Outstanding Care,
Compassionate People,
Healthier Communities

Sherwood Forest Hospitals
NHS Foundation Trust

CANCER ACCESS POLICY

POLICY

Reference	GV 013
Approving Body	Cancer Steering Group
Date Approved	24th September 2024
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**

YES	**NO**	**N/A**
		X

Issue Date	14/10/2024
Version	4
Summary of Changes from Previous Version	Changes to the below numbered sections. **6.5** Inclusion of Direct Access Brain MRI Pathway **6.9** Rewording to specify referrals must not be rejected back to GP when insufficient information is provided. **6.13** Inclusion of guidance for routine referrals where cancer is suspected. **6.14.3** Rewording of the screening section in relation to first seen guidance. **6.14.10** Patient Thinking time – guidance provided to not exceed 1 week. All guidance remains in line with CWT v12
Supersedes	Cancer Access Policy v3
Document Category	Governance
Consultation Undertaken	Cancer Steering Group
Date of Completion of Equality Impact Assessment	17/07/2024
Date of Environmental Impact Assessment (if applicable)	N/A
Legal and/or Accreditation Implications	Developed in line with best practice Model Access Policy. Elective Care Improvement Support Team NHSE/NHSI
Target Audience	This policy applies to any staff involved in the management of cancer patients at the Trust irrespective of who is making the booking and where the activity is scheduled. The policy does not apply to emergency care
Review Date	September 2025
Sponsor (Position)	Chief Operating Officer
Author (Position & Name)	Cancer Services Manager, Samantha Owen
Lead Division/ Directorate	Corporate
Lead Specialty/ Service/ Department	Cancer Services

Position of Person able to provide Further Guidance/Information	Cancer Services Manager

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
N/A	**N/A**

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APPENDICIES

1.0 INTRODUCTION

Sherwood Forest Hospitals NHS Foundation Trust is committed to ensuring that patients receive treatment in accordance with the NHS Constitution, national objectives, targets and the Long Term Plan. https://www.england.nhs.uk/cancer/strategy/

This policy sets out the Trusts local policy and operational standards associated with meeting the National Cancer Waiting Times guidance v12 from NHS England. This policy is designed to ensure efficient and equitable handling of referrals and should be used in conjunction with the Trusts Elective Care and Access Policy.

Our Patient's best interests are at the forefront of this policy. The timescales within which patients on a cancer pathway are treated is a vital quality issue and key indicator of the quality of cancer services offered at SFHFT.

All Staff within the Trust have a responsibility to manage all cancer pathways to ensure that patients are treated within timescales that meet the National Cancer Waiting Times and in accordance with clinical priorities.

2.0 POLICY STATEMENT

The purpose of this policy is to ensure that all patients on a cancer pathway are managed equitably and consistently, in line with national waiting time standards and the NHS Constitution.

The policy:

- Is designed to ensure the management of elective patient access to services is transparent, fair, equitable and managed according to clinical priorities.
- Sets out the principles and rules for managing patients through their urgent suspected cancer pathways.
- Applies to all clinical and administrative staff and services relating to urgent suspected cancer patient access at the trust.

The policy covers those responsible for referring patients, managing the receipt of referrals, booking outpatient activity, management of diagnostics and maintenance of the waiting list for the purpose of taking a patient through their referral to treatment pathway. This policy applies to the management of all patients on a suspected or confirmed cancer pathway at the Trust irrespective of who and where the booking and scheduling of patient's activity is undertaken.

3.0 DEFINITIONS/ABBREVIATIONS

Section 12 Appendices.

4.0 ROLES AND RESPONSIBILITIES

Whilst the Chief Executive has overall responsibility for achieving the Trusts national standards as the accountable officer, all staff with access to the elective care patient administration systems (PAS - The Trust use Careflow) have a duty to maintain the information held within and are accountable for their accurate data input.

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

- Divisional Clinical Chairs and Divisional Managers have a shared responsibility for implementation of the Cancer Access 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 patient tracking list (PTL), and for the management of these patients through their pathways.

- Hospital Consultants, Clinical Nurse Specialists along with the divisional teams have a shared responsibility for managing patients waiting times.

- The Information Manager is responsible for the timely provision of operational information to support delivery of patient pathways and for the reporting of information within and external to the organisation. Including the production of PTLs which support the Divisions in managing waiting lists and Cancer Waiting Times standards.

- The Careflow PAS Manager is responsible for the management of the Careflow system on which patient information and waiting lists are held.

- Waiting List Administrators and Patient Pathway Coordinators for outpatients, diagnostics and elective inpatient or day care services are responsible for the day-to-day management of their lists and are supported in this function by the divisional general managers and directors who are responsible for achieving access standards.

- Operational managers are responsible for ensuring the NHS e-referral service directory of services (DOS) is accurate and up to date and available to referrers.

- General practitioners (GPs) and other referrers play a pivotal role in ensuring patients are fully informed during their consultation of the likely waiting times for a new outpatient appointment. GPs should ensure quality referrals are submitted in line with the DOS to the appropriate provider first time.

- The Trust is responsible for providing information to the ICB relating to the DOS and referral criteria and providing relevant feedback when GP's have not followed guidance, which can then be shared with GPs.

- The trust is responsible for a providing a robust mechanism of receiving feedback when this or other trust policies are breached.

- The ICB are responsible for ensuring there are robust communication links for feeding back information to GPs.

5.0 APPROVAL

The policy was formally ratified at the following committees:

Contributors	Communication Channel:	Date
Cancer Steering Group	For Ratification	24/09/2024

6.0 DOCUMENT REQUIREMENTS: CANCER ACCESS POLICY

6.1 Adjustments to cancer pathways

Adjustments to cancer pathways and waiting times are allowed for two reasons:

1) If a patient does not attend (DNA) their initial outpatient 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 patients first seen appointment and the 62-day standard.

2) An adjustment for treatment can be applied if a patient declines a 'reasonable' offer of admission for treatment (for both admitted and non-admitted pathways).

NB: For cancer patients under the 31-day or 62-day standard "reasonable" is defined 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.

6.2 Management of 1st Did Not Attend (DNA) Appointments, diagnostics, and staging following 1st appointment

Patients must be offered and have accepted at least two initial appointments (outpatients or diagnostics/test).

Any patient who DNAs their 1st appointment will be offered another appointment within 7 days. If the patient does not accept an appointment within this timescale a further appointment will be offered up to a maximum of 14 days from the date of the DNA appointment. Patients **should not** be referred back to their GP after **DNA** of their 1st appointment.

If the patient DNAs a second appointment they may be referred back to GP care, subject to clinical review and the discretion of the clinician 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.

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.

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.

Patients should not be referred back to their GP after first DNA or cancellation of any appointment/treatment.

Patients can be referred back to their GP after multiple (two or more) DNAs or cancellations. Patients cannot be referred back to their GP following 1 DNA and 1 cancellation.

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.

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.

6.3 Urgent Suspected Cancer Referrals (USCR): Pathway Definitions

In accordance with national standards and guidelines, the Trust is committed to ensuring patients referred urgently with suspected cancers or breast symptoms, where cancer is not suspected, will be seen at the earliest opportunity.

There is no national standard on time to date a first appointment. USCR will be seen at the earliest opportunity to enable 28-day faster diagnosis. USCR can only be "downgraded" by the GP, Dentist or Optometrist - if a consultant thinks the Urgent Suspected Cancer referral is inappropriate this should be discussed with the referrer and the referrer asked to withdraw the USCR. **The referral cannot be rejected.**

6.4 Management of Urgent Suspected Cancer Referral pathways

The rules for cancer pathways apply a strict gateway control to ensure patients are seen quickly and cancers diagnosed at the earliest opportunity. USCR will be seen at the earliest opportunity to enable 28-day faster diagnosis from:

a) GP, Dentist or Optometrist referral for urgent referrals where cancer is suspected, and if this is not possible, the Trust must take all reasonable steps to offer a range of alternatives.

b) Symptomatic breast referral (cancer not suspected), and if this is not possible, the Trust must take all reasonable steps to offer a range of alternatives.

The following 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 appointment dates offered.

6.5 Direct booking

The Trust has a directly bookable service for the following tumour sites: ENT, Maxillofacial, Ophthalmology, Breast, Gynaecology, Skin, and Urology. The Central Support Team will advise the appropriate Divisional Business Unit/Service Manager regarding capacity issues daily and action taken.

6.6 Clinical Assessment Service

For the tumour sites of Lung, 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 an urgent suspected cancer appointment slot.

Some Upper GI referrals are suitable for straight to test within Endoscopy and Radiology 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.

Some Lung referrals are suitable for straight to test within radiology 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 Lung service.

Some Lower GI referrals are suitable for straight to test and are vetted by the straight to test colorectal nurses for clinical suitability prior to offering a clinical/ straight to test appointment. This vetting should take place within 24 hours of receipt into the LGI service.

Some patients will be referred into the Trust by their GP on a direct access chest x-ray pathway. If this chest x-ray shows an abnormality the patient will be offered a CT. If this CT confirms the abnormality the patient will remain under the care of the Trust without the need for a referral from the GP.

In this instance, this should be recorded as an USCR, following triage of the CT resulting in follow-up being required in secondary care. The cancer waiting times pathway start date should be recorded as the date of this triage.

Some patients will be referred into the Trust by their GP on a direct access Brain MRI pathway, if this MRI shows an abnormality the reporting radiologist can follow the pathways below. The MRI will be performed within a few days and the report will be forwarded back to the referring GP.

6.7 Patient inability to attend

Should the patient not be able to attend their initial USCR appointment then alternative appointments should be offered at the earliest opportunity. Patients should not be referred back to the GP because they are unable to accept a first appointment following their USCR referral due to, for example, a social commitment, ill health or logistical issues.

Any patient who contacts the Trust to change their appointment should be offered another appointment date at the earliest opportunity. It is expected that a certain proportion of patients will choose to wait longer, the operational standard takes this into account.

Patients who continually change appointments or cancel, should be reviewed by the clinician and a wellbeing call arranged if required.

6.8 GP referral within 24 hours

A GP should refer a patient within 24 hours of making the decision to refer. A GP should refer a patient even if a patient cannot make themselves available for their initial appointment/test on referral, 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 USCR Proforma, including dates not available.

6.9 USCR 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.

6.10 USCR 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** have their referral rejected back to their GP.

The trust has a local agreement with the ICB, where patients referred in without a FIT result can be rejected back to the GP.

6.11 NHS E-RS Advice and Guidance (A&G) for cancer pathways

The Advice and Guidance (A&G) function should not be used in place of an USCR. For example, where a patient clearly meets NG12 criteria this should usually result in an USCR.

A&G can be converted into an USCR appointment in line with the local referral and commissioning guidelines and where this happens must be classed as an USCR, not a consultant upgrade.

Where an A&G referral is converted the e-RS pathway start will capture the date on which the provider converts the referral. When making the decision to convert A&G directly into a referral and appointment, the clinician reviewing should take into consideration whether they have the required information, and whether the patient is likely to know there is a suspicion of cancer.

6.12 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. USCR can only be "downgraded" by the GP - if a consultant thinks the USCR is inappropriate this should be discussed with the GP and the GP asked to withdraw the USCR status.

If this request is authorised by the GP, then the USCR must be withdrawn by the GP and then re-submitted as an urgent or routine referral. If the request is not authorised by the GP, then the patient will remain on the urgent suspected cancer pathway.

6.13 Management of Routine Referrals where cancer is suspected on triage/vetting

Patients referred on a routine referral, where upon triage/vetting cancer is suspected, **should not** be rejected back to the GP. The patient must be upgraded using the **Consultant Upgrade Policy**

6.14 Pathway Definitions

6.14.1 Diagnostic and Treatment Pathways (31 and 62-day)

Any patient referred as an USCR or breast symptomatic 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).

A pause can be applied to the pathway for patient choice, this 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 both admitted and non-admitted settings. 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 to pausing a patient pathway, 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.

6.14.2 Management of 31 and 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 by letter so that they are aware of the elevated priority of the referral. The date of upgrade, is the date the Cancer Service is notified.

The Trust has a **Consultant Cancer Upgrade Policy** which provides clear and documented instructions about who can upgrade and how to upgrade patients.

6.14.3 Screening patients

Screening patients are not USCR. 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
- Bowel
- Cervical (Gynaecology)

The pathway start date (day 0) is when a referral is received by a provider in the screening pathway for further investigation after an initial screening test. The date first seen for the individual screening programmes are as follows:

- Breast – first attendance for breast screening assessment
- Bowel – first attended appointment with specialist screening following FOBT or FIT result
- Cervical – first attended colposcopy appointment.

Referrals from cervical screening to be counted against Faster Diagnosis Standard (FDS) and 62-day standard are:

- Cytology showing borderline changes in endocervical cells or high grade (moderate or severe) or worse (I.e. abnormalities within scope of the standard) This includes patients with possible invasive cancer, possible glandular neoplasia, severe dyskaryosis and moderate dyskaryosis.

Referrals marked as routine, and patients covered by the Referral to treatment (RTT) pathway are as follows:

- All cervical screening programme referrals not included in priority 2 (i.e. abnormalities not covered by this standard – cancer not suspected/likely)

- If a patient comes from the cervical screening programme under a routine referral and cancer was then suspected, they should be upgraded.

6.14.4 When does the 62-day standard start for the three cancer screening programmes?

The pathway start date 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 – date of abnormal screening result.

6.14.5 Where Patients are not immediately fit for diagnostics/treatment

If it is known that a patient is clinically unfit for diagnostic/treatment needed within the timeframe scheduled for their appointment, appointments should not be made 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.

The operational requirement for the 28-, 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.

6.14.6 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 31-days of the Decision to Treat, even if they have been referred on an USCR.
e) Rare Cancers
   Rare cancers (children's, testicular and acute leukaemias) are treated within 31-days of an USCR or consultant upgrade.

6.14.7 Reasonable Notice (CWTs)

All offers of 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 treatment dates which they know a patient cannot attend.

6.14.8 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.

6.14.9 Patient Choice

The operational standard now considers 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 treatment if the date is offered within the 3 and /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. 31 and 62-day pathways or placed on pending lists for non-admitted treatment) because they cannot guarantee attendance.

6.14.10 '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. The recommendation for thinking time is a maximum and not exceeding 1-week, clinical teams should agree the shortest possible period of appropriate thinking time dependent on the patients' circumstances.

6.14.11 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 Careflow system. The Trust is required to provide proactive arrangements to ensure that patients referred back to their GP/GDP/Optometrist 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 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, however 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 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 to end a 62-day pathway if the initial choice of first definitive treatment is not available within the standard time due to capacity problems, patient choice or fitness.

6.15 Faster Diagnosis Standard (FDS)

The cancer waiting time's service standard is:

- Maximum 28 days from receipt of a GP, Dentist or Optometrist USCR, breast symptomatic referral or urgent screening referral, to the point at which patient is told they have cancer, or cancer is definitely excluded.

6.15.1 Adjustments

The only waiting time adjustment which can be recorded for 28-day FDS are those applicable to the first seen date where a patient DNAs their 1st attendance.

6.15.2 Ending the FDS Pathway

The 28-day FDS pathway ends only at the point of communication with the patient, whether that is to inform them of a diagnosis of cancer, a ruling out, or if they are going to have treatment before a clinical diagnosis of cancer can be made.

Where all reasonable diagnostics to exclude cancer have been completed and the patient is discharged back to their GP, the point at which this is communicated to the patient should be recorded as the end of the 28-day FDS pathway. In such scenarios this should be recorded as a ruling out of cancer.

6.15.3 Communicating to the Patient

All diagnoses of cancers should be made through **direct face-to-face** communication with the patient, unless otherwise explicitly agreed with the patient.

Reasonable forms of communication with patients to confirm cancer has been ruled out include:

- direct communication with the patient, over phone, Skype or similar.
- written communication by letter, or by email.
- face to face communication at an outpatient appointment.

Where direct communication is not possible due to the patient not having the mental capacity to understand a diagnosis either temporarily or permanently, communication to the patient's recognised carer or a parent/guardian should be recorded in the same way as if the patient was told directly.

The Trust should ensure that the communication is easy to understand, and that support is available to patients who would like further information.

6.15.4 Diagnoses of a different type of cancer than initially referred.

For a patient where a specific cancer is ruled out but is still considered high risk and requiring further urgent investigation, an inter-specialism referral should be considered the normal course of action. The 28-day FDS clock continues to run until suspicion of cancer has been reasonably ruled out.

If a patient is referred for a suspected cancer and a different cancer is incidentally found that is unrelated to the referral, the 28-day FDS pathway will end when the patient is told their diagnosis or, where it comes first, the decision to treat the incidental cancer.

6.15.5 Exclusions from FDS

The following exclusions apply to the FDS standard:

- Patient died before a communication of diagnosis - This is to be used where a patient dies before a communication of cancer diagnosis or exclusion of cancer.

- Patient declined all diagnostic appointments - This can only be used where a patient declines all diagnostics appointments and is therefore discharged back to the GPs care or exceptionally when agreed with the patient followed up routinely in secondary care.

- Patient declined all appointments - This can only be used where a patient declines all appointments and is therefore discharged back to the GPs care. In this scenario this should be clearly communicated to the GP.

- Patient opted for private diagnostics - This can be applied where a patient has opted to have their diagnostics through private funding.

- Repeated DNA/Patient triggered cancellations - This can only be applied following multiple DNAs and patient cancellations where a clinical decision is made to discharge the patient back to the GPs care.

- Patient ineligible for NHS funded care - This can be applied if a patient is found to be ineligible for NHS funded care, and as a result is discharged by the provider. This cannot be applied if a patient continues on the pathway under NHS care.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Continuous validation of the PTL will be used to identify any areas of non-compliance with the policy, which may identify themes, departments or individuals where further training is required.

8.0 TRAINING AND IMPLEMENTATION

Any member of staff who has a role in the booking or scheduling of patients or the preparation or administration of patient attendances should familiarise themselves with the policy. The Cancer Services department will be responsible for training relevant managers and team leaders who will be responsible for cascading it to their teams

9.0 IMPACT ASSESSMENTS

This document has been subject to an Equality Impact Assessment, see completed form at Appendix 2

This document is not subject to an Environmental Impact Assessment.**10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS**

Evidence Base:

- The policy supports the delivery of the NHS Constitution, the national waiting time standards for Cancer and the national waiting time standards for Referral to Treatment (RTT).
- Cancer Waiting Times Version 12.
- NHSE/NHSI Guidance advice on maintaining cancer treatment during the COVID-19 response. Publications approval reference: 001559.

Related SFHFT Documents:

- Elective Care Access Policy.
- Consultant Upgrade Policy.

10.0 APPENDICES

Definitions

Term	Definition
Urgent Suspected Cancer Referral	A patient is referred urgently with suspected cancers or breast symptoms, where cancer is not suspected for a first outpatient appoint or 'straight to test'.
28-day Faster Diagnosis Standard	Maximum four weeks (28 days) from receipt of urgent GP, Dentist or Optometrist referral for suspected cancer, breast symptomatic referral or urgent screening referral, to the point at which patient is told they have cancer, or cancer is definitely excluded.
31-day pathway	The starting point for 31-day standard is the date a patient agrees a plan for their treatment or the date that an earliest clinically appropriate date (ECAD) is affected for subsequent treatments.
62-day pathway	Any patient referred by a GP with a suspected cancer on a Urgent suspected cancer referral pro-forma, referral from a screening service, a referral from any healthcare professional if for breast symptoms or where a routine referral has been upgraded by a hospital clinician, must begin treatment within 62 days from receipt of referral.
B	
Breach	A pathway which ends when a patient is seen/receives their first treatment outside the, 62-day referral to treatment or the 31-day Decision to treat to treatment.
C	
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 Service	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.

Term	Definition
D	
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.
Did Not Attend (Was not brought)	DNA In the context of the operating standards, this is defined as where a patient fails to attend an appointment/admission without prior notice. WNB Applies to children and young people (who require the presence of a parent or carer to attend appointments) who did not attend a planned appointment and had not cancelled the appointment.
Direct access	Where GPs refer patients to hospital for diagnostic tests only and return to the GP for their care. These patients will not be on an open RTT pathway.
E	
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.
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
I	
Inpatient	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night.
P	
Pathway	Urgent Suspected Cancer Referral Patient Pathway is generated from a referral for upgrade and maps the patients' core journey. It is defined by a 20 digit unique pathway ID.
R	
Reasonable offer	Considered to be any date offered within the cancer waiting time standards.
Referral	Referral can be originated by the GP as e-referral, ICR etc. Where a referral is made to a specialist in a particular field for advice on the best way to manage a condition, this may involve a referral for tests and investigation that cannot be performed in a GP surgery and/or for a consultation in an outpatient setting. An outpatient episode starts on receipt of the referral and ends on discharge back to GP care.
S	
Straight to test	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of a cancer pathway.

Acronyms

Term	Definition
CAS	Clinical assessment and (treatment) service
DNA	Did not attend: patients who give no prior notice of their non-attendance
DTA	Decision to admit
DTT	Decision to treat (date): the date on which the clinician communicates the treatment options to the patient and the patient agrees to a treatment
ECAD	Earliest clinically appropriate date
E-RS	(National) E-Referral Service
FDS	Faster Diagnosis Standard
GP	General practitioner: a physician whose practice consists of providing on-going care covering a variety of medical problems in patients of all ages, often including referral to appropriate specialists
ICE	Inter consultant referral
IPT	Inter-provider transfer
PAS	Patient administration system records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient
PPI	Patient pathway identifier
PTL	Patient tracking list. A tool used for monitoring, scheduling and reporting on patients on elective pathways (covering both RTT and cancer).
RTT	Referral to treatment
TCI	To come in (date). The date of admission for an elective surgical procedure or operation.
USCR	Urgent Suspected Cancer Referral
WNB	Was not brought

APPENDIX 2- EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Cancer Access Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: 17/07/2024			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	Availability of this policy in languages other than English	Alternative versions can be created on request.	None
Gender	None	Not applicable	None
Age	None	Not applicable	None
Religion	None	Not applicable	None
Disability	Visual accessibility of this document	Already in font size 12. Use of technology by end user. Alternative versions can be created on request	None
Sexuality	None	Not applicable	None

Pregnancy and Maternity	None	Not applicable	None
Gender Reassignment	None	Not applicable	None
Marriage and Civil Partnership	None	Not applicable	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	Not applicable	None

What consultation with protected characteristic groups including patient groups have you carried out? None for this version, in that all previous principles remain in accordance with previous version (which was subject to consultation) and this version is primarily a reformat and codification of agreed practices.

What data or information did you use in support of this EqIA? one for this version, in that all previous principles remain in accordance with previous version (which was subject to consultation) and this version is primarily a reformat and codification of agreed practices

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? No

Level of impact
please indicate the perceived level of impact:
Low Level of Impact

Name of Responsible Person undertaking this assessment: Samantha Owen Cancer Services Manager

Signature:
Samantha Owen

Date:
17/07/2024