Barking, Havering and Redbridge University Hospitals NHS Trust

Patient Access Policy
Elective, Cancer and Diagnostic Services

This policy can be made available in other formats and languages upon request to the PALS office on 01708 435 454

Contents Include:

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CONTENTS

APPENDICES

Did Not Attend (DNA) Pathway for Adults at Risk

For DNA:
Adults at Risk who do not attend a clearly communicated first appointment or who cancel two appointments for the same condition will be offered a new appointment where the original clock will be nullified and a new clock started. See paragraph 9.6.1 Did Not Attend (DNA) at first or subsequent appointment.

Outpatient/Inpatient administrative staff should:

- Check patient details held on Medway are correct against Symphony
- Inform the Lead healthcare professional to review the healthcare records/E-Pro/Symphony and consider the risk to the adult of not attending the appointment (see risk assessment below)
- Request the Lead Healthcare professional to contact the Adult at Risk to ascertain the reason for DNA – record in the healthcare or electronic records who was spoken to and the reason given for the DNA. Arrange another appointment.

If the Adult at Risk DNAs the second appointment the Lead healthcare professional MUST….

Notify the GP in writing:

- Of the DNA/Cancellation and that no further appointment will be sent unless specifically requested;
- Of the outcome of the telephone contact with the patient, particularly if unable to contact;
  AND
- Request GP to make contact with the Adult at Risk and arrange a welfare visit

If there are possible safeguarding adult concerns Lead healthcare professional MUST…

Send a DNA/Cancellation letter to the GP and copy the relevant Adult Social Services
AND
Inform the Trust's Safeguarding Adult Team - a Safeguarding Adult Referral may be required

All actions must be documented in healthcare records / E-Pro / Symphony and comments on Medway

Risk Assessment Triggers:

Vulnerabilities – learning disability, cognitive impairment, complex health needs, alcohol/substance misuse, main carer
Medical concerns
Medication for chronic illness
Pending investigation results
Number of DNA's
Frequent attender to the Emergency Department
Known to other hospitals/agencies/social services

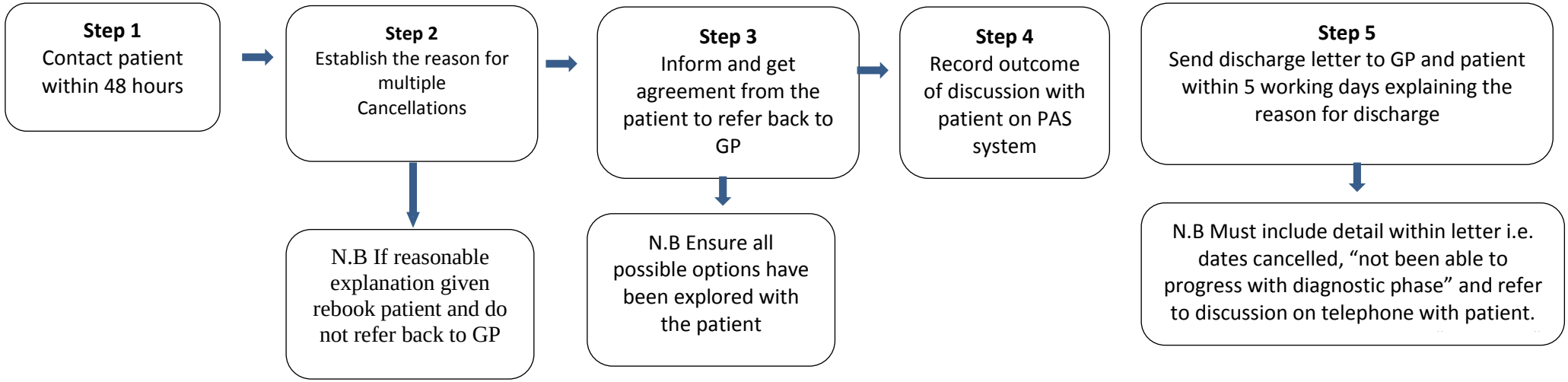
Be mindful of cancellation by family member/carer trying to avoid adult at risk meeting with professionals

PROCESS TO DISCHARGE PATIENTS ON SUSPECTED CANCER PATHWAY

N.B Individual personal circumstances should be taken into account when using this process i.e. Learning Disabilities, Mental Health, and Dementia etc.

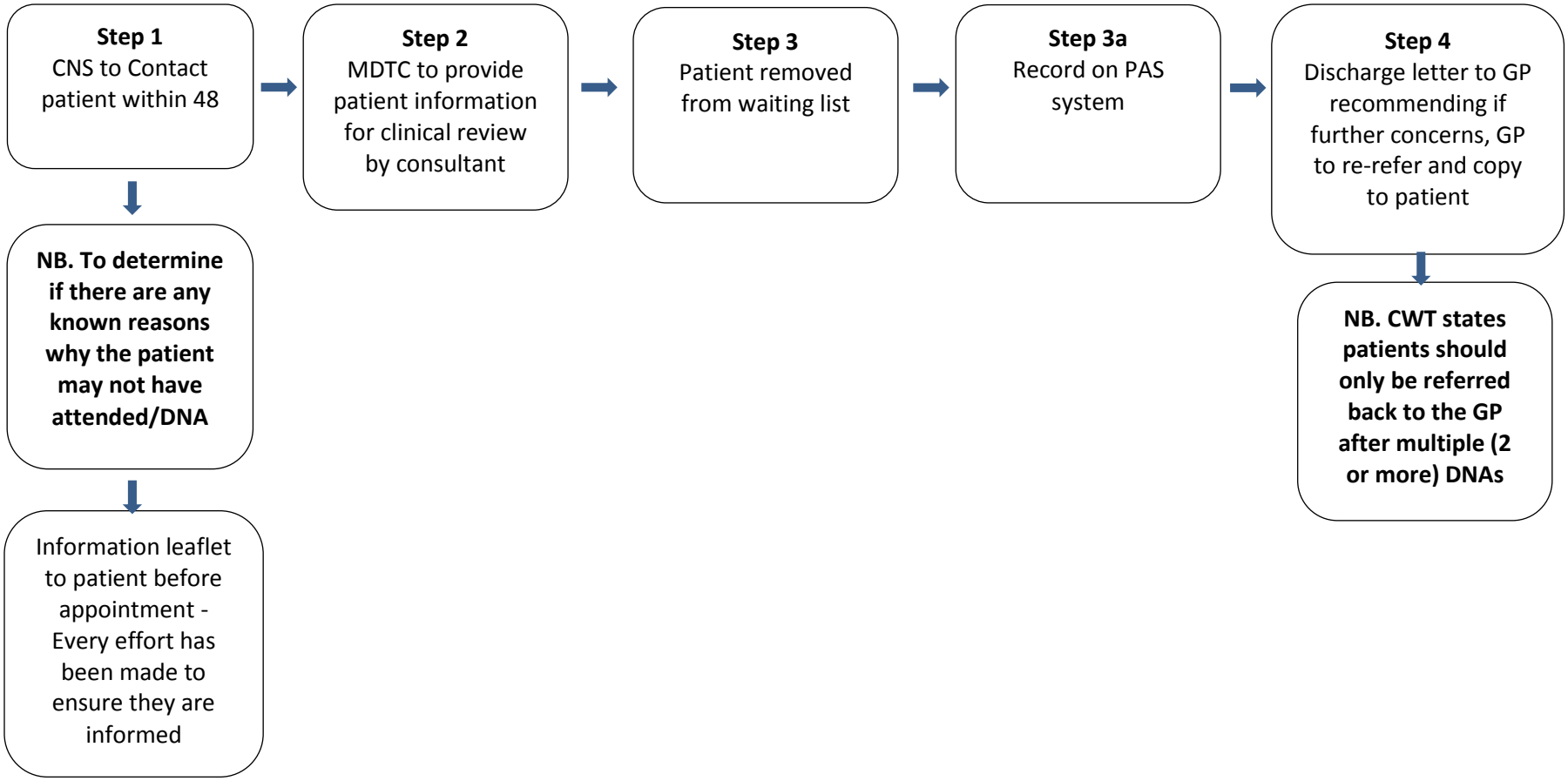
1. Process for multiple (two or more) cancellations in line with Cancer Waiting times Ref 4.11 CWT guidance version 9

Responsible for patient contact: Appointment call centre/Admissions/MDT coordinators



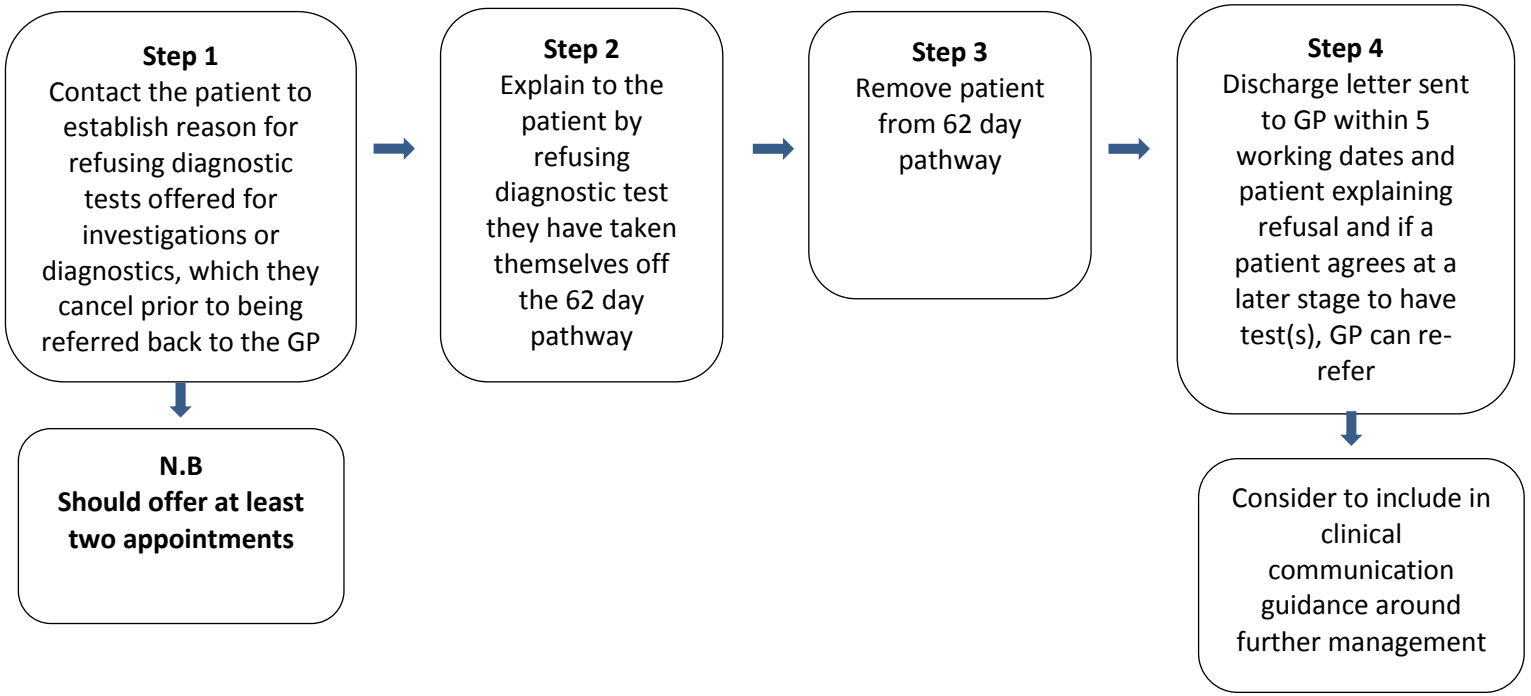
2. Process for patients who DNA two or more appointments (during pathway) – CWT ref 4.11. This does not include 1st outpatient appointment
(N.B. changed to reflect local arrangements).

Responsible for patient contact: Clinical Nurse Specialist (CNS)/MDT coordinators (MDTC)



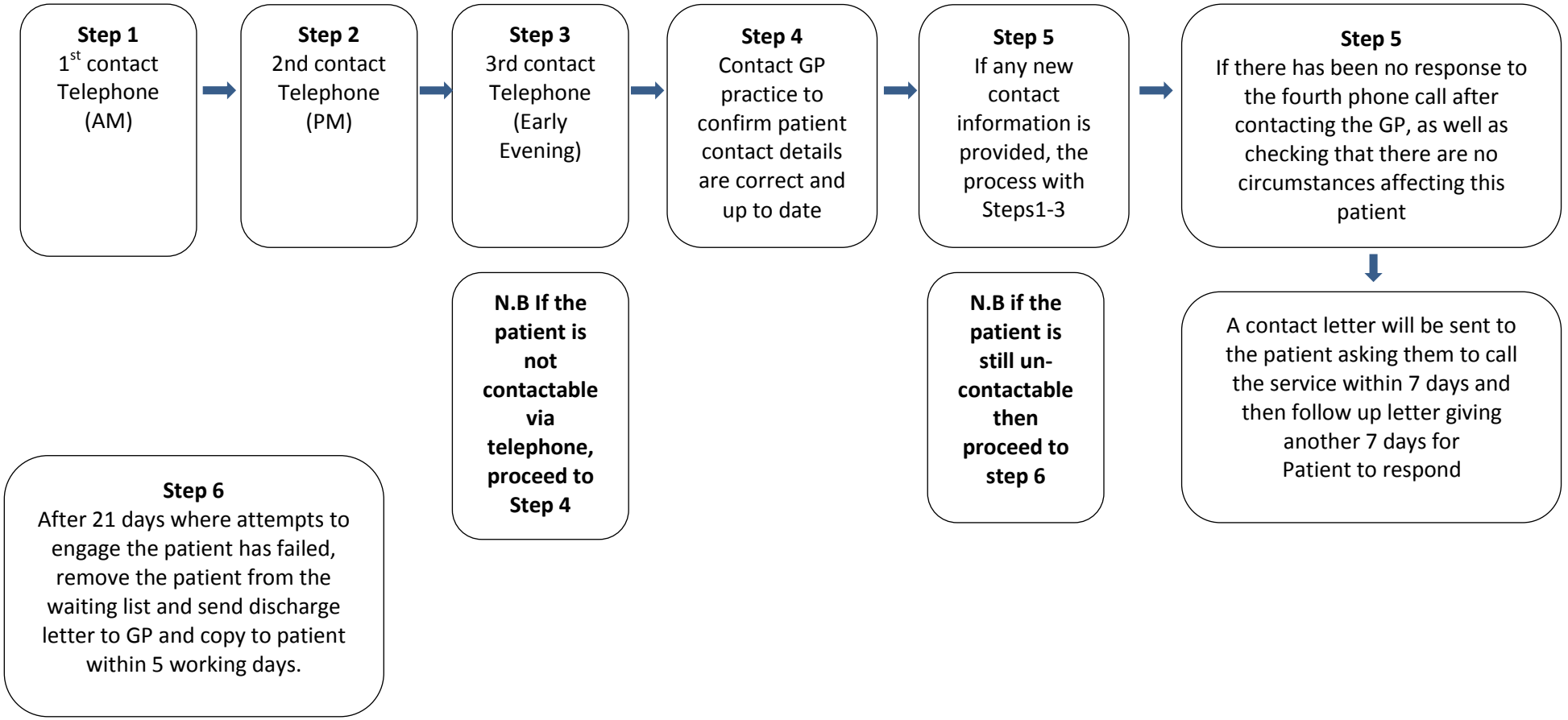
3. Process for patients who have refused altogether the diagnostic tests that may diagnose cancer (CWT 3.2.3)

Responsible for patient contact: Clinical Nurse Specialist - MDT to provide CNS with patient information to contact the patient – agreed at CNS forum 28.11.16



4. Process for patients who cannot be contacted (does not apply to first outpatient appointment as this is managed by Cancer Referral Office)

Responsible for patient contact: Appointment call centre/Patient pathway coordinators/MDT coordinators



1. INTRODUCTION

This policy has been developed to outline the requirements and standards for managing patient access to secondary care services from referral to treatment on routine, diagnostic and cancer pathways, for both Barking, Havering & Redbridge University NHS Trust (BHRUT, the Trust) and the Clinical Commissioning Groups (CCGs) who commission BHRUT services.

The policy covers the processes for booking, notice requirements, patient choice and waiting list management for all stages of routine and cancer pathways. This policy supports a maximum wait of 18 weeks from referral to first definitive treatment and all other key waiting times access standards relating to cancer and diagnostics This also includes all the stages that lead up to treatment, including outpatient consultations, diagnostic tests and procedures. The policy has been co-signed by BHRUT's Clinical Commissioning Groups.

The access and referral guidelines which this Policy contains will enable all patients referred to the Trust to be treated efficiently, equitably and in line with National Access Standards and Cancer Waiting Times guidance. The best interests of patients are foremost in the Trust's guidelines and patients are managed according to clinical priority and in line with the NHS Constitution.

This policy must be read in conjunction with the National guidance on Referral to Treatment (RTT) waiting times, the Cancer Waiting times guidance v 9.0 and any other guidelines and best practice guidance. Compliance with this policy and national RTT, Diagnostics and Cancer guidance will be routinely monitored through Access Board Meetings and non-compliance raised with the relevant operational leads to resolve.

This policy has been revised to reflect changes to national monitoring and reporting of 18 week maximum referral to treatment times launched in October 2015 and to integrate cancer targets into the overall access policy.

The length of time before a patient receives an outpatient appointment, investigation and hospital treatment is an important quality issue and is an indicator of the efficiency of the services provided by the Trust. Treating patients and delivering a high quality, efficient and patient focused service is a core responsibility of the Trust but can only be effective if there is a shared understanding and agreement from the wider local health community.

This policy supports a maximum wait of 18 weeks from referral to first definitive treatment in line with the NHS Constitution. The 18 week patient pathway does not replace other waiting times, targets or standards where these are shorter than 18 weeks such as National Cancer targets which are also included in this policy.

Access arrangements and targets for diagnostic reporting standards and cancer services are different than for RTT pathways.

Full details of patient rights under the NHS Constitution can be located on the NHS website searching under "NHS Constitution". Patients' right to choice continues to be at the heart of what we do at the Trust and patients may view the patient choice framework 2014-2015 https://www.gov.uk/government/publications/nhs-choice-framework.

This policy should be read in conjunction with the Trust Overseas Visitors Policy, the Consultant to Consultant Referral Guidance and the Trust's Safeguarding Policies.

This policy document is available to the general public and has been written to provide information on how patients access services. The document can be accessed via the Trust's website.

2. PURPOSE

This policy sets out the principles regarding how patients access our services and how the Trust manages the administration of access to services. The policy is not meant to describe the detail of the operational processes involved in the administration of the waiting list. The Trust has a range of Standard Operating Procedures (SOPs) to set out details on how the patient pathway should be managed by the Trust and its stakeholders

This policy also incorporates the guidelines set out in the *NHS Outcomes Framework 2014/15* and in planning guidance for commissioners *'Everyone counts'.*

This policy sets out roles and responsibilities around patient access to ensure that all key individuals, namely, BHRUT staff, local Clinical Commissioning Groups (CCGs), and General Practitioners (GPs) have a clear, shared and agreed understanding of their mutual roles and responsibilities in the successful clinical management of patients booked for elective treatment.

This policy sets out specific guidance on the management of waiting lists agreed by BHRUT and supersedes all previous versions of the policy.

All staff, both clinical and managerial, involved in managing waiting lists are expected to follow this policy. The policy is not a comprehensive guide to all aspects of waiting list management, but sets out guidance on the key policy areas that require particular attention to facilitate Referral to Treatment (RTT) measurement and managing total waiting times for individual patients. General guidance on RTT management is available from the Department of Health publication *'Right to start Consultant Led Treatment within 18 weeks – January 2012'* found on the Department of Health website. Guidance on Cancer Waiting times is outlined in http://systems.digital.nhs.uk/ssd/cancerwaiting/cwtguide9.pdf

3. DEFINITIONS

Relating to Elective Pathways

For the purposes of this policy, definitions of the terms used are given below:

Active monitoring	An RTT waiting time clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedure at that stage. A new waiting time clock would start when a decision to treat is made following a period of active monitoring (previously known as "watchful waiting").
Admission	The act of admitting a patient for a day case or inpatient procedure.
Admitted pathway	A patient on a pathway that is likely to end in a clock stop within an admitted setting (day case or inpatient).

BHRUT (The Trust)	Barking, Havering & Redbridge University Hospitals NHS Trust.
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.
Cancellation	If a patient declines an appointment after it has been booked, giving any notice, this is termed a patient cancellation.
Care professional	A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.
CAO	Central Appointments Office
Choose and Book (now called NHS e-Referral Service)	From June 2015 this has been replaced by 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.
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.
Clinical Triage	The process by which clinical staff prioritise, approve and agree referrals
Clock Start	A waiting time clock starts when any care professional or service permitted by an English NHS Commissioner to make such referrals, refers to: a) A consultant-led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner; b) An interface or referral management or assessment service, which may result in an onward referral to a consultant-led service before responsibility is transferred back to the referring health professional or general practitioner. I.e. the start of an 18 week referral to treatment pathway. The commencement of a patient pathway which is initiated by a health care professional referring to a Consultant led service
Clock Stop	The point at which a decision is made and communicated to the patient that treatment has commenced, a period of active monitoring has commenced or decision not to treat has been made on an 18 week referral to treatment pathway
Clock Continues	The clock continues to tick until either the first definitive treatment is given, or another event occurs which can stop the clock
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 nonmedical 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.
Consultant to Consultant referral (C2C)	The internal referral of a patient from one Consultant to another within the same NHS Trust. This can be between Consultants in the same, or differing specialties

DNA – Did Not Attend	Where a patient fails to attend an appointment/admission without prior notice.
Decision to admit (DTA)	Where a clinical decision is taken to admit the patient for either a day case or inpatient treatment.
Decision to treat	Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatment performed in other settings e.g. as an outpatient.
Direct Access	'Direct Access' diagnostics is any arrangement where a GP can refer a patient directly to secondary care for a diagnostic test/procedure without having to attend a consultant OP appointment first. The GP remains managing the on-going care – no clock start/no active RTT pathway commences.
First definitive treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter for clinical judgment, in consultation with others as appropriate, including the patient. A FDT on an 18 week referral to treatment pathway is applied when the treatment addresses the condition for which the patient was originally referred to secondary care.
Fit (and available)	Patients must be fit i.e. medically fit enough to undergo the intended treatment and available for treatment within 18 weeks from referral.
GDP	General Dental Practitioner
GP	General Practitioner
Incomplete pathways	For as long as the clock is still running on an RTT pathway, it is called "incomplete". Patients may have been seen in clinic by a hospital doctor, and may have had diagnostic tests, but they have not yet started definitive treatment (or been discharged) and so they have an "incomplete" pathway. Month End Incomplete pathways: This is the key indicator for national reporting on RTT every month. This indicator reports the percentage of patients on incomplete pathways within 18 weeks against the total number of patients on an incomplete pathway as at the end of a calendar month. This is a 'snapshot' on the day of reporting. The organisation's performance is measured against a target of 92%.
Interface service (non-consultant led interface service)	All arrangements that incorporate any intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care. 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 provided services, outside of their traditional (practice or community based) setting.
Inter-provider Transfer/Inter-provider minimum data set (IPTMDS)	An NHS provider may transfer patients to other providers where it is in the best clinical interests of the patient to receive diagnostic tests or care and treatment elsewhere. The Inter-Provider Transfer Minimum Data Set (IPTMDS) supports the requirement to transfer administrative data to allow the monitoring of a patients progress along an 18 Weeks pathway where care has been transferred between providers.

MDS	Minimum Data Set – Information which should be contained in all referrals.
Non-admitted pathway	A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment' i.e. patients in an outpatient setting with no decision to admit
Non consultant-led	Where a consultant does not take overall clinical responsibility for the patient
Non Treatment clock stop	A clock stop may be applied to a patient pathway for reasons other than treatment. For example, a patient declines treatment having been offered it or a clinical decision is made not to treat;
NHS provider	An NHS Provider is an organisation that can supply services under commissioning agreement, e.g. GP/GDP, Referral Management Centre, GPwSI, Hospital Trust, and Community Services such as Specialist Palliative Care Teams. A cancer or RTT clock can stop at any of these NHS organisations if they provide *definitive* Treatment.
Outsourcing	Outsourcing is an arrangement with a private or NHS organisation to provide additional inpatient, diagnostic or outpatient services which could also be or usually have been provided in-house. This typically happens when demand exceeds the hospitals capacity.
OAC	Outpatients Appointment Centre
PAS	Patient Administration System (IT system). BHRUT uses Medway as its PAS system. It contains a record of patient events on each pathway.
PoLCE	Procedure of Limited Clinical Effectiveness
PTL	Patient Tracking List – Lists of patients who are under the care of the Trust used to track their progress along their pathways at various stages in their treatment and care. Not all patients therefore will be on active RTT or cancer reportable PTLs.
Reasonable offer (of appointment)	A reasonable offer is an offer of a time and date that gives the patients a minimum of three or more weeks from the time that the offer was made for an outpatient or diagnostic appointment, inpatient or day case procedure.
Referral Management or Assessment service (RMS)	Services 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. This may led into a consultant led pathway in which case the clock could start in the RMS.
Referral to treatment (RTT) period	The part of a patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other clock stop. The maximum time any patient may wait for RTT is 18 weeks.
RIS	Radiology Information System
Staff	Anybody working on behalf of the Trust whether permanently employed, agency, bank, locum, contractor, volunteer or on work experience
Straight to test	This is an internal pathway within the Trust where a patient is sent straight to test post receipt of referral and 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.
Somerset	Cancer Register System

Substantively new or different treatment	The start of a new waiting time clock upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.
TAL	The Appointments Line (TAL) provides a telephone booking service for patients to book, check, change or cancel their appointments via the NHS e-Referral Service. It also supports choice discussion with the aid of the NHS Choices website and the information held within the Directory of Services.
TCI date	'To come in' – the date given to a patient to undertake an operative procedure or treatment
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. The clock would stop for the original referral in this service.
UBRN (Unique Booking Reference Number)	The reference number that a patient receives on their appointment request letter when generated by the referrer through the NHS e-Referral Service. The UBRN is used in conjunction with the patient password to make or change an appointment.
Unfit for Treatment	A clinical decision is made that the patient is unsuitable for surgery/treatment and they are discharged back to primary care or a decision is made not to treat e.g. on-going heart problems that make anesthesia unsafe. The RTT clock is stopped
Unwell (for treatment)	The treatment is cancelled by the provider after admission for clinical reasons (e.g. patient deemed temporarily unfit for surgery due to chest infection). The RTT clock should continue to tick
Vulnerable Person	A vulnerable person could be an adult or child at risk who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation. This definition is from the DOH guidance 'No Secrets DoH 2000'.

Definitions related to the Cancer Pathway

2 Week Standard (Cancer)	• Maximum 2-week wait from urgent GP (GMP, GDP or Optometrist) referral for suspected cancer patients (new or recurrences) to first outpatient attendance. • Maximum 2 week wait from referral of any patient with breast symptoms (where cancer is not suspected) to first hospital assessment. Note: Calculated from date of Receipt of Referral to date First Seen.
31 Day Standard (Cancer)	• Maximum 31-days wait for treatment for all new cancers. Note: Calculated from date of Decision to Treat to date of Treatment. • Maximum 31-days wait for all second or subsequent treatments for all cancer patients, including those diagnosed with a recurrence: ○ surgery or drugs ○ radiotherapy or other modality Note: Calculated from date of Decision to Treat /Earliest Clinically Appropriate Date (ECAD) to date of Treatment.

62 Day Standard (Cancer)	• Maximum 62-days wait for urgent GP (GMP, GDP or Optometrist) referrals for suspected cancer. • Maximum 62-days wait for treatment, for all referrals for Breast Other Symptoms Note: Calculated from date of Receipt of Referral to date of Treatment. • Maximum 62-days wait for treatment, for all referrals from a national screening program me (Bowel, Breast and Cervical). Note: Calculated from date of Receipt of Referral to date of Treatment. • Maximum 62-days wait for treatment, for all referrals upgraded by a hospital consultant. Note: Calculated from date of Decision to Upgrade to Date of Treatment. Maximum one month (31 days) from urgent GP (GMP, GDP or Optometrists) referral to first treatment for acute leukemia's, testicular cancer and children's cancers.
AOS	Acute Oncology Service
CRO	The Cancer Referral Office
Clock pause (cancer)	A clock can only be paused once the patient has declined a 'reasonable' cancer treatment admission date for *definitive* Treatment (day-case or in-patient).
CWT	Cancer Waiting Times
Decision to Treat (clock start for cancer 31 day standard)	This is the date that the MDT decision for cancer management is communicated to the patient and is agreed by the patient. There cannot be a Decision to Treat without patient agreement to the specific treatment.
ECAD (clock start cancer 31 day standard)	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. An ECAD date can be changed once it is set but only if the date has not passed.
First Seen (clock stop for Cancer 2 week wait)	The date First Seen in a cancer pathway is the date of the patient's initial assessment following referral. This may be an outpatient appointment or a diagnostic investigation (straight to test) e.g. CT chest
Inter-Provider Transfers (IPT)	Patients can begin their suspected cancer journey at one NHS provider, have investigations at another provider and end up being treated at a third provider. They can also get transferred back to sender (e.g. after specialist tests). The 14-31-62 day cancer clock does not stop whilst a patient is being transferred from/to another NHS organisation, only responsibility for recording the next applicable clock stop in the pathway is relinquished. Recent draft guidance states that should the patient need to be transferred to another provider, the referring Trust must do so within 38 days with all minimum dataset as per locally agreed tumour specific best practice pathway.

MDT	Multi-Disciplinary Team
NHS Provider	An NHS Provider is an organisation that can supply services under commissioning agreement, i.e. GP (GMP, GDP or Optometrist), Referral Management Centre, GPwSI, Hospital Trust, Community services such as Specialist Palliative Care Teams. A cancer clock can stop at any of these NHS organisations if they provide *definitive* Treatment. A cancer clock does not stop because the patient's care is being transferred across any of the above organisations.
Non-NHS Provider	A Non-NHS Provider is an organisation that supplies: • private services (paid for by patient or their insurance); • healthcare services outside England and Wales; • Services commissioned and paid for by an NHS organisation. In this scenario, the commissioning NHS organisation remains responsible for tracking cancer patients and reporting any applicable cancer standards. e.g. Outsourcing Cancer Waiting Times only apply to NHS patients, including those who are transferred to NHS from Non-NHS, but excluding those who are transferred from NHS to Non-NHS.
Reasonable Offer 2 week wait office bookings (First Appointment)	For all appointments booked by or on behalf of 2ww CRO, 'reasonable' offer is defined as a choice of 2 dates within 14 days.
Reasonable Offer of Admission (Cancer) (TCI)	At BHRUT an offer of a single admission date will be deemed 'reasonable' if it gives the patient 1 weeks' notice from the date the offer was made depending on clinical need and urgency. This notice principle for 'reasonable' offer applies to appointments for outpatients, see & treat clinics, investigations, one-stop services and day-case admissions as well as in-patient admissions, but does not apply to patients who are able and willing to accept an appointment at shorter notice.
Screening (Clock start) (Cancer)	Screening is a national early detection service commissioned by PCTs. Patients who meet certain criteria are called to have a periodical investigation and if this reveals an abnormality, they undergo further assessments before being referred for further management at their local NHS provider. Screening referrals start a 62-day cancer clock as follows: • Bowel = date of receipt of referral for an appointment to discuss suitability for colonoscopy with a specialist screening practitioner • Breast = date of receipt of referral for further assessment (i.e. not back to routine recall) • Cervical = date of receipt of referral for an appointment at a colonoscopy clinic
Treatment (clock stop for 31 and 62 day standard)	This is described in the Cancer Dataset as the definitive intervention aimed at removing/debulking a tumor or stopping/slowing the cancer spread. All definitive Treatment modalities will stop the 31 and 62-day cancer clocks including active monitoring/specialist palliative care.

Waiting Time Adjustment (Cancer)	Adjustments are allowed on a Cancer pathway for: A patient who does not attend a first outpatient appointment/diagnostic clinic and gives no notice then the clock can be re-set from the receipt of referral to the date upon which the patient makes contact to rebook their appointment. This is called Waiting Time Adjustment (First Seen). A patient declining a reasonable offer of admission for treatment in an admitted care (or ordinary admission or day case) setting. For patients on a 31 or 62 day pathway the adjustment would be the time between the date of the declined appointment to the point where the patient could make themselves available for an alternative appointment

4. ROLES AND RESPONSIBILITIES

CHIEF EXECUTIVE
The Chief Executive has overall statutory responsibility for the patient safety, governance and performance management as related to the delivery against the access standards and is accountable to the Trust Board for their delivery.

EXECUTIVE DIRECTORS
Each Executive Director is responsible for ensuring that annual Trust objective setting and review is timely and effective within their sphere of responsibility. They play a key role in ensuring targets for Key Performance Indicators within their remit are agreed, communicated and delivered and that issues escalated to them in relation to that delivery are effectively managed.

CHIEF OPERATING OFFICER
Is the individual responsible for the operational management and delivery of this policy: overseeing executive responsibility for the application of the policy and overall delivery of access standards by ensuring:

- Robust systems are in place for the performance management and improvement of national, local and internal targets around RTT, Diagnostics and Cancer;
- Production of the monthly Integrated Performance Report highlighting to the Board areas not meeting RTT, Diagnostics or Cancer requirements (and actions to address) by exception;
- Plans to address areas of RTT, Diagnostics and Cancer requiring improvement are developed and implemented;
- That appropriate support is in place for teams facing significant RTT, Diagnostics and Cancer issues that may take some time to resolve / address.

DIVISIONAL MANAGERS are responsible for overseeing the Senior Managers responsible for implementation of this policy.

Are responsible for delivery of services to the standards of this policy within the areas of their general responsibility.

HEAD OF PATIENT ADMINISTRATION
Is the individual responsible for the accurate application of this policy within the Outpatients Department. Is responsible for alerting staff to the presence of the policy on the intranet as well as ensuring hard copies are available in all booking areas.

CONSULTANTS
Responsible for the clinical decision making required to implement this policy and to ensure patients are not disadvantaged as a result of application of the rules herein.

SPECIALTY MANAGERS/SERVICE MANAGERS/PATIENT PATHWAY MANAGER
Are responsible for the correct application of this policy within their specialty departments and to ensure patients have access to hospital services in line with the rules herein

DIVISIONAL ADMISSIONS – PATIENT PATHWAY MANAGERS AND TEAM LEADERS
Are the individuals responsible for the accurate application of this policy for admissions.

ALL RELEVANT ADMINISTRATIVE STAFF
Are responsible for the accurate and timely administration of a patient pathway according to the definitions and rules set out within this policy.

PATIENT PATHWAY COORDINATORS
Are responsible for tracking patients along their pathways and alerting Senior Managers when there are issues relating to the completion of their pathways within 18 weeks.

CANCER MANAGEMENT TEAM
Support the weekly Cancer performance management process by providing support and challenge to all Cancer MDTs and their sites. Undertakes first line performance management actions, escalating to the Chief Operating Officer where required in line with the Performance/ Operational Delivery Escalation process and ensuring accurate and timely national reporting. Work with the sector on improving the flow of patients between external providers, (ITTs**).**

TRUST INFORMATION TEAM
The Information team provides the accurate and timely data and an analysis/interpretation of performance data for performance review and follow up purposes and delivering national reporting to the required timetable.

ALL STAFF
In order to maintain the highest standards of data quality and patient confidentiality, all staff are responsible for ensuring that any data created, edited, used or recorded on the Trust's PAS system, within their area of responsibility, is accurate and recorded in accordance with this policy and other Trust policies relating to the collection, storage and use of data.

4.1 KEY PRINCIPLES

General Medical Practitioners/General Dental Practitioners and Other Referrers

The Trust relies on GPs and other referrers, supported by local commissioners, to ensure referrals are appropriate, accurate and contain the MDS they are responsible for ensuring patients are fit and available for treatment and care and that patients understand their responsibilities, potential pathway steps and timescales when being referred. This will help ensure patients are:

- Referred under appropriate clinical guidelines;
- Offered a choice of provider, as outlined in national guidance;
- Aware of the speed at which their pathway may be progressed;
- Able to accept timely appointments throughout their treatment.

They should also:

- Inform the patient that failure to attend a first appointment may result in the referral being returned
- Any exceptions should be highlighted upon referral
- Ensure that referrals are in line with the CCG's PoLCE and where required approval has been obtained ***(Intranet\Quality & Safety-Guidelines, Procedures & Forms-PoLCE).***
- Ensure that suspected cancer patients are given appropriate information about why they are being referred and the importance of being seen quickly so that they accept and keep early appointments

Patients

Patients should be clinically fit for assessment, ready, willing and able to attend throughout their pathway if the Trust is to deliver a successful 18 week patient pathway, in line with patients' constitutional rights. This includes:

- Attending their hospital appointment or ensuring that they contact the hospital to cancel it, giving as much notice as possible;
- Managing their own health where possible;
- Involvement in the management of their treatment pathway;
- Ensuring they inform their health care provider of any changes in personal circumstances, particularly contact details and registered GP;
- Being available and attending reasonably offered and accepted appointments (avoidance of DNA)

General

Since the end of December 2008 no one should wait more than 18 weeks (126 days) from referral from any Healthcare Professional, to a Consultant led service, to the start of their hospital treatment or where there is a decision not to treat. This includes all the stages that lead up to first treatment, including outpatient consultations, diagnostic tests and procedures.

The 18 week patient pathway does not replace other waiting times, targets or standard where these are shorter than 18 weeks. This includes waiting times for cancer patients, diagnostics, audiology services, Allied Health Professional services such as physiotherapy and waiting times for rapid access chest pain clinics which should adhere to national or locally agreed waiting times.

This Policy describes the way in which Barking, Havering and Redbridge University NHS Trust (BHRUT) will manage patients who are waiting for treatment on admitted, non-admitted, cancer or diagnostic pathways. It includes the management of patients at all sites where BHRUT operates, including outreach clinics.

The Trust will ensure that the management of patient access to services is transparent, fair, and equitable and managed according to clinical priority. The Trust will support and respect patient choice as applicable in this policy.

All patients should be seen as quickly as possible and in order of clinical need. The Trust will give priority to clinically urgent patients, within the 18 week Referral to Treatment standard. Where patients have the same or comparable clinical need, they will be treated in chronological order.

War veterans and service personnel injured in conflict must receive priority treatment if the condition is directly attributable to injuries sustained in conflict.

Any referral to a consultant led service starts an 18 week clock.

In line with Referral requirements, the Trust anticipates a patient should be available to attend their first Outpatient appointment within a timeframe that will enable their first definitive treatment to be delivered within 18 weeks of that referral. If a patient is unavailable to attend their first appointment for a significant period of time and the clinician in charge of their care is concerned about the potential for clinical harm through that choice, they should discuss this with the referrer and a plan in the best clinical interests of the patient determined.

The Trust encourages confirmed patient booking of appointment and a record of active acceptance on the PAS systems. There must always be active patient engagement in the offer and agreement of reasonable dates recorded appropriately on the system. Active acceptance from the patient refers to their confirmation of acceptance of an appointment date achieved in writing or verbally.

Letters to patients confirming appointments or any other event in their pathways should outline the consequences of failing to attend an appointment.

Patients must only be added to the waiting list if they meet agreed protocols and policies and are fit, ready and available to come in at the time the decision is made to add to the waiting list.

The Trust will monitor the Referral to Treatment (RTT) pathway by using Patient Tracking Lists (PTL) measuring the patients length of wait from referral to new outpatient appointment, diagnostic test, elective admission and open pathway follow-up appointments, to first definitive treatment.

It is the responsibility of all members of staff to understand the Access principles and definitions. Any non-compliance with this policy will be managed in line with the Trust's Disciplinary Policy, available on the Intranet under All Policies.

4.2 Key Elements of Achieving the Access Standards

The maximum length of time that a patient may wait from referral (i.e. clock start date) to medical or surgical consultant led care, until treatment commences, is 18 weeks unless the patient chooses to wait longer, does not cooperate with offers of appointments or for clinical complexity reasons. The 18 week RTT pathway is based on a clock start when a referral is received and a clock stop when the patient begins first definitive treatment, a clinical decision is made that treatment is not required or a patient chooses to decline treatment.

This policy includes timescales in which certain activities and tasks should be performed in order to ensure the 18 week maximum RTT pathway is achieved.

Overall, the Trust aims to receive, accept and provide a first outpatient appointment for all referrals within 6 weeks, provide any diagnostic phase of the pathway within 6 weeks and an admitted phase within 6 weeks, in line with good practice.

4.2.1 Summary of Access Standards

The following national access targets, DoH (2008), apply to all patients:

- 92% of patients on an incomplete non-emergency pathway (yet to start treatment), waiting no more than 18 weeks.
- 8% of incomplete pathways who do not achieve this standard may have very complex diagnostic or treatment pathways or choose to wait longer than 18 weeks (127 days).
- All patients will be seen in chronological order within 18 weeks; and no patient will wait longer than 52 weeks.
- No patient will wait longer than 6 weeks for a diagnostic test or image.
- 93% of all urgent GP (GMP, GDP or Optometrist) referral for suspected cancer to first outpatient attendance will be seen within 14 days of receipt of referral.
- 93% of patients referred with breast symptoms (where cancer not suspected) to first hospital assessment will be seen within 14 days of receipt of referral.
- 85% of urgent GP (GMP, GDP or optometrist) referral for suspected cancer to first treatment (62 day classic).
- All patients referred by GMP,GDP or Optometrist as suspected cancer or breast symptomatic who are subsequently diagnosed with cancer will commence treatment within 62 days of receipt of referral.
- 90% of patients referred from screening programmes (bowel, breast, cervical) as suspected cancer who are subsequently diagnosed with cancer will commence treatment within 62 days of receipt of referral.
- All patients that are upgraded by Consultants as suspected cancer will commence
- Treatment within 62 days of the date of upgrade (no operational standard).

- 96% of patients diagnosed as a new cancer will receive treatment within 31 days of Decision to Treat (DTT) irrespective of treatment.
- All patients that are having a subsequent treatment for cancer will receive treatment within 31days of the DTT/ECAD for surgery (94%), drug treatment (98%) and radiotherapy (94%).

4.2.2 Clock Start for 18 weeks

An 18 week clock starts when a GP, Dentist or other health care professional refers a patient to the Trust for any elective service for the patient to be assessed and, if appropriate, treated before responsibility is transferred back to the referrer. For paper referrals the clock starts on the date when the Trust receives the referral. For a referral made through the NHS e-Referral Service, this is when the patient books their appointment and the Unique Booking Reference (UBRN) is converted.

4.2.3 A New Clock Start for 18 weeks

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 that patient's agreed care plan or at the end of a period of active monitoring. A new RTT clock will start when a 'due date' for a patient on a planned list is passed by 6 weeks or more.

4.2.4 Clock Stops for 18 weeks

The 18 week RTT clock stop will occur when first definitive treatment for the condition for which they have been referred or a decision is made not to treat. This is defined as an intervention intended to manage a patient's disease, condition or injury and avoid further intervention. First definitive treatment is a matter for clinical judgement in consultation with others as appropriate including the patient.

A clock stop may occur for non-treatment such as a patient choosing to decline treatment or a clinical decision is made and communicated to the patient that treatment is not required

4.2.5 Clock Pauses for 18 weeks and Cancer

On 1st October 2015, the NHS Commissioning Board and CCGs (Responsibilities and Standing Rules) (Amendment) (No.2) Regulations 2015 came into effect, removing the provision for a patient pause. The October 2015 Rules Suite reflects this change.

Therefore, from 1st October 2015 there is no provision to pause or suspend an RTT waiting time clock under any circumstances.

In the case of cancer patients, a clock can only be paused once the patient has declined a 'reasonable' cancer treatment admission date for *definitive* Treatment (day-case or in-patient). For cancer patients who make themselves unavailable <u>for social reasons</u> in the 'admission stage', a 'clock pause' can be applied between the first reasonable TCI date offered and the date that the patient becomes available again.

Patient pauses are not permitted before a reasonable TCI date is offered and pauses are not permitted for medical reasons or cancellations.

4.2.6 Clock Continues for 18 weeks

From the clock start, the clock continues to tick until either the first definitive treatment is given, or another event occurs which can stop the clock. The clock continues through events such as diagnostic tests, subsequent outpatient appointments prior to treatment and when a patient is added to the waiting list for a procedure.

The clock continues when the patient is transferred to another health care provider (e.g. another hospital - see Inter-Provider Transfers **[4.6]**

4.2.7 Active Monitoring for 18 weeks Initiated by the patient

During consultation with a patient, the patient may decide that they wish to wait to see if their condition deteriorates or improves prior to making a decision whether to have surgery. If this occurs the patient would be placed into active monitoring until their next appointment

4.2.8 Initiated by a care professional

During a consultation a patient may be asked to take action e.g. cease smoking, lose weight or the clinician may want to see if the condition improves or declines before considering an intervention. Patients with significant comorbidities preventing them having surgery as first definitive treatment may be actively monitored for their referred condition until they are fit for surgery. These decisions would place the patient into a period of active monitoring.

The Trust will stop a patient's 18 week clock if a decision is made to actively monitor the patient's condition and not to treat at this stage. Active monitoring will not be used for thinking time.

A new 18 week clock starts if and when a decision to treat is made.

4.3 Referral, Outpatient Booking and Management Process

There are a number of ways in which a patient may be referred into BHRUT:

4.3.1 NHS e-Referral Service (ERS) (formerly known as Choose and Book)

The GP may generate a referral which enables the patient to choose the hospital and book an appointment convenient to them from the choice available.

ERS has been set up to poll, on a daily basis, a number of weeks in advance (which is specified by each service - surgical and medical). The clock will start from the time the patient converts their referral into an appointment or upon notification of an Appointment Slot Issue (ASI). The Trust will contact patients if an ASI occurs to inform them the Trust has received their request. However, if the patient has chosen BHRUT and no appointments were available on the day; the Appointments Office will be alerted and will contact the patient within 4 working days.

Patients who cancel a UBRN (Unique Booking Reference Number) appointment, but do not subsequently rebook within 14 days will have their appointment request cancelled, unless there were no appointments available on the day. Should the patient attempt to re-use the UBRN number after that time, they will be instructed to call the Central Appointments Office (CAO) or national line. The Patient will be informed at that point to go back to their GP.

The Appointments Line (TAL) provides a telephone booking service for patients to book, check, change or cancel their appointments via the NHS e-Referral Service. It also supports choice discussion with the aid of the NHS Choices website and the information held within the Directory of Services.

4.3.2 Paper Referrals

All paper referrals will be date stamped on receipt at BHRUT. This will be the clock start date. Details will be appended to the PAS system until the Consultant has undertaken a clinical triage of the referral.

All referrals received by the Trust which are sent directly to Consultants must be date stamped and then forwarded to the appointments office on the day of receipt to allow the correct clock start date to be recorded, patient's details to be entered onto PAS and for the referral to be scanned into the system.

Once the referral has been triaged and prioritised, an appointment letter will be sent to the patient with notice (minimum 10 working days), giving the patient an opportunity to ring and change if not convenient.

For 2-week wait (2ww) cancer referrals, urgent GP (GMP, GDP or optometrist) suspected cancer referrals should be made using the Pan London new 2 week referral forms and faxed to the Cancer Referral Office (CRO) without delay. **https://bhrhospitals.nhs.uk/referring-to-our-services**

The Cancer Referral Office (CRO) is responsible for processing 2week wait (2ww) and breast symptomatic referrals within 14 working days.

NB: In the case of Cancer two week waits, if a referral is received which does not contain the information needed to process it, then the referring GP should be contacted immediately, thereby minimising the delay to the patient. This does not constitute a reason for making a pause to the pathway and patients should not be referred back to their GP to stop a pathway.

4.3.3 Electronic referral via email to Cancer Referral Office

For 2-week wait (2ww) cancer referrals, urgent GP (GMP, GDP or optometrist) suspected cancer and breast symptomatic referrals should be made using the Pan London new 2 week referral forms and sent electronically bhr-tr.crooffice@nhs.net.

4.3.4 Consultant Upgrade to a cancer pathway

Upgrades to a cancer pathway (e.g. based on clinical suspicion, following test results) can be made at any time in the patient's pathway up to the Multi-Disciplinary Team (MDT)/Decision to Admit date. All patients not already on a 62-day or 31-day pathway can become consultant upgrades and from any source **with the exception of:**

- two week wait referrals for suspected cancer;
- two week wait referrals for breast symptoms (not suspicious of cancer);
- Urgent screening referrals.

These are exceptions because the patient would automatically be on a 62 day period if cancer was diagnosed.

A consultant upgrade starts on the date the decision has been made to upgrade a patient to a cancer pathway (e.g. based on clinical suspicion, following test results). It does not start on the date of receipt as in 2ww referrals. Examples are:

a) a member of the clinical team sends an e-mail requesting that a patient (not already on the 62-day cancer pathway) is upgraded as there is a high indication of malignancy;
b) consultant sees patient in clinic or on the ward and decides, after reading test results, to investigate further for potential malignancy;
c) Consultant reads a routine referral letter and marks the referral '2ww' or 'cancer' or 'urgent ca': the date of decision would be the upgrade date.

An upgrade must be on or before a decision to treat a patient has been agreed (i.e. before the decision to treat date recorded as the cancer treatment period start date (if recorded). It must also be on or before the multidisciplinary team meeting where the care plan that was subsequently agreed with the patient was discussed i.e. the Multidisciplinary team discussion date (cancer) (if recorded).

Consultants can make upgrades by completing a Pathway Review form, by writing on a referral, or by e-mailing #Cancer Referral Office (RF4) BHR Hospitals.
http://intranet/forms/suspectedCancerPathway

4.3.5 Consultant Upgrades start a 62-day cancer clock.
Patients referred from screening centres must be notified to the CRO immediately using secure electronic systems in line with national policy.

4.3.6 Rapid Access Chest Pain
In the case of referrals to the Rapid Access Chest Pain, all patients with new exertional chest pain should be seen in outpatients within 14 days of receipt of the GP referral. The results/outcome form is sent with a letter to the GP after the patient's consultation.

4.3.7 Direct Access
Where a GP refers a patient for diagnostic reasons with a view to making a decision to refer or not based on the results, the patient will not have an 18 week clock started for the direct access diagnostic test. These tests are subject to the six week diagnostic standard.

Straight to Test (after Hospital Triage)
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. The clock starts on receipt of referral and stops when the patient is referred back to Primary Care.

Choice of Consultant/ Named Referrals
The Trust will pool referrals unless the patient indicates a particular choice of clinician, in order to achieve quicker availability, equitable workload and shorter wait times. Referrals should be made to a service rather than to a named clinician. Referrals will be pooled with the exception of clinical need and patient choice.

Consultant to Consultant Referrals

These are referrals generated within the Trust for patients seen by a Consultant, who subsequently decides that a different specialty would best serve the patient for the condition for which they were originally referred. Unless definitive treatment has been given, the original clock will continue.

A patient who needs to be seen by another specialty for a different condition will be referred back to the GP for a new referral to be generated and a new clock will start on receipt of that referral – as per our local agreement with commissioners. However, if the patient's condition is clinically urgent, a Consultant to Consultant referral will be made.

4.3.8 Acute Oncology Service (AOS) Referral

For Acute Oncology patients where the diagnosis of a likely cancer is known or judged to have been made in ED there are named clinics which have appoint slots identified according to the Acute Oncology Fast Track Referral Protocol (appointment within 7 days). **Referrals are made using the Blue Request for Consultation and faxed to the Cancer Referral Office on 435367 or 435074.** The site specific clinics slots offering this service are for Breast, Lung, Colorectal, Upper GI, Gynecology, Urology, Head & Neck, Hematology, Skin and CNS. **[Blue form located on the oncology ward MRD055]**

Patients with a known diagnosis of cancer and already under a named Oncology Consultant or Team will be referred via the Acute Oncology Nurse on 6804.

Minimum Data set for referrals

New referrals must provide evidence of meeting minimum referral criteria and include a daytime contact number and a Minimum Data Set:

- Full name of patient
- Patient date of birth
- Patient gender
- Patient full address including postcode
- Patient up to date contact telephone number (including a mobile number for text reminder service
- Patient NHS number
- Referrer details (including telephone, e-mail or other contact details)

The Trust encourages referrers to attach any relevant prior investigation results with referrals to ensure that patients are treated in an appropriate and timely way and to ensure unnecessary repeats of tests are avoided.

The Trust also requests that GPs and other referring agents notify the Trust if the patient is service personnel, as war veterans injured in conflict must receive priority treatment, if the condition is directly attributable to injuries sustained in conflict.

Outpatient Referral Management

The following principles will be adhered to:

- Referrals must be registered within 24 hours (48-72 hours if the referral is received on a Friday).
- Clinical Triage must take place within two working days of receipt of referral.
- 2 week referrals to Cancer Referral Office must be registered within 24 hours of receipt of referral.
- Patients should be given 3 weeks reasonable notice for their appointment offer to be valid.

4.4 PATIENT TRACKING LISTS (PTL)

PTLs are used to track the length of wait for individual patient pathways and ensure that patients are seen in line with the principles of this policy. PTL's show all open RTT pathways of patients on both Non-Admitted and Admitted pathways according to the RTT rules for clock starts and stops referred to in this policy.

Cancer patients have a separate PTL derived from the cancer database. All 2ww, Breast other Symptoms, Consultant Upgrades and Screening referrals must be logged on the cancer database within 48 hours of receipt of referral and/or initial assessment date being agreed by the patient (whichever is later).

Subsequent treatments must be recorded on the cancer database as soon as they are known.

When a cancer pathway ends because no cancer has been diagnosed, the patient's tracking can end. Patients must remain on the PTL as Cancer Status: 'Suspected Cancer' until a benign diagnosis or confirmation of no cancer diagnosed is given to the patient and referrer.

In the event of the patient being referred as suspected cancer for the same signs/symptoms, a new patient pathway episode can be created.

4.4.1 Removal of Patients from the Cancer PTL

When a cancer pathway ends because no cancer has been diagnosed, the patient's tracking can end. In accordance with the waiting time rules, patients must remain on the PTL as Cancer status: 'Suspected Cancer' until a benign diagnosis or confirmation of no cancer diagnosed is given to the patient and referrer. http://intranet/forms/suspectedCancerPathway

Patients must not be removed from the PTL whilst diagnostic investigations remain outstanding, unless the consultant in charge of the patient's care has communicated a definitive benign diagnosis to the patient and referrer, either by clinic letter or by completion of the 'suspected cancer case review' form

On receipt of this form, MDT coordinators should fax/post it to the referrer and scan/place the original in the patient's medical notes; at this point, the cancer status: 'No cancer diagnosis' should be recorded on the Somerset database.

Providing the above is adhered to, in the event of the patient being re-referred as suspected cancer for the same signs/symptoms, a new patient pathway episode can be created on the Somerset database.

4.4.2 Process to Discharge Patients on suspected Cancer Pathway

Multiple (2 or more) cancellations in line with cancer waiting times (4.11 Cancer waiting time guidance version 9) **[flowchart page 6]**

1. Patients who DNA 2 or more appointments during pathway in line with cancer waiting times (4.11) this does not include 1st. outpatient appointment **[flowchart page 7]**
2. Patients who have refused altogether the diagnostic tests that may diagnose cancer in line with cancer waiting times (3.2.3) **[flowchart page 8]**
3. Patients who cannot be contacted (does not apply to 1st. outpatient appointment as this is managed by cancer referral office) **[flowchart page 9]**

4.5 PROCEDURE OF LIMITED CLINICAL EFFECTIVENESS (POLCE)

The Trust must adhere to the Barking and Dagenham, Havering and Redbridge CCG POLCE (procedures of limited clinical effectiveness, available on the Intranet under Quality & Safety-Guidelines, Procedures & Forms-PoLCE).

There must be evidence in the referral that prior approval or funding approval has been given prior to the patient coming in for a potential procedure that falls within the remit of the POLCE policy. If the approval is not attached, the consultant will request approval and the 18 week clock will remain running. Patients who require prior /funding approval cannot have their RTT clock stopped while waiting for approval. We need to cover the scenario if it is not evident the patient requires approval until a decision to admit has been made.

4.6 TERTIARY/INTER-PROVIDER REFERRALS

Where an acute tertiary referral for the same condition is needed, the consultant should make that referral and also copy the referral details to the patients GP.

Where an elective tertiary referral is considered necessary for a different condition, the consultant should refer the patient back to their GP for forward referral.

A completed RTT Minimum Data Set (MDS) proforma must be sent with all inter-provider transfers.

For Inter-provider transfers, the patient will remain on the original provider's waiting list until the patient has been accepted by the receiving provider.

Patients transferred in to BHRUT must be entered on the PAS database within one working day of receipt.

Cancer Tertiary referral dataset (obtained from the Somerset database) must always accompany a cancer patient's transfer. The IPT Team must also be notified by e-mail (#IPT-Team) of all incoming and outgoing cancer transfers for 18 week clock purposes (see Inter Provider Transfers) http://intranet/forms/MDTReferralProtocol

MDT Coordinators are responsible for obtaining feedback from the onward Trust and for recording Decision to Treat and Treatment at that Trust on the Somerset database. Incomplete cancer pathways cause incorrect statistical data to be reported, which impacts negatively on cancer funding allocations.

4.7 INTER-PROVIDER TRANSFERS (IPT) – Cancer

For cancer related Inter-Provider Transfers, the Trust will ensure that all necessary information is sent in a timely manner to tertiary centres in accordance with Cancer Network agreements

Patients can begin their suspected cancer journey at one NHS provider, have investigations at another provider and end up being treated at a third provider. They can also get transferred back to sender (e.g. after specialist tests).

The 14-31-62 day cancer clock does not stop whilst a patient is being transferred from/to another NHS organisation, only responsibility for recording the next applicable clock stop in the pathway is relinquished.

Recent guidance states that should the patient need to be transferred to another provider, the referring Trust must do so within 38 days with all minimum dataset as per locally agreed tumour specific best practice pathway.

4.8 IPT RESPONSIBILITY FOR MEETING THE CANCER TARGET

Where 2 NHS Providers are involved in a single cancer pathway, they will share the breach equally if the 62-day standard is not met. Changes to this arrangement is contained in the https://www.england.nhs.uk/wp-content/uploads/2016/03/cancr-brch-allocatn-guid-2016.pdf
We will aim to complete the relevant diagnostics and transfer cancer patients by day 38 of their pathway as per the Pan-London agreement.

4.9 OVERSEAS VISITORS

Patients who are identified as overseas visitors must be referred to the Overseas Visitors Department for clarification of status regarding entitlement to NHS treatment before registration takes place (see Overseas Visitors Policy) available on the Intranet.

4.10 PRIVATE PATIENTS

In order to ensure that BHURT is able to recover all income due from the treatment of private patients, the private patient office must be informed of all private patient activity within the Trust. Consultants are responsible for ensuring that their private patients, whether inpatient or outpatient are identified as such. The 18 week target does not apply to such patients. If a private patient is subsequently referred to the NHS their RTT clock will start on the date the hospital receive it. All patients will be treated by urgency then in chronological order. If a NHS patient decides to be treated privately their clock will stop and they will be discharged from our care on the date the patient informs BHRUT of their decision.

4.11 BOOKING PATIENTS

General Principles for Booking

- All patients must be seen in order of clinical priority and length of wait.
- Patients can negotiate their appointment time and date.
- No patient waiting for an outpatient appointment can be suspended or paused.
- No patient waiting for an admission date can be suspended or paused, with the exception of cancer where the clock can be adjusted.
- A decision to add a patient to an outpatient, diagnostic or elective waiting list must be recorded on the Trust's PAS system within one working day.

4.11.1 Reasonable Offer

The standard definition of 'reasonable' offer is an appointment or admission (TCI) offer of two dates that are three or more weeks from the date that the offer was made or two weeks for a diagnostic test

Patients who decline one reasonable offer must be offered one further reasonable date.
If two reasonable offers are declined for either a new or follow-up outpatient consultation, following a clinical review the patient may be discharged to their GP. Any referral back to the GP will be based on a clinical decision and in the best interests of the patient.

If a patient does not want an outpatient appointment for 8 weeks or more, this will trigger a clinical review and the patient may be discharged back to their GP. Any referral back to the GP will be based on a clinical decision and in the best interests of the patient.

This notice principle for 'reasonable' offer applies to appointments for outpatients, see & treat clinics, investigations, one-stop services and day-case admissions as well as in-patient admissions, but does not apply to patients who are able and willing to accept an appointment at shorter notice or cancer patients.

At BHRUT in the case of cancer/urgent an offer of an appointment date will be deemed 'reasonable' if it gives the patient 1 weeks' notice from the date the offer was made.

Such long notice periods (3 weeks notice), if applied to cancer patients, would lead to inappropriate clinical delay as well as a high level of breach of the 31 and 62-day standards. It is also accepted that the vast majority of patients will, by the time they are contacted for an admission, be aware of the degree of clinical urgency in delivering treatment to them.

At BHRUT an offer of a single admission date for cancer patients will be deemed 'reasonable' if it gives the patient 1 weeks' notice from the date the offer was made.

For all appointments booked by or on behalf of the Cancer Referral Office (CRO), 'reasonable' offer is defined as a choice of 2 dates within 14 days, with 3 days' notice.

All 2ww patients and 'Breast other Symptoms' patients will be offered a choice of 2 reasonable dates within 14 days of referral receipt date.

All appointments will be confirmed in writing.

4.12 CLINIC CANCELLATION OR REDUCTION

Patients should not be cancelled more than once. No appointment will be cancelled more than twice.

A minimum of six weeks' notice of annual or study leave is required for clinic cancellation or reduction.

Clinic cancellation with less than six weeks' notice can only be authorised by the appropriate Divisional Manager.

Divisions should advise outpatient staff as to re-booking rules for patients displaced through a cancelled clinic. As a guide both new and follow-up appointments should be re-booked for 2-3 weeks' time of their cancelled appointment date and no more than 6 weeks' time. If required, services should move patients who have waited less time to accommodate.

Where the clinician feels a patient may be at risk of clinical harm please carry out a review and rebook accordingly to urgency. Also alert outpatients to these individual patients when providing rebooking guidance.

Clinicians may want to review individual patients being rebooked or provide guidelines for groups of patients being rebooked when cancelling a clinic.

4.12.1 Hospital Cancellations on Day of Surgery

Following a "last minute cancellation" for non-clinical reasons (on the day of surgery, day of admission or following admission), patients have a right to be offered a new date for treatment that is both within 28 days of the cancellation and within their RTT breach date.

If a patient is cancelled by the hospital prior to their admission date due to lack of an available bed, the patient will be rescheduled as soon as possible.

4.12.2 Cannot Attend (CAN)

Patients may cancel their outpatient appointment up to 24 hours before the start of the clinic without penalty.

4.12.3 Did Not Attend (DNA) at First or Subsequent Appointment

In order to reduce the number of unnecessary DNA's, the Trust will send out a text reminder for an increasing number of services where a mobile number is held in the Trust systems.

If a patient DNA's a clearly communicated appointment, or if they cancel two appointments for the same condition, this will trigger a clinical review and they may be returned to the care of their GP if it is in their best clinical interest. This decision should be recorded on Medway. If the clinician does not think this is a safe approach, they will not be discharged and should be rebooked.

4.12.4 Exclusions

Cancer and suspected cancer patients
Vulnerable adults
Children

4.12.5 Fair and Equitable Treatments

To ensure fair and equitable treatment, the following is in place to support the above:
The patient has been made an offer with reasonable notice

It is simple and easy for patients to cancel or reschedule their appointments by either phone or email

It has been made clear to the patient through any verbal and all written communication about the appointment that the patient will be returned to the care of the GP if he or she DNAs

All and any cases where the patient, GP or other referrer believes that this was not a true DNA and that the patient should be reinstated, must be referred to the Outpatient General Manager for escalation

4.13 ADMISSIONS DNAs

For urgent patients who DNA, they will be contacted and a new date agreed. If they DNA a second time this will trigger a clinical review and the Consultant may discharge back to their GP as above and the patient removed from the waiting list.

Routine patients who DNA their elective admission will be clinically reviewed and may be discharged to their GP as above if it is in their best interests. If the clinician does not think this is a safe approach, they will not be discharged and should be rebooked.

4.13.1 PAEDIATRIC DNAs

There is a Trust Safeguarding Children & Young People (Child Protection) Policy. The arrangements set out in that policy should be read in conjunction with this policy. In the event of any doubt the Safeguarding Children & Young People (Child Protection) Policy, available on the Intranet, has primacy.

Clinical records must be reviewed by a Consultant whenever a child does not attend their appointment, as per the Trust Children & Young Persons (Age 0-18yrs) Did Not Attend(DNA) and Cancellation of Appointments (available on the Intranet). The Consultant will undertake a risk assessment to determine if significant harm could be caused by the non-attendance.

The Consultant may choose to:

- Discharge the patient back to the referrer, informing the GP, referring professional and the parents/carers; offer one further appointment, copying letter to the GP and parent/carer;
- In the event of any safeguarding concerns - the consultant should refer the child to social services ensuring that the GP and referring professional are informed.
- If necessary the Trust Children's Safeguarding Team can be contacted for advice (via the hospital switchboard 01708 435000)

The Consultant will always inform the Social Worker if a child known to be subject to a Child Protection Plan does not attend a planned appointment. Contact can made by telephone but must always be followed up in writing - concerns about non-attendance should be provided and the letter copied to the GP, School Nurse or Health Visitor.

4.13.2 DNA PATHWAY FOR ADULTS AT RISK (flowchart page 6)

4.13.3 FOR CANCER PATIENTS, PATIENT CANCELLATIONS AND DNAs BEYOND DATE FIRST SEEN

Please refer to Cancer Waiting Times guidance for patient cancellations and DNA beyond date first seen. Local process has been agreed with Commissioners in December 2016 regarding discharging patients back to the GP.

4.14 DIAGNOSTIC APPOINTMENTS

Diagnostic referral and booking should comply with RTT 18 weeks and Diagnostic 6 week wait standards. National guidance on the diagnostic 6 week standard can be found on the NHS England website.
https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/

4.14.1 Results Reporting

Reporting of results must be completed in time to allow progress through all likely stages of the RTT pathway.

The consultant is responsible for deciding and actioning the outcome of the patient's diagnostic tests and ensuring there is a:

- Letter to the patients GP
- Follow-up appointment if necessary
- Addition to waiting list
- Discharge recorded on PAS within 5 working days

In the event that results for diagnostics show no further follow-up is necessary, the consultant must ensure this is recorded in the patient's clinical notes and added to the PAS system.

4.15 PATIENT ATTENDANCE

On arrival at clinic, the patient will be booked in and all patient details will be checked and amended as necessary on PAS. In particular, details of contact telephone numbers and mobile numbers to support the Trust text reminder service should be checked. The status of overseas visitors will be checked and the Overseas Manager will be notified where it is suspected or known that the patient is an overseas visitor.

4.15.1 Arrangements for Follow-Up Appointments

Patients may require follow up attendances prior to their treatment beginning. These reviews form part of many patient pathways. Staff making follow up appointments (or rescheduling previously booked follow up appointments), need to be mindful of the current treatment status of patients and ensure that follow up appointments are scheduled at a time appropriate for each patient's overall 18 week pathway.

4.15.2 Clinic Outcomes

Clinic receptionists must enter an accurate clinical outcome and treatment status based on the decision of the clinician, recorded on the Trust clinical outcome form by the consultant, on the Trust PAS system within 24 hours.

All outcomes must indicate that either a further appointment is required for clinical reasons or that the patient does not require a further appointment.

All clinic outcome forms must be completed and recorded on the Trust PAS system by the next working day.

Where a procedure has taken place in outpatients, the procedure code must be recorded on the outcome form and PAS updated.

4.16 MANAGEMENT OF ELECTIVE ADMISSIONS

4.16.1 Adding Patients to an Inpatient Waiting List

The decision to add a patient to the waiting list must be made by the consultant or their Designate and a TCI (To Come In) form completed by the clinician.

All TCI forms must be signed by a consultant

The patient must have accepted the clinician's advice on elective treatment prior to being added to the waiting list.

Patients requiring bilateral procedures will be listed for the first operation and treated within their 18 week pathway. Once the patient is fit and ready to proceed with the second operation, the procedure will be listed and a new clock will start.

Additions to the waiting list must be recorded on the Trust PAS within **two** working days of the decision to admit (**one** working day for cancer referrals).

Patients must not be added if:

- They have significant comorbidities and are unfit for procedure and unlikely to become fit within three weeks of being added to the waiting list – patients should be referred back to their GP. This does not include patients who have minor illnesses such as a cough or a cold which will be resovled in a few weeks time.
- They are not ready for the surgical phase of treatment – active monitoring is put in place/patient is discharged
- They elect to have 'thinking time' – RTT clock continues

4.16.2 Thinking time

Patients are allowed thinking time and the clock continues. However, a decision has to be made within 2 weeks. It is the responsibility of the service to ensure this timeline is kept to and patients managed appropriately. Active monitoring may be applied by a patient not wanting to pursue surgery but see how their condition progresses instead.

4.16.3 Use of Planned Waiting List

Planned waiting lists are for those patients who have had a clinical decison to be recalled to hospital for a further stage in their course of treatment or surgical investigation with a planned/due date. They will not be classified as being on a waiting list for statistical or RTT measurement purposes.

4.16.4 A patient is added to the Planned list:

When their treatment is part of a planned sequence of clinical care determined on clinical criteria i.e. where clinically the patient needs to wait a specified period of time or their treatment needs to be repeated at a specific frequency. This includes planned diagnostic tests or treatments or a series of procedures carried out as part of an agreed treatment plan.

When the patient has been given a date or approximate date at the time that the Decision to Admit was made.

Patients who are on an RTT pathway should not be placed on a planned list if they are unfit for a procedure or operation. Instead their clock should keep running unless a clinical decision is made to discharge or start active monitoring.

A patient's RTT clock will not be running while on a planned list but will start once their 'due date' is passed by more than 6 weeks.

There should be no patients on a planned waiting list for social reasons.

4.16.5 Pre-Operative Assessment (POA)

Patients due for admission for elective surgery will be seen in a Pre-Operative Assessment clinic (POA) by specially trained experienced staff to identify their current health status and fitness to undergo anaesthetic and surgery. The Pre-Operative Assessment is conducted following the 'decision to admit'.

The purpose of the assessment is to ensure that each patient is admitted to hospital for surgery, in optimal health and with an agreed plan of care. A Consultant Anaesthetist provides support and advice to the POA for all patients with complex medical conditions via anaesthetic review. The patient may require prescribed medication prior to surgery in these circumstances such as anaemia, which will be supplied to the patient prior to surgery.

Patients will be seen for an inpatient POA at Queens Hospital or King George's Hospital, regardless of where their surgery will take place. Some patients undergoing local / local anaesthetic-sedated procedures may also require a POA although this will not apply to all local anaesthetic treatments.

The pre-operative assessment involves recording an accurate history provided by the patient of their medical health to date, including information provided by their GP at point of referral to the hospital. This includes medication history, alcohol intake, and smoking history as well as chest auscultation and for a majority of patients, phlebotomy MRSA screening, diagnostic tests and ECG.

4.16.6 Patients Unfit for Treatment

Once added to an elective waiting list, if the patient becomes unfit for their surgery, following a clinical review they may be removed from the elective waiting list and returned to the care of their GP if appropriate. A patient will be considered unfit if they are unlikely to become fit enough for their treatment within three weeks and are suffering from significant medical problems that would prevent surgery going ahead imminently. A patient who is unwell with a short term illness (e.g. coughs or colds) which would not affect their surgery in the longer term will NOT be removed from the elective waiting list.

If a patient is discharged with long term illness back to their GP they may be re-added directly to the elective waiting list for surgery following consultation and a review with the clinician they were originally listed under. This will prevent patients attending appointments unnecessarily.

Patients that are confirmed as unfit for surgery e.g. high blood pressure may be referred back to their GP for treatment and monitoring purposes. Once the patient's fitness improves, they may be referred back to the Trust by their GP.

Patient clocks cannot be paused for medical reasons.

4.16.7 Booking an Admission Date

Patients will be selected according to clinical priority (according to each specialty's definition) and then those who have waited longest.

War veterans and service personnel injured in conflict must receive priority treatment if the condition is directly attributable to injuries sustained in conflict.

Patients on waiting list for admission for two or more unrelated procedures

Where patients are on separate waiting lists for unrelated procedures in different specialties, the clinicians in charge should discuss the clinical priority of each procedure and the dates set accordingly. The RTT clocks will continue as long as the first definitive treatment has not been completed for either proceedure.

It is the responsibility of the treating clinician to establish whether a patient is already on a waiting list for another procedure and then to discuss with the clincian responsible for the patient's other condition.

Contacting Patients to Arrange a Date for Elective Admission

Patients will be contacted by telephone to arrange a time and date for their admission/appointment and this is confirmed in writing.

Patients who cannot be Contacted

Staff will attempt to call the patient twice at different times of the day and week. If the patient is not contactable via telephone they will be sent a letter asking the patient to call the admissions office.

If there has been no response to the contact letter from the patient and reasonable notice has been given, the address and other details are correct (having been checked with the GP practice), and the GP practice has not made BHRUT aware of any particular circumstances affecting this patient, then the patient will be removed from the waiting list, after clinical review and returned to the care of the GP. The RTT clock will be stopped.

Patients must be informed that if they do not respond within 21 days it will result in their removal from the waiting list and their care passed back to the care of their GP.

Notice of Annual/Study/Professional Leave

Cancellations of clinics or procedures by the hospital should only occur in exceptional circumstances. Consultants and other medical staff are required to give at least six weeks' notice of all annual/study/professional leave.

All requests with less than 6 weeks' notice must be authorised by the Divisional Manager. Managers must pass this information to theatres, outpatients and admissions. An escalation protocol is in place in the event that less notice has been given in order to avoid disruption to booked clinics.

Patients Admitted as an Emergency

Patients who are admitted and treated as an emergency for the same condition for which they are currently known by the Trust, will have their related pathway clock stopped.

Patients, who are admitted as an emergency for an unrelated condition but have an open, existing pathway, will continue on their RTT pathway.

4.17 CANCER 2 WEEK WAIT (2WW) REFERRALS

A 2ww referral to cancer services which starts a 62 day cancer target clock will also start an 18 week clock.

The patient should be referred by the GP/GDP or Optometrist to BHRUT within 24 hours of the decision to refer on the 2ww pro-forma via cancer referral office nhs.net **bhr-tr.crooffice@nhs.net** and e-referral.

Patients with suspected cancer who are referred urgently must be seen at the earliest opportunity and within a maximum of 14 days. All patients should be booked an appointment by day 7 of the receipt of the referral date. The date a referral is received is day zero.

To ensure these 14 day targets are met, the process to be followed for managing the referral, contacting the patient and arranging an appointment are different from those followed for routine referrals:

Two week cancer referrals will be received on the dedicated nhs.net email by the Central Referral Officer and allocated to the relevant department.

Referrals must be registered within 24/48 hours on PAS and Somerset Cancer Register (SCR).
The patients must be contacted by telephone within one working day of the referral being received to arrange an appointment. This must be escalated at day 3 if an appointment has not been booked or has been booked over day 14

The patient must be offered an appointment date initially that falls within 7 days of the referral being received. A booked appointment must be showing on PAS within 2 days of the referral being received

After agreement of appointment on the telephone a confirmation letter should be sent by 1st class mail.

If the patient is not contactable by telephone, the GP should be contacted to ensure the correct details are being used and to find out whether the GP has any further telephone numbers for the patient.

If the patient still cannot be contacted by telephone, an appointment within 14 days should be made and sent to the patient by 1st class mail. The letter should be copied to the GP.

4.17.1 Cancer 2 Week Rule Referrals sent to the wrong provider

If a referral has been sent to the wrong provider then the referrer should be contacted immediately and asked to withdraw the referral and re-refer to the correct provider.

4.17.2 Clinically inappropriate referrals – non-cancer

If the referral is clinically inappropriate, the consultant may not accept the referral. If this is the case, the reason for the decision will be communicated to the referrer, with a patient copy of the letter being sent within 15 working days of receipt by the Trust.

4.17.3 Cancer – Inappropriate referrals

Referrals cannot be downgraded without discussion and agreement by the receiving consultant with the original referrer (GP). Any joint decision to downgrade a referral must be documented in the health records and the patient must be communicated with. The patient must then be reappointed as an 18 week referral.

4.17.4 Screening Referrals

Patients who are screened and then referred to BHRUT for further management must be recorded by Cancer Waiting Times Co-coordinator and monitored by the MDT coordinators who have the correct level of cancer system access. Any such referrals received by other departments must be forwarded immediately to the CRO for action.

Patients referred from screening centers must be notified to the CRO using secure electronic systems in line with national policy. Internal electronic communications should be sent to the address #Cancer Referral Office (RF4) BHR Hospitals, external electronic communications should be sent to the address BHR-TR.CROOFFICE@NHS.NET.

4.17.5 Inter MDT Transfer

Patients referred from one MDT to another should be made via the Trust Inter MDT Referral form http://www.bhrhospitals.nhs.uk/cancerservices/cancer2.php

4.17.6 Family History

Family History Clinics are for asymptomatic patients.

Cancer Waiting Times only apply to patients who exhibit suspected/confirmed cancer symptoms, therefore, patients referred to Family History services are excluded from all cancer monitoring systems and reports. However if a cancer is diagnosed during investigation, patients would follow the 31 day standard.

Note: This is calculated from the date of Decision to Treat to date of Treatment.

5. THE DEVELOPMENT OF THIS POLICY

This policy was updated, and the Trust Cancer Access Policy incorporated, using the Trust Policy Template and giving consideration to all the elements required within the Trust Policy for the Development and Management of Trust-Wide Procedural Documents.

The group nominated as responsible for this Policy is the Access Board.

This Policy was updated through a working group consisting of the Head of Patient Administration for Outpatients, the Deputy Chief Operating Officer, and a group of operational service managers involved in elective access management. The draft policy was presented to Trust Access Board and Operational Management Group in October 2016. The NHS Intensive Support Team and the Clinical Commissioning Groups (CCGs) have reviewed the content of the policy.

This policy has been shared with the Divisional Managers, Specialty Managers, Clinical Directors and leads for comment and amended as appropriate.

5.1 Consultation and Communication with Stakeholders

Stakeholders identified for this process are:

Chief Operating Officer
Divisional Managers
Admissions and Outpatient Booking Team Leaders
CCGs
CSUs

Stakeholders have been involved in the review of this policy via membership of the working group set up to undertake the work.

5.2 Equality Impact Assessment

This policy has been equality impact assessed to ensure that the guidance provided does not place at a disadvantage any service, population or workforce over another. A completed Equality Impact Assessment is attached

5.3 Approval and Ratification

A copy of the Checklist for Review and Approval of Policies has been completed for this Policy and submitted with the final draft for approval and ratification.

This policy was reviewed and approved by the Access Board 11th July 2017

This policy was reviewed and ratified by the Policy Ratification Panel on 17th July 2017.

6. REVIEW AND REVISION ARRANGEMENTS

6.1 Review

This document will be reviewed every 3 years, unless legislation, guidance or Trust practice changes sooner.

6.2 Revision

The Trust Cancer Access Policy has been amalgamated into this version of the Patient Access Policy.

Details of all/any revision to this Policy are documented in Amendments – Section 11.

7. DISSEMINATION AND IMPLEMENTATION

7.1 Dissemination

This policy will be available to all staff via the Trust Intranet, and all previous versions will be archived in the Trust Policy Archive. Staff will be informed of its issue via inclusion in the staff newsletter The Link.

A desktop presentation (screen saver) will draw staff attention to the presence of the policy on the intranet.
Relevant administrative areas will have a hard copy of the policy present in their areas.

7.2 Implementation
Training will be provided for staff involved in the delivery of this Access Policy.

All staff involved in the administration and management of waiting list and outpatient waits must attend the relevant training course prior to gaining access to Medway PAS.

This includes outpatient appointment centre, outpatient's clerks, admissions officers, medical secretaries, ward receptionists, central validation team and relevant clinical staff along with staff in any other areas where their role relates to delivery of this policy.

Staff must have specific guidance on key tasks and processes tailored to their specific duties and requirements. It is the responsibility of line managers to ensure that all staff have such guidance.

Patient Pathway Coordinators must attend an induction programme and have the opportunity to visit individual specialties; they should meet all key individuals.

On the job training should only be given by permanent members of staff who have been assessed as fully competent.

All training should be based on standards of practice laid down in the Trust policy. New members of staff must be supervised closely until such time as line managers are satisfied as to their level of competence.

After mandatory Medway PAS induction training and completion of Medway PAS competency tests, staff should receive further instruction in the capabilities of the system and working practices within their department.

The training of ward receptionists must include their responsibilities in waiting list administration.

All admissions officers must undergo Conflict Resolution Training.

18 Weeks, PTL and waiting list awareness seminars/sessions will be provided for staff involved in RTT PTL management to identify training needs

Additional patient information leaflets to ensure patients are aware of their rights as well as their responsibilities regarding this policy are in development and will be made available through the patient information desk. The Trust will consider whether this information is routinely sent to patients at the point of booking their first appointment.

Management of performance in relation to this policy will take place at the Access Board and through weekly Patient Tracking List (PTL) meetings.

8. MONITORING

8.1 Compliance

Compliance with this policy will be overseen by the Access Board which meets weekly and is chaired by the Chief Operating Officer. This is the forum where the Trust monitors its elective access performance and, therefore the compliance with this policy.

8.2 Operational waiting list management

The day-to-day management of the waiting list is performed by inpatient and outpatient teams, however this task only works effectively where specialities take responsibility for their services, through the relevant Service Manager and Clinical Lead.
Specialty management team responsible for working with the Appointment booking teams to ensure sound waiting list management.

8.3 Escalation

Admissions staff and Cancer appointment office staff and Cancer Referral Office staff will escalate any actual or potential problems relating to waiting list management, booking 2 week referrals to their line manager when these cannot be resolved. Where further assistance is required the relevant Divisional Manager and Head of Performance will be informed of any issues, which cannot be resolved directly.

The Specialty Managers and the Divisional Manager responsible for 18 Week RTT and Cancer Waiting times will be notified immediately of any patient who is likely to exceed a maximum waiting time target.

If a problem cannot be resolved at this level, the Clinical Director for the specialty must be notified. The Chief Operating Officer is responsible for waiting list/RTT/Cancer PTL management in the Division.

8.4 Management Information

The General Manager of every Specialty with a waiting list/RTT and Cancer PTL is responsible for ensuring that waiting list data is available to the consultants. The manager will be responsible for agreeing the type of information and frequency of distribution of waiting list data, and monitoring reports for their consultants and Divisional Director.

On a weekly basis, Information Department staff will run standard reports, to identify any patients at risk of breaching waiting time standards in the coming weeks and circulate to Specialty Divisional and General Managers.

Information Department staff will produce a weekly suite of waiting list reports for each speciality that allows managers to understand the dynamics of their waiting lists. Analysis at individual consultant or clinical team level, or at procedure level, will be made available on request.

This suite will be supplemented by reports to aid waiting list housekeeping, covering such areas as patients waiting for more than one procedure and patients with inappropriate TCIs.

The Access Board and Trust Executive Committee will receive monthly performance reports including progress towards meeting waiting list targets, with any areas for concern highlighted.

What will be monitored and/or Standard To Be Achieved	How/Method	Frequency	Lead	Reported to	Deficiencies/gaps recommendations and action plans followed up by	Implementation of any required change responsibility of
RTT & CWT performance	Performance submission	Monthly	Chief Operating Officer	Trust Board	Chief Operating Officer	Chief Operating Officer
Diagnostic waiting time performance	Performance submission	Monthly	Chief Operating Officer	Trust Board	Chief Operating Officer	Chief Operating Officer
DNA rate	Activity information	Monthly	Divisional Managers	Access Board	Divisional Managers	Divisional Managers
Cancellations on the day	Cancelled operational report	Weekly	Divisional Managers	Access Board	Divisional Managers	Divisional Managers
Patient complaints related to Access/waiting times	Complaints report	Monthly	Divisional Managers	Access Board	Divisional Managers	Divisional Managers
Incidents relating to patient waiting times	Patient Safety report	Monthly	Divisional Managers	Access Board	Divisional Managers	Divisional Managers
Compliance to the policy through well managed PTL	Patient Tracking List meetings	Weekly	Service Manager Cancer services	Access Board	Divisional Managers	Divisional Managers

Any deficiencies identified during monitoring will be recorded and reported to the Access Board. The nominated persons and, ultimately, the Trust Executive Committee, will be responsible for ensuring that an action plan has been developed, is followed through, all required actions taken to remedy the deficiency/s identified and, where appropriate, information disseminated within the Trust to enable learning from the experience.

9. REFERENCES

NHS Outcomes Framework 2013/14

Right to start Consultant Led Treatment within 18 weeks – January 2012

Department of Health. Referral to Treatment Consultant led Waiting Times. October 2015

NHS Commissioning Board and CCGs (Responsibilities and Standing Rules) (Amendment) (No.2) Regulations 2015

NHS Outcomes Framework 2014/15 and in planning guidance for commissioners 'Everyone counts'.

Improving Outcomes: A Strategy for Cancer, January 2011.

National waiting times monitoring dataset Guidance. Version 9. October 2015

National Cancer breach allocation guidance April 2016

Procedures of Limited Clinical Effectiveness Policy (Barking & Dagenham, Havering and Redbridge CCGs)

NHS Constitution patient choice framework 2014-2015

https://www.gov.uk/government/publications/nhs-choice-framework.

10. ASSOCIATED DOCUMENTATION

This policy should be read in conjunction with the following policies:

Consultant to Consultant Referral Guidance
Safeguarding Children & Young People (Child Protection) Policy
Overseas Visitors Policy
Disciplinary Policy intranet/quality&safety/all policies
Overseas Patient Policy Intranet/quality&safety/non-clinical policies
Children & Young Persons (Age 0-18yrs) Did Not Attend(DNA) and Cancellation of Appointments Intranet/quality&safety/all policies
Suspected Cancer Pathway Intranet/quality&safety/guidelines,procedures&forms
MDT Referral Protocol

11. AMENDMENTS

Amendments to Version 3.

Page/Section	Change
All	Amalgamated Cancer Access Policy
4	Referenced, PoLCE
4.1	Disciplinary,
4.8	Overseas Patient
4.12.1	Children & Young Person (0-18yrs) DNA
4.211 and 4.3.1	Added reference for Suspected Cancer Pathway
4.5	Added reference for Tertiary/Inter-Provider Referrals
Page 5	DNA Pathway for Adults at Risk
Page 6 – 9	Process to Discharge Patients on suspected Cancer Pathway (4 processes)
Page 11	Amended to consultant to consultant referral guidance

CHECKLIST FOR THE REVIEW AND APPROVAL OF POLICIES

To be completed and attached to any policy when submitted to the appropriate committee for consideration and approval or ratification.

	Title of Policy being reviewed: Patient Access Policy Elective, Cancer & Diagnostic Services	Yes/No/ Unsure	Comments, including where information is included in the document
1.	**Title**		
	Is the title clear and unambiguous?	Y	Front cover of document
	Is it clear whether the document is a policy, protocol or guideline?	Y	Policy stated in title
2.	**Rationale**		
	Are reasons for development of the document stated?	Y	Introduction
3.	**Development Process**		
	Is the method described in brief?	Y	Section 5
	Are individuals involved in the development identified?	Y	Section 5
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Y	Section 5
	Is there evidence of consultation with stakeholders and users?	Y	Section 5
4.	**Content**		
	Is the objective of the document clear?	Y	Introduction and Purpose (sections 1&2)
	Is the target population clear and unambiguous?	Y	Section 1&2
	Are the intended outcomes described?	Y	Section 2
	Are the statements clear and unambiguous?	Y	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	Referenced in section 9
	Are key references cited?	Y	Section 9
	Are the references cited in full?	N	No formal citation of academic literature
	Are local/organisational supporting documents referenced?	Y	Throughout
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Y	Section 6
	Does the document identify which committee/group will ratify it?	Y	Section 6
	If appropriate, have the joint staff side committee (or equivalent) approved the document?	N	N/A

	Title of Policy being reviewed: Patient Access Policy Elective, Cancer & Diagnostic Services	Yes/No/ Unsure	Comments, including where information is included in the document
7.	**Dissemination and Implementation**		
	Is there information about how this Policy will be disseminated?	Y	Section 7
	Does the implementation planned include the necessary training/support to ensure compliance?	Y	Section 7 – part 7.2
8.	**Document Control**		
	Does the document identify where it will be held?	Y	Section 7
	Have archiving arrangements for superseded documents been addressed?	Y	Section 7
9.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Y	Section 8
	Is there a plan to review or audit compliance with the document?	Y	
10.	**Review Date**		
	Is the review date identified?	Y	
	Is the frequency of review identified? If so, is it acceptable?	Y	Annually
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Y	Access Board

Individual/Group/Committee Approval			
If you are happy to approve this policy, please sign and date below and forward to the chair of the committee where it will receive ratification.			
Name		Date	11th July 2017
Signature			
On behalf of	Access Board		
Committee Ratification			
If the committee is happy to ratify this policy, please sign and date below and forward copies to the person with responsibility for disseminating and implementing the policy and the Head of Compliance & Risk			
Name		Date	17th July 2017
Signature			
On behalf of	Policy Ratification Panel		

EQUALITY IMPACT ASSESSMENT TOOL

To be completed and attached to any policy when submitted to the appropriate committee/group for consideration and approval or ratification.

Policy Title	Patient Access Policy
Policy Number	2017/CG/237
Responsible Individual/Committee/Group	Chief Operating Officer
Approving Committee/Group	Access Board
Ratifying Panel	Policy Ratification Panel

		Yes/No	Comments
1.	**Does the policy affect one group less or more favourably than another on the basis of:**		
	Age	N	
	Disability – learning disabilities, physical disability, sensory impairment and mental health problems.	N	
	Race	N	
	Nationality	N	
	Ethnic origin – including gypsies and travellers	N	
	Gender / Gender reassignment	N	
	Religion	N	
	Beliefs	N	
	Sexual orientation – including lesbian, gay and bisexual people	N	
	Domestic circumstances	N	
	Social and employment status	N	
	Marital/partnership status	N	
	HIV status	N	
	Political affiliation	N	
	Trade Union membership	N	
2.	**What is the overall purpose of this policy area, function or activity?**		To provide the Trust with definitive guidance for management of patients accessing elective services at BHRUT
3.	**What approaches are currently used to measure progress and performance in this area?**		Patient Access Board reviews performance against access standards described in the policy
4.	**What counts as success in this area?**		Compliant performance with elective access standards as well as high patient satisfaction with access to elective services
5.	**Are there opportunities within this policy to:**		
	Eliminate illegal discrimination	N	
	Promote equality of opportunity	N	
	Promote good relations between people of different groups?	N	

		Yes/No	Comments
6.	**Is the impact of the policy likely to be negative e.g. is there risk of:**		
	Illegal discrimination		
	Reducing equality of opportunity for some groups?		
	Harming relations between different people of different groups?		
7.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**		
8.	**If so, what action could be taken to reduce adverse effects and promote or enhance positive effects?**		
9.	**Please describe the options available for incorporating equality monitoring into routine arrangements?**		

If you have identified a potential discriminatory impact of this policy document, please refer the issue to the Trust Workforce Equality, Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Trust Workforce Equality, Diversity and Inclusion Lead, People and Organisational Development department, Queen's Hospital.