or different from the patients agreed care plan is one that must be made locally by a care professional in consultant with the patient.
T	
Therapy or Healthcare science intervention	Where a consultant-led or interface service decides that therapy (for example physiotherapy, speech and language therapy, podiatry, counselling) or healthcare science (e.g. hearing aid fitting) is the best way to manage the patient's disease, condition or injury and avoid further interventions;
U	
UBRN (Unique Booking Reference Number)	The reference number that a patient receives on their appointment request letter when generated by the referrer through Choose and Book. The UBRN is used in conjunction with the patient password to make or change an appointment.