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NHS
Buckinghamshire Healthcare
NHS Trust

Elective Care Access Policy

BHT Pol 241

Version 3.3

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Document History

Version	Issue	Reason for change	Authorising body	Date
3	1	Formal Review	EMC	Sept 2018
3	2	Extension Request	TPSG	Mar 2023
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Associated Documents

BHT Ref	Title	Location/Link
BHT Pol 093	Multi-agency Policy for Safeguarding Vulnerable Adults	https://intranet.buckshealthcare.nhs.uk/documents/safeguarding-adults-policy
BHT Pol 066	Equal Opportunities and Diversity Policy	https://intranet.buckshealthcare.nhs.uk/documents/equality-and-diversity-policy/
BHT Pol 192	Private Patient Policy	https://intranet.buckshealthcare.nhs.uk/documents/private-patient-policy/
BHT Pol 192	Overseas Visitor Policy	https://intranet.buckshealthcare.nhs.uk/patient-care/overseas-visitors/
	Service line specific Standard Operating Procedures	https://intranet.buckshealthcare.nhs.uk/document-library/standard-operating-procedures-sops/
	18 weeks / RTT Rules Suite	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/464956/RTT_Rules_Suite_October_2015.pdf
	Access Policy – Patient Version on Internet	http://www.buckshealthcare.nhs.uk/Downloads/patient-leaflets-surgery/Elective%20waiting%20lists%20explained%20-%20information%20for%20patients.pdf

Contents

Elective Care Access Policy

1. Introduction

Buckinghamshire Healthcare NHS Trust (BHT) and Buckinghamshire Clinical Commissioning Group (CCG) are united in their commitment to ensure patients receive treatment in accordance with national standards and objectives. The purpose of this policy is to outline the expectations and requirements in terms of managing patients referred into all elective care pathways.

Buckinghamshire Healthcare NHS Trust (hereafter referred to as 'the Trust') is committed to providing a service that offers an exemplary standard of care to patients and to offer services that are fair and accessible to all, providing patient choice and delivering a positive patient experience.

The delivery of patient care will be patient focussed, clinically led and consistent with the values of the Trust. Clear communication and transparency between all stakeholders, including referrers, hospital staff and patients, will underpin the delivery of services in the elective pathway.

The Trust is committed to provide sufficient levels of resources to provide the best care for our patients and treat them within national waiting time standards.

Patients are seen and treated based on their clinical need, providing fair and consistent access for all.

Patients have a personal responsibility for their own health.

2. Objectives

This policy covers the way in which the local health economy will collectively manage administration for patients who are waiting for or undergoing treatment on an admitted, non-admitted or diagnostic pathway.

As set out in both NHS Five Year Forward View and the NHS Constitution, patients have the right to start consultant led treatment within maximum waiting times. The policies and procedures comprising this policy adhere to national best practice and provide a framework to ensure that patients are treated transparently, fairly and reasonably.

The Trust will give priority to clinically urgent patients and treat everyone else in turn. The Trust will work to meet and better the maximum waiting times set by NHS England for all groups of patients.

The Trust will at all times negotiate appointment and admission dates and times with patients. The Trust will work to ensure fair and equal access to services for all patients.
Cancer patients are expected to be managed to the Referral to Treatment (RTT) guidance laid out in this document, supported and overridden by specific cancer guidance laid out in section 5.

3. Trust Values

All Trust policies are developed in such a way to reinforce the '**CARE**' Values developed to strengthen commitment to deliver safe and compassionate care; staff are asked to be mindful of Trust values when applying this policy, in summary to:

- **C**ollaborate: to work together as a team
- **A**spire: to strive to be the best
- **R**espect: valuing each person as an individual
- **E**nable: for all to take responsibility

4. Equality and Diversity Statement

Inherent within all practices, the Trust is committed to the promotion of equal opportunities and the principles of equality and diversity, providing personal, fair and diverse services across the Trust. As with all our policies the Trust takes its responsibilities under the Public Sector Equality Duty (PSED) very seriously and no employee should receive less favourable treatment because of a protected characteristic e.g. (age, disability, gender, marital status, pregnancy/maternity, race, religion, sexual orientation, gender reassignment).

Further guidance can be found in the Trust's Equal Opportunities Policy and on our equality and diversity pages on our Trust website.

http://www.buckshealthcare.nhs.uk/About/equality-and-diversity.htm or
Gov. Website - https://www.gov.uk/guidance/equality-act-2010-guidance

5. Scope

The Purpose of this policy is to guarantee that the best interests of our patients are served by ensuring that the Trust's services are managed in line with national waiting time standard and the NHS Constitution (April 2010). This policy gives guidance to staff within the Trust on providing access to services for patients. This will be achieved by ensuring that all staff understand their role in managing patient access and the delivery of waiting time standards. This policy applies to the principles and procedures for the management of the different groups of patients encompassing elective pathways.

These are categorised as follows:

- Patients on a Referral to Treatment (RTT) pathway awaiting treatment;
- Patients not on an RTT pathway but still under review by BHT clinicians
- Patients on a cancer pathway
- Patients who have been referred for a diagnostic investigation either by their GP or by an BHT clinician

6. Definitions

The table below provides a summary of the national care elective standards.

Referral to Treatment	
Incompletes	92% of patients on an incomplete pathway (i.e. still waiting for treatment) to be waiting no more than 18 weeks (or 126 days)
Diagnostics	
Applicable to the following diagnostic investigations	99% of patients to undergo the relevant diagnostic investigation within 6 weeks (or 41 days) from the date of decision to refer to appointment date
Cancer	
Two Week Waits	❒ 93% of patients to be seen within two weeks of an urgent GP referral for suspected cancer either by an outpatient appointment or via a straight to test pathway ❒ 93% of patients to be seen within two weeks of a GP referral with breast symptoms (where cancer is not suspected)
Decision to Treat to Treatment (31 Day Wait)	❒ 96% of patients to receive their first definitive treatment for cancer within 31 days of the decision to treat ❒ 94% of patients to receive subsequent treatment for cancer within 31 days of the decision to treat/earliest clinically appropriate date to start a second or subsequent treatment where that treatment is surgery ❒ 98% of patients to receive subsequent treatment for cancer within 31 days of the decision to treat/earliest clinically appropriate date to start a second or subsequent treatment where that treatment is an anti-cancer drug regime ❒ 94% of patients to receive subsequent treatment for cancer within 31 days of the decision to treat/earliest clinically appropriate date to start a second or subsequent treatment where that treatment is a course of radiotherapy ❒ Maximum wait of 31 days from urgent GP referral to first treatment for children's cancer, testicular cancer and acute leukaemia - no performance measure set for this – monitoring as a part of the 62 day wait for first treatment
Referral to Treatment (62 Day Wait)	❒ 85% of patients to receive their first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

	❒ 90% of patients to receive their first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service (breast, bowel and cervical) ❒ Maximum wait of 62 days for patients to receive their first definitive treatment for cancer where their consultant has upgraded their referral to urgent – no national performance measure set for this at present.

All the standards within the table above are set at less than 100% to allow for tolerances which apply in the following scenarios:

- ❒ Exceptions – applicable to RTT pathways where it is in the patient's best clinical interest to extend treatment
- ❒ Choice – applicable where patients choose to extend their pathways via rescheduling previously agreed appointment dates or admission offers
- ❒ Co-operation – applicable where patients do not attend previously agreed appointment or admission dates.

7. Roles and Responsibilities

7.1. The Local Health Economy (LHE)

LHE is collectively responsible for the production, review and revision of this policy on at least an annual basis. All organisations will have a designated lead in this respect.

7.2. Clinical Commissioning Groups

CCGs are responsible for ensuring that GPs and all other primary care staff adhere to the principles set out in this policy.

7.3. General Practitioners

- ❍ Ensure that the patient is clinically suitable for their referral and intended pathway of care;
- ❍ Ensure that the patient is prepared to be treated within the maximum *Referral to Treatment* times;
- ❍ Initiate the referral through the use of the E-Referral Service, identify clinically appropriate services for the patients, and discussing all locations available at the provider(s) of the patient's choice;
- ❍ Provide the national minimum core data set when transferring care to another provider;
- ❍ Ensure that where appropriate, funding for interventions not normally funded has been obtained prior to referral.

7.4. Trust

- ❍ Chief Executive / Chief Operating Officer

The chief Executive Officer (CEO) and Chief Operating Officer (COO) have overall responsibility for the implementation of this policy and board level accountability for the delivery

of elective access standards. The COO is responsible for ensuring the delivery of targets and monitoring compliance of elective access standards.

- Clinicians

Clinicians have a responsibility for adhering to key internal procedures in the proactive management of patients along their RTT journey. Key examples are the timely and accurate completion of the clinic outcome form and swift review of referrals.

- General Managers / Operational Managers

General Managers and Operational Managers are responsible for ensuring that staff are fully trained / competent in and performance managed against the principles and associated SOPs relevant to their role.

- Administration Staff

All administration staff must abide by the principles in this policy and the supporting standard operating procedures.

- Internal Reporting mechanisms

The Access Policy is reviewed annually and routinely updated in accordance with national guidelines, Local Health Economy rules and to reflect changes to Trust processes. It is available to all staff via the Trust website.

The Access principles and associated performance metrics are monitored through the weekly Access and Performance Group initially and subsequently the weekly Performance Escalation Meetings chaired by the Chief Operating Officer. This forum reports into the Trust Executive and Board.

8. General Principles

8.1. Structure of the Policy

The policy is structured in such a way which makes it easy to navigate in both hard copy and electronically. Where a separate Standard Operating Procedure (SOP) or document is referenced, a hyperlink will be shown allowing the reader to be taken directly to it if desired. The principles within the policy are applicable across all organisations within the area, as detailed on the covering page. SOPs are generally specific to each organisation so there may be a number of different versions.

The policy is split into the following five sections:

1 General Principles.
2 Pathway Specific Principles – following a logical chronological patient journey. Where there is a Standard Operating Procedure (SOP) providing a detailed process to be followed at a given stage, this is referenced at the relevant point. Readers can either click on the link taking them to the SOP or turn to the back of the Access Policy where they are listed as appendices.
3 Cancer Pathways and SOPs which follow the same format as Pathway Specific Principles.

4 Reference Information
5 Standard Operating Procedures

8.2. Entitlement to NHS Treatment

The NHS constitution (NHS Constitution - Patient choice - NHS Choices) 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
- A referral from their GP for treatment into a consultant-led service, with 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
- Patients should be allowed to choose their time of treatment taking account of clinical advice where undue delay may present a risk to them.

If this is not possible, the Trust has to take all reasonable steps to offer a range of alternatives.

The right to be seen within the maximum waiting times does not apply:

- If the patient chooses to wait longer against clinical advice
- 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 services are not covered by this constitution:

- Maternity / Obstetric services

Patients registered with a GP in either Northern Ireland, Scotland or Wales are also eligible for elective treatment, subject to prior approval from their local health board.

Patients must be treated within the national waiting time standards. Failure to achieve these targets and thresholds will put the Trust at risk of breaching its terms of authorisation and may lead to financial penalties within the NHS standard acute trust contract.

8.3. Patients not Eligible 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 a ***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 and Social Care Overseas Visitors Regulations
- Charge those liable to pay in accordance with Department of Health and Social Care 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.

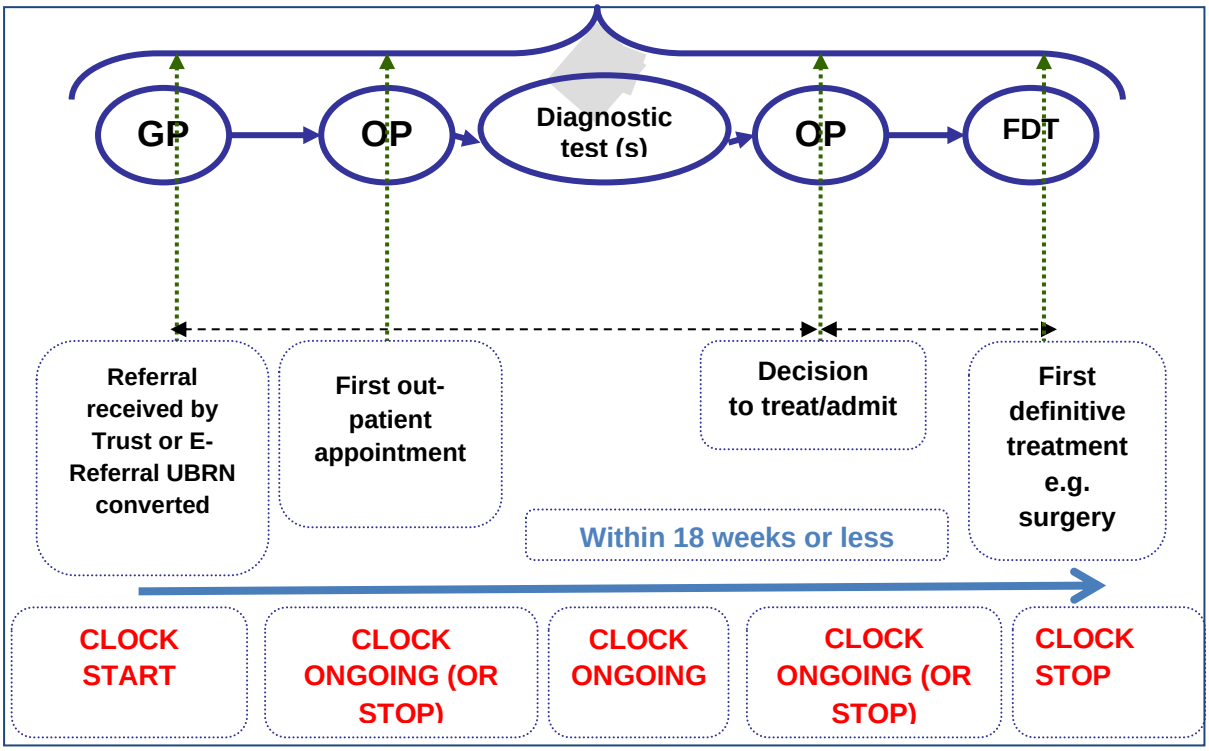
The Trust needs to check every patient's eligibility for treatment. An NHS number does not give automatic entitlement to free NHS treatment. Therefore, at first point of entry, patients may be asked questions which will assist the Trust in assessing 'ordinarily resident status'.

8.4. Patient Information

The Access Policy is available for patients and the general public to view on the Trust website. A patient information leaflet is also available and summarises the key points and principles. These will be available from outpatient departments and the outlets aforementioned.

8.5. Overview of the National RTT Rules

The full national RTT rules suite can be accessed by clicking here. Detailed local application of the rules is provided in the standard operating procedures within section five at the end of this policy. An overview of the rules however is shown using the diagram and narrative below.



8.5.1. Clock Starts

The RTT clock starts when:

- A referral is received into a consultant led service, regardless of setting, with the intention that the patient will be assessed and if appropriate, treated before clinical responsibility is transferred back to the referrer.
- A referral is received into an interface or referral management assessment centre which may result in an onward referral to a consultant led service before clinical responsibility is transferred back to the referrer.
- A patient self refers into a consultant led service for pre-agreed services agreed by providers and commissioners.

8.5.2. Clock Stops

The RTT clock stops upon:

- first definitive treatment,
- if a decision is made that treatment is not required
- if the patient declines treatment,
- if it is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care,
- if a clinical decision is made to start at period of active monitoring,
- if a patient does not attend as per the guidance below.

First Definitive Treatment is defined as:-

An intervention intended to manage the patient's condition, disease or injury to avoid further intervention. What constitutes First Definitive Treatment is a matter of clinical judgement in consultation with others, where appropriate, including the patient.

If a patient requires a therapeutic procedure or surgery as a day case or inpatient, the clock stops upon admission. If the patient's treatment is medication prescribed in outpatients or if a decision not to treat is made in outpatients, this information is captured on MEDWAY or the Electronic Clinic Outcome Form (eCO) if the patient has been seen in an outlying clinic where MEDWAY is not available. There may also be occasions where a decision not to treat is made in an 'ad hoc' setting, for example following review of diagnostic results by a clinician in the office. Clock stops such as these must also be captured in MEDWAY (using an administrative clock stop) and communicated to the patient accordingly.

8.5.3. Patients Who Do Not Attend (DNA)

These rules are applicable only if the patient has had the opportunity to agree their appointment or admission date in advance such as face to face, by phone or e-referral or the appointment has been clearly communicated by post or electronic means of communication.

8.5.4. First Appointment Following Initial Referral

If a patient DNAs their first appointment following the initial referral which started their RTT clock, their RTT clock should be nullified (i.e. not stopped and reported).

Should the patient be offered another date, a new RTT clock will start on the date that the patient's next appointment is booked. For example, if the patient DNA's an appointment on 4th July and a conversation with the patient happens on 7thJuly to agree another appointment for 18th July, the new clock starts on 7th July.

8.5.5. Any Other Outpatient Appointment, Diagnostic Appointment or Admission along the Patient's Pathway

- If the patient is offered another appointment / admission date – the RTT clock continues.
- If the patient is discharged back to GP – the RTT clock stops (following confirmation that it is not contrary to the patient's best clinical interests).

8.5.6. Patient Reschedules of Outpatient & Diagnostic Appointments

If a patient chooses to reschedule their outpatient or diagnostic appointment, their RTT clock should continue to tick, even if they wish to reschedule their first appointment following initial referral.

For any non-planned diagnostic appointment, the 6 week waiting time is reset to the appointment date where the patient cancels or DNAs (see section on Diagnostic Pathways).

8.5.7. Patient Reschedules of Admission Dates and Patient- initialled delays

If a patient has previously agreed to a reasonable admission (i.e. three weeks' notice and a choice of two dates) offer which they subsequently wish to change, the cancellation does not stop the RTT clock. As part of the rebooking process, the patient should be offered alternative dates for admission.

There is no maximum length to patient-initiated delays that does not take account of individual patient circumstances. However, clinicians will provide booking staff with guidelines as to how long (in general) patients should be allowed to defer their treatment without further clinical review. Patients requesting a delay longer than this should have a clinical review to decide if this delay is appropriate. If the clinician is satisfied that the proposed delay is appropriate then the trust should allow the delay, regardless of the length of wait. If the clinician is not satisfied that the proposed delay is appropriate then the clinical risks will be clearly communicated to the patient and a clinically appropriate TCI date agreed. If the patient refuses to accept the advice of the clinician then the responsible clinician must act in the best interest of the patient. If the clinician feels that it is in the best clinical interest of the patient to discharge the patient back to the care of their GP and inform them that treatment is not progressing then this will be made clear to the patient. This must be a clinical decision, taking the healthcare needs of each individual patient into account.

8.5.8. Active Monitoring

Active monitoring is where a decision is made that the patient does not require any form of treatment currently but is to be monitored in secondary care. When a decision to commence a period of active monitoring is made and communicated with the patient, the RTT clock stops. Stopping a patient's clock for a period of active monitoring requires careful consideration on a case by case basis and its use needs to be consistent with the patient's perception of their wait. For example, stopping a clock to actively monitor a patient knowing full well that some form of diagnostic or clinical intervention would be required in a couple of days' time, is unlikely to make sense to a patient, as they are likely to perceive their wait as being one continuous period from the time of their initial referral. Its use may be more appropriate where a longer period of active monitoring is required before any further action is needed.

Patients may initiate the start of a period of active monitoring themselves (for example by choosing to decline treatment to see how they cope with their symptoms). However, it is not appropriate to use patient initiated active monitoring to stop patients' clocks where a patient does want to have a particular diagnostic test/appointment or other intervention, but wants to delay the appointment for social reasons.

8.6. Pathway Milestones

The agreement and measurement of performance against pathway specific milestones is an important aspect of successful RTT sustainability. Pathway specific milestones should be agreed for each specialty (in line with robust demand and capacity analysis) in terms of the point of the pathway by which the following should occur:

- First outpatient appointment
- Treatment decision
- Treatment

The Trust will aim to identify and work to set timescales for each 'stage of treatment' by speciality as best practice identifies. If urgent, timescales will be clinically appropriate.

8.7. Restricted Procedures, Treatments and Interventions

Prior Approval Guidance must be adhered to – any procedures undertaken without prior authorisation, will not be funded by the Commissioners. A GP should request an opinion prior to referral to secondary care for conditions that are normally within this exclusion group. In these circumstances the 18 week clock will begin when approval for referral to secondary care has been received by the GP and the GP proceeds to make a formal referral. Where Trusts receive referrals without the appropriate authorisation, the referral will be returned to the GP.

Where it is not clear from a referral that a patient requires a restricted procedure, the referral will be accepted and funding approval will be requested at the point the decision is made to treat the patient with a restricted procedure. The RTT clock will not be paused at this point and will continue until the definitive treatment is carried out.

All applications for funding are to be directed the Trusts' IFR team who will apply and chase funding authorisation on behalf of divisional teams. Applications must be on the correct proforma for the relevant proposed procedure or in the form of a clinical letter including all the information requested on the proforma. The email address for the Trusts' IFR team is buc-tr.bucksnhsifr@nhs.net.

Note: The timescales for responses vary between CCGs ranging from 2 to 4 weeks.

8.8. Access to Health Services for Military Veterans

In line with December 2007 guidance from the Department of Health and Social Care, all staff must be aware of the Armed Forces Covenant and acknowledge that all veterans and war pensioners should receive priority access to NHS care for any conditions which are related to their service subject to the clinical needs of all patients. Military veterans should not need first to have applied and become eligible for a war pension before receiving priority treatment. GPs should notify the Trust of the patient's condition and its relation to military service when they refer the patient so that the Trust can ensure that it meets the current guidance for priority service over other patients with the same level of clinical need. In line with clinical policy, patients with more urgent clinical needs will continue to receive clinical priority.

Armed Forces personnel and their families move more frequently than the general population and these moves are required as part of their military commitment .Where a military veteran is being referred directly from another Trust, the Trust must ensure that the patients' pathway is not delayed and they are prioritised against patients with the same clinical need. Where a referral for a military veteran is received the referral must be escalated to team leaders for prioritisation.

Booking staff need to be aware of any patients belonging to the Armed forces who are referred to us for their continued treatment. It is important that these patients have their referral to treatment dates recorded correctly to ensure they are not disadvantaged and that they receive their treatment in a timely fashion.

If the information is not received correctly the Booking Teams must contact the referring Trust to clarify the referral to treatment start dates and clarify where the patients are on their pathway.

8.9. Private Patients

If a patient has been seen privately, and wishes to be treated at the Trust, by the same consultant as an NHS Patient, the patient must first obtain an NHS referral letter from their GP or referring consultant. On receipt of this letter the patient may then be treated as a new referral in outpatients or placed on a waiting list for investigations or treatment but will be treated according to their NHS medical priority. The RTT clock starts at receipt of referral to the NHS.

8.10. Overseas Patients

Trust will ensure they assess patient's eligibility for NHS care in line with the Guidance on implanting the overseas visitor's hospital charging regulations. Any concerns or suspicions are to be directed to the Overseas Visitors team on 110 8150 or 5131.

8.11. Vulnerable Patients

It is essential that patients who are vulnerable for whatever reason have their needs identified at the point of referral. This group of patients might include but is not restricted to:

- ❒ Patients with learning difficulties or psychiatric problems;
- ❒ Patients with physical disabilities or mobility problems;
- ❒ Elderly patients who require community care;
- ❒ Children (under 18) for whom there is a safeguarding concern.

8.12. Communication with Patients

The rules and principles within which the local health economy will operate to deliver elective care to all patients; whether they be urgent suspected cancer referrals, 18 week pathway patients or patients on planned waiting lists; must be made clear and transparent to patients at each stage of their pathway. All communications with patients whether verbal or written must be informative, clear and concise.

A key principle for RTT is that patients are explicitly made aware of the implications on their RTT wait should they choose to delay their treatment, either through cancellation of appointments, declining 'To Come in' (TCI) offers or non-attendance.

Commissioners and providers will need to be able to demonstrate (to an auditor or the CQC or in the event of a patient complaint) that cases that take longer than 18 weeks to reach the start of first definitive treatment are legitimate exceptions.

8.13. Accessible Information

The Accessible Information standard became legal requirement in August 2016. This information standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of

patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

The trust is required to record patients' communication needs within Medway with a view to ensuring that each patient is communicated to by the correct means of communication required, such as via email or by the use of sign language in an outpatient clinic situation for example.

Medway provides 'Alerts' functionality to record a patient's communication. Communication alerts can be added to a patient's record and can be used to ensure staff are aware of important aspects of a patient's communication need. All staff need to be aware of the Accessible Information policy and where they are made aware of a patient's communication need they should record an alert against the patient's record on Medway for future reference.

Where an Accessible Information alert is recorded on Medway, patients are to be provided correspondence via the preferred means, i.e. SMS, email, digital portal, paper where possible. The Bulk Mail service commencing in June 2018 will provide this functionality for all appointment letters printed from Medway where a communication alert is recorded

8.14. Elective Care Governance Structure

The Trust and host commissioners have robust governance structures in place to monitor report and manage elective access across the LHE.

The Trust has weekly operational PTL meetings chaired by an Associate Director. This forum is accountable to the Chief Operating Officer.

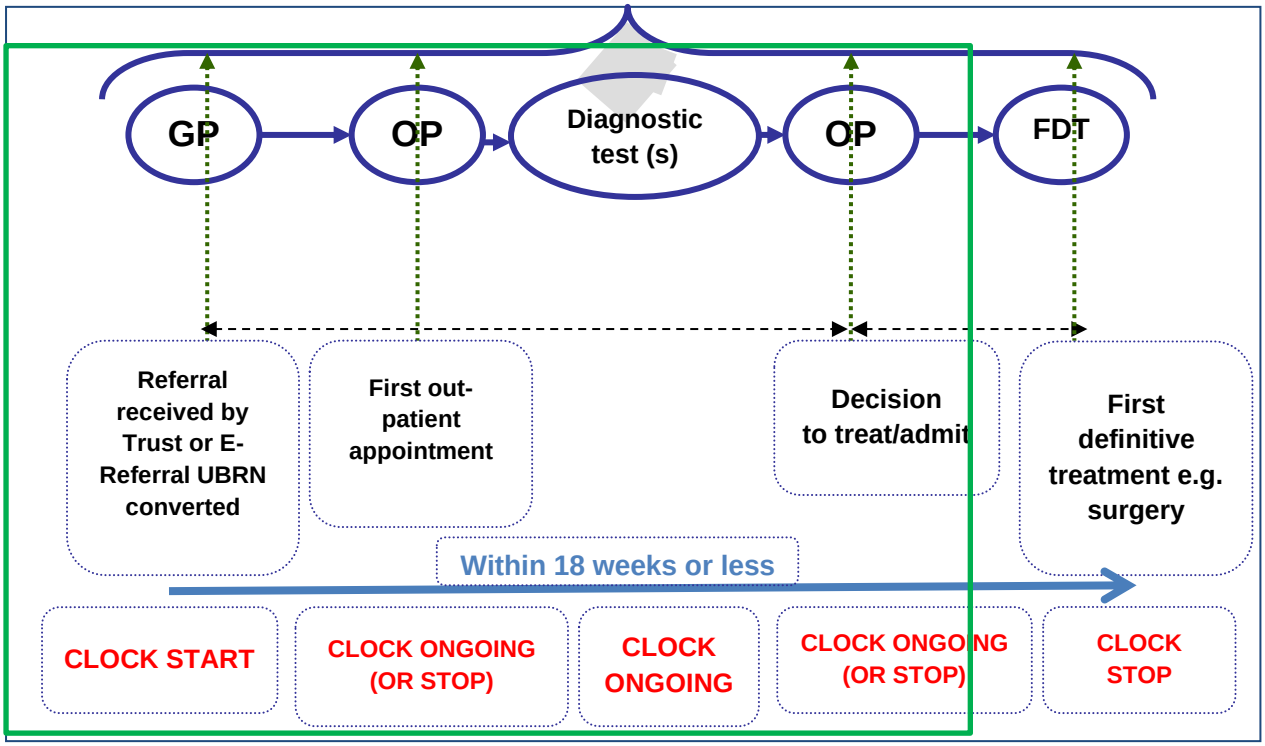
The Trust and host Clinical Commissioning Group (CCG) meet monthly to address all access and key performance issues which in turn informs the monthly Contract and Performance meeting and is chaired by the CCG and Commissioning Support Unit (CSU).

8.15. Information, Monitoring & Reporting

- ❒ RTT monitoring and reporting will be managed through the information schedule of the provider acute contract. In addition other statutory returns to NHS England and monitor will be provided as required.
- ❒ Internal monitoring of RTT and other performance areas such as cancer and diagnostic pathways will be managed via a weekly forum.
- ❒ The Trust will ensure robust systemic governance of data quality is in place with clear work plans, reporting and escalation.

9. Section 2 – Non Admitted Pathway Principles

The non-admitted stages of the patient's pathway comprise both outpatients and the diagnostic stages, as highlighted by the section below. It starts from the clock start date (i.e. the date the referral is received or the Inter Trust Start Date as supplied by the Referring Trust) and ends when either a clock stop happens in outpatients (this could be the first, second or a further appointment, or an administrative appointment if the decision is taken outside a hospital appointment) or when a decision to admit is made and the patient transfers to the admitted pathway.



The following pages detail the agreed policies and principles, starting with Referral Management. Where there is further guidance in the services Standard Operating Procedure (SOP) to support a particular point this will be highlighted.

9.1. Referral Management

9.1.1. Pre Requisites Prior to Referral

- **Primary Care -** In line with national RTT rules, before patients are referred, GPs and other referrers should ensure that patients are ready, willing and able to attend for any necessary outpatient appointments and/or treatment and that they fully understand the implications of any surgery or other treatment which may be necessary. Referrers should always refer to secondary care via the E- Referral Service (ERS) where available.

- **Secondary Care - It** is the responsibility of the management teams in conjunction with clinicians to ensure that the E-Referral Service (ERS) Directory of Services (DoS) is up to date in terms of the service specific criteria and that clinics are mapped to the relevant services. This gives the best chance of the patient being booked into the correct clinic at the first visit and reduces the rejection rate.

9.1.2. Referral Sources

- **General Practitioners** – The vast majority of referrals should be made from primary to secondary Care (GP to consultant) for the following reasons:

  a. To maximise the choice opportunities for patients in terms of provider, date and time of appointment.
  b. To contribute to the management of secondary care capacity by ensuring only those genuinely needing secondary care receive it, and in a more timely way as part of an RTT pathway.

- **Other Referrals**

When a consultant decides that the opinion of another consultant/service should be sought (i.e. condition is different than that referred), for all routine patients, he/she shall write back to the referring GP detailing this opinion so that the patient and their GP can agree on further management.

There are, however, circumstances in which a consultant to consultant referral is clinically appropriate, i.e. urgent referrals or same/related conditions to the original referral. No matter how well defined these circumstances are, there will always be occasional exceptions where consultants and commissioners will have to take a view based on individual patients and clinical circumstances.

Cancer referrals will be expedited as clinically required to ensure timeliness of appointments, diagnosis and subsequent treatment can be delivered.

- **External Consultant to Consultant Referrals / Inter Trust Transfers**

Referrals to other providers must be accompanied by the national Inter-Provider Transfer Administrative Minimum Dataset (IPTAMDS). All fields must be completed as fully as possible.

Although primarily designed to help monitor patients on Referral to Treatment Time pathways, the IPTAMDS should accompany all inter-provider referrals, such as requests for diagnostic tests and referrals back to originating Trusts following treatment. [Form should be as per in the SOP and on the Intranet]

Patients Referred from Other Providers (including Primary Care Interface Services) should be accompanied by a completed IPTAMDS (Appendix 1). Where the IPTAMDS does not accompany the referral it may follow within 48 hours.
Whether an IPTAMDS is received or not, the identity of the referring Trust and Referral to Treatment Time information must be recorded as per the Standard Operating Procedures.

9.1.3. Referral Methods

The Local Health Economy jointly supports and is working towards all referrals being made directly electronically via the E-Referral Service (ERS). Note that from October 2018,

referrals for acute specialty GP referrals will only be accepted via ERS, in line with the national Paper Switch Off project.

If referring via ERS is not possible then we encourage referrals to be emailed to the trusts central email address for routine and urgent referrals – *buc-tr.BHTreferrals@nhs.net.* Faxed referrals on the appropriate pro-forma will be accepted where this is an agreed process for a provider to receive faxes (e.g. 2 week wait referrals). Faxed referrals for any other patients will be accepted to avoid disadvantaging the patient and will be managed accordingly until electronic referrals are the sole mechanism of receipt. There are currently three recognised methods of referral for non-cancer referrals as described below. All referrals must be registered onto MEDWAY within 48 hours of receipt for a routine and 24 hours for an urgent.

- **E-Referral Service**

  The Trust will endeavour to give patients their choice of site within the Trust but as a single provider, patient appointments may be offered a different site if appropriate treatment is available. If patients choose to wait for a particular site or consultant, the implications on their overall RTT wait for treatment should be clearly explained to them. If this subsequently causes the patient to wait more than 18 weeks for treatment, this will be accounted for within the operational tolerances.

- **Directly Bookable Services**

  Directly Bookable Services (DBS) enables the GP to book a first outpatient appointment slot while their patient is in the surgery, or will give the patient a Unique Booking Reference Number (UBRN) and a password so the patient can use The Appointment Line (TAL) or go online to book a slot at the hospital of their choice. If the surgery comes under a Clinical Assessment Service it is the CAS that will do the booking. The Trust will ensure that sufficient capacity is available for patients to directly book their first appointment. Patients who have been directly booked will have a referral auto created on MEDWAY by the E-Referral Service (ERS) (ERS) software and the RTT clock start will be auto triggered from the referral received date on MEDWAY.

  Exceptions to this are where the patient has experienced an Appointment Slot Issue (see below) where the clock starts at the point that the slot issue is experienced, or when the referral has been sent on from a Primary Care Interface Service, when the referral should be treated as an Inter-Provider Transfer.

- **Indirectly Bookable Services**

  GP referrals that have been booked under the Indirect Booking rules will need to have a referral added to MEDWAY at the point of which the patient contacts the hospital to arrange their appointment. The referral received date (i.e. the RTT clock start date) must be the date at which the patient has contacted the hospital, unless referred through a Primary Care Interface Service.

- **Paper Based Referrals**

  The Trust is exploring developments to move away from paper referrals and to replace them with electronic referrals whether that is through e-Referral or email. Until such a time when all referrals are paperless, all paper based referrals should be sent to a designated centralised location within the Trust - *buc-tr.BHTreferrals@nhs.net.* Upon

receipt of paper based referrals, the date of receipt should be clearly and permanently marked. This date is the RTT clock start date.

9.1.4. Referral Criteria / Minimum Data Sets

The referrer is responsible for ensuring that the referral letter contains the essential minimum data set. This might include but is not limited to include the patient's NHS number, full patient demographics and including a day, evening and mobile telephone number that the patient would like to be contacted on as well as sufficient clinical data to enable the appropriate appointment to be made. The letter should also state the patient's current drug regime, clinical question to be answered and significant past medical history.

Where possible, referrals should be addressed to a speciality rather than a named consultant and the patient will be offered an appointment with the consultant with the shortest waiting time. Named referrals will be allocated to the relevant consultant but if they do not have sufficient capacity to accept the referral then a decision will be made in conjunction with the consultant and the speciality operational / service manager to allocate the referral to an appropriate alternative consultant. Exceptions to this would be where denying access to a sub-speciality opinion would compromise clinical care or patients choose to wait to see the consultant they had requested.

9.1.5. Clinical Triage / Review of Referrals

All referrals should be triaged to ensure clinical suitability, unless there are clear guidelines and evidence that demonstrates patients are all typically referred correctly first time.

9.2. First Appointment

"Reasonableness" criteria should be applied when offering patients appointments for diagnostic tests/procedures. This means that patients should be offered at least two appointments dates and have at least 3 weeks' notice of the appointment. Should a patient accept an appointment less than three weeks into the future, this becomes a reasonable offer.

Patients should be appointed firstly by their clinical priority (i.e. urgent patients first) and then within chronological order of their RTT clock start date.

9.2.1. Referrals made via the NHS e-Referral Service (ERS)

Patients who do not book their appointment while with their GP can telephone the Appointments Line or go online to make their appointment using their Unique Booking Reference Number and password. GP Surgeries that fall within Clinical Assessment Service areas will send all their referrals (excluding 2WW) to their relevant CAS as per their local agreement. The CAS's will process the referrals as per locally agreed process.

It is essential that sufficient appointment capacity is available to book patients within their clinical priorities and specialty specific milestones for first appointments.

9.2.2. Appointment Slot Issues (ASIs)

If this process is not possible due to lack of capacity, the UBRN will be directed to the Trust via the 'Defer to Provider' function on the e-Referral Service for local management to resolve. This is referred to as an ASI. The RTT clock is ticking from the point at which the patient attempted to book their appointment even though they will not be visible on the Trust's patient administration system at this point.

Any referrals that have resulted in an ASI must be provided capacity for within ERS and booked accordingly within 7 days of the initial referral. ASI referrals should not be booked manually outside of ERS unless the appointment is to be offered at a different site to that referred to.

ASIs result in a poor patient experience and time consuming administrative workarounds. Sufficient capacity must therefore be made available via ERS to ensure patients can book directly into services. This is the responsibility of the operational/service management team responsible for the speciality and will be monitored via the weekly Access and Performance Group meeting.

9.2.3. Paper Based Referrals

- **Urgent Referrals** - Urgent patients that are referred via the paper referral process will be registered onto the Trust MEDWAY system and should be contacted via telephone to arrange an appointment or by letter to confirm the appointment which has been made. A letter must also include details of how to cancel and reschedule appointments.

- **Routine Referrals –** Routine patients that are referred via the paper referral process will be registered onto MEDWAY **within 48 hours** and should be contacted via letter to confirm the appointment which has been made. The appointment must be booked within pathway specific milestones.

Patients should be offered a choice of dates and an appointment made which is mutually convenient. The patient's details including daytime contact number must be checked and corrected at this time and all appointment offers must be recorded on MEDWAY. A letter should be sent to confirm the appointment, which must also include details of how to cancel and reschedule appointments.

Where a patient is referred to a pooled service, they are to be offered an appointment with the consultant with the shortest waiting time.

9.3. Hospital Initiated Appointments

- In the event of a hospital initiated cancellation, the patient's RTT clock continues to tick from the original referred received date.
- The patient will be contacted to arrange an alternative appointment date and time. Both an apology and a reason for cancellation will be given. The Trust will make every effort to ensure that they do not cancel patient's appointments.
- If the cancellation is within two weeks of the appointment date, the patient will be informed of the cancellation by telephone and a further appointment will be agreed to ensure that their delay is minimised.

- Clinics must not be cancelled with less than 6 weeks' notice for reasons except sickness as per the Trusts clinician leave policy.

9.4. Patient Initiated Appointment Cancellations

Patients who wish to cancel their appointment and do not require a further appointment or treatment should be removed from the waiting list, their RTT clock stopped and a letter should be sent to the patient and their GP confirming their decision.

9.5. Patient Initiated Appointment Changes

Patients will have the opportunity to change appointments during their pathway once within each pathway milestone before being referred back to their GP.

Exceptions to this are:

- when a clinical decision is taken that discharging the patient is contrary to the patient's clinical interests;
- clinically very urgent referrals including cancer, or active surveillance for cancer, rapid access chest pain, and other critical illnesses;
- children of 16 years and under or vulnerable adults.
- Patients' previous appointment was cancelled by the Trust and this was the rearranged appointment.

Such decisions should be made by the treating clinician on a case by case basis. The RTT clock continues to tick during the appointment reschedule but will be stopped if the patient is being discharged back to their GP.

Where a patient self-cancels their first appointment made via ERS on more than 1 occasion, the patient will be contacted to alert to being discharged if the appointment is changed a further time. A letter will be sent to the GP to confirm this discharge.

Many patients are sent SMS reminders of their future appointments at 7 days and 2 days prior. The 7 day SMS is a two-way, requesting a patient to confirm their attendance or to request a cancellation or a reschedule. Staff must identify these responses on the ENVOY system and action on Medway with 24 hours of receipt.

9.6. Clinic Attendance

9.6.1. Arrival of Patients

- Patient demographic details should be checked at every clinic attendance and amended as necessary on MEDWAY. The status of overseas visitors will be checked at this time. The relevant manager must be notified where it is suspected that there is an overseas visitor.
- All patients must have an attendance / arrival status recorded, i.e. Attended or Did Not Attend.

9.6.2. Clinic Appointment Outcomes

All patients must have an outcome (e.g. follow up or discharge) and an updated RTT status recorded on MEDWAY (or an Electronic Clinic Outcome form (eCO) completed for all appointments (including DNAs) by the Clinician **by the end of each clinic**. This

includes patients who have already started treatment and have had a previous clock stop as they may need to start a new clock due to a new treatment plan or continue being monitored. It is critical that the data is recorded in an accurate and timely manner.

9.6.3. Clinic 'Cashing up'

All teams should aim to cash up clinics at the end of each clinic appointment where a clinic outcome form is provided, being fully cashed up within 72 working hours of the clinic. Clinicians have the ability to complete electronic outcome forms upto 7 days from the appointment and therefore, 9 working days is the final deadline for cashing up any appointments. Where it is not possible to action an appointment the 'on hold' function on MEDWAY must we used for escalation. These are as follows:-

- Added To Waiting List
- Awaiting diagnostic/treatment/test results
- No Outcome Form
- Insufficient Capacity
- SOS

These will be monitored weekly through the Access and Performance Management meeting.

9.6.4. Follow Up Appointments

- Patients who require another appointment should be fully booked i.e. should be able to agree the date and time of their follow up appointment as they leave the outpatient appointment. If the appointment is not made at this time, patients who require an appointment within 6 weeks, must be booked within 48 hours by the reception team where capacity is available.

- Where capacity is not available, the appointment must be 'cashed up' as On HOLD' with a reason of INSUFFICIENT CAPACITY and be escalated to reception team leaders. Operational Managers will be provided with capacity escalations routinely.

- All patients that require a follow-up appointment whether being booked or being placed on hold must have a 'To Be Seen By' date recorded on Medway when out-coming the appointment.

9.7. Did not Attends (DNAs)

A DNA (sometimes known as FTA or Failed to Attend) is defined as where a patient fails to attend an appointment/admission without prior notice.

Patients who rearrange their appointments in advance (irrespective of how short the period of notice they give) should not be classed as a DNA. On the day cancellations should not be recorded and treated as DNAs.

Any patient who does not attend their agreed appointment (new or follow up) should have their DNA reviewed by a clinician and if there is no clinical reason to continue with the patients

referral, the patient should be discharged back to the care of their GP. Once the clinician agrees that this is the correct course of action, both patient and GP will be notified of this in writing to ensure the referring GP is aware and can action further management of the patient if necessary. The patient's RTT clock will be stopped.

A patient that DNAs their first appointment should be discharged back the referrer. For any follow-up appointments that are DNA attended, a patient should be offered 1 further DNA before discharge.

Exceptions to this are:

- when a clinical decision is taken that discharging the patient is contrary to the patient's clinical interests;
- clinically very urgent referrals including cancer, or active surveillance for cancer, rapid access chest pain, and other critical illnesses;
- children of 16 years and under or vulnerable adults (see below)
- patients with prisoner status should not be discharged

The patient must first be contacted to ascertain the reasons for DNA and ensure compliance to attend a rescheduled appointment. Where circumstances were beyond the patient's control, the Trust will endeavour to be as flexible as possible.

The RTT clock will continue following a DNA unless it is the first appointment that has resulted in a DNA.

For paediatric patients after the reason for a DNA has been established, this should be documented in the health records. A further appointment needs to be offered to the patient and the importance of attendance needs to be reiterated to the parent / carer. If the patient DNA's a further outpatient appointment, Trust staff will refer to their local SOP.

If there are any safeguarding concerns about a child or young person under the age of 18 years further guidance should be sought from the relevant Trust policy or safeguarding lead.

Due to the organisation required and frequent changes related to the management of prisoners, any patients with a 'prisoner' status should not be discharged following a DNA.

9.8. Clinic Management

9.8.1. Ad Hoc Clinic Cancellation & Reductions

Consultants, medical staff and other health professional staff must give at least six weeks' notice of annual leave. Under exceptional circumstances such as sickness absence, the Consultants team or alternative health professional should make every effort to cover the clinic. Leave should be given as early as possible to minimise the effect on clinics and comply with the Trust requirement for 6 weeks' notice of Consultant leave.

The Trust is committed to offering certainty to patients as well as choice in arranging care. As such, every effort will be made to avoid cancelling patient's appointments. Every effort will be made to backfill absent clinicians by the speciality. Cancellation will be a last resort.

Clinics should not be cancelled or reduced for any purpose with less than 6 weeks' notice unless there are exceptional circumstances. Any such cancellation requests will require General Manager and SDU lead formal approval.

Any requests for additional clinics to be created should comply with the reasonable notice guidance of offering patients at least 3 weeks written notice and ideally be 6 weeks in advance of the clinic date.

9.8.2. Outpatient Clinic Capacity

Operational teams should systematically undertake a review of clinic templates and room capacity to ensure they are aligned to demand (contracted activity). It is expected that clinic templates will be reviewed at least annually or sooner if there are changes required.

Clinic templates must be agreed with the relevant clinician and provide sufficient capacity for the various types of clinic appointment required:-

- ❒ Cancer 2 week wait appointment slots
- ❒ New appointment slots
- ❒ Fup appointment slots
- ❒ Post-operative appointment slots

Any clinic template changes need to allow a lead in time of 6 weeks for any cancellation or additional capacity booking requirements.

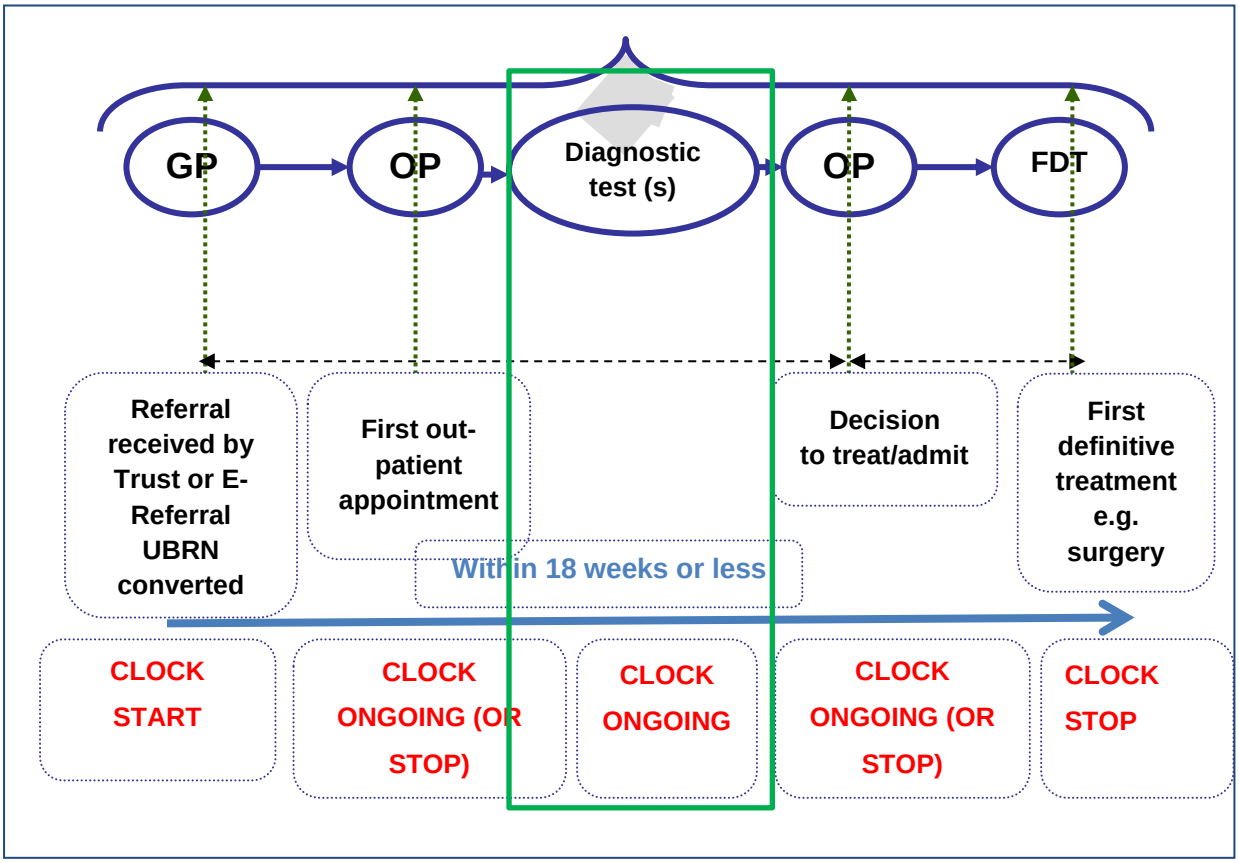
10. Diagnostic Pathway Principles

The section within the border on the diagram below represents the diagnostic stage of the RTT pathway which forms part of the non-admitted pathways. It starts at the point of a decision to refer and ends upon the diagnostic procedure being reported on.

It is important to note however, that patients can also be referred for diagnostic investigations directly by their GP where they will not be on an RTT pathway but will be subject to the diagnostic waiting time standard of a maximum of six weeks from receipt of request to investigation being done.

The following pages detail the agreed diagnostic policies and principles .Where there is a Standard Operating Procedure (SOP) to support a particular point, a link will provided in blue and underlined, in order to take the reader directly to it.

10.1. Diagnostic Patients on RTT Pathways



Where a patient is referred for a diagnostic test to take place, the principles and policies within the non-admitted section should be adhered to in terms of booking, cancellation and DNAs.

Some diagnostic tests will be undertaken on an admitted basis.

Patients who are referred for diagnostics as part of an RTT pathway need also to be seen within the current diagnostic waiting time.

The Trust will work to establish one-stop appointments with outpatient and diagnostic elements occurring concurrently wherever clinically appropriate.

10.2. Subsequent Diagnostics

Where the patient has received first definitive treatment for a condition they were referred for and subsequent new treatment plan is agreed following the result of a 'check'/surveillance diagnostic, a new RTT clock should commence.

10.3. Straight to Test

In the event of a GP referring a patient straight to diagnostic test as part of a locally agreed pathway of care, this would start an RTT pathway unless the clinician recognises the patient to be on an active monitoring pathway.

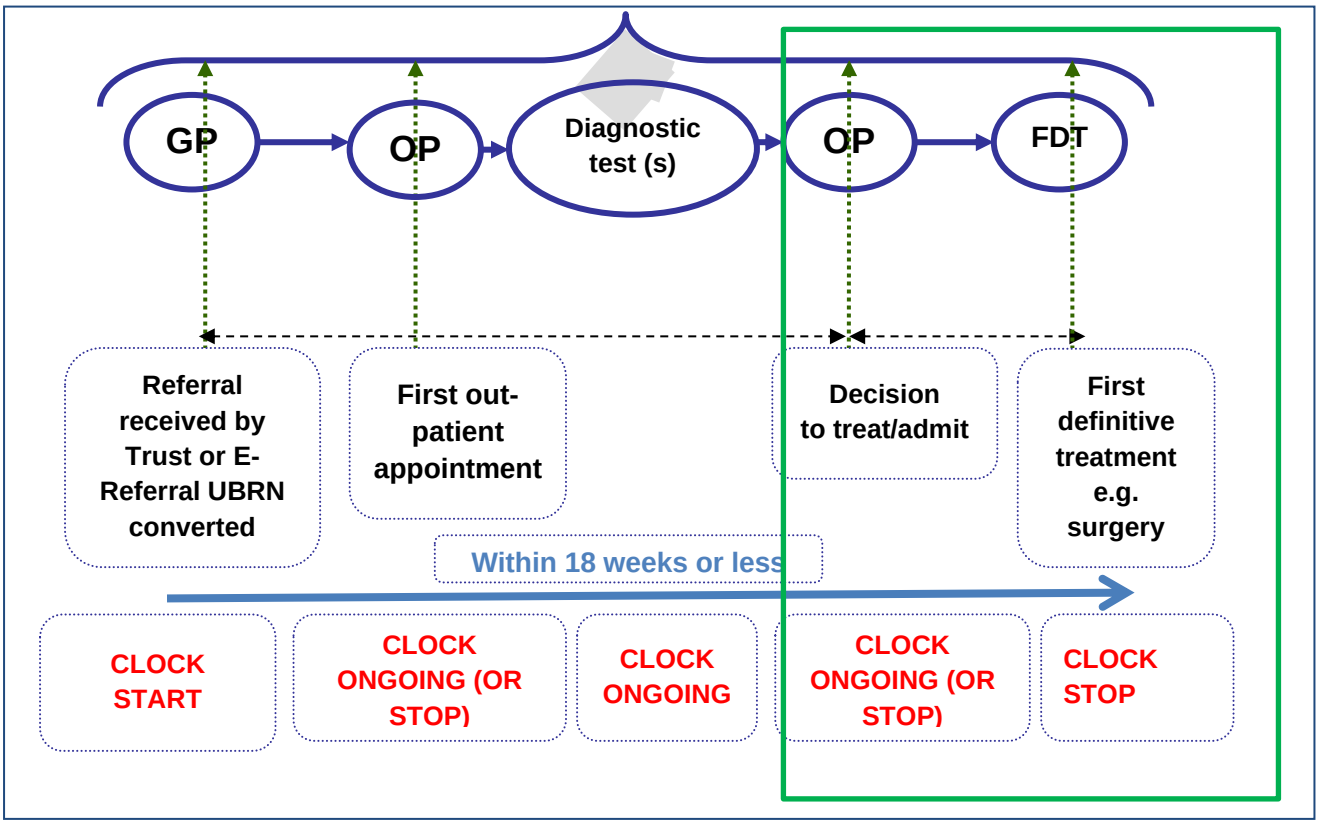
10.4. Direct Access

Where a GP refers a patient for a diagnostic test but retains clinical responsibility for the patient and makes a decision regarding referral on the basis of the results; this does NOT constitute

an RTT pathway. An RTT clock only commences if the GP subsequently makes a referral to a consultant led service.

11. Admitted Pathways

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



The following pages detail the agreed policies and principles, starting with the Decision to Admit. Where there is a Standard Operating Procedure (SOP) to support a particular point, a link will provided in blue and underlined, in order to take the reader directly to it.

11.1. Decision to Admit

The decision to admit a patient for surgery (as a day case or inpatient) must be made by a consultant or another clinician who has been given delegated authority. A patient should only be added to an active waiting list for surgery if:

There is a sound clinical indication for surgery

The patient is clinically fit, ready and available to undergo surgery. Patients who are added must be clinically and socially ready for admission on the day the decision to admit is made.

Following pre-operative assessment, patients who are not fit for treatment should be removed from the list. The Pre-op department would be required to liaise with the GP to ensure fitness however such patients should be referred back to their GP unless optimisation is expected to take two weeks or less.

The intended procedure requires CCG funding prior approval. A number of procedures have been deemed low priority by the CCGs and therefore Prior Approval is required. For these procedures there must be evidence that the correct pathway has been followed and an approved prior approval form must have been received. It is the responsibility of the management team in the specialty where the surgeon works to gain prior approval for the procedure. All patients must be added to the waiting list at the time a Decision to Treat is made and prior approval must be sought thereafter (please note that the RTT clock continues during the time approval is sought if this is a treatment normally given as part of the original referral). If approval is rejected, the patient must be removed from the waiting list and referred back to the GP with a letter documenting that prior approval was rejected.

A copy of the letter must also be sent to the patient.

A waiting list Request on MEDWAY will be completed at the time of the decision to admit, in full by the clinician making the decision to admit for all patients added to the waiting list.

11.2. Pre-anaesthetic and Pre-Operative Assessment

Patients should be pre-operatively assessed as soon as possible following the decision to admit. Any patients that are ASA 1 or 2 should be assessed in the daily filter clinics.

The purpose of these assessments is to ensure all patients are fit for treatment and that that they are listed for the appropriate type of admission (day case, short stay or inpatient care).

Patients who are not fit for treatment should be removed from the waiting list on MEDWAY. These patients should be referred back to the GP unless optimisation is expected to take two weeks or less. This needs to be a clinical decision based on the time it will take to optimise the patient and the likely gap between decision to admit and date of admission. Examples of patients that are unlikely to be optimised within two weeks are as follows:

- ❒ Patients with high blood pressure;
- ❒ Patients needing to lose weight;
- ❒ Patients with cardiac or respiratory problems;
- ❒ Patients currently not fit for treatment & requiring a diagnostic test before a definitive decision to admit can be made.

The decision to proceed with these types of patients lies entirely with the consultant anaesthetist/consultant surgeon who following a review will make a decision whether to proceed.

Patients who are not presently fit will be fully investigated and an individual management plan agreed with the clinician. If optimisation is likely to take under two weeks, their RTT pathway will continue. If it is likely to take over two weeks then their RTT pathway will be stopped either with active monitoring or decision not to treat depending on the clinical management plan.

11.3. Adding Patients to the Admitted Waiting List

Patients must be added to the admitted waiting list on MEDWAY within two working days of the decision to admit.

From the point of adding the patient to the admitted waiting list, the patient transfers from a non-admitted pathway to an admitted pathway.

When adding a patient onto the waiting list in Medway, staff must ensure all information is gathered and recorded in line with the Service's Standard Operating Procedures (SOP).

11.4. Listing Patients/Offering TCI Dates

Where patients are not fully booked the Trust's Incomplete Patient Tracking List (PTL) must be used as the data source for scheduling admitted patients.
Listing must be undertaken by selecting patients firstly by their clinical priority and then within chronological order of RTT wait time.

Patients must be contacted to have the opportunity to agree their TCI date. This must be by telephone initially and only solely by letter where the patient could not be contacted on 2 separate attempts.

Patients should be offered two separate dates with at least three weeks' notice for day case or inpatient admissions (i.e. two reasonable offers).

Where available, patients can be offered dates with less than three weeks' notice and if they accept, this then becomes a 'reasonable' offer.

If the patient fails to call within 2 weeks of an invitation to ring letter being sent, the waiting list entry is removed as the patient has declined treatment. Reasonable steps should be taken by the Trust to ensure the patient received the invitation. It is also good practice for there to be a clinical review before the patient is discharged, following which a letter is sent to the patient and their GP and the patient's RTT pathway will be closed.

A letter must be generated immediately following the agreement of a 'To Come In' (TCI) date. The TCI letter must contain all the relevant information associated to the attendance, as listed in the Service Standard Operating Procedure (SOP).

11.5. Patient Cancellation/ Declining of TCI Offers

When offering TCI dates, patients may need to decline for social reasons due to other commitments which cause them to be unavailable, e.g. holidays or exams. Patients could decline offers immediately during the telephone conversation or cancel / decline at any point between initially accepting and the admission date itself.

Clinicians should provide booking staff with guidelines as to how long (in general) patients should be allowed to defer their treatment without further clinical review. A patient requesting a delay longer than this should have a clinical review to decide if the proposed delay is appropriate. If the clinician is satisfied that the proposed delay is appropriate, the Trust should allow the delay and report the unadjusted waiting time on the national RTT monthly return, regardless of length of wait reported. However, if the treating clinician deems that referral back to the GP is in the best clinical interests of the patient then that would be acceptable and should be documented clearly in the patient record. Such decision should be made on a case by case basis.

Many patients are sent SMS reminders of their future appointments at 7 days and 2 days prior. The 7 day SMS is a two-way, requesting a patient to confirm their attendance or to request a cancellation or a reschedule. Staff must identify these responses on the ENVOY system and action on Medway with 24 hours of receipt.

11.6. Validation of Patients on the Admitted Waiting List

Some patients on the elective waiting list may no longer need their treatment (e.g. if they have been treated elsewhere) or need their operation to be performed by a different Trust (e.g. where a patient moves to another part of the country). To ensure that only those patients still needing their treatment are on the waiting list and to comply with the Data Protection Act, the Trust will validate the waiting list on a daily basis. This will ensure the waiting list is consistently accurate and managed.

11.7. Units for Surgery – Reinstating Patients onto the Admitted Waiting List

Patients should only be added to a waiting list if they are fit and ready for treatment. Patients who require thinking time may be considered appropriate for active monitoring by their clinician.

Sometimes a patient is identified as unfit for treatment after they have been placed on a waiting list and there are several options to manage this. The decision should be based on clinical advice and what could be least detrimental to the patient's progression through their pathway.

Where a patient is identified as temporarily unfit for treatment, i.e. patients who would be expected to recover in 2 weeks, the clock will continue to tick.

Patients identified as medically unfit for a longer period of time for a condition that can be managed in primary care or one that requires further investigation should be discharged back to their GP, to be re-referred when they have been assessed as medically fit. In the case of discharges, re-referrals should then be made by the GP when the patient is fit for surgery, which would initiate a new clock start and pathway.

Alternatively a clinician can make a decision to commence active monitoring, stopping the clock.

11.8. Hospital Cancellation of TCI

11.8.1. Cancellation by the Trust for Clinical Reasons

If the operation is cancelled because the patient is unfit for surgery or the operation is no longer required the clock stops and the patient should be referred back to their GP. The exception to this is patients who would be expected to recover in 2 weeks, the clock continues for these patients.

11.8.2. Cancellation by the Trust for Non-Clinical Reasons

The Trust will only cancel a patient's admission when it is not possible to carry out the procedure (e.g. bed capacity, unplanned leave, emergency cases). Before any cancellation is made, this must be discussed with the senior manager for that speciality. Everything must be done to try and avoid a hospital cancellation as it causes distress to the patient and an operational problem to the hospital.

If it is absolutely necessary for the hospital to cancel a patient's surgery, the patient will normally be given a new admission date at the time of cancellation. If this is not possible it is the responsibility of the senior manager who authorised the cancellation to ensure that the patient has a new date of admission within 28 days if the patient is cancelled on or after the day of admission or as soon as possible if cancelled prior to this.

Should it be necessary to cancel elective admissions, priority will be given to clinically urgent cases and long waiters.

11.9. Planned Waiting List

Patients who are waiting to be recalled to hospital for a further stage in their course of treatment are classed as Planned Admissions. This is an admission where the date of admission is determined by the clinical needs to the treatment. Examples of these would be follow up chemotherapy sessions, or a removal of internal fixation, three months post operation, check cystoscopy or repeat colonoscopies. These patients will be held on a 'planned waiting list', separate from the other waiting list, however will be subject to the same monitoring and validation process.

Operational managers are responsible for reviewing the planned list on a weekly basis to ensure compliance. This review will include checking that patients are being brought in, in accordance with their planned review dates and have been listed appropriately to the planned list definition.

Patients on planned waiting list are outside the scope of RTT rules. 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. Planned activity is also sometimes known as 'surveillance'. Examples of procedures which should be on a surveillance list are:

- ❒ Check procedures such as cystoscopies, colonoscopies etc.
- ❒ Patients proceeding to the next stage of treatment e.g. patients undergoing chemotherapy or removal of metal work.

Patients who wait beyond their 'planned by date' should be transferred to the active waiting list with a new clock start date.

11.10. Patients Who do not Attend (DNA) Admission

It is important that the patient has been given instructions of who to notify and how if they subsequently cannot come in for their operation /procedure and that the letter clearly states the consequences of not attending for their appointment date. Patients who fail to attend their agreed operation date, once reviewed by their clinician to ensure there is no clinical risk to them being discharged, should be removed from the waiting list and referred back to their GP.

The RTT clock will stop (reported as non-admitted clock stop). Exceptions to this rule are:

- ❒ Patients undergoing cancer treatments;
- ❒ Urgent referrals based on clinical judgement.

In the circumstance that the clinician feels it would be detrimental to the patient's health if a TCI date was not re-booked, then the patient must first be contacted to ascertain the reasons

for DNA and ensure compliance to attend a rescheduled appointment. The rescheduled appointment must be made from the original referral and the RTT clock will continue.

Due to the organisation required and frequent changes related to the management of prisoners, any patients with a 'prisoner' status should not be discharged following a DNA.

11.11. Bilateral Procedures

Patients will only be put onto the admitted waiting list for one procedure at a time when requiring bilateral procedures.

The RTT clock will stop when first definitive treatment for the first side begins. A second new clock starts once the patient is fit and ready to proceed with the second procedure.

11.12. Admitting Patients

Where a patient's admission is a procedure or operation constituting first definitive treatment as part of an RTT pathway, the admission on MEDWAY will stop the patient's clock.

11.13. Emergency Admission for an Elective Procedure

Where patients are admitted as an emergency for an elective procedure the patient will be removed from the waiting list and their RTT week clock stopped.

If the patient is admitted as an emergency but does not have the procedure they were waiting for electively carried out, then their original RTT clock does not stop.

Three scenarios may now apply:

- If, as a result of their emergency admission, the patient is no longer fit to have the original procedure they were waiting for and a clinical decision is made to refer the patient back to primary care, then this decision would stop the original RTT clock. The clock stops on the date that the decision is made and communicated to the patient and the patient is removed from the waiting list.
- If the patient is deemed to be temporarily unfit due to the circumstances around their emergency admission (for example, patient admitted as an emergency overnight with a chest infection) but the consultant decides to keep the patient under review, pending a return to fitness, then the patient could be classified as being under active monitoring, and if so, the RTT clock would stop and the patient is removed from the waiting list.
- If the patient is deemed to be temporarily unfit due to the circumstances around their emergency admission (for example, patient admitted as an emergency overnight with a chest infection), but the consultant decides to retain the patient for the procedure for which they were originally waiting, the RTT clock would continue to tick.

11.14. Removals Other than Treatments

Patients who state that they do not wish to receive treatment will have their waiting list entry removed and their clock stopped.

12. Cancer Pathways

The purpose of this policy is to clearly set out the principles and processes relating to the management of suspected cancer patients and patients within Buckinghamshire Healthcare NHS Trust with a confirmed diagnosis of cancer.

The aim is to ensure that the management of cancer patient access to services is transparent, fair, and equitable and according to clinical priority. It is the intention of this policy to ensure that referrals are handled efficiently and equitably, in line with national guidance Cancer Waiting Time's guidance and always in the 'spirit' of this guidance where it is down to local interpretation, so as always to ensure that the patient's best interests are at the forefront of the Trust policies and practices.

This guidance will be reviewed when the national guidance is updated in addition to the regular reviews that will take place. Should the local policy, due to review time scales at any point directly contradict a new version of the national guidance, the national guidance will take precedence.

Where a group from the Strategic Clinical Network identifies additional recommendations regarding access policies for cancer these will be reviewed and inserted into this policy if agreed.

The Trust has historically been committed to and continues to be committed to improving access for all its patients.

12.1. Thames Valley Cancer Policy

This document sets out the core issues for Cancer Access that should be consistent across the Thames Valley. Local operational policies describing how good access is achieved will still be necessary.

The best interest of the patient should be at the forefront of decisions on how to manage patients. This should override any permission allowed in this policy for referring patients back to their GP. This is of particular importance for children and vulnerable adults.

A copy of the Thames Valley SCN Cancer Access Policy can be accessed at Appendix 10 of this document or requested from the Cancer Management team.

12.2. National Standards

12.2.1. Headline Measures

- Maximum 2 weeks wait from:
  - urgent GP/GDP referral for suspected cancer to first outpatient attendance [Operational Standard of 93%];
  - referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment [Operational Standard of 93%];
- Maximum 62 days from:
  - urgent GP/GDP referral for suspected cancer to first treatment [Operational Standard of 85%];
  - urgent referral from NHS Cancer Screening Programmes (breast, cervical and bowel) for suspected cancer to first treatment [Operational Standard of 90%];

- consultant upgrade of urgency of a referral to first treatment [Monitored by the Department of Health and Social Care but no Operational Standard as yet];

12.2.2. Supporting Measures

- Maximum 31 days wait from:
  - decision to treat to first definitive treatment [Operational Standard of 96%];
  - decision to treat/earliest clinically appropriate date to start of second or subsequent treatment (s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is:
    - surgery [Operational Standard of 94%]
    - drug treatment [Operational Standard of 98%]
    - radiotherapy [Operational Standard of 94%]
- Maximum 31 days from urgent GP referral to first treatment for children's cancer, testicular cancer, and acute leukaemia [No separate Operational Standard – monitored within 62 day standard].

12.2.3. Clock Starts

- 2WW (and symptomatic breast referrals) – date received by the hospital
- breast screening - receipt of referral for further assessment (i.e. not back to routine recall);
- bowel screening - receipt of referral for appointment to discuss suitability for colonoscopy with a specialist screening practitioner (SSP);
- cervical screening - receipt of referral for appointment at colposcopy clinic.

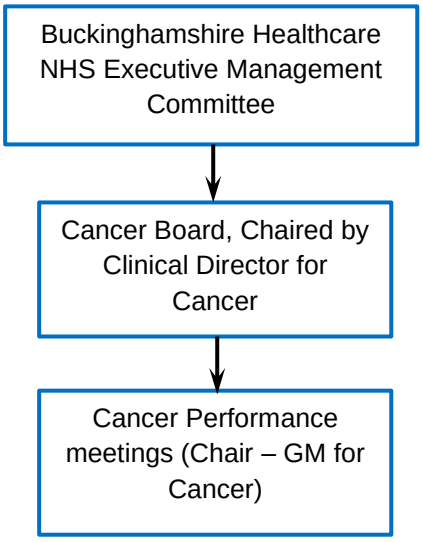
12.2.4. Timeliness of GP/GDP Referral

The patient should be referred by the GP/GDP to the Trust at the earliest opportunity. The operational standard for the two-week pathway takes account of the higher volume of patients being seen outside of two weeks owing to patient choice.

The GP/GDP should ensure that patients, even if low level of suspicion for cancer are available within the two week period, since receipt of this referral flags to the Trust that an appointment within two weeks is required.

12.3. Monitoring Compliance and effectiveness, Roles and Responsibilities

Trust Cancer Performance Reporting Structure



All staff involved in the management of cancer patients' access are to follow the standards laid out in this policy. Specific roles and responsibilities are laid out in each section below.

Monitoring mechanisms and reporting structures are currently being developed to ensure compliance and where standards are below those expected corrective action will be taken e.g. further training and support.

In accordance with training needs analysis, staff involved in the implementation of this Policy, both clinical and clerical, will undertake training provided by the Trust both at induction and by way of regular annual updates. It is the responsibility of all members of staff to understand the principles and definitions.

All medical staff are responsible, through the Clinical Director to the Medical Director, for ensuring they comply with their responsibilities as outlined in this Policy.

Staff involved in managing patients' pathways for cancer must not carry out any action about which they feel uncertain or that might contradict this Policy unless it is for reasons of patient safety, to improve efficiency, or essential for training responsibilities. It is the responsibility of any member of staff uncertain of the appropriate course of action to seek advice from the Clinical Director or Divisional Director of Nursing for Cancer in the first instance.

The Clinical Care Group Director and Director of Operations for each Clinical Care Group and General Managers are accountable for delivery of the cancer waiting time targets and have overall responsibility for implementing and ensuring adherence to the policy within their area.

12.4. Pre-Requisites Prior to Referral (Primary Care)

The referring GP will inform the patient that they are being referred on a two week wait pathway for suspected cancer. If the referring GP has not informed the patient of this prior to referral

this will be clearly indicated on the referral form providing the reason why this is the case. If a GP feels it is not appropriate to mention 'cancer' they should if possible emphasise to the patient that they feel it is important for them to be seen quickly and that the patient should make themselves available to attend appointments within a short timeframe.

12.5. Minimum Referral Data Set

The Trust actively encourages GPs to refer patients electronically as the primary method of referral, using the TVCA agreed referral forms. .

In cases where the GP does not have access to this form, a traditional letter referral containing full referral information may be received.

The clock start is the receipt of the referral.

Receipt of referral is day 0 for the two week wait standard.

The Thames Valley Cancer Network have agreed a standard suspected cancer referral proforma for each tumour type which it encourages GPs and other referrers to use; however, the Trust still accepts referrals that are not received on the proforma. It is expected that all referrals no matter their format should contain the following minimum dataset:

- Full name of patient (correctly spelt)
- Patient's DOB
- Patient's gender
- Patient's full address
- Patient's up-to-date contact telephone number (where possible also a mobile number)
- Patient's NHS number
- Full clinical details on the reason for the referral in line with NICE suspected cancer referral guidance
- Referrer details (including telephone and fax number)
- In the case of breast referrals – stating whether the patient is a suspected cancer patient or a symptomatic patient.
- Indication of whether the patient is aware of the nature of the urgency of the referral
- Patients available to be seen within two weeks

12.6. Suspected Cancer Referrals not Containing Required Information or Sent to Wrong Provider

If a referral is received not containing information needed to process it, then the referring GP/GDP should be contacted immediately by the 2WW Office, 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/GDP to stop a pathway.

If the Trust receives a referral for a patient for a service we do not provide (as we are not commissioned to provide the service) i.e. a referral sent to the wrong organisation; then it should be immediately forwarded to an appropriate provider by the 2WW office, thereby ensuring there is no delay to the patient pathway. The date of receipt is when the referral was originally received by the Trust, not the day it was forwarded on to the appropriate provider, and this does not constitute a reason for making a pause in the pathway. The GP/GDP should

be contacted and advised to enable a change in future practice. Patients should not be referred back to their GP to stop a pathway.

12.7. Receiving a Suspected Cancer Referral within the Trust

It is now established practice that all suspected cancer referrals go to the central 2WW Offices:

- The contact email for the 2WW Office is: Buc-tr.CancerBHT2WWreferral@nhs.net
- Contact telephone numbers for the 2WW Office are: 01296 315588 / 01296 315643

All 2WW services are available for booking on the Electronic Referral System. It is the joint responsibilities of the TVCA, local CCGs and the Trust to ensure that this is reiterated to referrers, encouraging them to use the electronic referral system (ERS) as the preferred means of referral and the only means of referral from October 2018.

In the event that a referral is not received directly in the 2WW Office e.g. a referral is received in another department, then it is the responsibility of the individual member of staff who opened/received the referral to date stamp it with the date that the referral was received in the Trust and e-mail it immediately to the 2WW Office on the address given above in order for the referral to reach the 2WW Office on the same working day and be processed urgently.

12.8. Booking of an Appointment

There is no prioritisation process for suspected cancer referrals as all appointments should be booked within 14 days of the actual date of receipt of the referral by the Trust. Most tumour types will have dedicated 2WW slots or clinics that any category of patient can be booked into.

There is however a clinical triage process to determine which clinics/diagnostic tests the patient should be booked into/undergo. There are local processes for the transport of these referrals to clinical teams for triage. All triaging should be completed within one working day.

- The relevant booking team will make all reasonable efforts to contact the patient to arrange or confirm their appointment. They will attempt to contact the patient on at least two occasions on different days and at different times to negotiate the appointment date and time.
- The team member making the call should inform the patient that they have been referred for an urgent appointment within 2 weeks.
- Fixed appointment letters must not be sent before either a date has been agreed, or at least two attempts to contact the patient by telephone, on different days and at different times, have been made. The dates and times of phone calls will be documented on the patient's tracking form. If the patient is not contactable then the GP should be contacted to establish why.
- 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/GDP.
- On confirmation of an appointment, the admin team should send out a confirmation letter to the patient confirming the appointment and enclosing any relevant Trust patient information leaflets.

12.8.1. Discharging Patients Where 2WW Office is not able to Make Contact

- Patients will only be discharged where there are no means possible to contact the patient to negotiate their appointment over the telephone or an address to send an appointment to the patient in the post. This occurrence is extremely rare.
- Before the patient is discharged, the 2WW Office must contact their GP/referrer to ensure that no other contact details are available.

12.9. Patients Who Choose to Have a 'Beyond Breach' Appointment Date – First Appointments

- Where a patient chooses to have their initial appointment outside of the 14 day waiting time (this may be for a number of reasons e.g. ill health, social or other reasons), the 2WW Office should record the earlier date offered within the 14 day period (on INFOFLEX). This is to ensure that the Trust has an audit trail showing that it was able to offer the patient an appointment within the maximum 14 day waiting time period.
- The clock will continue to tick and the patient will be counted as a breach. Breaches attributed to patient choice have been taken into account within the operational standard of 93%
- The patient should be offered a further appointment as soon as possible after they are available.
- The patient should not be discharged back to their GP unless they state that they no longer require the appointment. In the case of a patient stating that they no longer require an appointment, the GP should be notified of this by telephone and followed up in writing.
-

12.10. Registration of Referrals onto the Patient Administration System

The Patient Administration System is the Trust's primary source of cancer waiting list information. Patient details must be entered on MEDWAY within 24 hours of receipt of referral if not already referred and registered via the electronic referral system. Following date stamping, the referral should then be registered on MEDWAY using the appropriate waiting list function.

Every patient should have a referral date registered on MEDWAY with a matching referral letter or a clear audit trail back to the original referral date and letter.

Due attention should be paid to ensure all the appropriate checks are undertaken to search for the patient on MEDWAY to avoid duplication of records. Due attention should be given to the fact that the GP may have sent more than one suspected cancer referral for different tumour sites. In these situations, it is advised that contact is made with the referrer to clarify.

12.11. Step Down Process

Patients will only be removed from the cancer PTL and associated cancer tracking processes in the following circumstances:

- ❒ Treatment completed
- ❒ Patient declines treatment
- ❒ Patient deceased

The MDT co-ordinator is required to provide evidence of written confirmation from the clinical team e.g. a histology report confirming a benign diagnosis, or letter confirming 'attended in clinic, reassured and discharged'. This written documentation is required prior to the patient being removed from the tracker by the appropriate cancer administrator.

12.12. Management of Initial Appointment Cancellations and DNAs

Where a patient first cancels any of their outpatient appointments, a further appointment must be made. It is always best practice to negotiate all appointments with patients rather than sending a fixed appointment.

Where a patient is unable to reschedule their cancelled appointment at the point of cancellation, the Trust will encourage the patient to make contact to rebook the appointment within 1 working day. The Trust has responsibility for all patients who are on an open pathway. The clock will continue to tick.

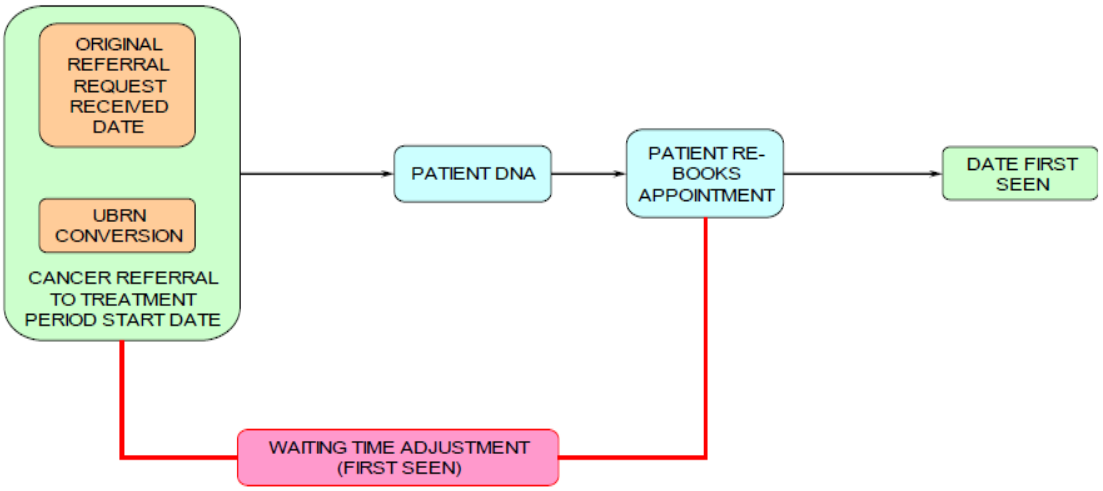
If after two patient cancellations, the patient requests a third or more, following discussion between the hospital clinician, GP and with the patient, a decision may be taken to discharge the patient back to the care of their GP/GDP if this is deemed to be in the best interests of the patient, and a dictated letter should follow. The Trust must obtain consent from the patient and document this on MEDWAY and INFOFLEX before discharging the patient. Again, this is to ensure that the patient is not left "unmonitored" in the system.

Where a patient first DNAs their initial outpatient appointment, the patient will automatically be offered a second appointment, within 14 days.

Usually, where a patient on a suspected cancer pathway DNAs their initial appointment for the second time, they should be discharged and referred back to the GP/GDP. This is to ensure that the patient is not left "unmonitored" in the system. The hospital clinician must be informed before a patient is discharged back to the referring practitioner after two or more DNAs. This must be noted in the patient's MEDWAY entry and outpatient notes.

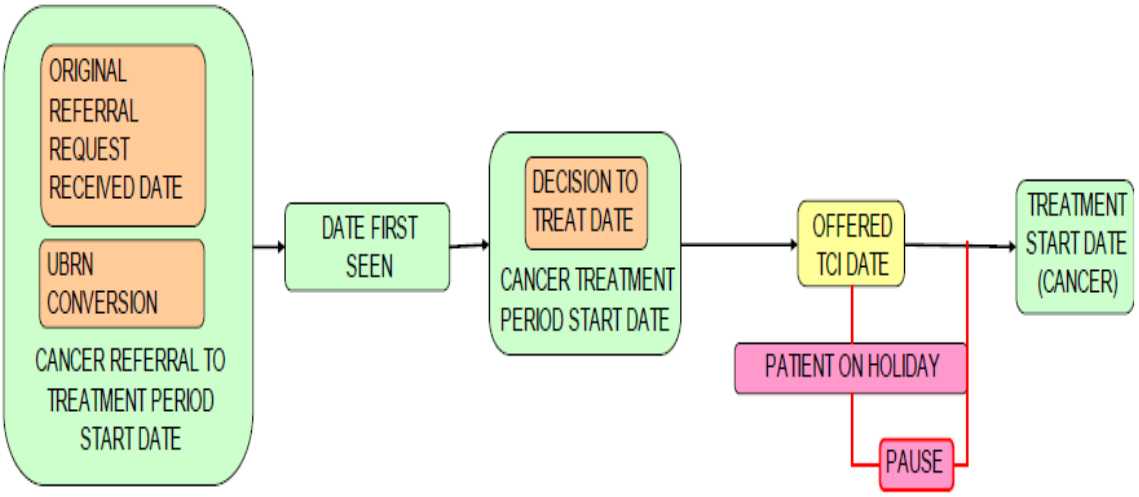
In an exceptional case, the clinician (who will review all patient hospital notes at the end of a clinic), may make a decision to offer a further appointment to the patient.

If a patient DNAs their outpatient appointment or diagnostic clinic attendance that would have been recorded as DATE FIRST SEEN then the clock can be stopped from the date of the receipt of the referral to the date the patient rebooks their appointment as shown below:



12.13. Pathway Adjustment for Admitted Pathway

A patient has to be offered a TCI date for admitted care (ordinary admission or day case) within



the 31 or 62 day period. If the offer of admitted care is declined, the clock can be stopped from the date the declined appointment would have been to the point when the patient could make themselves available for an alternative appointment as shown below:

12.14. Reasonableness – Outpatients and Admitted Treatment

Cancer waiting times are too short for the usual Trust definition of reasonable offer (3 weeks' notice and choice of 2 dates) to apply. NICE guidance says that an offer was reasonable if "there was a sufficient amount of notice and the provider took account of personal circumstances".

All offers of admitted treatment are considered reasonable if they are between the start and end of the relevant cancer pathway, but should account for the preparations and planning that patients (and carers) often need to take and the clinical priority of the patient. It is recommended that a minimum of 1 calendar weeks' notice should be provided for all offers of inpatient treatments and 3 working days for outpatient appointments; however this does not

preclude the Trust from offering an earlier appointment so long as the patient has fully agreed this earlier date.

The Trust will 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/GDP.

12.15. Consultant Upgrades

A consultant upgrade may occur where a referral is received and the receiving consultant (or other designated member of the clinical team) considers that the patient should be monitored on a 62 day cancer pathway as it is likely that the symptoms point towards a diagnosis of cancer.

This decision to upgrade must be made before the decision to treat (DTT) date is confirmed with the patient otherwise the referral will not be eligible for an upgrade. Once the decision to upgrade has been made the Trust will communicate this to the relevant GP/GDP at the earliest opportunity

Where a decision to upgrade a referral is made, within 24 hours of the decision being made, an email should be sent to the MDT co-ordinator containing the complete minimum data set. The MDT co-ordinator will then ensure that the patient is appropriately tracked on the cancer tracking system (Info flex) and file the proforma/email in the patient's hospital notes, with a copy forwarded to the original referring clinician, so that they are aware of the elevated priority of the referral.

Details of referrals that become consultant upgrades are uploaded onto Open Exeter as part of the monthly cancer performance returns. As yet, a national operational standard has not been agreed for this performance target but performance is monitored by the Department of Health and Social Care.

12.16. Patient Fitness

If a patient is not immediately fit for the diagnostics/treatments needed then previously this would have been a medical suspension; however, the operational standard for the 14 day, 31 day 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/GDP, placed on a pending list, moved between cancer pathways or moved solely onto an 18 week pathway.

This applies also to the first appointment where this is in a straight to test setting. Patients should not be given appointments when it is known 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/GDP. The clock should continue to tick.

12.17. Downgrading Referrals and Clinically inappropriate Referrals

Should the consultant consider the two-week wait referral to be clinically inappropriate then this should be discussed with the GP/GDP and the GP/GDP asked to withdraw the two-week wait priority. The consultant is not permitted to "downgrade" the referral.

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

The specialty admin team will record this information and send to the cancer MDT pathway coordinator who will then update the record appropriately with this information and close the 2WW pathway. This would nullify the pathway and the record would not be uploaded to Open Exeter.

If the patient cannot 'guarantee' attendance for tests or treatment within a certain timescale then they should still remain on their referred pathway.

The 62 day operational standard (85%) takes into account that some breaches are likely owing to patients choosing to wait longer. In addition, an adjustment is allowed if a patient declines a reasonable offer for admitted treatment (see section on reasonableness). 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.

If a patient is unavailable for non-admitted care for a period of time, then they should remain on their referred pathway.

Exceptions: The only exceptions exist where the patient declines all further treatments or investigations, or DNAs two diagnostic events in a row. In this situation, the clinician should liaise with the patient's GP/GDP and discharge the patient back to their GP/GDP who will discuss with them directly what the obstacles are which are preventing them from undertaking the investigation(s).

A treatment status of 'Active Monitoring' or 'Watch and Wait' must not be used incorrectly to stop a patient pathway. A 2WW referral will not be downgraded by a consultant without the active consent of the referring practitioner.

12.18. 'Thinking Time'

Where a patient has requested thinking time prior to making a decision to proceed with a treatment option, the clock will continue to tick. A local period of one week has been agreed as a local monitoring and escalation trigger point to ensure the patient is not 'lost in the system' and is being given the support needed to make a decision about their treatment.

The tolerance in relation to the operational standard takes in to account patients who go beyond the locally recommended timescales, i.e. choose to wait longer to make a decision about their treatment.

The patient's clock will continue to tick during this period and must not be paused/adjusted, even if the patient requires longer to make a decision.

12.19. Active Monitoring /Surveillance

Active monitoring/surveillance (in terms of cancer waits) should only be used 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.

Active monitoring will not be used while waiting for a diagnosis to be confirmed or staging to be completed; neither will it be used to allow for thinking time or to address capacity issues that mean the proposed active treatment would not be available in 31/62 days.

If suspected prostate cancer is not yet confirmed and a patient needs repeat PSA (prostate specific antigen) testing this is not active monitoring.

If a diagnosed prostate patient is offered a range of treatments and wants to take a couple of weeks to think about the options this is not active monitoring.

If a diagnosed prostate patient is offered a range of treatments, selects brachytherapy and has to wait for this procedure it is not appropriate to say the patient is on active monitoring.

However, if a prostate patient has a tumour that is not causing any significant problems and they decide that they don't want to pursue active treatment immediately but have the cancer kept under check by repeat PSA etc. this would be active monitoring.

12.20. Inter Trust Transfer (ITT)

Where a patient's care is provided by the Trust and another provider organisation and the patient is on a 62 day cancer pathway, both providers share responsibility for ensuring that their respective parts of the dataset are uploaded and for ensuring that the 62 day waiting time service standard is met.

The Department of Health and Social Care (DHSC) now has a national cut-off point by which referrals to a treating provider should be received – day 38. (Ref National cancer Breach Allocation Guidance, April 2016 , Gateway reference 04998

All ITT forms should be received electronically in the secure nhs.net account (This account will be checked at least once on a daily basis by the cancer information team and the Trust will confirm receipt of the ITT within one working day.

Any supporting clinical information must be sent to the treating Trust within 48 hours of the decision to refer.

Where the Trust needs to refer patients to other providers for treatment, the ITT form will be completed in full and sent by the MDT co-ordinator to the appropriate formal contact point at the receiving Trust within 24 hours of the decision to refer.

The treating Trust should confirm patient's management plan within 3 working days of agreement at the relevant MDT or outpatient appointment.

Where a patient's care is transferred from one provider to another during their diagnostic or treatment pathway, an ITT form should be sent by the referring Trust as a mechanism by which the receiving Trust is forewarned of a likely transfer, before referral and clinical documentation can be dispatched.

The tumour site MDT co-ordinator from the referring hospital is responsible for ensuring that the ITT form is sent within 24 hours of the decision to refer the patient.

An escalation process and timescales have also been agreed where turnaround times not adhered to:

- ❒ If the required information is not received within the agreed turnaround times (above) then the referring Trust should chase up the receiving Trust. Any difficulties should be documented).
- ❒ If the required information is still not received after a further 3 working days then this issue should be escalated to the cancer manager who will contact their counterpart at the other Trust, copying in the Cancer Lead.

12.21. Patients Disengaged from Cancer Pathway

12.21.1. (Local agreement – Buckinghamshire CCG / Bucks Healthcare NHS Trust)

Whilst GPs ask patients if they are available to attend for a 2 week wait appointment, it is not always the case that a patient is asked to commit themselves to a treatment pathway of 62 days from referral.

A number of suspected cancer patients decline to attend for diagnostic tests and are deemed to be 'disengaged' from their cancer pathway, by their own personal choice. Often this is for family reasons, e.g. holidays, weddings, and family commitments.

Where it is very evident that the patient does not wish to be treated within 62 days, (and where the Trust has offered them clear dates for diagnostics/ treatments & they have declined all ‘reasonable offers’ to be treated), we would ask that the referring GP removes the patient from the cancer 62 day pathway, and they are treated as urgent instead. These individual cases should be reviewed by the Lead Cancer manager & Clinician with the CCG Commissioners and agreed on a case by case basis only.

12.22. Radiology Requests

Radiology requests will be made using the electronic ICE system. The referrer must select the correct episode of care when making the request.

The radiology request must be clearly marked “suspected cancer” or “cancer”, in the clinical history section and by using the cancer priority flag, if it is suspected that the patient has cancer or if the patient is already on a cancer pathway. This will allow administrative staff in the relevant areas to process these patients’ appointments as urgent within 5 to 7 days and ensure that the individual portions of the pathway are delivered in a time that allows achievement of the waiting time target overall.

12.23. Booking the admission for Cancer Treatment

Once the clinician has decided to admit the patient for a procedure either as a day case or inpatient, they will request (order) the procedure on the waiting list card, indicating the priority as urgent.

The Booked admissions team should always phone patients first to agree either the date of POA or their TCI date. Send confirmation letter after appointment has been agreed with the patient.

Cancer patients must be given a TCI within 2 weeks of request.

12.24. Patients Admitted as Emergency

Where a patient is admitted as an emergency for the same condition as their 2WW referral (i.e. related to the suspected cancer) before they are seen they should no longer be recorded against a two week wait standard. The emergency admission is the referral into the system and effectively supersedes the original referral. However, such a patient could be upgraded onto the 62 day period if a consultant or authorised member of their team suspects cancer is the cause of the admission.

Patients, who are admitted as an emergency for a different condition, continue with their existing pathway.

12.25. Subsequent Treatment

Subsequent treatment starts a 31 day cancer clock from decision to treat date or earliest clinical appropriate date and ends when definitive treatment is delivered which could be:

- ❒ An anti-cancer intervention aimed at shrinking a tumour or delaying the growth or spread of the cancer
- ❒ Provision of palliation for the cancer symptoms
- ❒ Active monitoring (if no other treatment is appropriate)
- ❒ Symptomatic support by non NHS palliative care services

12.26. Earliest Clinical Appropriate Date (ECAD)

The earliest clinically appropriate date applies to patients whose treatment plan involves a sequence of more than one treatment modality, but where further decision to treat dates are not applicable. It can be either:

- ❒ A pre-determined date, set by the clinician responsible for the patient's care when it is anticipated that the patient will be fit to start the next stage of the care pathway
- ❒ A date set during a clinical review or on receipt of test results, when it is anticipated the patient will be fit to start the next stage of the care pathway
- ❒ An ECAD date can be changed once it is set, but only if the date has not passed. ECAD starts a 31 day cancer clock.

12.27. Family History

Family history clinics are for asymptomatic patients and are therefore excluded from all monitoring and reports. Cancer waiting times only apply to patients who exhibit suspected or confirmed cancer symptoms.

12.28. Overseas Visitors and Private Patients

Patients who choose initially to be seen privately but are then referred to the NHS for first or subsequent treatment will be monitored on the 31 day cancer pathway for first definitive treatment or subsequent treatment.

Patients who receive their initial treatment from a private provider but then seek subsequent treatments through the NHS would be classed as subsequent treatments (even if it is the first one they had on returning to the NHS).

Please refer to the relevant sections in the Patient Access Policy (found on the Trust Intranet) for guidance on how to identify record and manage overseas visitors and private patients.

12. Distribution and Implementation

This policy has been checked by the Chief Operating Officer, the Director of Performance and Planning, the Cancer Management Team and the Patient Access General Manager. It has also been reviewed by commissioners for comment and reviewed at EMC.

It will be placed on the Trust website and the local intranet.

All administrative staff will be advised to review the policy and it will link with the local Standard Operating Procedures being used in each service line.

13. Appendices

APPENDIX 1 - Definitions

A

Active Monitoring

A waiting time clock may be stopped where it is clinically appropriate to start a period of active monitoring in secondary care without clinical intervention or diagnostic procedures at that stage.

A new waiting time clock would start when a decision to treat is made following a period of active monitoring (also known as watchful wait)

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 waiting time clock.

If a patient is subsequently referred back to a consultant led service, then this referral starts a new waiting time clock.

Admission The act of admitting a patient for a day case or inpatient procedure.

Admitted Pathway A pathway that end 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 Professionals Act 2002.

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. Consultant led waiting times 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 E-Referral Service (ERS), 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 consultant led waiting times, 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 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 treatment performed in other setting e.g. as an outpatient.

E

eCO (Electronic Clinic Outcome Form)

The eCO form is the means by which a clinician communicates each patients next steps in their pathway. It is completed online and instantly available for receptionists to action the request and relevant RTT coding.

ERS (Electronic referral system)

The 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 the 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 RTT 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

See Therapy or Healthcare science intervention

Intervention

I

Interface service

(non) Consultant-led Interface service

All arrangements that incorporate any interventions any intermediary levels of clinical triage, assessment and treatment between primary and secondary care.

Consultant-led referral to treatment relates to hospital/consultant led care. Therefore, the definition of the term 'interface service' for the purpose of consultant led waiting times does not apply to similar 'interface' arrangements established to deliver traditionally primary care or community provides services, outside of their traditional (practice or community based) setting.

The definition of the term does not also apply to:

- Non consultant le 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.

M

Medway Medway is the acute Trust's patient information system on which all episode and clinical alert details are held.

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 services*

R

Reasonable offer A *reasonable* offer is an offer of time and date three weeks or more from the *time that the offer was made.*

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 local clinical discussions about good referral practice.

A waiting time clock only starts in 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 consultant led referral to treatment period, a new waiting time clock starts upon the decision to start a substantively new or different treatment that does not already form part of the patient's care plan.

It is recognised that a patient's care often extends beyond the consultant led referral to treatment period, and that there may be a number a number of planned treatments beyond first definitive treatment

However, where a further treatment is required that was not already planned; a new waiting time clock should start at the point the decision to treat was made.

Scenarios where this might apply include:

- Where less 'invasive/intensive' forms of treatment 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 appointments, where a decision to try a substantively new or different treatment. In this context, a change to the dosage of existing medication may not count as a 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 form the patient's agreed care plan is one that must

	be made locally by a care professional in consultation 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

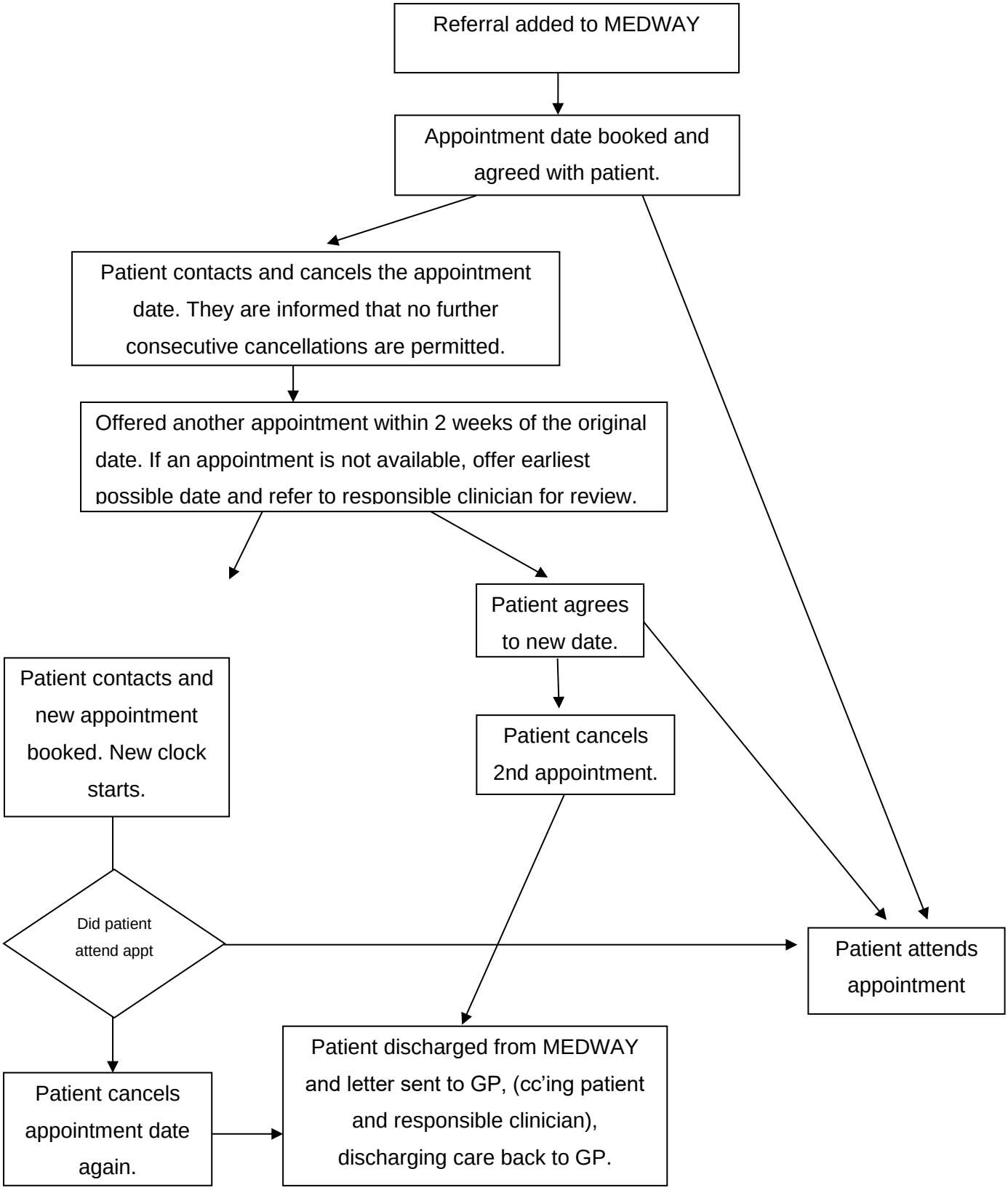
UBRN (Unique Booking Reference Number)	The reference number that a patient receives on their appointment request letter when generated by the referrer through E-Referral Service (ERS). The UBRN is used in conjunction with the patient password to make or change an appointment.

Appendix 2: INTER-PROVIDER ADMINISTRATIVE DATA TRANSFER DATA COLLECTION TEMPLATE

Referring organisation name:	Referring organisation code:
Referring clinician:	Referring clinician registration code:
Referring treatment function code:	Contact name:
Contact phone:	Contact e-mail:
Patient Details:	
Patient's family name:	Patient's forename:
Title:	Date of birth:
NHS number:	Local patient identifier:
Correspondence address: Post code:	Contact details: Patient is lead contact ☐ Lead contact if not the patient: ☐ Lead contact name: Contact home tel no: Contact work tel no: Contact mobile: Contact e-mail:
GP Details:	
GP Name:	GP practice code:
Referral To Treatment Information:	
Patient Pathway Identifier:	Allocated by (organisational code):
Is the patient on an 18 Weeks RTT pathway: Yes ☐ No ☐ (98)	
Is this referral the: Start of a new pathway – (New condition or change of treatment) ☐ (12) Continuation of an active pathway – (1st definitive treatment not given) ☐ (20) Continuing treatment for a stopped pathway (1st definitive treatment given) ☐ (90)	
Is this referral for: Diagnostic test only ☐ Opinion only ☐	
Date of decision to refer to receiving organisation:	Clock start:
List all organisations involved in the 18 Weeks pathway	
Receiving Organisation Details:	
Receiving organisation name:	Receiving organisation code:
Receiving clinician:	Receiving treatment function code:
Date IPTAMDS sent:	
For Receiving Organisation:	
Date received:	

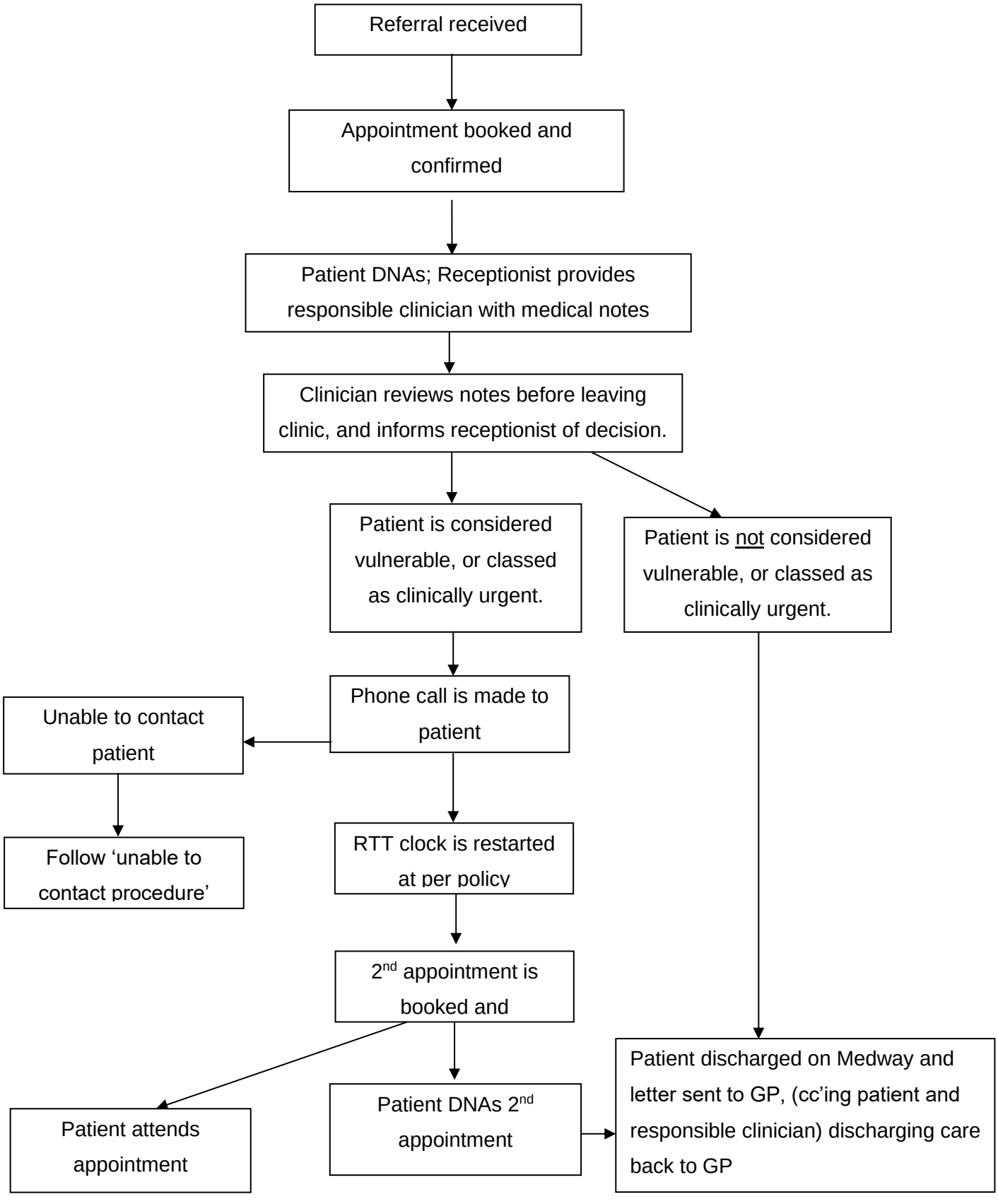
APPENDIX 3 – DNA Pathways

All the following flows should be incorporated in the SOPs specific for each specialty



Appendix 4: OUTPATIENT DNA PROCESS – New appointments

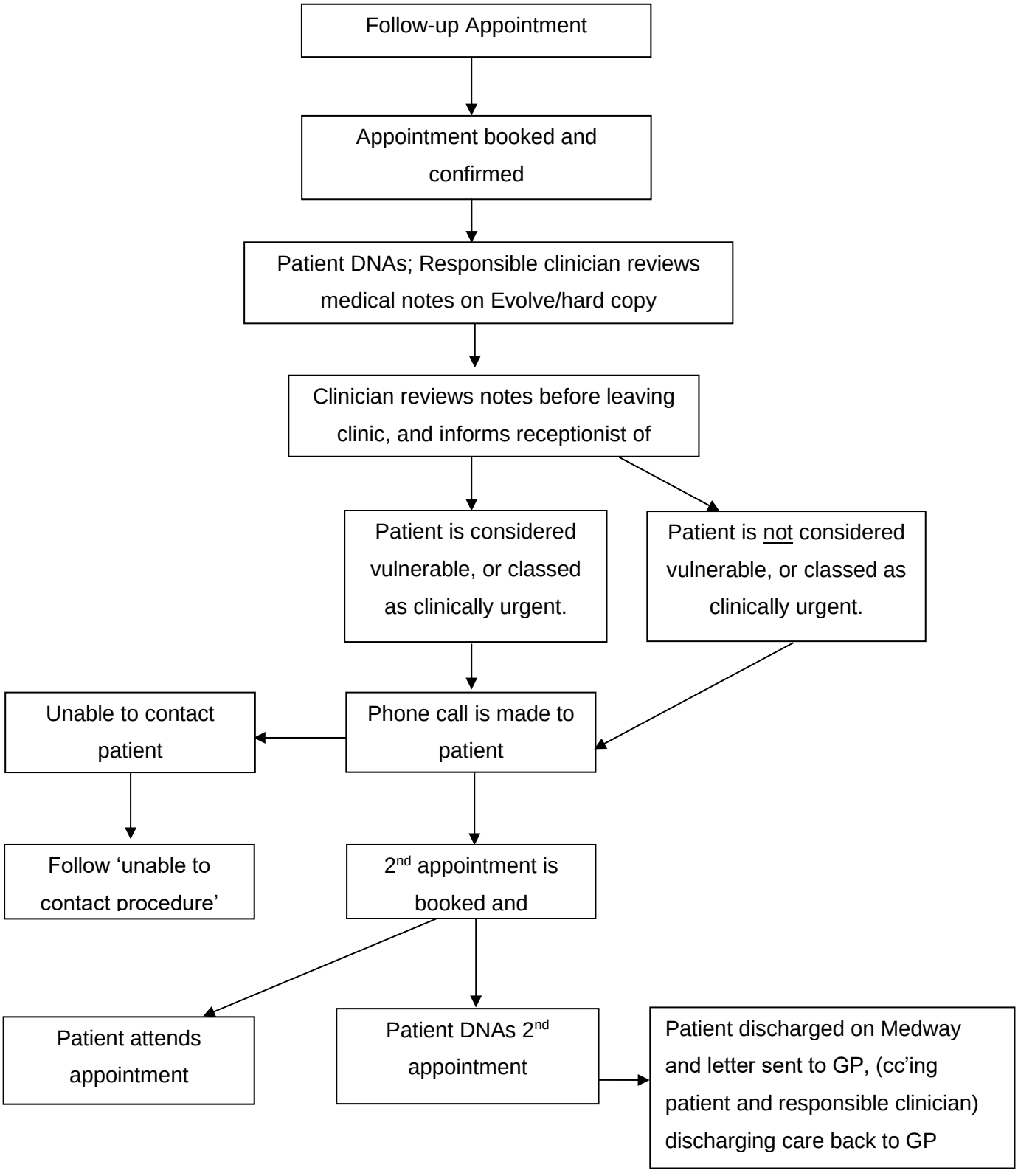
New Outpatient Appointments - 'DNA' Process



Appendix 5: OUTPATIENT DNA PROCESS –Follow-up appointments

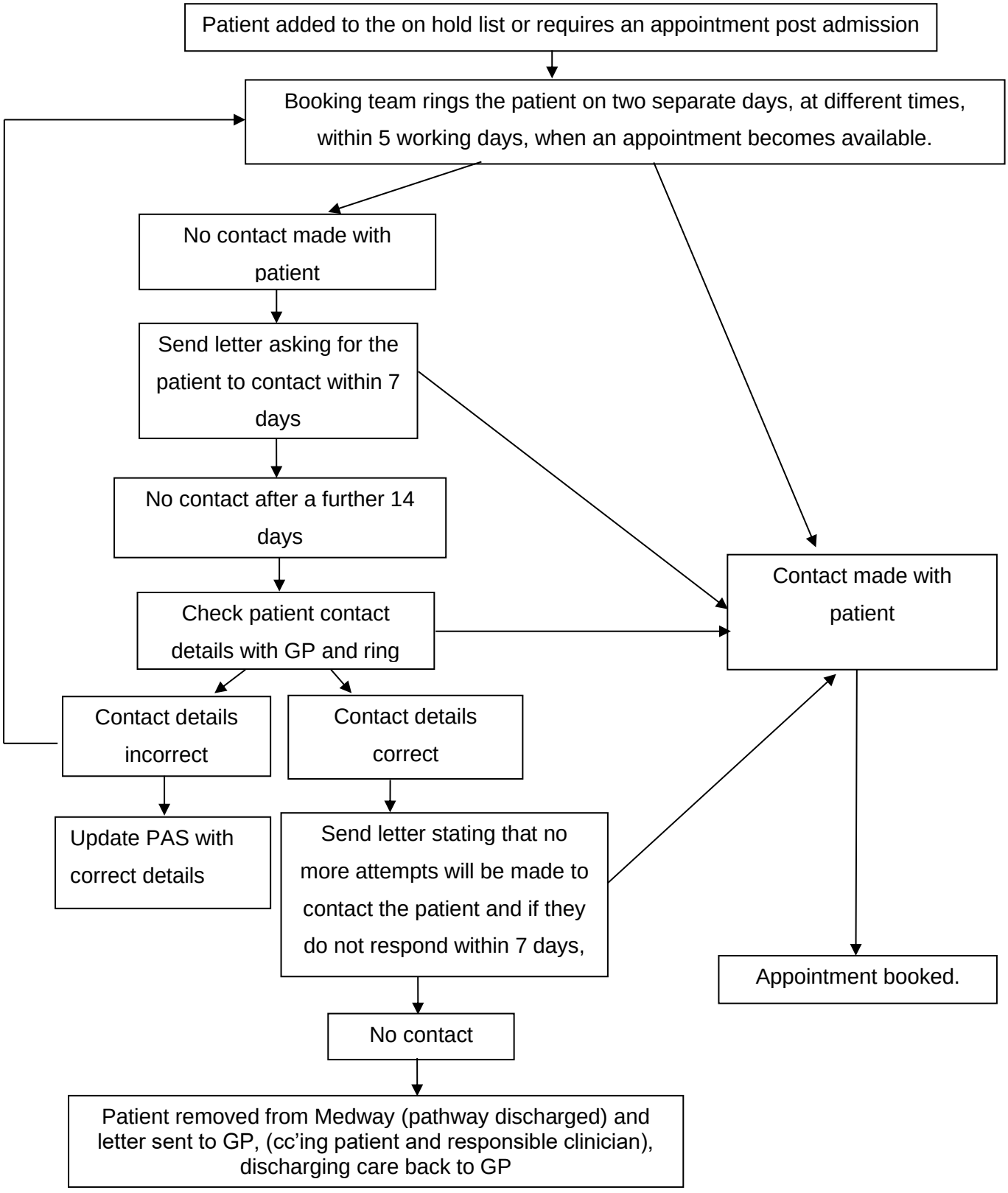
Follow-up Outpatient Appointments –

'DNA' Process



Appendix 6: OUTPATIENT UNABLE TO CONTACT PROCESS

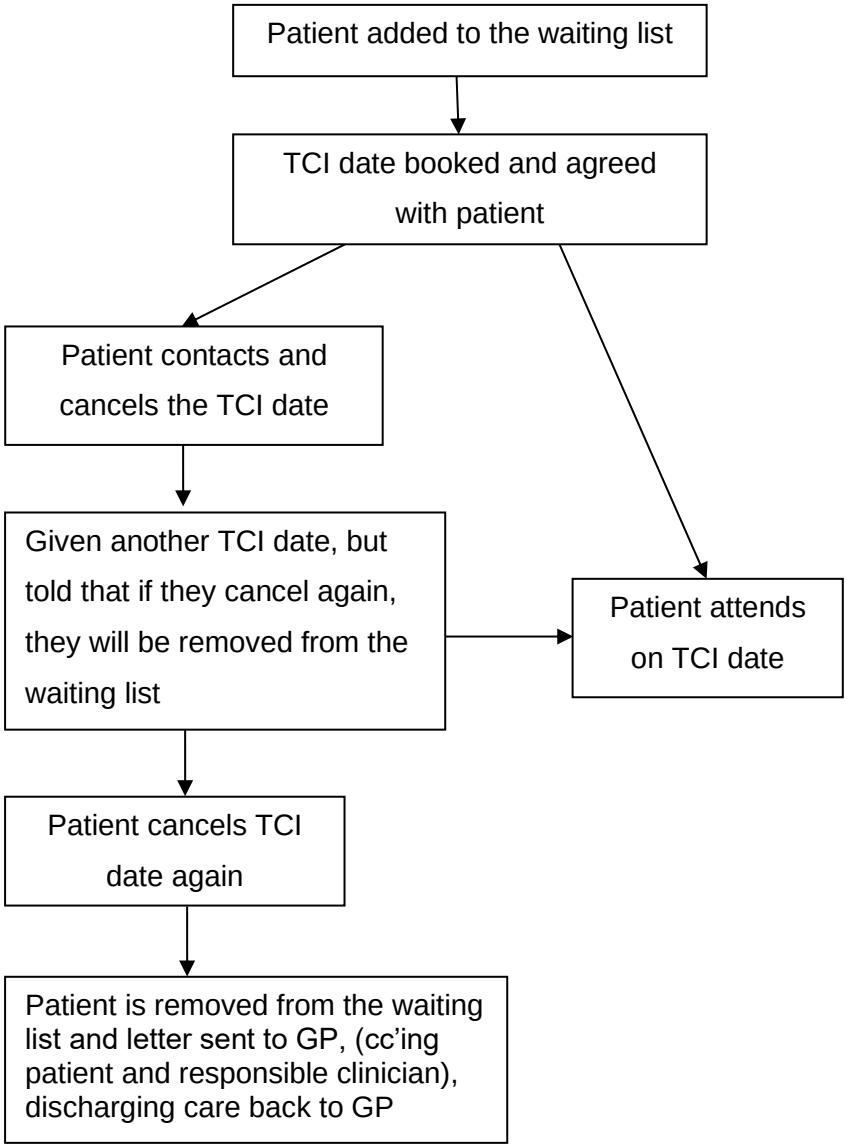
Outpatient Appointments - 'Unable to contact' Process



Appendix 7: INPATIENT CANCELLATION PROCESS

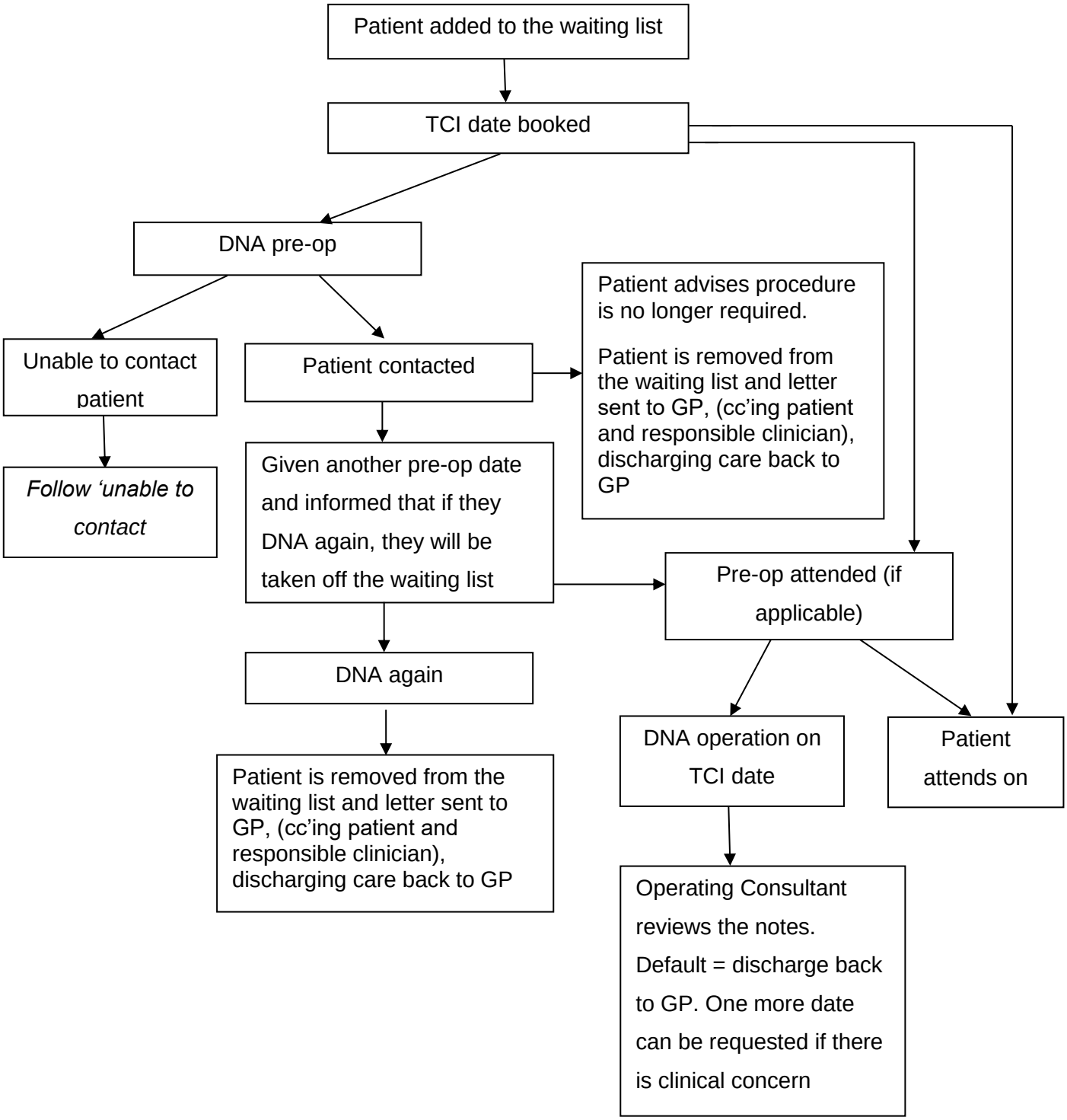
Daycase/Inpatient Procedures –

'Cancellation' Process



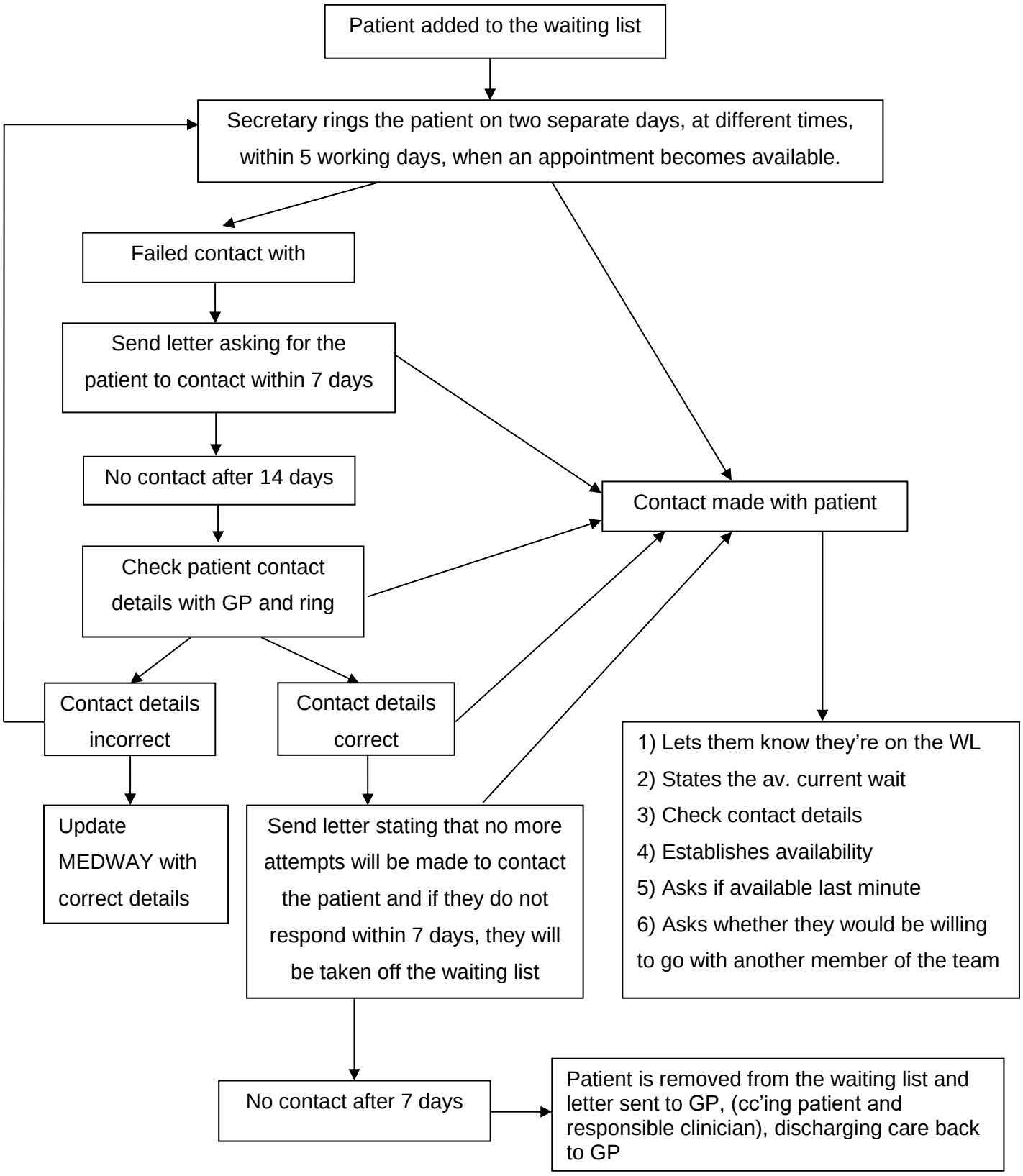
Appendix 8: INPATIENT DNA PROCESS

Daycase/Inpatient Procedures - 'DNA' Process



Appendix 9: INPATIENT UNABLE TO CONTACT PROCESS

Daycase/Inpatient Procedures - 'Unable to contact' Process



Appendix 10 – TVCAP Policy Document

Thames Valley Cancer Access Policy
July 2016
Adopted by Buckinghamshire Healthcare NHS Trust 11/11/16

This document sets out the core issues for Cancer Access that should be consistent across the Thames Valley. Local operational policies describing how good access is achieved will still be necessary.

The best interest of the patient should be at the forefront of decisions on how to manage patients. This should override any permission allowed in this policy for referring patients back to their GP. This is of particular importance for children and vulnerable adults[1].

1. Thames Valley Cancer Access Policy - National Guidance

This policy is based on the national guidance and is designed to clarify local policies where the national guidance is not explicit. The two pieces of guidance are:

- Cancer Waiting Times a Guide (version 9.0)
- Cancer Breach Allocation

Details of the national standards and dataset can be found here. Cancer Waiting Times Standards are also in Appendix 1.

2. Primary Care Responsibilities

The responsibilities of GPs and dentists when making 2 week wait referrals (including symptomatic breast referrals) are to:

1. Ensure that the patient meets the clinical criteria for a 2 week wait referral.
2. Carry out all relevant investigations and tests as specified on the referral proforma.
3. Complete the referral proforma in full.
4. Initiate the referral through the use of Choose and Book or other electronic method.
5. Provide the national minimum core dataset when transferring care to another provider See Appendix 2.
6. Respond quickly to queries raised by the receiving Trust for more information.
7. Ensure the patient understands the nature of the referral and the need for urgency.
   NB booking staff will assume patient has this understanding[2]. The referral will indicate that this information has been given to the patient and if not the reason for not giving the information will be given.
8. Ensure patient is able and willing to be seen within 2 weeks.

[1] Including but not limited to; patients with learning difficulties or psychiatric problems; patients with physical disabilities or mobility problems and elderly patients who require community care
[2] See CWT Guide 3.1.14.

3. Receiving Organisation Responsibilities

This Access Policy applies to all NHS commissioned providers of cancer diagnosis and treatment in the Thames Valley. This includes the provision of nationally mandated data by independent sector providers.

3.1. Two Week Wait Appointments

9. Contact the referrer immediately if the required information is not complete.
10. The Directory of Services should make clear which providers should be sent which referrals. Providers should forward immediately to an appropriate provider any referral that is for a service not provided.
11. A 2 week wait referral can only be withdrawn or downgraded by the referrer.
12. Enable 2 week wait referrals to be booked via Choose and Book or other electronic method.
13. Offer one reasonable appointment or investigation date within 2 weeks[3]. An appointment must not be made in circumstances where it is known that the patient will be unavailable to attend thus to induce a series of DNAs or cancellations resulting in referral back to the referrer.
14. If a patient does not attend their first appointment a second appointment should be made.
15. If an adult patient does not attend their second appointment the provider may refer the patient back to their GP[4].
16. If a patient has not booked an appointment within 28 days of first being contacted the provider may refer the patient back to their GP following clinical discussion.
17. Patients should be able to cancel and re-book their first appointment.
18. Patients who cancel their second appointment may be referred back to their GP but only if this has been agreed with the patient[5].

3.2. Cancer Treatment

3.2.1. Inpatient or Day-case Admission

19. A patient requiring inpatient or day-case admission should be given at least two reasonable offers of an admission date within the *Referral to Treatment* and *Decision to Treat to Treatment* standards. Reasonable is defined as any offered appointment between the start and end of the 31 or 62 day standard.
20. Patients should be able to cancel and re-book their first offered admission date.
21. Patients who cancel their second offered admission date may be discharged but only if this has been agreed with the patient[6]. The patient should fully understand that they are removing themselves from the cancer or suspected cancer pathway.

[3] See CWT Guide 3.1.21
[4] See CWT 3.1.23
[5] See CWT 3.1.23
[6] See CWT 4.1.6

3.3. Decision to Treat

22. Where a patient is consented for a surgical investigation and a separate surgical treatment simultaneously, this will be recorded as the DTT for tracking purposes.

23. If at the time of decision there was still uncertainty as to the likelihood of surgery, for example if alternative treatment modalities are still being considered or it is not clear if the patient is respectable or if the disease has spread, the decision to treat should be considered to be the date on which surgery was confirmed as the most suitable treatment option and the patient agreed to this. This may be via a telephone conversation if the patient was not brought back to clinic. Where this is the case, the CNS should document the call and decision to treat date agreement.

3.4. Waiting time rules and adjustments

Rules for waiting time adjustments and clock stops for cancer are defined as per CWT guidance, in addition below there is some local clarity around this guidance:

3.4.1. Patients who are hard to engage

24. The cancer waiting times guidance states that;
The Provider cannot deliver on a patient who is not prepared to "be on the pathway"[7].

It also states that;
"However, multiple (two or more) DNAs elsewhere [than TCI for admitted treatment] in the pathway can result in a patient being referred back to their GP."[8]

However the guidance is also explicit about the circumstances in which a patient cannot be discharged.

25. Patients who DNA or cancel multiple appointments after the initial first outpatient appointment should be encouraged to come in via interventions from the CNS and GP. Discharge to the GP should be as a last resort and should wherever possible be explained to the patient first and should be accompanied by a letter to the GP stating that the patient has been discharged and may be re-referred when they wish to be seen.

26. Patients should be kept on a 62 day pathway for tracking purposes until they are treated, cancer is ruled out or the patient is discharged.

27. Following treatment, a validation decision may be taken on patients who have proven hard to engage through repeated DNAs and cancellations. It could be considered that these patients are '*not prepared to be on a pathway'* i.e. they are indicating that they do not wish to be treated within 62 days and the provider therefore '*cannot deliver'* on such a patient. Therefore these patients will be removed from a 62 day pathway and treated as a 31 day patient only. *Hard to engage* patients will be defined as follows:
    - Patients who DNA two appointments for outpatients or any investigations consecutively, or three appointments throughout the pathway as a whole;
    - Patients who have cancelled any one appointment more than twice, or cancelled three or more separate appointments;
    - Patients who DNA two appointments in the pathway and cancelled two or more separate appointments;

[7] See CWT 3.3.12
[8] See CWT 4.1.49

- Patients who, through patient choice, are unavailable for a diagnostic test for a period of 28 days or more.
- This policy is for use on 62 day pathway patients only and should be applied retrospectively, to enable the patient to remain on tracking whilst active treatment is still being considered.

3.4.2. Lengthy medical deferrals

28. Pauses are not allowed to be applied for patients who are unfit to be treated for medical reasons. Active monitoring should not be used for patients who are medically deferred in normal circumstances. However on occasions a treatment plan may be changed significantly as a result of serious comorbidities requiring treatment first (e.g. treatment of a second cancer, major heart disease), to the extent that the patient agrees to a period of active monitoring prior to reassessment for treatment at a future date. Such patients are often kept on tracked pathways during the monitoring period for safety reasons.
29. Where a patient has been unwell for a continuous period of two months or more, at validation post-treatment it should be considered whether the patient was effectively on active monitoring during this period. This will depend on the documented conversations with the patient around management of their cancer whilst unfit for treatment, and on the individual circumstances. It should be clear that the patient has understood that active treatment is not possible at the current time and has agreed to 'wait and see' whether they will be able to undergo cancer treatment once their other health problems have been resolved, and understands that cancer treatment may or may not be possible depending on disease progression during that time, which will be reassessed prior to a plan being decided. This policy is for use on 62 day pathway patients only and should be applied retrospectively, to enable the patient to remain on tracking whilst active treatment is still being considered.

3.4.3. Nurse led clinics

30. A nurse clinic can be counted as a clock stop for a two week wait referral providing the
    - The nurse is part of the consultant team.
    - The triage makes an active decision about which is the appropriate next step. This therefore applies to nurse triage clinics for straight to test in suspected colorectal cancer. Such clinics need not be face to face.

3.4.4. Lung nodules

31. Patients with lung nodules that are not deemed cancer but are to be rescanned in a number of months should be removed from the 62 day tracking and put on the consultant upgrade to 62 days pathway. The form of words used to communicate the outcome of this diagnostic process if for clinicians to decide on a case by case basis but the most accurate description may be that the diagnosis is "uncertain neoplasia". This does not alter the fact that they are being manged as if they do not have cancer.

3.5. Inter-trust Referrals

32. Providers will refer patients on for treatment as determined by locally agreed pathways and MDT management decisions. Referring providers should complete the activities set out in the Network Timed Pathways prior to referral.

33. A provider that normally treats but cannot do so in the required timeframe can transfer the care to another provider with the agreement of the patient and the receiving provider.

34. Where a cancer or suspected cancer patient is referred from one provider to another at some point in the pathway. Both providers share responsibility for ensuring that their respective parts of the dataset are uploaded and for ensuring that waiting time service standards are met.

35. In all circumstances an ITR form should be sent to ensure the treating organisation has the relevant details to allow for effective tracking of this patient.

36. The date of the inter-trust referral will be the date by which the receiving trust has all the information needed to proceed with the diagnosis and management of the patient. This will be; Inter-trust Referral Form, radiology images and reports, pathology reports and clinical letter.

37. The MDT Outcome of a Specialist MDT at the receiving provider may substitute for a clinical letter but this must be stated in each the MDT Outcome. If the referring provider needs an outpatient appointment with the patient before treatment at the receiving provider can begin then this must always be confirmed by clinical letter.

38. All MDT operational policies should state the clinical content, method of communication and timescales for the passing of clinical information for inter-provider transfer. This should include details for Item 36.

39. Network Site Specific Groups will review MDT operational policies to make ensure referring and receiving providers operate compatible policies.

40. All clinical letters and ITR forms should be in the form of e-mails or attached to e-mails (ie not posted or faxed).

41. An inter-trust referral will be triggered even when patients are referred for solely for a diagnostic test

42. Appendix 4 sets out the agreed tracking and data for inter-trust referral forms.

3.5.1. Breach Allocation

For two provider pathways

43. Where a referring provider routinely carries out the items specified in the Network Timed Pathways Policy the Inter-trust referral date will be when these have been completed and communicated (along with the ITR Form and clinical letter as set out in Item 37).

44. The national Breach Allocation Policy will be followed to adjust performance.

Scenario	Trust 1	Trust 2	Trust 1	Trust 2
1	>Day 38	≤Day 62	0	1
2	≤ Day 38	≤Day 62	0.5	0.5
3	≤Day 38	>Day 62		-1
4	>Day 38	>Day 62 and ≤ Time1 +24	-1	
5	>Day 38	>Day 62 and >Time1 +24	-0.5	-0.5

Time 1 – Day referral from Trust 1 to 2

Green +ve – allocation of pass
Red –ve – allocation of breach

For three or more provider pathways

This includes pathways where the first and third provider is the same

45. For pathways where patients are routinely referred to another provider for a diagnostic test only (including those cases where some go on to be treated at the second or subsequent provider and others are returned to for local treatment) providers will bilaterally agree the timescales for diagnostics test and reports to be complete. See Appendix 4 for a list of these pathways. By default the timescale will be

- Referred for diagnostic test by Day 19
- Diagnostic test reported and communicated within 19 days.

46. Breach allocation for three part or more pathways will be shared 50:50 between the first and last provider (as happened prior to October 2016) unless separate agreement is made locally for individual cases.

Reporting Breach Allocation

47. Providers will share details of breaches that are subject to allocation by the 15th working day of the month following the treatment. Providers will validate the details before formal upload.
48. Providers will submit breach allocation adjustments to their CCG and NHS Improvement on the 5th working day of the month after treatment (ie concurrently with deadline for upload to Open Exeter). The first report due will be for patients treated in October 2016.

4. Monitoring of the Access Policy

49. Providers will record all waiting times adjustments as part of the CWT Dataset.
50. Breach reasons will be recorded in accordance with national guidance and grouped as set out in Appendix 5.
51. Providers will report to their CCG all patients referred back to primary care under the rules allowed in this Policy. This information should be submitted each quarter to their host CCG.

TVCAP Appendix 1

National Operational Standards

Measure	Operational Standard
All Cancer Two Week Wait	93%
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	93%
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	85%
62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	90%
62-Day Wait For First Treatment From Consultant Upgrade: All Cancers	90%
31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	96%
31-Day Wait For Second Or Subsequent Treatment: Anti-Cancer Drug Treatments	98%
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	94%

TVCAP Appendix 2

Minimum Dataset for 2 week referrals from GP

- Full name of patient (correctly spelt)
- Patient's DOB
- Patient's gender
- Patient's full address
- Patient's up-to-date contact telephone number (where possible also a mobile number)
- Patient's NHS number
- Full clinical details on the reason for the referral in line with NICE suspected cancer referral guidance. The specific data required for each tumour is defined as completion of the Thames Valley proforma for that tumour.
- Referrer details (including telephone and fax number)
- In the case of breast referrals – stating whether the patient is a suspected cancer patient or a symptomatic patient.
- Indication of whether the patient is aware of the nature and urgency of the referral.
- Indication of whether the patient is available during the 2 weeks following referral.
- All referrals should include a 2ww proforma; however additional information (i.e. in the form of a clinic letter) may be included.

NHS
Thames Valley Strategic Clinical Network

TVCAP Appendix 3

Inter Trust Referral (ITR)
Data Transfer Process
Draft 1

Agreed Actions and Timescales

Action	When	Tracking
First Seen Trust		
Decision to Refer	In MDT, in clinic, other	
Send ITR form to safe e-mail account (where possible to a generic account to prevent delays and encourage consistency)	As soon as MDT Coordinator knows of referral, but within 1 working day of Decision to Refer	Logged when sent
Send clinical letter to safe e-mail account (where possible to a generic account to prevent delays and encourage consistency).	With ITR form if available, otherwise within 3 working days	Logged when sent
Send weekly Referral List (highlighting any referrals not acknowledged).	Weekly	Logged when sent
For third Trust referrals second trusts sends their ITR form and clinical letter and the one from the first Trust to safe e-mail account	As soon as MDT Coordinator knows of third Trust referral	Logged when sent
Treating Trust		
Check safe e-mail account for ITR form	Daily (week days)	Logged when received Acknowledge receipt
Check for clinical letter	As soon as ITR received. MDT coordinator to chase after 3 days if not with ITR	Logged when received Acknowledge receipt
Notify sending trust of onward referral to third trust	As soon as MDT Coordinator knows of onward referral	Logged when sent
Send ITR, DTT and treatment data to First Seen Trust	Within 5 working days of date of treatment	Logged when sent

ITR - Inter Trust Referral

Third Trust
Where receiving Trust refers patient on to a third Trust for treatment

Safe e-mail accounts
Each provider to list the safe e-mails accounts for referral to each tumour site.

ITR Form Data
Data to be sent from First Seen Trust to Treating Trust

- NHS Number
- Patient Name
- Date of Birth
- Consultant referred to
- Tumour Site

- Cancer Referral Decision Date (GP)
- Urgent Cancer Referral Type
- Wait category (2ww, 62 day, consultant upgrade, 31 day only etc.)
- Primary Diagnosis (if known)
- Proposed treatment type (if known)
- Decision to Treat Trust (if appropriate)
- Waiting time adjustment (first seen)
- Waiting time adjustment (Treatment)
- Delay reasons (provide separately for before and after first seen periods)
- Reason for referral (i.e. first treatment, subsequent treatment, diagnostics only, MDT discussion only etc…)

ITR Treatment Data

Data to be sent from Treating Trust to First Seen Trust

- NHS Number
- Patient Name
- Date of Birth
- (GP) Cancer Referral Decision Date
- Decision to Treat Date and Trust
- First Definitive Treatment
- First Definitive Treatment Date and Trust
- Cancer Status
- Primary Diagnosis (ICD)
- Waiting time adjustment
- Delay reason (to cover the 62 day period, for agreement between organisations)

If applicable:

- First Seen By Specialist Date and Trust
- Multidisciplinary Team Discussion Date

Diagnostics only Pathways

Patients that are referred for a diagnostic test and return to original Trust for treatment. This includes pathways where some patients remain at second provider for treatment and others returned to original Trust.

TVCAP Appendix 4

Recording Breach Reasons

DELAY REASON REFERRAL TO TREATMENT (CANCER)

From Going Forward on Cancer Waits a Guide Version 8.0

Code	Code Text	Group Definition
1	Clinic cancellation	System
2	Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this PATIENT)	System
3	Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)	System
4	Elective cancellation (for non-medical reason)	System
5	Elective capacity inadequate (patient unable to be scheduled for treatment within standard time)	System
7	Complex diagnostic pathway (many, or complex, diagnostic tests required)	Complex
10	Treatment delayed due to co-morbidity (patient unfit for treatment episode, excluding recovery period following diagnostic test)	Medical
11	Diagnosis delayed due for medical reasons (patient unfit for diagnostic episode, excluding planned recovery period following an invasive diagnostic test)	Medical
13	Delay due to recovery after an invasive test (patient diagnosis or treatment delayed due to planned recovery period following an invasive diagnostic test)	Complex
14	Patient Did Not Attend treatment appointment.	Patient
16	Patient Choice (patient declined or cancelled an offered appointment date for treatment)	Patient
17	Patient choice delay relating to first outpatient appointment	Patient
18	Health Care Provider initiated delay to diagnostic test or treatment planning	System
19	Patient initiated (choice) delay to diagnostic test or treatment planning, advance notice given	Patient
20	Patient Did Not Attend an appointment for a diagnostic test or treatment planning event (no advance notice)	Patient
21	Patient failed to present for elective treatment (choice)	Patient
22	Patient care not commissioned by the English NHS (waiting time standard does not apply)	Other
98	Other reason	Other

Thames Valley Strategic Clinical Network

Definitions of complex

Any patient where:

- investigations are required that are not within the normal pathway;
- investigations need to be repeated (as long as this wasn't due to equipment breakdown);
- referral was originally into a different cancer site;
- advice from another clinical team is required due to another condition that needs to be checked or treated (apart from general anaesthetic reviews).

DELAY REASON COMMENT (REFERRAL TO TREATMENT)
From Going Forward on Cancer Waits A Guide Version 8.0.

This is the free text comment field to describe why the maximum 62 day period has been breached. ***It should not include the name of the patient, any other personal details or clinician(s) involved in the case.***