ELECTIVE ACCESS AND BOOKING CHOICE POLICY

POLICY

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Approving Body	Planned Care Steering Group, Clinical Chairs		
Date Approved	17/04/2025		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
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Legal and/or Accreditation Implications	Developed in line with best practice Model Access Policy. Elective Care NHSE/NHSI		
Target Audience	This policy applies to any staff involved in the management of all cancer, urgent and routine patients at the Trust irrespective of who is making the booking and where the activity is scheduled. The policy does not apply to emergency care		
Review Date	17/04/2026		
Sponsor (Position)	Deputy Chief Operating Officer		
Author (Position & Name)	Head of RTT and Corporate Planned Care Validation Team		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Planned Elective Care		
Position of Person able to provide Further Guidance/Information	Head of RTT and Corporate Planned Care Validation Team		

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

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APPENDICIES

1.0 INTRODUCTION

The Trust is committed to delivering high quality and timely elective care to patients; and to promoting and providing services which meet the needs of individuals and does not discriminate against any employee, patient, or visitor.

This policy is issued and maintained by the Chief Operating Officer (the sponsor) on behalf of the Trust, at the issue defined on the front sheet, which supersedes and replaces all previous versions. This document defines the Elective Access, Booking & Choice Policy for Sherwood Forest Hospitals NHS Foundation Trust (hereafter referred to as 'the Trust').

This policy:

- Sets out the rules and principles under which the Trust manages elective access to outpatient appointments, diagnostics and elective inpatient or day case treatment.

- Gives staff clear direction on the application of the NHS Constitution and the NHS Choice Framework in relation to elective waiting times.

- Demonstrates how elective access rules should be applied consistently, fairly, and equitably.

The Trust's Elective Access Booking and Choice Policy has been developed following consultation with key stakeholders including the Clinical Commissioning Groups, GP'S, Clinical Leads, Divisional General Managers, and other relevant Trust Staff.

The Policy will be reviewed and ratified bi-annually; unless changes to the National Elective Care Access Rules are introduced or locally agreed principles are developed.

The Access Booking and Choice Policy must be read in full by all staff involved in elective patient care and staff should attend any relevant Trust Elective Care training sessions provided.

The Access Booking and Choice Policy will be supported and underpinned by a comprehensive suite of Standard Operating Procedures (SOPS) that are available to read and print from the Trusts Corporate Planned Care Web page. All clinical and administrative staff must ensure compliance with the principles contained within this document and specific guidance contained within the SOPS.

2.0 POLICY STATEMENT

The purpose of this policy is to ensure that all patients requiring access to outpatient appointments, diagnostics and elective inpatient or day-case treatment are managed equitably and consistently, in line with national waiting time standards and the NHS Constitution and the NHS Choice Framework.

This policy:

- Is designed to ensure the management of elective patient access to services is transparent, fair, equitable and managed according to clinical priorities
- Sets out the principles and rules for managing patients through their elective care pathways

- Applies to all clinical and administrative staff and services relating to elective patient access at the trust.

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

- Arrangements for suspected or confirmed cancer patient pathways are set out specifically within the Cancer Access Policy. However, all patients on a suspected cancer pathway will also have an active RTT wait which they will continue to be managed against if they are found to not have cancer before their treatment is completed.

- The policy does not apply to emergency care.

There may be situations which are not covered by this document. If you require further assistance or clarification on any aspects of this policy, in the first instance please contact your direct line manager or the RTT and Planned Care Educator for more specific queries. Contact the Cancer Management Team for queries relating to the application of cancer waiting times standards

3.0 DEFINITIONS/ ABBREVIATIONS

See Glossary Appendix 1

4.0 ROLES AND RESPONSIBILITIES

The Trusts Chief Executive has overall responsibility for achieving the national standards, as the accountable officer. All staff with access to the Patient Administration Systems (CareFlow PAS) have a duty to maintain the information held within and are accountable for their accurate data input.

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

- The Trusts Deputy Chief Operating Officer is responsible for ensuring that this Policy is implemented across Trust services and that operational systems and processes are developed, coordinated and monitored.

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

- All Consultants, Clinical Nurse Specialists and their clinical teams in collaboration with divisional teams have a shared responsibility for managing patients waiting times and therefore should have a level of understanding of the RTT standards and rules.

- The Trusts Chief Digital Information Officer is responsible for the timely provision of operational information to support delivery of patient pathways and for the reporting of information within and external to the organisation including the production of Patient Tracking Lists (PTLs) which support the Divisions in managing waiting lists and RTT standards.

- The Trusts Patient Administration System (PAS) Manager is responsible for the management of the CareFlow system on which patient information and waiting lists are held.

- All Waiting list administrators for outpatients, diagnostics, elective inpatient, or day care services are responsible for the day-to-day management of their lists and for compliance with all aspects of the Trusts Elective Access Policy. They are supported in this function by the general managers and divisional directors who are responsible for achieving all access standards.

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

- General Practitioner's (GPs) and other referrers play a primary role in ensuring patients are fully informed of the likely waiting times for a new outpatient consultation and of the need to be contactable and available to be seen once referred. A patient's GP should ensure quality referrals are submitted in line with the DOS to the appropriate provider first time. Inappropriate referrals, including those which do not meet agreed referral criteria, will be rejected, and returned to the referrer with an explanation, or forwarded on to the appropriate department.

- ICB's are responsible for ensuring all their patients are aware of their right to treatment at an alternative provider if their RTT wait goes beyond 18 weeks. In this instance, the ICB must take all reasonable steps to offer a suitable alternative provider, or if there is more than one, a range of suitable alternative providers, able to see or treat patients more quickly than the provider to which they were referred. A suitable alternative provider is one that can provide clinically appropriate treatment and is commissioned by a clinical commissioning group or NHS England.

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

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

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

- The Trusts Information Manager, The Head of RTT and the Cancer Management Team are responsible for providing subject matter expert advice and guidance in the application of the national pathway management rules, this policy, and its application throughout the Trust

Our patients can make a significant contribution to managing their own conditions by following the below guidance as described in the The-NHS-constitution-for-England.

- Maintaining their own and their families, good health, and wellbeing as well as taking personal responsibility for it.

- By ensuring that they are registered with a GP practice as this is the main point of access to NHS care as commissioned by NHS bodies.

- By providing accurate information about their health, condition, and status.

- By ensuring that they keep and attend their appointments or by cancelling within a reasonable timeframe to allow for another patient to use the appointment.

5.0 APPROVAL

This policy was formally ratified at the following committees:

Contributors:		Date:
Outpatient Improvement Group	For input and Information	26/02/2025
Operational Management	For input and Information	21/03/2025
Planned Care Steering Group (PCSG)	For Ratification	17/04/2025
ICB	For input and Information	April 2025
Planned Care Board	For Ratification	May 2025
Medical Managers/Clinical Chairs	For Information	Date to be Confirmed

6.0 DOCUMENT REQUIREMENTS

6.1 Elective Access Principles and Individual Patient Rights

The NHS has set maximum waiting time standards for elective access to healthcare. In England, waiting time standards for elective care (including cancer) come under two headings:

- The individual patient rights (as in the NHS Constitution). The-NHS-constitution-for-England

- The standards by which individual providers (The Trust) and commissioners are held accountable by NHS Improvement and NHS England.

The NHS Choice Framework states in Section 3 that a patient can choose where to go for their first appointment as an outpatient **and**

- Section 4 - a patient can be asked to be referred to a different hospital if they must wait more than 18 weeks before starting treatment and / or if you wait more than 2 weeks before seeing a specialist for suspected cancer.

- These are legal rights, but there are exceptions to be aware of detailed in the NHS Choice Framework – i.e. if your referral is not urgent and the service you require is led by a consultant and it may not always be possible to change your provider - for example, if you require specialist care. NHS Choice Framework - what choices are available to you in your NHS care - GOV.UK -Choice Framework 15/16 leaflet 4: Changing your hospital

Further pledges and rights that the public include

- The choice of care provider (Hospital Trust) and clinician.

- Routine conditions it is expected that the patient will commence their treatment following a referral into a consultant-led service, within a maximum waiting time of 18 weeks to treatment.

- For urgent referrals where a cancer is suspected it is expected that the patient will be seen by a cancer specialist within a maximum of two weeks from a GP referral Where this is not possible, the Trust must take all reasonable steps to offer a range of alternatives.

The right to be seen within the maximum wait time does not apply in the following circumstances:

- If as a patient, you choose to wait longer either by making a choice to wait or by failing to attend appointments.

- If delaying the start of the treatment is in the best clinical interests of the patient.

- If it is clinically appropriate for the patient's condition to be monitored by the hospital without further treatment or diagnostic procedures at that stage.

Patients will be made aware of the travel reimbursement scheme, so they can make an informed decision regarding where and when to have their treatment. Travel Reimbursement Scheme.

6.2 Patient Eligibility for NHS Treatment

The Trust has an obligation to identify any patients who are not eligible for free NHS treatment and specifically to assess liability for charges in accordance with Department of Health guidance /rules.

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

Further information is provided in the following link to tailor this part of the policy.

Healthcare for visitors to the UK from the EU - GOV.UK (www.gov.uk)

Healthcare for EU citizens living in or moving to the UK - GOV.UK (www.gov.uk)

6.3 Patients Moving Between NHS And Private Care

A Patient can choose to move between NHS and private status at any point during their treatment without prejudice. Where it has been agreed, for example, that a surgical procedure is necessary the patient can be added directly to an NHS elective waiting list if clinically appropriate. Likewise, a patient who chooses to move to an Independent Provider (Hospital) can be onwards referred by the Trust via and Inter-provider Transfer (IPT).

It is important that a patient makes their Specialty Team aware if they have moved their care to a private provider or have already had treatment at a private provider at the earliest possible opportunity to allow for another patient to use their appointment.

Additionally, any overseas visitors who choose to pay for their treatment where they are liable for charges will be considered and managed as private patients.

6.4 Commissioner Approved Procedures and Evidence Based Interventions (EBI)

Evidence Based Interventions (EBI) may be referred to or otherwise known as 'Procedures of Limited Clinical Value' (PLCV), 'Service Restricted Procedures' (SRP) or 'Value Based Commissioning' (VBC)

A Patient may be referred for specific treatment where their symptoms will need to meet set criteria before the Trust is able to surgically treat the patient. This may be because there is limited evidence of clinical effectiveness for the intended surgery, or the procedure may be considered cosmetic.

Where a patient is referred in for a procedure that is on the EBI list it is the General Practitioners responsibility to send the patient in with the required approval. If this is not received, the Trust may reject the referral until the required approval is in place.

If the decision to treat the patient is made following the referral process e.g. after an outpatient appointment or diagnostics, the Trust must apply for prior approval of the relevant CCG prior to undertaking the procedure and this must be approved. If the prior approval request is rejected, the surgery will not be able to be undertaken by the Trust and the patient will be discharged back to the care of the GP.

All Trust Clinicians must make themselves aware of the list of procedures to ensure it is appropriate to offer the procedure prior to listing the patient and approval is requested and granted.

6.5 Communication Between Patients, the Trust and General Practitioners

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

It is a patient responsibility to attend agreed appointments, and this should be communicated to the patient on referral to ensure they are able to make themselves available to attend.

Where patients are unable to attend or miss their appointments without any prewarning, the Trust will have an agreed process to explore the possible causes of patient non-attendance and support the patient to attend where possible to enable their care pathway to continue. The clinician responsible for the patient's care will be advised of delay in care due to patients attendance so they can make an informed decision whether it is appropriate to offer further appointments.

Regular two-way communication with the patient is key to ensure that patients are fully informed and aware of any appointments for their care. Wherever possible this will be undertaken by digital means. The Trust will comply with the Accessible Information Standard.

6.6 Uncontactable Patients

Patients should make every effort to ensure that they are contactable whilst under the Trust's care. This includes updating their address, telephone and GP details if they change or are incorrect.

Where a patient is uncontactable when attempting to offer appointment dates, Firstly the Trust will check the patient's demographic data with the GP Practice to ensure telephone numbers and addresses are correctly recorded on PAS.

Where a patient cannot be reached by the initial phone call, three further attempts on different days at different times (ideally one out of hours where possible)

If the patient still cannot be reached, a letter should be sent giving the patient three weeks to make contact to book their appointment. If the patient does not make contact within those three weeks they can be returned to their referrer if there is a clinical decision to discharge.

6.7 Reasonableness

The Trust will endeavour to offer reasonable dates for any appointment or admission. A reasonable offer is one that is made with at least three weeks' notice of the appointment or admission date. When offers are made verbally or via letter or email a minimum of two dates with at least three weeks' notice will be offered for patients to choose from.
However, if appointment or admission dates under three weeks are available at short notice these can be offered to patients but will only be considered as reasonable if they are offered verbally and the patient accepts them.

6.8 Chronological Booking

Patients will be selected for booking appointments or admission dates according to their clinical priority meaning that the most clinically urgent patients will be booked first. Where patients have the same clinical urgency dating will be in chronological order, this means that the patients who have been waiting longest will be seen first.

6.9 Military Veterans

In line with the Armed Forces Covenant published in 2016, all veterans and war pensioners should receive priority access to NHS care for any conditions related to their service, this means that where there is no impact on the clinical urgency of other patients, military veterans care will be prioritised i.e. they will be treated first. Armed-Forces-Covenant

6.10 Prisoners

All rules relating to the booking of patient appointments and admission dates applies to prisoners in the same way. Any delays in treatment incurred because of difficulties in prison staff being able to escort patients to appointments or for treatment will not affect the recorded waiting time for the patient.

The Trust will work with staff within the prison services to minimise delays through clear and regular communication channels and by offering a choice of appointment or admission date in line with reasonableness criteria.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

7.1 Competency

- The Trust will provide the necessary training for staff in the use of CareFlow PAS and specific functions within the system relating to each individual member of staff's job role, ensuring a clear understanding of expectations is communicated.

- As a key part of their induction programme, all appropriate new starters to the Trust will undergo role specific mandatory elective care training. This will be contextual training applicable to their job role.

- Existing staff will undergo role specific mandatory elective care training on an annual basis, both classroom based and e-learning.

- All staff will undertake competency tests, and the outcomes will be clearly documented to provide evidence that the required level of knowledge and ability has been attained.

- There will be at least 2 assessors in each division and the assessor's competency will be assessed by the Corporate Planned Care Team.

- Performance and capability will be monitored and managed as part of the Errors Escalation Process.

- This policy, along with the supporting suite of Standard Operating Procedures and PAS User guides, will form the basis of all training programmes

7.2 Compliance

- Clinicians, functional teams, specialties, and staff will be performance managed against key performance indicators (KPIs) applicable to their role. Role specific KPIs are based on the principles in this policy and specific aspects of the Trust's standard operating procedures.

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

7.3 Governance

The following governance structure is in place:

7.4 Supporting Tools, Monitoring Systems and Application of the Policy

The Trust has a responsibility to record accurate information regarding patient waits for treatment. This includes recording the correct start date and treatment or stop date for all Referral to Treatment applicable patient pathways. All information relating to a patient's pathway will be recorded in the Trusts Patient Administration System and monitored through reporting via the Incomplete Referral to Treatment (RTT) Patient Tracking List (PTL) and reported via the weekly submitted Waiting List Minimum Data Set Return (WLMDS)

8.0 TRAINING AND IMPLEMENTATION

This Policy must be read, and application managed alongside the Trust suite of Planned Care supporting standard operating procedures (SOPs) that are in place to underpin the access policy principles. In addition, the Trusts Elective Care Training Strategy will describe the required training to support staff in the application of the policy.

8.1 National Referral to Treatment and Diagnostic Standards Rules Application

- **Referral to Treatment (RTT) Incomplete Standard** – 92% of patients on an incomplete pathway (i.e. still waiting for treatment) to be waiting less than 18 weeks from receipt of GP referral or decision to treat

- **Diagnostic Standard (Applicable to a specified selection of diagnostic tests)** – 99% of patients to undergo their investigation within 41days (5W and 6D) from the date of the decision to refer for the test

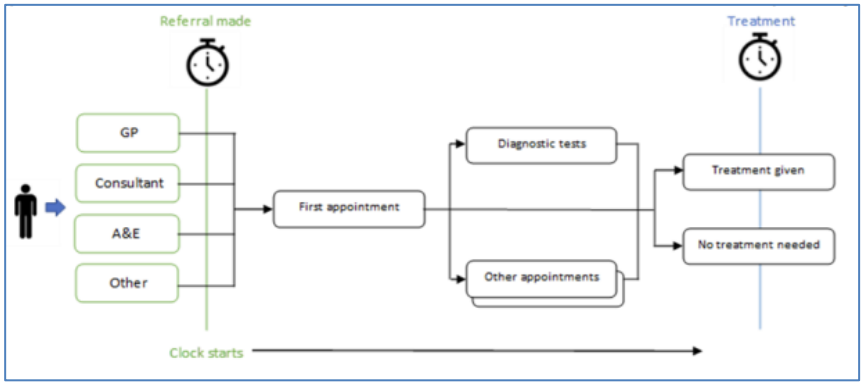
There are separate cancer standards which are defined withing the Cancer Access Policy

The 92% standard is set less than 100% to consider circumstances where it is not possible to treat the patient within 18W. these could be

- **Clinical exceptions**: when it is in the patient's best clinical interest to wait more than 18 weeks for their treatment.

- **Choice:** when patients choose to extend their pathway beyond 18 weeks by declining reasonable offers of appointments, rescheduling previously agreed appointment dates/admission offers, or specifying a future date for appointment/admission

- **Co-operation:** when patients Do Not Attend (DNA) previously agreed appointment dates or admission offers (TCI) and this prevents the Trust from treating them within 18 weeks



The above picture shows a standard patient care pathway that must take place within 18W

8.2 Clock Starts (Rules 1- 3)

The RTT clock starts when any healthcare professional such as a GP refers to a consultant-led service.

The RTT clock start date is the date the trust receives the referral. For referrals received through NHS e-Referral, the RTT clock starts the day the patient converts their unique booking reference (UBRN). If there is a significant delay between the original referral date and receipt of referral, the Trust will manage the referral as per the original referral date to avoid disadvantaging the patient

Rule 1: Referrals By Care Professionals or Services

a) a referral is received into a consultant-led service, with the intention that the patient will be assessed and if appropriate, treated before clinical responsibility is transferred back to the referrer.eg GP referral.

b) a referral is received into an interface or referral management assessment centre which may result in an onward referral to a consultant-led service before clinical responsibility is transferred back to the referrer

Rule 2: Self-Referrals

A patient self-refers into a consultant-led service for pre-agreed services agreed by providers and commissioners.

Rule 3: The Need for A New Clock Start

Upon completion of a previous consultant-led RTT wait, a new waiting time clock only starts:

1. When a patient becomes fit and ready for the second of a consultant-led bilateral procedure.

2. Upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan.

3. Upon a patient being re-referred into a consultant-led, interface or referral management or assessment service as a new referral.

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

5. When a patient rebooks their appointment following a first appointment did not attend (DNA) that stopped and nullified their earlier clock.

8.3 Clock Stops (Rule 4 And 5)

Rule 4: Clock Stops for Treatment

1. First definitive treatment starts. First definitive treatment is defined as 'an intervention intended to manage a patient's disease, condition, or injury and/or avoid further intervention'. This could be:

- Treatment provided by an interface service.

- Treatment provided by a consultant-led service.

- Therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions.

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

Rule 5: Clock Stops for Non-Treatment

A waiting-time clock stops when it is communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay that:

- It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care.

- A clinical decision is made to start the patient on a period of active monitoring.

- A patient declines treatment having been offered it.

- A clinical decision is made not to treat.

- A patient does not attend (DNA) their first appointment following the initial referral that started their waiting time clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient

- A patient DNAS any other appointment and is subsequently discharged back to the care of their GP, **provided that:**

  I. The provider can demonstrate that the appointment was clearly communicated to the patient.

  II. Discharging the patient is not contrary to their best clinical interests.

  III. Discharging the patient is carried out according to local, publicly available or published policies on DNA.

  IV. These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (for example, children) and are agreed with clinicians, commissioners, patients, and other relevant stakeholders.

8.4 Exclusions to RTT Rules

The following services and types of patients are excluded from RTT reporting:

- Obstetrics and midwifery.
- Planned patients.
- Referrals to a non-consultant led service. (Audiology waits for treatment are reported through the Community Health Services Dataset)
- Referrals for patients from non-English commissioners.
- Genitourinary medicine (GUM) services.
- Emergency pathway non-elective follow-up clinic activity.

8.4.1 Non-Consultant-Led Pathway and RTT Clocks

Referrals to therapy or healthcare science interventions (e.g. physiotherapy, dietetics, orthotics, and surgical appliances) can be:

- Directly from GPs where an RTT clock would NOT be applicable.

- During an open RTT pathway where the intervention is intended as first definitive treatment or interim treatment. Depending on the pathway or patient, therapy or healthcare science interventions could constitute an RTT clock stop.

  Equally the clock could continue to tick. Therefore, it is critical that staff in these services know if patients are on an open pathway and if the referral to them is intended as first definitive treatment.

8.4.2 Physiotherapy

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

- For patients on an orthopaedic pathway referred for physiotherapy as interim treatment (as surgery will be required), the RTT clock continues when the patient undergoes physiotherapy.

8.4.3 Surgical appliances

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

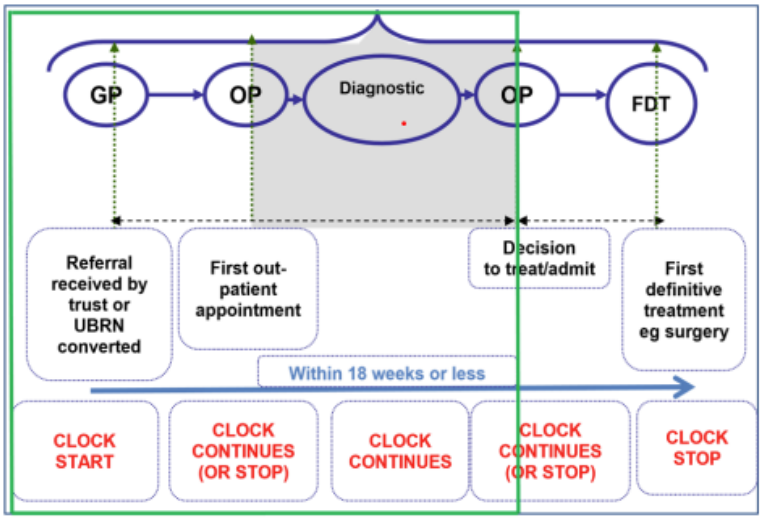
8.4.4 Dietetics

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

8.5 Pathway-Specific Milestones

8.5.1 Non-admitted pathways

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



Referral Routes

Referrals to Consultant Led Outpatient Service

It is the referrers responsibility to inform the patient of the intention to refer into the Trust and to ensure that the patient understands the need for the referral, that the patient is both clinically fit enough and prepared to receive any potential treatment that maybe required, and the patient should be available to attend the Trust within 18 weeks from referral.

Where the referring Care Professional knows that the patient is unavailable for an extended period for example living or working abroad for a few months, has extended holiday or has work or study commitments, and the referral is for a routine clinical condition, it may be more appropriate for the referral to be made when the patient can fully engage with their care

All patient referrals from GPs to a consultant-led service should be made electronically through the national e-Referral Service (e-RS). The Electronic Referral System (e-RS) is the main referral system for NHS referrals and provides an easy way for patients to choose their first hospital or clinic appointment with a specialist. Bookings can be made online, using the telephone, or directly in the GP surgery at the time of referral (If a paper referral is received from a GP, the surgery will be contacted to ask them to re-refer via eRS wherever this is an option).

To support this process each service will have an up-to-date Directory of Service (DOS) published within the NHS e-Referral system. This will direct GPs to refer patients into the most appropriate service and prevent rejected referrals or unnecessary internal onward referrals.

It is important that all referrals contain good quality information about the patient and need for the referral and, where appropriate, pre-referral checks/tests or other requirements are completed. This will maximise effective patient management by helping to direct patients into the most appropriate pathway for their condition helping to facilitate timely patient care and in turn supporting service efficiency.

Referrals cannot be rejected based on length of wait for a first appointment or for waits incurred through Referral Assessment Services (RAS), Clinical Assessment Services (CAS) or via another provider through IPT.

The duty of care for the patient rests with the referrer until such time as the referral is accepted by the Trust or by an authorised Clinician where this will then pass to the responsible clinician at the Trust.

8.5.1.1 Advice & Guidance Referrals

Advice and Guidance is a e-RS functionality that allows primary care GPs to seek clinical advice from the Trusts clinicians without the need for an outpatient appointment. The Trust is monitored on turnaround times for response to advice and guidance requests. If the Trust clinician feels it is clinically appropriate to see the patients in and outpatient appointment, they can convert an Advice and Guidance conversation into a referral if this has been previously authorised by the primary care GP. Advice and Guidance (A&G) does not start an RTT waiting time unless the consultant converts the request.

8.5.1.2 Directly Bookable Appointments

Directly bookable services are available to be referred into and allow the patient to make an appointment based on available outpatient capacity. A directly bookable service will include an e-RS polling range, urgency of referral and appointment slots which can be booked by the patient or the referrer. Patients will be booked into an appropriate appointment, according to the priority of their referral.

8.5.1.3 Appointment Slot Issues (ASIs)

An appointment slot issue (ASI) occurs when there is no outpatient appointment slot available for patients to book into. When patients are unsuccessful in directly booking their first outpatient appointment via e-RS, the patients RTT waiting time will start from the date the patient first attempted to book their appointment, for example, when the hospital receives the referral on to the ASI worklist.

8.5.1.4 Clinical Assessment Services (CAS), And Referral Assessment Services (RAS)

A referral to a CAS or an RAS starts the patients RTT waiting time from the day the referral is received in the CAS/RAS. If the patient is referred on to the Trust having not received any treatment in the service, the trust inherits the RTT waiting time for the patient. This referral route helps to maximise effective patient management by directing patients into the most appropriate pathway steps for their condition facilitating timely patient care and in turn supporting service efficiency.

The Trust receives referrals from this type of service from

- Musculoskeletal (MSK) referral pathway to Orthopaedics, Pain Management, Rheumatology
- Ophthalmology and Dermatology

8.5.1.5 Paper-Based Referrals

All non-e-RS Referrals will be managed, and appointments booked in order of clinical priority (urgent before routine) and then chronologically in line with waiting time.

8.5.1.6 Incoming Inter-Provider Transfers (IPT to SFH)

This occurs when another Trust/Hospital Provider send a patient to the Trust to take over the care for the patient. The Trust expects to receive accompanying Minimum Data Set (MDS) pro-forma with the IPT, detailing the patient's current waiting time information as the Trust will inherit any previous wait already incurred at the referring trust if they have not yet been treated. If the IPT is for a diagnostic test only, the referring trust retains responsibility for the patients waiting time. All IPT referrals will be received electronically into the Trust's secure generic NHS net email account in the central booking office.

8.5.1.7 Outgoing Inter-Provider Transfers (IPT from SFH)

This occurs when the Trust sends a patient to a different Trust/Hospital Provider to take over the care for the patient. The Trust will ensure that outgoing IPTs are processed as quickly as possible to avoid any unnecessary delays in the patient's pathway.

The Trust will send accompanying Minimum Data Set (MDS) pro-forma with the IPT. This will detail the patient's current waiting time information enabling the receiving organisation to process the referral appropriately to record any inherited wait already incurred at the sending Provider. If the outgoing IPT is for a diagnostic test only, the Trust will retain responsibility for the patients waiting time.
Referrals and the accompanying MDS will be emailed securely from the specialty NHS.net account to the generic central booking office NHS.net account of the receiving organisation.

Where the transfer of responsibility and reporting may affect acceptance of the pathway, for example, due to an extended time the patient has waited previously, reporting arrangements should be discussed and agreed with all relevant providers and commissioners to enable the patient's transfer.

8.5.1.8 Internal Referrals (Consultant to Consultant)

There are times when a consultant at the Trust may need to refer a patient to another colleague, either within the same specialty or in another specialty. The NHS Standard Contract states that where a patient has been referred to one service within a provider by the GP, or has presented as an emergency, the provider clinician is allowed to make an onward outpatient referral to any other service, without the need for a referral back to the GP. Therefore the Trust's Consultant to Consultant Referral Policy allows patients to be referred to another speciality for a condition not related to the reason for the original referral. NHS England » 2024/25 NHS Standard Contract

Other Elective Referrals

8.5.1.9 Rapid Access Chest Pain Referrals (RACPC)

Rapid Access chest pain patients must be seen by a specialist within 14 days of the Trust receiving the referral. To ensure this is achieved:

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

All referrals from GPs are reviewed and if there is not appropriate information within the referral or they do not fit the RACPC criteria the referral will be declined. Patients referred from the Emergency Department or from a ward following an inpatient stay are required to fit the exact same criteria as e-referrals.

8.5.1.10 Dental Electronic Referral Service (powered by REGO)

As dental practitioners do not have access to e-RS their referrals are accepted into the Trust via the REGO system. Once vetted by the clinician the booking team will contact the patient to arrange a suitable appointment.

8.5.1.11 Diabetic Retinopathy Access Screening

Patients referred from the Diabetic Eye Screening Programme are made direct to the Head & Neck Outpatient Booking Team via email; these do not go via the GP. The Screening Programme must meet the following national standards regarding referrals into the hospital eye clinic:

- Urgent referrals – patient must be seen within 6 weeks of their screening appointment (Preferably in Medical Retina/Diabetic clinics)
- Routine referrals – patients must be seen within 13 weeks of their screening appointment (Preferably in Medical Retina/Diabetic clinics)

All diabetic patients referred by the screening programme must be offered a second appointment in the event of an appointment DNA or cancellation.

8.5.1.12 Urgent GP Orthopaedic/Fracture Appointment Referrals

GP's can refer directly to a consultant led fracture clinic, this would be classed as an emergency and the patient would not be applicable to a waiting time target.

8.5.2.1 Referral Vetting Process

Patients referred via e-RS should be able to choose, book and confirm their appointment before the Trust receives and accepts the referral. The GP initially grades the referral with the appropriate priority such as Urgent or Routine using the information supplied by the Trust within the Directory of Services (DOS).

The Trust consultant should then review their referrals on the NHS e-Referrals Service system to ensure the patient is booked into the correct service and allocated the correct urgency. The Consultant or nominee will clinically review referrals to decide the appropriateness and urgency of the referral.

- Referral accepted Outpatient appointment needed – the patient will be offered an appointment with the relevant speciality clinic in line with clinical urgency and current waiting times.
- Referral accepted patient sent straight to test – Clinician will organise request for the diagnostic test, and this will be booked in line with clinical urgency and chronologically in diagnostic waiting time order (DM01) where applicable
- Referral returned to referrer with advice – the referral will be returned to the referrer with clinical advice
- Referral Returned to referrer and rejected - the referral will be returned to the referrer with explanation of the reason for the rejection. Referrals which do not meet agreed referral criteria will be rejected and returned to the referrer with an explanation via the rejected referral option within NHS e-Referrals Service.
- Referral Redirected or forwarded on to the appropriate department. – the referral will be redirected in e-RS to the most appropriate service by the specialty team or central booking team. A confirmation letter of the specialty change will be sent to the patient.

8.5.2.2 First Appointment Booking (Non-e-RS Directly bookable)

All appointment offers will aim to be offered under reasonable Criteria*

* The Trust will endeavour to offer reasonable dates for any appointment or admission. A reasonable offer is one that is made with at least three weeks' notice of the appointment or admission date. When offers are made verbally or via letter or email a minimum of two dates with at least three weeks' notice will be offered for patients to choose from. However, if appointment or admission dates under three weeks are available at short notice these can be offered to patients but will only be considered as reasonable if they are offered verbally and the patient accepts them.

Depending on the specialty and referring condition appointments will be offered either face to face or virtual (non-face to face) – delivered via digital technology such as telephone, video, online clinical questionnaires or digital image share. Where possible diagnostic tests will be offered on the same day as a clinic appointment.

8.5.2.3 Consultant Upgrade

Where it is decided to upgrade the patient's priority to a 62 Day Cancer Pathway following Outpatient consultant, the consultant will telephone the Cancer Upgrade Line to upgrade the patient and will also complete the Upgrade Template. For patients upgraded to treatment within 62 days, these patients will have a 62 day start on the date of the upgrade.

8.5.2.4 Patient Initiated Follow Up (PIFU)

PIFU is an initiative that allows patients to access follow-up appointments on an 'as and when' required basis thus giving patients autonomy over when they are seen. This allows for outpatient capacity to be used for those patients most clinically needed rather than routine follow-ups for clinically stable patients. PIFU enables patients to make an appointment to see us if they have an exacerbation or flare -up of their condition. A defined criteria for adding to PIFU and a relevant time for the patient to return to the Trust before discharge and subsequent rereferral is set. The decision to move the patient to a PIFU pathway will be jointly agreed between the patient and their Clinician at their clinic attendance and will be documented and communicated in writing to the patient.

8.5.2.5 Follow-up appointments

It may not always be clinically necessary to bring the patient back to a face to face follow up appointment. This can be avoided by discussing likely treatment plans at the first outpatient appointment and using follow-up telephone consultations and written communication with the patient and GP. Use of PIFU pathways can support the reduction of follow-up appointments.

8.5.2.6 Outpatient Waiting list (Partial Booking)

In most specialties the Trust operates an outpatient waiting list (Partial booking) system for patients who require a follow-up appointment. Rather than give the patient a fixed appointment in the future patient will be added to an electronic list. Where patients are contacted to invite them to make an appointment nearer to the date the appointment is due. This process helps to give patient choice of appointment date therefore reducing both patient and hospital cancellations and DNA's

Occasionally patients when contacted to book an appointment will decline the offer of appointment and request to be discharged (either by telephone or via envoy) To ensure the clinical safety, any adult patient who requests discharge from an outpatient appointment pathway will be referred to the responsible clinician to assess the implications of the patient's discharge from the pathway and to confirm discharge or request another appointment. Consideration for safeguarding of paediatric patients and adults who are classed as having vulnerable characteristics and a request to discharge is made must result in a full clinical review of all requests.

8.5.2.7 Discharge

The patient has been discharged from the Trust back to the care of the referring care professional when no further clinical consultation is required. Once a patient is discharged and a further consultation is required, a new referral must be sought from the referring care professional which will start a new RTT waiting time where the service or pathway is RTT applicable. A decision to discharge must be communicated to both the patient and the GP clearly in writing.

8.5.3 Diagnostics

Many patients require diagnostics to determine the appropriate diagnosis and their subsequent treatment. Diagnostic tests can be for example a blood test, an endoscopy procedure, ECG, or x-ray. Diagnostics form part of a patients non-admitted pathway. A diagnostic period starts at the point a decision is made to refer a patient for a diagnostic test and ends when the result or report from the diagnostic procedure is available to the requester.

It is very likely that a patient referred for a diagnostic test will also have an active RTT waiting time. Whereas an RTT waiting time starts at the point the original referral was received their DM01 Diagnostic waiting time starts at the point the decision is made to refer for a diagnostic test.

National Diagnostic Waiting Time Rules - DM01

- Diagnostic start: the waiting time starts at the point of the decision to refer for a diagnostic test by either the GP or the consultant. For electronic referrals via e-RS, this is the time that the UBRN is converted, i.e., when the patient has accepted an appointment.

- Diagnostic stop: the diagnostic waiting time stops at the point at which the patient undergoes the diagnostic test (however the RTT waiting time where applicable will continue to tick until the patient has received definitive treatment or a decision not to treat is made).

8.5.3.1 Straight-To-Test Diagnostics

For patients who are referred to a consultant led service, it may be appropriate for a diagnostic test to be completed prior to the patient being seen in clinic or to negate the need for an outpatient consultation at all. This service helps to streamline and expedite patient care. These are called straight-to-test referrals and are sometimes managed via a RAS or CAS.

8.5.3.2 Direct Access Diagnostics

Patients who are referred directly for a diagnostic test (but not consultant-led treatment) by their GP – that is, clinical responsibility remains with the GP – will only have a diagnostic clock running. These are called direct access referrals. If the GP chooses to refer the patient to a consultant led service in secondary care based on the direct access test results the receipt of the new GP referral would start an RTT waiting time.

8.5.3.3 Therapeutic Procedures

Some procedures may have been intended to be diagnostic up until a point during the procedure, when the clinician decides that a treatment can take place. In this instance both the Diagnostic waiting time will stop, and if the treatment is classed as definitive, the RTT waiting time will also stop.

8.5.4 Admitted Pathways

Any patient who has a decision to admit for treatment will be captured and monitored on the admitted waiting list. Wherever possible patients added to the admitted waiting list should be fit, ready and available to come in as resource allows.

However, they should still be added to the list after a decision to admit if fitness has not yet been confirmed at preoperative assessment. Patients should also be added to the admitted waiting list if there is a decision to treat but the patient has declared a period of unavailability.

The active inpatient or day case waiting list (admitted PTL) includes all patients who are currently awaiting elective admission. The only exceptions are planned patients, who are awaiting admission at a specific clinically defined time.

8.5.4.1 Patients Requiring More Than One Procedure

- If more than one procedure will be performed in the same scheduled slot by the same surgeon, the patient should be added to the waiting list with all the procedures noted.

- If different surgeons will work together to perform more than one procedure, the patient will be added to the waiting list of the consultant surgeon for the priority procedure, with the additional procedures noted.

- Where a patient requires more than one procedure performed on separate occasions, (bilateral procedures) such as first definitive treatment followed by a new decision to treat for a second or subsequent treatment or bilateral procedures that are completed separately the patient:

    1. Will be added to the active waiting list for the primary (first) procedure

    2. When the first procedure is complete and the patient is fit and able to proceed with the second procedure, will be added (as a new waiting list entry) to the waiting list and a new RTT wait will start note: RTT waits for bilateral procedures should be sequential and not concurrent.

8.5.4.2 Planned Waiting Lists

A patient will only be added to an admitted planned waiting list if there is a clinical reason they need to have a procedure at a specific time or repeated at a specific frequency, such as a repeat colonoscopy. (Patients who are on an RTT pathway should not be placed on a planned list if they are unfit or unavailable for a procedure or operation)

A patient's due date [Guaranteed admission date (GAD)] for their planned procedure will be added to the planned waiting list entry. Patients on planned waiting lists will be scheduled for admission at the clinically appropriate time and they should not have to wait any longer after this time has elapsed.

When patients on planned lists awaiting admission for treatment are clinically ready for their treatment to begin and reach their due date for their planned procedure, they will either be admitted for the procedure or transferred to an active waiting list and a new RTT waiting time will start.

Patients who require a diagnostic test at a specific point in time for clinical reasons (such as for post-treatment surveillance) are exempt from the diagnostic clock rules and will be held on a planned waiting list with a clinically determined due date identified. However, if the patient's wait goes beyond their due date for the test, they will be transferred to an active waiting list and a new diagnostic waiting time will start

8.5.4.3 Clinical Prioritisation

When a patient is added to the waiting list the clinician will assign them a clinical prioritisation code. Clinical prioritisation criteria for each elective specialty should be agreed by clinical leads following guidance from respective Royal Colleges. These follow a standard format as detailed below:

P code	Booking timescale	Review timescale
P1a	Emergency procedures to be performed in <24 hours – **would not usually apply to patients awaiting elective admission**	
P1b	Procedures to be performed in <72 hours – **would not usually apply to patients awaiting elective admission**	
P2	Procedures to be performed in <1 month	1 month
P3	Procedures to be performed in <3 months	3 months
P4	Procedures to be performed in >3 months	

All patients, including those who have chosen to delay treatment, should be reviewed to make sure their condition or preference has not changed. The maximum time between reviews is 6 months. Reviews should be undertaken in line with the timescale indicated by the patient's priority category or sooner if appropriate (for example, if a change in the patient's condition has been highlighted).

8.6 Patient Choice

Patients have the legal right to choose the organisation and clinician for their referral and first outpatient appointment.

- The Trust may offer the patient an earlier appointment with a different consultant team but if the patient declines this offer, the RTT waiting time will continue.

The patient during their care pathway may request to be seen by another clinical team for their treatment.

- If the Trust can support this change internally or locally within services provided, then the RTT waiting time would continue and an Interconsultant or Interprovider referral made.

- If the Trust is unable to support this change internally or locally within services provided and requires the patient to be discharged back to their GP to make a fresh referral, the waiting time will stop at discharge back to the GP.

The Trust and our Clinical Teams provide services across different sites with a provision of outpatient, day case and inpatient facilities at these sites. Patients may be offered the choice of appointment or admission dates at an alternative provider to enable the patient to be seen and treated more quickly where this is clinically appropriate unless they have previously chosen to delay treatment.

The Trust will ensure that the patient is aware of hospital site options when making their choice to be treated, so that they are aware of any limitations to where their chosen consultant team can perform their procedure and by the clinical appropriateness of the services available at the sites.

This may include factors such as:

- The fitness of the patient due to the nature of their condition or other health limitations
- The availability of inpatient beds
- Access to High Dependency and critical care services
- Specialist on-site equipment required for the procedure

8.7 Patient and Hospital Initiated Delays - Admitted and Non-Admitted Pathways

There are no blanket rules when assessing compliance with appointments and admissions or a maximum number of cancellations or default to discharge. Therefore, it is important that clinicians make all decisions on next steps based on an individual patient basis. Clinicians should strike a balance between the trust's responsibility for acting in the patient's best clinical interests and the fact that patients have a right to choose to delay. Delays in the patient's pathway can be caused by

Non-Admitted Pathway

- Missed Appointments (Did Not Attend/DNA)
- Missed Appointments (Was Not Brought WNB (CYP))
- Cancelled Appointment – Patient Initiated
- Cancelled Appointment – Hospital Initiated
- Declines Appointment Offers
- Patient failure to provide samples
- Patient failure to return clinical equipment

Admitted Pathway

- Missed Admissions (Did Not Attend/DNA)
- Cancelled Admission Dates – Patient Initiated - Clinical
- Cancelled Admission Dates – Hospital Initiated - Clinical
- Cancelled Admission Dates – Patient Initiated – Non - Clinical
- Cancelled Admission Dates – Hospital Initiated – Non - Clinical
- Declines Offers of date to come in (TCI)
- Unfit for Surgery
- On the day cancellations

8.7.1 Non-Admitted Pathway

8.7.1.1 Missed OP Appointments (Did Not Attend/DNA/Was Not Brought/WNB(CYP)

Patients should be made aware of their responsibility to do what they can to attend the appointment however if the patient does fail to attend the clinician will review all missed appointments at the end of their clinic to make a clinical decision regarding next steps. (Appointments missed by paediatric and other vulnerable patients will be managed as per the Trust's safeguarding policy)

A clinician can decide to discharge the patient back to the original referrer where this is not contrary to the patient's best clinical interests. The clinician may consider previous attendance history whilst making a clinical judgement to offer another appointment.

8.7.1.2 Missed First Appointments (New)

If a patient misses (DNA) their first booked appointment following initial referral, the RTT waiting time will stop and the pathway is nullified in all cases (Rule 5e). Regardless of if another offer of appointment is made to the patient.

- **If the patient subsequently contacts the trust to rebook their first appointment**, this will start a new RTT waiting time on the date that the patient contacts the trust to rebook their new appointment.

- **If the clinician indicates another first appointment should be offered to the patient**, a new RTT clock will be started on the date this decision to reoffer is made. If it is not possible to book an appointment due to capacity pressures or lack of available appointment slots, the clock should still start from the decision to offer another appointment, and the patient should be added to a capacity waiting list as an alternative to booking their appointment.

- **If the patient is being discharged back to the care of their GP.**

1. First appointments – the RTT waiting time is nullified (stopped) **provided**.

    I. The Trust can demonstrate that the appointment was clearly communicated to the patient.
    II. Discharging the patient is not contrary to their best clinical interests, which may only be determined by a clinician.
    III. Discharging the patient is carried out according to local, publicly available, policies on DNAs;
    IV. These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (for example, children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders.

Patients who rearrange their appointments in advance (*irrespective of how short the period of notice they give*) should not be classed as a DNA.

8.7.1.3 Missed Subsequent Appointments (Follow-Up)

Patients should be made aware of their responsibility to do what they can to attend the appointment. However, if the patient does fail to attend and it is deemed clinically appropriate to continue to offer further appointments and retain clinical responsibility for the patient, the patient's waiting time should continue. If patients wait more than 18 weeks because of such delays, the 8% tolerance within the RTT standard is in place to account for this.

If the subsequent appointment is with a support specialty/service, for example preoperative assessment or diagnostics or therapy services and is missed, the decision about rebooking should be made by the responsible requesting clinician.

If the clinician, following engagement with the patient, decides it is in their best clinical interest to be discharged back to their GP or referrer,

2. Follow-up appointments - the RTT waiting time can be stopped **provided**,

    I. The Trust can demonstrate that the appointment was clearly communicated to the patient

    II. Discharging the patient is not contrary to their best clinical interests

    III. Discharging the patient is carried out according to local, published, policies on DNAs

    IV. These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (for example, children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders

8.7.1.4 Cancelled and Rearranged Appointments

If the patient gives any notice that they cannot attend their appointment (even if this is on the day of the clinic), this should be recorded as a cancellation and not a missed appointment (DNA) A cancelled or rearranged appointment, either patient-initiated or Trust -initiated, does not in itself have an impact on the patients RTT waiting time, only the decisions made after.

8.7.1.5 Patient - Initiated Cancellations

Patients should be made aware of their responsibility to do what they can to not cancel a previously booked appointment, but this will happen on occasion.

However, if the patient repeatedly cancels appointments, the responsible clinician should review the appropriate next steps for the patients care and may decide the most appropriate action is to discharge them back to the care of their GP e.g. where repeated cancellations represent a patient safety issue.

Patients will not be discharged back to their GP simply because they have cancelled or rearranged appointments; referral back to the GP should always be a clinical decision, based on the individual patient's best clinical interest. However, clinicians should strike a balance between the trust's responsibility for acting in the patient's best clinical interests and the fact that patients have a right to choose to delay and the clinician may consider previous attendance history whilst making a clinical judgement to offer another appointment

An RTT pathway should only be stopped following a clinical review and decision to discharge (where this is in the patient's best clinical interest) or where following discussion there is agreement between the clinician and the patient to initiate a period of active monitoring.

Where a patient cancels at short notice i.e. <48 hours before appointment or has cancelled 2 or more appointments on the same pathway, providers should ensure that the patient's reasons for this are understood, and a clinical review is undertaken.

As a result of the clinical review the next steps might be

- To discharge the patient provided this is not contrary to their best clinical interests. In this instance the RTT waiting time would stop and rereferral would be required in future.

- To offer the patient a further appointment. In this instance the RTT waiting time would continue.

8.7.1.6 Hospital - Initiated Cancellations

Hospital-initiated changes to patient appointments for reasons such as staff availability, suspension of services or equipment failure will be avoided as far as possible, as the Trust recognises that this is poor practice and results in inconvenience to patients and delays care pathways.

Trust clinicians are actively encouraged to book annual leave and study leave as early as possible, providing 6 weeks' notice if a clinic must be cancelled or reduced.

Patients will be contacted immediately if the Trust identifies it needs to cancel their appointment and they will be offered an alternative date that will allow patients on an active RTT pathways to be treated as quickly as possible. Equally, patients not on open RTT pathways will be reviewed as close to the clinically agreed timeframe as possible.

8.7.1.7 Failure to Provide Samples or to Return Clinical Equipment

The Trust may request the patient provides a clinically sample to be tested to support diagnosis and direct the patient's treatment plan. This might be a blood test prior to a diagnostic or a urine sample for example. The patient will be instructed where and how to provide the sample and will be given the required receptacle for collection where applicable.

Or The Trust may provide the patient with a piece of medical equipment for a diagnostic test to be performed at home over. This may be to support diagnosis and direct the patient's treatment plan. This might be a sleep study or cardiology test for example. The patient will be instructed where and how to return the equipment.

If the patient fails to deliver the sample or return the equipment this may impact on the patients care and delay the pathway significantly. Where a patient has not returned the sample or equipment, they will be contacted and supported with additional information or help as necessary.

If the patient still does not deliver the sample or equipment after 3 weeks, a clinical review will be undertaken as to the best course of action. A clinician can decide to discharge the patient back to the original referrer where this is not contrary to the patient's best clinical interests.

8.7.2 Admitted Pathway

8.7.2.1 Missed Admissions (DNA/WNB)

A missed admission (DNA/WNB) occurs when a patient fails to attend an admission (TCI) without prior notice. Patients who rearrange their admission date in advance (irrespective of how short the period of notice they give) should not be classed as a DNA. Patients who do not attend for admission will have their pathway reviewed by their consultant.

As a result of the clinical review the next steps might be

- To discharge the patient provided this is not contrary to their best clinical interests. In this instance the RTT waiting time would stop and rereferral would be required in future.

- To offer the patient a further date to come in (TCI). In this instance the RTT waiting time would continue.

8.7.2.2 Patient - Initiated Admitted Cancellations

Patients should be made aware of their responsibility to do what they can to not cancel a previously booked date to come in for treatment, but this will happen on occasion.

However, if the patient repeatedly cancels TCI dates, the responsible clinician should review the appropriate next steps for the patients care and may decide to avoid the patient coming to harm, the most appropriate action is to discharge them back to the care of their GP.

Patients should not be discharged back to their GP simply because they have cancelled or rearranged admission dates; referral back to the GP should always be a clinical decision, based on the individual patient's best clinical interest with that said clinicians should strike a balance between the trust's responsibility for acting in the patient's best clinical interests and the fact that patients have a right to choose to delay.

An RTT pathway should only be stopped following a clinical review and decision to discharge (where this is in the patient's best clinical interest) or where following discussion there is agreement between the clinician and the patient to initiate a period of active monitoring.

Where a patient cancels at short notice i.e. <48 hours before appointment or has cancelled 2 or more appointments on the same pathway, providers should ensure that the patient's reasons for this are understood, and a clinical review is undertaken.

As a result of the clinical review the next steps might be

- To discharge the patient provided this is not contrary to their best clinical interests. In this instance the RTT waiting time would stop and rereferral would be required in future.

- To offer the patient a further TCI date. In this instance the RTT waiting time would continue.

8.7.2.3 On-The-Day Cancellations – Hospital Initiated

Where a patient is cancelled on the day of admission or day of surgery for non-clinical reasons, they will be rebooked within 28 days of the original admission date and must be given reasonable notice of the rearranged date.

The patient may choose not to accept a date within 28 days. If it is not possible to offer the patient a date within 28 days of the cancellation, the trust will offer to fund the patient's treatment at the time and hospital the patient chooses, where appropriate.

8.7.2.4 Patients Who Are Clinically Unfit for Surgery

Patient should be assessed for fitness for a procedure at the earliest possible opportunity following a decision to admit for treatment and where patients are known to be unfit, they will not be added to the elective waiting list until fit to proceed. If following a decision to admit for treatment is made the patient is deemed to be unfit to go-ahead with the procedure, the nature and duration of the clinical fitness issue should be assessed.

8.7.2.5 Short-Term Illnesses

If the clinical issue is likely to be short-term in nature and resolve quickly and has no impact on the original clinical decision to undertake the procedure (for example, cough, cold), the patient will remain on the surgical waiting list and the RTT waiting time continues.

8.7.2.6 Longer-Term Illnesses or Clinical Fitness Issue

If the clinical fitness issue is more serious and the patient requires optimisation or treatment for their condition prior to their surgery, clinicians should decide what is in the best clinical interests of the patient, this could be,

- The patient requires optimisation within secondary care prior to surgery e.g. for a cardiology or respiratory issue. The patient will be placed on active monitoring for fitness resulting in a stop to the RTT waiting time. The patient's next steps should be agreed by the clinician including the timeframe for further review or follow-up to assess their condition and fitness to proceed. The pathway should remain visible on the relevant PTL or waiting list report to support ongoing management of the patient.

- The patient requires treatment for another unrelated condition or a period of recovery following treatment for another condition before proceeding with their pathway. The patient will be placed on active monitoring for fitness resulting in a stop to the RTT waiting time. The patient's next steps should be agreed by the clinician including the timeframe for further review or follow-up to assess their condition and fitness to proceed. The pathway should remain visible on the relevant PTL or waiting list report to support ongoing management of the patient.

- The patient requires optimisation and will be managed within primary care e.g. for management of high HbA1c (blood sugar control) or hypertension (high blood pressure) and will be discharged back to the care of their GP whilst optimised and rereferred back to secondary care when they are fit to proceed. The patients RTT waiting time will stop in this scenario.

Patient pathways will not be subject to a clock stop whilst an assessment of fitness is made e.g. through diagnostic testing, only once optimisation is required.

8.7.2.7 Duration of Patient-Initiated Delays

There is not a maximum length to a patient-initiated delays and requests must take account of individual patient circumstances. The Trust will request a clinical review for all patients wishing to delay treatment for an extended period to protect patients who may come to harm by choosing to delay their treatment. This includes those patients who may come to harm by repeatedly cancelling or failing to attend appointments.

If a patient requests to delay treatment for more than 12 weeks, there should be a clinical review to assess the potential impact on the patient's condition and treatment plan.

- If the clinician is not satisfied that the proposed delay is appropriate, then the clinical risks should be clearly communicated to the patient and through shared decision making a clinically appropriate date to come in (TCI) or appointment date agreed.

If following a shared decision-making conversation, and on the advice of the clinician, the patient still is unable to commit to a date then the responsible clinician must act in the best interest of the patient.

It is not acceptable to refer patients back to their GP simply because they wish to delay their appointment or treatment. However, it would be acceptable where referring patients back to their GP is in their best clinical interests and decisions should be made by the treating clinician on a case-by-case basis

- If the clinician feels that it is in the best clinical interest of the patient to discharge the patient back to the care of their GP and inform them that treatment is not progressing, then this must be made clear to the patient and GP in writing. This must be a clinical decision, taking the healthcare needs of each individual patient into account.

- If the clinician feels that it is safe to delay the patient's treatment they may wish to stop a patient's waiting time, through agreeing to start a period of active monitoring with the patient. In this instance the patient would likely be removed from the treatment waiting list where applicable and a future appointment organised at a suitable timeframe when the patient is available to be treated to reassess the patient and add to the waiting list. In this instance a new decision to treat will be recorded and a new RTT waiting time will start. Although the patient's clock will start from 0 weeks as normal, the Trust will endeavour to offer a further appointment or TCI date in line with their clinical prioritisation/ urgency and act as if the patient is on the RTT waiting list at the point they were before active monitoring started.

- If the Clinician feels it is safe for the patient to delay treatment, but they wish for the patient to remain on the treatment waiting list where applicable, Patient choice will be applied to the patients RTT pathway, the pathway will be excluded from National reporting via the Waiting List MDS but the original wait for the patient will be maintained and monitored. The patient will be dated as soon as they are available for a date for admission or appointment.

8.7.2.8 Patients Who Decline Appointment or Admission Date Offers

Most patients generally choose to be seen and treated at the earliest opportunity. However, patients are entitled to wait longer if they wish to and to choose a suitable time to receive their treatment planning their appointments around their personal circumstances. The Trust will not penalise patients following a patient decision to delay treatment.

If patients decline appointment or TCI dates that they are offered or contact the trust to cancel a previously agreed appointment or admission date, this information must be recorded on the Trusts PAS system. The RTT waiting time will continue until a clinical decision is made about the next steps.

When a patient declines 2 reasonable offers of dates either appointment or TCI (which may be at different sites) that are within 6 weeks of each other and the patient wishes to delay their pathway, the consultant should review the patient pathway to ensure that the delay in care/treatment is clinically acceptable and not contrary to the patient's best clinical interest.

- The consultant can agree a period of active monitoring with the patient, which should include an appropriate timeframe for further follow-up or review.

In this instance the patient would be removed from the elective waiting list where applicable and the RTT waiting time would stop for the specified timeframe and restart when the patient confirms that they are ready to receive treatment. In this instance a new decision to treat will be recorded and a new RTT waiting time will start. Although the patient's clock will start from 0 weeks as normal, the Trust will endeavour to offer a further appointment or TCI date in line with their clinical prioritisation/ urgency and act as if the patient is on the RTT waiting list at the point they were before active monitoring started.

- If the decision is to keep the patient on the elective waiting list and offered a further date of appointment or date to come in for treatment (TCI). Patient choice will be applied to the patients RTT pathway, the pathway will be excluded from National reporting via the Waiting List MDS but the original wait for the patient will be maintained and monitored. The patient will be dated as soon as they are available for a date for admission or appointment.

- If the decision is to discharge the patient, the RTT waiting time would stop. this decision must be made clear to the patient and GP in writing. This must be a clinical decision, taking the healthcare needs of each individual patient into account

8.7.2.9 Patients Who Decline Earlier Appointments or Treatment at An Alternative Provider

It may be necessary during a patient's pathway, to allow the patient to be treated more quickly, to offer the option to be seen or treated at another provider.

This may be at a private provider as part of an outsourcing arrangement or at another NHS Trust under mutual system support. The same process and waiting time rules apply as for patients who cancel or decline appointment or admission offers. However, offers of alternative providers must state the likely date that the patient will be treated, the organisations and the potential clinician to allow the patient to make an informed choice to accept or decline the offer. Offers must still also meet the reasonableness criteria**.**

It is important that the Trust fully understands a patient's social and clinical factors to best assist them in deciding whether to move to an alternative provider. In instances where transport is a barrier to earlier treatment this could be provided by the Trust where applicable.

8.7.2.10 Thinking Time

The Trust recognises that it is good practice for patients to be given full information about all treatment options available to them, including medical nonoperative or 'do-nothing 'to enable the patient to make an active decision to choose surgery.

This may involve the patient being given 'thinking time' by the consultant, so as not to rush the patient into a decision. If the clinician and patients in clinic agree a short, 'thinking time' then the RTT pathway should continue and incorporate this delay. An example might be a patient offered invasive surgery such as a hernia repair, but the patient would like a few days to consider this before confirming they wish to go ahead with the surgery.

The Trust will ensure a discussion with the patient takes place when more than 14 days have passed without a decision to confirm the patient wishes and plan next steps.

If a longer period of 'thinking time' is agreed between the patient and the clinician, then it may be more appropriate to actively monitor the patient until they feel able to decide on next steps.

An example is where the clinician offers a surgical intervention, but the patient is not keen on invasive surgery at this stage, as they view their symptoms as manageable. A review appointment is agreed for three months' time and the patient is placed on active monitoring. The RTT waiting time would stop at the point that the decision is made to commence active monitoring. A new RTT waiting time would start when a decision to treat is made following the period of active monitoring when the patient and clinician decided to go ahead with surgery.

9.0 IMPACT ASSESSMENTS

Equality Impact Assessment (Appendix 2)

The Trust is committed to ensuring that none of its policies, procedures and guidelines discriminate against individuals directly or indirectly based on gender, colour, race, nationality, ethnic or national origins, age, sexual orientation, marital status, disability, religion, beliefs, political affiliation, trade union membership, and social and employment status.

An EIA of this policy/guideline has been conducted by the author using the EIA tool developed by the Diversity and Inclusivity Committee. (22/12/15).

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance)

10.1 Evidence Base and Further Reading:

- Recording And Reporting Referral to Treatment (RTT) Waiting Times For Consultant-Led Elective Care
- SOP's, Process Guides and Departmental Local Guidance
- The-NHS-Constitution-For-England
- NHS Choice Framework - GOV.UK (Www.Gov.Uk)
- Travel Reimbursement Scheme.
- Healthcare For Visitors to The UK From the EU - GOV.UK (Www.Gov.Uk)
- Healthcare For EU Citizens Living in Or Moving to The UK - GOV.UK (Www.Gov.Uk)
- https://www.gov.uk/government/publications/how-the-nhs-charges-overseas-visitors-for-nhs-hospital-care/how-the-nhs-charges-overseas-visitors-for-nhs-hospital-care
- Https://Www.England.Nhs.Uk/Evidence-Based-Interventions/- National Policy
- Value Based Commissioning Policy - Nottinghamshire ICB Policy
- ICB Clinical 003 - Prior Approval Policy - Lincolnshire Policy
- NHS England » 2024/25 NHS Standard Contract

- Accessible Information Standard.
- Armed-Forces-Covenant
- https://www.england.nhs.uk/outpatient-transformation-programme/did-not-attends-dnas/
- Was Not Brought/Did Not Attend Policy CYP
- Safeguarding Children and Young People Policy
- https://www.england.nhs.uk/long-read/good-communication-with-patients-waiting-for-care/#introduction
- https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/
- https://www.gov.uk/guidance/equality-act-2010-guidance

10.2 Related SFHFT Documents:

Related Policies and Guidelines and/or Other Documents available on the SFH Intranet

- Cancer Access Policy
- Overseas Visitor Policy
- Restricted Procedures Policy
- Private Patient Policy
- Management of Children who do not attend appointments Policy
- Elective Care Training Strategy

APPENDIX 1 - Glossary*

Term	Definition
Active monitoring	Where a clinical decision is made to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures. Often referred to as 'watchful wait'.
Advice and Guidance (A&G)	By providing a digital communication channel, A&G allows a clinician (often in primary care) to seek advice from another (usually a specialist) prior to or instead of a referral.
Active waiting list	The list of elective patients who are fit, ready and able to be seen or treated at that point in time. Applicable to any stage of the RTT pathway where patients are waiting for hospital resource reasons.
Appointment Slot Issue (ASI)	A list of patients who have attempted to book their appointment through the national E-Referral Service but have been unable to due to lack of clinic slots.
Bilateral procedures	Where a procedure is required on both the right and left sides of the body.
Breach	A pathway where the period waited to be seen or receive treatment exceeds the access standard, national or local target time.
Clinical Assessment and Treatment Service (CATS)	Clinical assessment and treatment service
Clinic Outcome Form (COF)	Used to record the RTT outcome and other clinical information after an outpatient appointment.

* **Model Access Policy v3.0**

Consultant-led service	A service where a consultant retains overall responsibility for the care of the patient. Patients may be seen in nurse-led clinics which come under the umbrella of consultant-led services.
Day case	Patients who require admission to the hospital for treatment and will need the use of a bed but who are not intended to stay in hospital overnight
Decision to admit (DTA)	Where a clinical decision is made to admit the patient for either day case or inpatient treatment.
Direct access	Where GPs refer patients to hospital for diagnostic tests only. These patients will not be on an open RTT pathway.
Did Not Attend (DNA)	Patients who give no prior notice of their nonattendance.
Elective care	Any pre-scheduled care which doesn't come under the scope of emergency care.
E-RS	(National) E-Referral Service
First Definitive Treatment (FDT)	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgement in consultation with the patient
Fixed appointments	Where an appointment or admission date is sent in the post to the patient without the opportunity to agree a date.
Full booking	Where an appointment or admission date is agreed either with the patient at the time of the decision or within 24 hours of the decision.
Incomplete pathways	Patients who are waiting for treatment on an open RTT pathway, either at the non-admitted or admitted stage.
Inpatients	Patients who require admission to the hospital for treatment and are intended to remain in hospital for at least one night

Integrated Care Board (ICB)	An organisation that brings NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS
Inter-provider transfer (IPT)	Inter-provider transfer is when a patient is transferred to another provider
Minimum Data Set (MDS)	Minimum information required to be able to process a referral either into a trust or for referral out to other trusts.
Nullified	Where the RTT clock is discounted from any reporting of RTT performance.
Partial booking	Where an appointment or admission date is agreed with the patient close to the time it is due.
Patient Administrative System (PAS)	A patient administration system records the patient's demographics (eg: name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient.
Patient-initiated delay	Where the patient cancels, declines offers or does not attend appointments or admission. This in itself does not the stop the RTT clock. A clinical review must always take place.
Patient Initiated Follow Up	PIFU is when a patient initiates an appointment when they need one, based on their symptoms and individual circumstances
Planned waiting list	Patients who are to be admitted as part of a planned sequence of treatment or where they clinically have to wait for treatment or investigation at a specific time. Patients on planned lists should be booked in for an appointment at the clinically appropriate time. They are not counted as part of the active waiting list or are on an 18-week RTT pathway.
Patient pathway identifier (PPID)	A unique identifier which together with the provider code uniquely identifies a patient pathway.

Patient Tracking List (PTL)	A tool used for monitoring, scheduling and reporting on patients on elective pathways (covering both RTT and cancer).
Reasonable offers	A choice of two appointment or admission dates with three weeks' notice.
Referral management centre (RMC)	The Referral Management Centre (RMC) provides a single point of access for professionals to make referrals into providers.
Referral to treatment (RTT)	The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.
Straight To Test (STT)	Arrangements where patients can be referred straight for diagnostics as the first appointment as part of an RTT pathway
To come In (TCI)	The date of admission for an elective surgical procedure or operation

APPENDIX 2 - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

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

(i.e. living in a poorer neighbourhood / social deprivation)			

What consultation with protected characteristic groups including patient groups have you carried out?

- None for this version, in that all previous principles remain in accordance with previous version (which was subject to consultation), and this version is primarily a reformat and codification of agreed practices.

What data or information did you use in support of this EqIA?

- Trust policy approach to availability of alternative versions

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- NO

Level of impact
Low Level of Impact

Name of Responsible Person undertaking this assessment: Joanna Taphouse Head of RTT

Signature: *Joanna Taphouse*

Date:20/03/2025

APPENDIX 3

CANCER ACCESS POLICY

POLICY

Reference	GV 013		
Approving Body	Planned Care Steering Group		
Date Approved	15/05/25		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
			X
Issue Date	15/05/2025		
Version	6		
Summary of Changes from Previous Version	**6.1.and 6.14.1** Addition applied to adjust outside the 62d target. **6.9** Addition applied to include the USCR LGI FIT rejection criteria. **6.14.5** Addition applied to make an adjustment if a patient is deemed clinically unfit to proceed (this would not include assessment to determine if fit to proceed) once a decision to treat has been made and requires other essential treatment prior to progressing their cancer pathway. **6.14.9** Addition applied to adjust outside the 62d target where patients are unavailable. **6.14.9** Addition applied to make adjustment where patients choose to wait for certain consultant for their treatment. **6.14.11** Addition applied to wider set of terminology for active monitoring.		
Supersedes	5		
Document Category	Governance		
Consultation Undertaken	Cancer Steering Group Planned Care Steering Group		
Date of Completion of Equality Impact Assessment	Enter date assessment was undertaken.		
Date of Environmental Impact Assessment (if applicable)	Enter date assessment was undertaken.		
Legal and/or Accreditation Implications	Developed in line with best practice Model Access Policy. Elective Care Improvement Support Team NHSE/NHSI		
Target Audience	This policy applies to any staff involved in the management of cancer patients at the Trust irrespective of who is making the booking and where the activity is scheduled. The policy does not apply to emergency care		
Review Date	May 2026		
Sponsor (Position)	Chief Operating Officer		

Author (Position & Name)	Associate Director of Planned Care Head of Elective Recovery Cancer Services Manager
Lead Division/ Directorate	Corporate
Lead Specialty/ Service/ Department	Cancer Service
Position of Person able to provide Further Guidance/Information	Cancer Services Manager

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
Template control	April 2024

CONTENTS

APPENDICIES

1.0 INTRODUCTION

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

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

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

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

2.0 POLICY STATEMENT

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

The policy:

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

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

3.0 DEFINITIONS/ ABBREVIATIONS

Section 12 Appendices.

4.0 ROLES AND RESPONSIBILITIES

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

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

- Divisional Clinical Chairs and Divisional Managers have a shared responsibility for implementation of the Cancer Access Policy within their Division's clinical and management teams and for ensuring compliance with the arrangements set out within this policy. They also have joint responsibility for ensuring clinical teams within their division have awareness of all patients on the Cancer patient tracking list (PTL), and for the management of these patients through their pathways.

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

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

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

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

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

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

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

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

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

5.0 APPROVAL

Contributors	Communication Channel:	Date
Planned Care Steering Group	For Ratification	15/05/2025

6.0 DOCUMENT REQUIREMENTS

6.1 Adjustments to cancer pathways

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

1) If a patient does not attend (DNA) their initial outpatient appointment – this would allow the clock to be re-set from the receipt of the referral to the date upon which the patient rebooks their appointment. This adjustment is relevant to the patients first seen appointment and the 62-day standard.

2) An adjustment for treatment can be applied if a patient declines a 'reasonable' offer of admission for treatment (for both admitted and non-admitted pathways) even if the offered date is outside the 62 day target.

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

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

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

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

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

GPs must have proactive arrangements in place to ensure that patients referred back to them are consulted with to establish the reasons for the DNAs.

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

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

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

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

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

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

A minimum of three days' notice should be provided for all offers of appointments and treatments, subject to agreement between the local Commissioner and the Trust that this is appropriate and desirable for their local population.

6.3 Urgent Suspected Cancer Referrals (USCR): Pathway Definitions

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

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

6.4 Management of Urgent Suspected Cancer Referral pathways

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

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

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

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

- Some patients will choose to wait longer, and others will not be clinically able to be seen within these time frames.

- If the patient fails to attend appointments that they had chosen from a set of reasonable appointment dates offered.

6.5 Direct booking

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

6.6 Clinical Assessment Service

For the tumour sites of Lung, Haematology and Upper GI a Clinical Assessment Service (CAS) is in place. Therefore, patients will be booked into an Internal CAS slot. When the referral has been through the CAS, the Trust will contact the patient to agree an urgent suspected cancer appointment slot.

Some Upper GI referrals are suitable for straight to test within Endoscopy and Radiology and are therefore vetted for clinical suitability prior to offering a clinic/straight to test appointment. Vetting takes place within 24 hours of receipt within the Upper GI service.

Some Lung referrals are suitable for straight to test within radiology and are therefore vetted for clinical suitability prior to offering a clinic/straight to test appointment. Vetting takes place within 24 hours of receipt within the Lung service.

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

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

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

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

6.7 Patient inability to attend.

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

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

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

6.8 GP referral within 24 hours

A GP should refer a patient within 24 hours of making the decision to refer. A GP should refer a patient even if a patient cannot make themselves available for their initial appointment/test on referral, since receipt of this referral flags to the receiving organisation that there is a potential cancer case on its way. The patient's availability should be included on the USCR Proforma, including dates not available.

6.9 USCR sent to the wrong provider.

If the Trust receives a referral for a patient for a service we do not provide, that referral should be forwarded immediately to an appropriate provider together with the minimum dataset. The date of receipt is when the referral was originally received, not the day it was forwarded, and this does not constitute a reason for making a pause in the pathway. The GP should be contacted and advised to enable a change in future practice. If the referral has been sent to another provider and forwarded to SFH for initial appointment it is the responsibility of that provider to ensure the patient is referred without delay, and to provide the minimum dataset.

6.10 USCR not containing the required information (minimum dataset)

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

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

- FIT test has not been completed (except for rectal mass).
- FIT less than 4
- FIT less than 10 in the absence of anaemia or thrombocytosis
- Blood results within 10 weeks of receiving the referral are not available on the referral form or ICE.
- A date for bloods to be taken within two days of referral is not included within referral form.

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

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

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

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

6.12 Management of 1st Appointment Cancellations

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

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

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

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

GPs must have proactive arrangements in place to ensure that patients referred back to them are consulted to establish the reasons for the cancellations and take action in the patient's best interests. USCR can only be "downgraded" by the GP - if a consultant thinks the USCR is inappropriate this should be discussed with the GP and the GP asked to withdraw the USCR status.

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

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

6.14 Pathway Definitions

6.14.1 Diagnostic and Treatment Pathways (31 and 62-day)
Any patient referred as an USCR or breast symptomatic referral, must be treated within the national waiting time standard of 62-days from receipt of referral.

Patients diagnosed with cancer will be given their first definitive treatment within 62-days of referral; subject to patient choice (i.e. the right to be treated within the maximum waiting times does not apply if the patient chooses to wait longer).

A pause can be applied to the pathway for patient choice, this would be the time between the date of the declined appointment (the offered To Come In date) to the point when the patient could make themselves available for an alternative appointment for treatment in both admitted and non-admitted settings. If a patient chooses to wait longer, and the first offered treatment date is outside of the 62-day standard, an adjustment can still be applied.

The following exceptions to pausing a patient pathway, could be applied:

- If delaying the start of the treatment is in the best clinical interests of the patient, for example where stopping smoking or losing weight is likely to improve the outcome of the treatment (pause of pathway is not applicable – national operational standard of 85% has been set to take account of this scenario).
- If it is clinically appropriate for the patient's condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage.

6.14.2 Management of 31 and 62-day Pathways: Consultant Upgrades
When routine referrals (i.e. those not on a 62-day pathway) are upgraded onto the 62-day pathway via the Consultant Upgrade process. This should be communicated back to the referring clinician by letter so that they are aware of the elevated priority of the referral. The date of upgrade is the date the Cancer Service is notified.

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

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

There are 3 national screening programmes:

- Breast
- Bowel
- Cervical (Gynaecology)

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

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

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

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

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

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

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

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

The pathway start date is receipt of referral (day 0) which for the individual screening programmes, means as follows:

- Breast - receipt of referral for further assessment (i.e. not back to routine recall).
- Bowel - receipt of referral for appointment to discuss suitability for colonoscopy with a specialist screening practitioner (SSP).
- Cervical – date of abnormal screening result.

6.14.5 Where Patients are not immediately fit for diagnostics/treatment

If it is known that a patient is clinically unfit for diagnostic/treatment needed within the timeframe scheduled for their appointment, appointments should not be made when it is known by the provider that they cannot attend owing to ill health in order to prompt a series of DNAs or cancellations resulting in referral back to the GP.

The operational requirement for the 28-, 31- and 62-day standards now takes this into account and therefore patients are required to remain on their cancer pathways and not be referred back to the GP, placed on a pending list, moved between cancer pathways or moved solely onto an 18-week pathway.

An adjustment can be applied if it is deemed clinically essential to treat another medical condition before treatment for cancer can be given, after a decision to treat the cancer has been made.

In such cases the adjustment would apply from the point at which it is confirmed that a patient needs treatment for the other medical condition, to the point at which after receiving treatment for this condition the patient is deemed clinically fit to commence their cancer treatment.

This adjustment cannot be applied for where a patient is advised to make lifestyle changes for example stop smoking, lose weight, or commence a period of prehabilitation prior to their cancer treatment. In these cases, the patient clock would continue. The 62-day and 31-day threshold is set to allow for patients in this scenario who will exceed the timescales.

This adjustment can be made even if outside the 62-day pathway.

6.14.6 Subsequent Cancer Treatments

a) Subsequent Drug Treatments
   All patients that require subsequent cancer drug treatments will be treated within 31-days of the decision to treat or "Earliest Clinically Appropriate Date".
b) Subsequent Cancer Treatments - Surgery
   All patients that require subsequent cancer surgery will be treated within 31-days of the decision to treat or "Earliest Clinically Appropriate Date".
c) Subsequent Cancer Treatments - Other
   All patients that require other subsequent cancer treatments will be treated within 31-days of the decision to treat or "Earliest Clinically Appropriate Date".
d) Recurrence of Cancer
   All patients with a confirmed recurrence of cancer in the same tumour site will be treated within 31-days of the Decision to Treat, even if they have been referred on an USCR.
e) Rare Cancers
   Rare cancers (children's, testicular and acute leukaemias) are treated within 31-days of an USCR or consultant upgrade.

6.14.7 Reasonable Notice (CWTs)

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

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

6.14.8 Contacting Patients to make Appointments.

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

6.14.9 Patient Choice

The operational standard now considers that more breaches are likely owing to patients choosing to wait longer. In addition, a pause is allowed if a patient declines a reasonable offer for treatment even if the date is offered outside the 62-day target.

An adjustment for where a patient chooses to wait for a certain consultant but where that consultant's capacity is outside of the 62d target, an adjustment would be made. An adjustment cannot be made where a consultant decides only they can treat the patient, but capacity falls outside of the standard.

Adjustment for treatment location could be made where a patient chooses to wait for a specific location but where that location is outside of the standard, an adjustment would be made (this will largely be N/A due to the majority of SFH treatments taking place at a single site).

Patients must not be moved between cancer pathways (i.e. 31 and 62-day pathways or placed on pending lists for non-admitted treatment) because they cannot guarantee attendance.

6.14.10 'Thinking Time' – when a patient decides between treatment options

No pathway pauses to the waiting time can be applied where a patient requires thinking time. "Thinking time" is one component of patient choice. The recommendation for thinking time is a maximum and not exceeding 1-week, clinical teams should agree the shortest possible period of appropriate thinking time dependent on the patients' circumstances.

6.14.11 Trust Response to Patient choice

If the patient cannot guarantee attendance for tests or treatment or are unavailable for non-admitted care within a certain timescale they will remain on their referred pathway unless the patient declines all further treatments or investigations. Decisions by patients (including dates/times/conversations) to decline treatment or investigation must be recorded in the patient notes and/or on the Careflow system. The Trust is required to provide proactive arrangements to ensure that patients referred back to their GP/GDP/Optometrist are consulted with in a primary care setting about the obstacles that prevented them from attending their appointment(s).

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

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

The trust has agreed a wider set of terminology for active monitoring that can be classed by the cancer service for the recording against the national cancer waiting times standards. If this terminology is used in patient letters, this will class as first definitive treatment and end the patients 31/62d pathway.

- Watch and wait
- Watchful waiting
- Active monitoring
- Period of surveillance
- Real-time, ongoing, or continuous monitoring.

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

6.15 Faster Diagnosis Standard (FDS)

The cancer waiting time's service standard is:

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

6.15.1 Adjustments

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

6.15.2 Ending the FDS Pathway

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

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

6.15.3 Communicating to the Patient

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

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

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

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

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

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

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

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

6.15.5 Exclusions from FDS

The following exclusions apply to the FDS standard:

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

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

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

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

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

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

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Continuous validation of the PTL will be used to identify any areas of non-compliance with the policy, which may identify themes, departments or individuals where further training is required.	Cancer Services Manager	Validation of PTL	Continuous	Cancer Steering Group

8.0 TRAINING AND IMPLEMENTATION

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

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix 2
- This document is not subject to an Environmental Impact Assessment.

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- The policy supports the delivery of the NHS Constitution, the national waiting time standards for Cancer and the national waiting time standards for Referral to Treatment (RTT).
- Cancer Waiting Times Version 12.1.
- NHSE/NHSI Guidance advice on maintaining cancer treatment during the COVID-19 response. Publications approval reference: 001559.
- Cancer Research UK
- Macmillan Cancer Information and Support

Related SFHFT Documents:

- Elective Care Access Policy.
- Consultant Upgrade Policy.

11.0 KEYWORDS

CWT, Pathway, 62d, 31d, FDS.

12.0 APPENDICES

Appendix 1. Definitions

Term	Definition
Urgent Suspected Cancer Referral	A patient is referred urgently with suspected cancers or breast symptoms, where cancer is not suspected for a first outpatient appoint or 'straight to test'.
28-day Faster Diagnosis Standard	Maximum four weeks (28 days) from receipt of urgent GP, Dentist or Optometrist referral for suspected cancer, breast symptomatic referral or urgent screening referral, to the point at which patient is told they have cancer, or cancer is definitely excluded.
31-day pathway	The starting point for 31-day standard is the date a patient agrees a plan for their treatment or the date that an earliest clinically appropriate date (ECAD) is affected for subsequent treatments.
62-day pathway	Any patient referred by a GP with a suspected cancer on a Urgent suspected cancer referral pro-forma, referral from a screening service, a referral from any healthcare professional if for breast symptoms or where a routine referral has been upgraded by a hospital clinician, must begin treatment within 62 days from receipt of referral.
B	
Breach	A pathway which ends when a patient is seen/receives their first treatment outside the, 62-day referral to treatment or the 31-day Decision to treat to treatment.
C	
Clinical decision	A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements.
Consultant	A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. The operating standards for referral to treatment exclude non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.
Consultant-led Service	A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.
D	
Decision to treat	Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatments performed in other settings e.g. as an outpatient.

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

APPENDIX 2 - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Cancer Access Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: 07/04/2025			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	Availability of this policy in languages other than English	Alternative versions can be created on request.	None
Gender	None	Not applicable	None
Age	None	Not applicable	None
Religion / Belief	None	Not applicable	None
Disability	Visual accessibility of this document	Already in font size 12. Use of technology by end user. Alternative versions can be created on request	None
Sexuality	None	Not applicable	None
Pregnancy and Maternity	None	Not applicable	None
Gender Reassignment	None	Not applicable	None
Marriage and Civil Partnership	None	Not applicable	None
Socio-Economic Factors	None	Not applicable	None

(i.e. living in a poorer neighbourhood / social deprivation)			

What consultation with protected characteristic groups including patient groups have you carried out?

-

What data or information did you use in support of this EqIA?

-

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

-

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

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Name of Responsible Person undertaking this assessment: Cancer Services Manager

Signature: Samantha Owen

Date: 07/04/2025