University Hospitals of Leicester NHS
NHS Trust

Cancer Access Policy

Approved By:	Policy and Guideline Committee
Date of Original Approval:	19 March 2021
Trust Reference:	B8/2021
Version:	V2
Supersedes:	V1 – March 2021
Trust Lead:	Charles Carroll, Head of Cancer Performance
Board Director Lead:	Jon Melbourne – Chief Operating Officer
Date of Latest Approval	16 August 2024 – Policy and Guideline Committee
Next Review Date:	December 2027

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

This is policy has been rewritten to align with the NHS England IST Model Cancer Access Policy released March 2024.

KEY WORDS

Cancer, pathway, CWT, FDS, USC, RTT, 62, 31, 28, 2ww, 2 week wait, Urgent Suspected Cancer

CONTENTS

1. INTRODUCTION AND SCOPE

This policy describes how the Trust will manage waiting times for patients with suspected cancer and a confirmed cancer diagnosis, to ensure that patients are diagnosed and treated as rapidly as possible within the national waiting times standards. Pathways will be supported by the best practice timed pathways currently available (as of May 2024: breast, colorectal, lung, prostate, OG, Gynae, skin and Head & Neck).

Whereas a patient may fall under many different rule sets (eg a suspected cancer referrals (2ww) will also start an 18-week RTT clock), the hierarchy of how the various rules are applied is:

1. Cancer Waiting Times
2. Cancer Access Policy
3. UHL Elective Care Access Policy
4. Specialty Standard Operating Procedures/Policies

This policy is consistent with version 12 of the NHS England's Cancer Waiting Times Guide and includes national dataset requirements for both waiting times and clinical datasets.

https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/cancerwaitingtimescwt

2. PRINCIPLES

As defined in the NHS Constitution, patients have the right to expect to be seen and treated within national operational standards ensuring timely diagnosis and treatment, equity of care and patient choice.

Patients will, wherever possible, be offered dates for appointment or treatment in chronological order, based on the number of days they have been waiting on their cancer pathway, unless there are clinical exceptions.

Wherever possible, patients will be given reasonable notice and choice of appointments and 'to come in' (TCI) dates as defined within the policy.

Accurate data on the trust's performance against the national cancer waiting times is recorded in the cancer management system and reported to the National Cancer Waiting Times Database within nationally predetermined timescales.

Where patients are at risk of breaching any of the cancer standards it is expected that all staff will follow the trusts cancer escalation policy.

3. DEFINITIONS AND ABBREVIATIONS

Active Monitoring - This is where a cancer diagnosis has been reached but it is not appropriate to give any active anti-cancer treatment at that point in time but an active treatment is still intended/may be required at a future date.

Cancer Pathway Navigator – also known as an MDT Co-ordinator, actively tracking patients along their pathways, managed within the Cancer Centre.

Chronological order (in turn) - the general principle that applies to patients categorised as requiring elective treatment. All elective patients should be seen and/or treated in the order they were initially referred for treatment.

CWT - Cancer Waiting Times, the national guide on how to manage patients for performance reporting purposes

DTA (Decision to Admit) - Where a clinical decision is made to admit the patient for either day case or inpatient treatment.

DTT (Decision to Treat) - When the patient and clinical agree a treatment plan decision to treat a patient as an inpatient, day case or outpatient setting.

DNA (Did Not Attend) – when a patient does not attend for the allocated appointment time and gives no notice

ECAD (Earliest Clinically Appropriate Date) – an ECAD is applicable to Subsequent treatments only and is the earliest date that it is clinically appropriate for the next activity that actively progresses a patient along the pathway for that treatment to take place.

e-RS (e-Referral System) – the NHS referral system used to refer patients from Primary Care to Secondary Care

FDS (Faster Diagnosis Standard) – the 28 Day standard for the patient to be informed of a diagnosis or ruling out of cancer.

FDT (First Definitive Treatment) - for cancer waits a first definitive treatment (FDT) is defined as the start of the treatment aimed at removing or eradicating the cancer completely or at reducing tumour bulk.

IPT (Inter-Provider Transfer) – an IPT form is sent when a patient's care is transferred between NHS trusts. This form provides information on the current pathway status of a patient, including the referral and breach dates.

MDT (Multi-Disciplinary Team) - an MDT comprises of medical and non-medical professionals who are responsible for the cancer patient's care. It includes clinicians from a variety of disciplines.

OPA (Out-Patient Appointment) – appointments to see patients, typically in clinic but can be virtual (telephone or video).

PAS (Patient Administrative System) – the Trust system where all patient appointments are booked and waiting lists are managed.

PTL (Patient Tracking List) - a report used to identify a patient's wait time along the pathway

RTT (Referral to Treatment) – the time between referral being received from Primary Care to Treatment commencing in Secondary Care.

SCR (Somerset Cancer Register) – the cancer management system for tracking and data collection for all suspected cancer/confirmed cancer patients

TCI (To Come In) - a proposed future date for an elective admission

4. ROLES AND RESPONSIBILITES

Chief Executive: The chief executive has overall responsibility and accountability for delivering access standards as defined in the NHS Constitution and Operating Framework.

Chief Operating Officer: Responsible for ensuring that there are robust systems in place for the audit and management of cancer access standards against the criteria set out in this cancer access policy and procedure document.

Associate Medical Director for Cancer: Responsible for ensuring high standards of cancer clinical care across the organisation in a timely manner, leading the development of the cancer strategy.

Associate Director of Operations - Cancer: Responsible for the monitoring of performance in the delivery of the 28-day, 31-day and 62-day standards alongside all cancer screening programmes and for ensuring the CMGs deliver the activity required to meet the Cancer Waiting Time standards.

Head of Cancer Performance: Responsible for ensuring:

- patient pathways are managed in accordance with Cancer Waiting Times Guide and this Cancer Access Policy
- active patient pathways are reviewed on a regular basis, escalating within the CMGs as appropriate
- a robust procedure for the external reporting of performance.

Macmillan Lead Cancer Nurse: Responsible for development of the cancer nursing strategy with professional line management responsibility for the trust's cancer clinical nurse specialists.

Tumour group clinical leads: Responsible for ensuring clinical pathways are designed to deliver treatment within 62 days of referral and diagnosis within 28 days of referral. Responsible for reviewing the outputs of any breach route cause analysis to develop actions to resolve any delays to patients.

Head of Operations & General Managers: Responsible for the monitoring of performance in the delivery of the cancer standards and for ensuring the specialties deliver the activity required to meet the waiting list standards. They are also responsible for ensuring all patients are booked in line with the tumour specific pathway milestones by ensuring adequate capacity is available and reviewing reports and resolving any breaches. In addition to this, they are responsible for evaluating the impact of any process or service changes on 28, 62- or 31-day pathways.

Consultants: Shared responsibility with their general managers for managing their patients' waiting times in accordance with the maximum guaranteed waiting time.

Clinical Nurse Specialists: Shared responsibility with their consultants and general managers for managing their patients' waiting times in accordance with the maximum guaranteed waiting time.

Cancer Service Manager: Responsible for monitoring delivery of key tasks by the MDT co-ordinators and the cancer referral booking office team.

Cancer Data Manager: Responsible for issuing daily PTLs and running audits of all urgent suspected cancer referrals and highlighting any data entry issues

Cancer Navigator Team Leader: Responsible for ensuring timely and accurate tracking within their teams and that patient pathways are managed to comply with this Cancer Access Policy and the current Cancer Waiting Times Guide

Cancer Pathway Navigators: Responsible for monitoring the cancer pathway for patients following the first attendance, ensuring it is managed in line with this policy and assisting in the proactive management of patient pathways on Trust systems, including PAS and the cancer management system.

2ww Team Admin Manager: Responsible for all cancer referrals and ensuring they are managed to comply with the cancer access policy, highlighting:

- patients booked past their tumour specific pathway milestone.
- patients with no appointment
- producing reports for the CMGs to resolve potential breaches.

2ww team and those designated to make suspected cancer outpatient appointments: Responsible for receiving urgent suspected cancer referral and breast symptomatic outpatient referrals and ensuring they are managed to comply with the cancer access policy and in line with their job descriptions.

Booking clerks/medical secretaries: Responsible for ensuring waiting lists are managed to comply with this policy and procedure document and in line with their job descriptions.

All staff (to whom this document applies)

All staff have a duty to comply fully with this policy/procedure and are responsible for ensuring they attend all relevant training offered.

All staff are responsible for bringing this policy to the attention of any person not complying with it.

All staff will ensure any data created, edited, used, or recorded on the trust's IT systems in their area of responsibility is accurate and recorded in accordance with this policy and other trust policies relating to collection, storage, and use of data to maintain the highest standards of data quality and maintain patient confidentiality.

All suspected cancer patient referrals, diagnostics, treatment episodes and waiting lists must be managed on the trust's systems. All information relating to patient activity must be recorded accurately and in a timely manner.

5. CANCER WAITING TIMES STANDARDS

Maximum 28 days from:

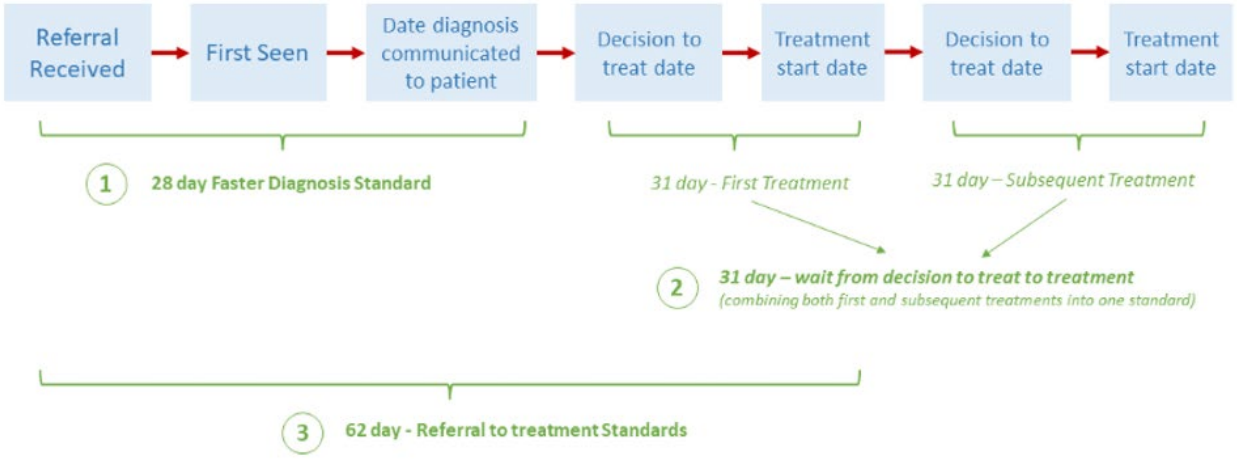
Receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer	77%

Maximum one month (31 days) from:

From Decision To Treat/Earliest Clinically Appropriate Date to Treatment of cancer	96%

Maximum two months (62 days) from:

From receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer	70%



6. SUMMARY OF THE CANCER RULES

6.1. Clock starts

NB All suspected cancer referrals (2ww) also start an 18-week RTT clock

6.1.1. 28 Day Faster Diagnosis Standard (FDS)

A 28-day (FDS) cancer clock will start following the below actions:

a) urgent referral for suspected cancer.
b) all referrals for breast symptoms (where cancer is not suspected).
c) urgent referral from NHS cancer screening programme.

6.1.2. 62 Day Standard

A 62-day cancer clock will start following the below actions:

a) urgent referral for suspected cancer.
b) all referrals for breast symptoms (where cancer is not suspected).
c) a consultant upgrade.
d) urgent referral from NHS cancer screening programme.

6.1.3. 31 day Standard

A 31-day cancer clock will start following:

a) a DTT for first definitive treatment.
b) a DTT for subsequent treatment.
c) an ECAD following a first definitive treatment for cancer.

If a patient's treatment plan changes, the DTT can be changed, i.e. if a patient had originally agreed to have surgery but then changed their mind and opted for radiotherapy instead.

6.2. Clock stops

NB In some cases where a cancer clock stops the 18-week RTT clock will continue, i.e. confirmation of a non-malignant diagnosis.

6.2.1. 28 day Faster Diagnosis Standard (FDS)

A 28-day (FDS) cancer clock will stop when:

a) A patient is told they have a cancer diagnosis including recurrent and unknown primaries.
b) A patient is told cancer is ruled out.
c) A patient is placed onto an interval scanning protocol.
d) A patient declines all diagnostic tests.
e) A patient agrees a decision to treat prior to a diagnosis being made.

NB patients in category b), c) & d) above, would also be removed from the 62 day pathway, e) would remain on the 62 day pathway until a treatment date was entered

6.2.2. 62 Day Standard

A 62-day cancer clock will stop when:

a) A patient undergoes a first definitive treatment or enabling treatment.
b) A patient with a confirmed cancer diagnosis is placed onto active monitoring.

6.2.3. 31 Day Standard

A 31-day cancer clock will stop following:

a) Delivery of first definitive treatment or a subsequent treatment
b) Placing a patient with a confirmed cancer diagnosis onto active monitoring (only for first treatment. Active monitoring isn't counted for 31 day when it is a subsequent treatment).

6.3. 2ww/Urgent Suspected Cancer (USC) referrals

All suspected cancer referrals should be referred via PRISM.

Day 0 is the date the referral was received.

The first appointment can be either an outpatient appointment with a consultant or member of their team or investigation relevant to the referral, i.e. 'straight to test.'

A telephone or virtual consultation can count as a first-seen date, provided it is a consultant led clinic, and a patient's full symptoms are considered.

All suspected cancer referrals will be checked for completeness by the 2ww team within 24 working hours of receipt of referral.

Although the 2 week wait standard no longer applies, it is still necessary to record the date first seen (this can be physically or virtually, a STT diagnostic or the date that a suspected skin cancer image is reviewed through tele dermatology).

For suspected cancer referrals received by the trust without key information the cancer team will contact the referrer by phone within 48 hours of receipt of referral to obtain the missing information. The referral process should begin, i.e. outpatient appointment booked for patient while information is being obtained, to ensure there is no delay to the patient's pathway.

Any suspected cancer referral received by the trust for a service that the trust is not commissioned to deliver will be returned to the referrer and asked to re-refer to the correct provider.

Any suspected cancer referral received inadvertently by the trust which was meant for another trust will be returned to the referrer and asked to re-refer to the correct provider.

6.4. Downgrading suspected cancer referrals

It is important to note the process for discussing the referral with the referrer and that only the person who made the referral can decide to withdraw the referral.

If a consultant thinks the referral is inappropriate this should be discussed with the referrer, only the referrer can downgrade or withdraw a referral. This is also the case where it is considered that insufficient information has been provided.

6.5. Two referrals on the same day

If two referrals are received on the same day, both referrals must be recorded and diagnosed in 28 days. If two primary cancers are diagnosed, treatment for both cancers should start within 62 days of receipt of referral if clinically appropriate.

6.6. Screening pathways

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

- Breast: receipt of referral for further assessment (i.e. not back to routine recall).
- Bowel: receipt of referral for an appointment to discuss suitability for colonoscopy with a specialist screening practitioner (SSP).
- Cervical: receipt of referral for an appointment at colposcopy clinic.

6.7. Consultant upgrades

Hospital specialists should ensure that patients who are not referred urgently as suspected cancer referrals or through the screening programmes, but who have symptoms or signs indicating a high suspicion of cancer, are managed on the 62-day pathway. This can be achieved by upgrading the patients onto a 62-day upgrade pathway.

The 62-day pathway starts (day 0) from the date the patient is upgraded.

If a request is made for the patient to be reviewed at the cancer MDT, the date of the request must be counted as a consultant upgrade unless the patient is already on a 62 day pathway or a decision to treat has been made.

Where a patient is to be referred for a Cancer MDT meeting at another provider, even for discussion only, it is important that the consultant upgrade is completed on or before the date of the inter-provider transfer.

Upgrades must occur before the DTT date. Patients not upgraded at this point will be measured against the 31-day DTT to first definitive treatment.

6.7.1. Who can upgrade patients onto a 62-day pathway

A consultant or authorised member of the consultant team can upgrade a patient if cancer is suspected. This could be:

- Specialist nurse/practitioner, either by triaging the referral form/letter or at nurse led initial clinic.
- Specialist registrar either by triaging the referral form/letter or at initial clinic.
- Radiologist/histologist/other trust clinicians on reviewing patients and/or diagnostics.

6.7.2. Upgrade responsibilities

The consultant or delegated member of the team upgrading the patient is responsible for informing the MDT co-ordinator that an upgrade has occurred. If a patient has been upgraded to a 62-day pathway, where appropriate, this should be communicated with the patient so they understand why they are being upgraded, and the GP should be notified by the upgrading clinician.

6.8. Subsequent treatments

If a patient requires any further treatment following their first definitive treatment for cancer, they will be monitored against a 31-day clock. The clock will start following the patient agreeing a treatment plan with their clinician. This will be the decision to treat (DTT) date.

In some circumstances it may be appropriate for the clinician to set an ECAD (earliest clinically available date) which is when a patient needs to recover following their preceding treatment. An ECAD can be adjusted but only if the date has not passed. The 31-day clock start date should be the same as the ECAD date for these patients.

6.9. Communication

All communications with patients whether verbal, written or digital must be informative, clear and concise. The Trust's Equality Team can support specialties with additional communication methods, for example in provision of easy reading materials, sign language interpretation or braille.

For patients who do not speak English, there is a telephone interpreting service available. Further information can be found via Interpreting and Translations page on UHL Connect

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. When clinical responsibility is being transferred back to the GP/referrer, e.g. when treatment is complete, this must be made clear in any communication.

6.10. Expediting Care

In the event that patients feel their condition has worsened whilst awaiting appointments, diagnostic tests or admission for treatment, they should contact the clinical team they are under the care of. Where appropriate, the use of NHS 111 or local A&E should be considered.

6.11. Chronological booking

Patients will be selected for booking appointments or admission dates according to clinical priority. Patients of the same clinical priority will be appointed or treated in RTT chronological order from the clock start date, i.e. the patients who have been waiting longest will be seen first. Patients will be selected using the Trust's patient tracking lists (PTLs) only. They will not be selected from any paper-based systems, standalone spreadsheets or other digital methods.

6.12. Reasonableness

Unlike for RTT there is no national definition of reasonableness for patients on a cancer pathway. Locally, for patients on a cancer pathway, an offer will be deemed to be reasonable if 48 hours' notice of an appointment/diagnostic test/admission is given.

6.13. Waiting-time adjustments

Unlike for RTT it is possible to make adjustments to patient clocks in specific instances:

- First Appointment - DNA: If a patient DNAs their initial (First) outpatient appointment or attendance at straight to test (STT) appointment, e.g. a straight to test endoscopy, the clock start date can be reset to the date the patient rebooks their appointment (the date the patient agrees the new appointment not the new appointment date).
- 62/31-Day pathways – Patient Choice: if a patient declines admission for an inpatient/day case procedure or outpatient procedure, providing the offer of admission was 'reasonable' the clock can be adjusted from the date offered to the date the patient is available.
- 62/31-Day pathways – Medical: 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, the clock can be adjusted 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 pre-habilitation prior to their cancer treatment.
- 62/31-Day pathways – Egg Harvesting: where a patient opts for egg harvesting prior to their cancer treatment, an adjustment can be applied from the point at which the decision is made until eggs are harvested.
- 62/31-Day pathways – Would Have Offered: if the patient during a consultation, or at any other point, while being offered an appointment date states that they are unavailable for a set period of time (e.g. due to holiday or work commitments), an adjustment can be applied from the date that would have been offered to the patient to the date that they are available.

Any adjustment must be supported by clear documentation in the cancer management system and PAS or other relevant clinical system. The trust will ensure that TCIs offered to the patient will be recorded.

6.14. Patient cancellations

Due to the urgency associated with cancer patients it is important that the Trust has a comprehensive approach to patient cancellations, DNAs and when patients are uncontactable and that this approach acts in the best interest of the patient.

If the patient gives any prior notice that they cannot attend their appointment (even if this is on the day of clinic), this should be recorded as a cancellation and not DNA. The Trust will make every effort to reschedule patient appointments at the convenience of the patient.

If a patient cancels an appointment the following guidance must be followed:

- Suspected cancer referral patients who cancel their First Appointment should be offered another appointment within seven days of the referral being received.
- Patients who cancel a follow-up appointment/investigation date will be offered an alternative date within seven days of the cancelled appointment (no waiting time adjustment will apply).

- All patients who are referred on a 62-day GP pathway (2ww), screening pathway or breast symptomatic referral who cancel two or more consecutive appointments (i.e. outpatient, diagnostic investigation) will be contacted by an appropriate member of staff to identify any factors that may be stopping the patient attending. Another appointment will be offered if the patient agrees.
- Patients can be discharged after multiple (two or more) appointment cancellations if this has been agreed with the patient following a clinical decision to do so.

6.15. Patient DNAs

Patients will be recorded as a DNA if they do not attend for the allocated appointment time and gives no notice or, if the patient arrives after the scheduled appointment time and it is not possible to fit them in (e.g. fully booked) or there is not enough time left to carry out the planned procedure/tests in the remainder of the session or, the patient turns up in a condition where it is not possible to carry out the required procedure. This includes patients who have not complied with appropriate instructions prior to an investigation i.e. if they have not taken a preparation they needed to take prior to the appointment, not stopped meds as instructed or arrives intoxicated and unsafe to continue.

If a patient DNAs any appointment they should be re-booked as quickly as possible, if they DNA a second time they should be escalated to the consultant in clinic for a decision on the next step which may include discharge back to the GP.

6.16. Patients who are uncontactable

If the patient is uncontactable at any time on their 62/31-day pathway, a record of the time and date of the call to them in the 'additional information' section on PAS should be made at the time of the call.

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), should be made to contact the patient. If the patient still cannot be reached, a letter and a text message should be sent giving the patient two weeks to make contact to book their appointment. If the patient does not make contact within those two weeks, a clinical review must take place to establish if the patient should be discharged to the referrer.

6.17. Patients who are unavailable

If a patient indicates they will be unavailable, the patient's healthcare records will be reviewed by the managing clinician to ascertain if the delay is safe for the patient. If the clinician has any concern over the delay, they will contact the patient to discuss if they can make themselves available. Patients will not routinely be discharged if they make themselves unavailable.

6.18. Diagnostics

The trust will maintain an agreed turnaround time standard for all 'straight to test' and subsequent diagnostic tests on a patient's cancer pathway depending on the tumour specific timed cancer pathway.

The national standard for diagnostic waiting times is 6 weeks from point of decision to refer to the diagnostic being carried out.

Cancer patients diagnostic waiting times are measured locally against 7 days or 10 days (ie Endoscopy procedures requiring prep)

6.19. Refusal of a diagnostic test

If a patient refuses a diagnostic test, the refusal will be escalated to the managing clinician or Service PTL Review to discuss with the patient. If the patient refuses all diagnostic tests, they can be removed from the cancer pathway and discharged back to their GP.

6.20. Managing the transfer of private patients

If a patient decides to have any appointment in a private setting, they should be removed from their NHS cancer pathway and tracking.

If a patient transfers from a private provider onto an NHS waiting list, they will need to be upgraded if they have not made a DTT and the consultant wants them to be managed against the 62-day target. If a DTT has been made in a private setting, the 31-day clock will start on the day the referral was received by the trust.

6.21. Tertiary referrals

The SCR Inter provider transfer (IPT) forms will be used for all outbound referrals for patients on a cancer pathway.

For all inbound referrals a minimum dataset, including an IPT form and all relevant diagnostic test results and images, will be provided before the Referral Received Date is agreed.

7. Clinical Harm Review Process

In accordance with the Trust 104+ Day Quality standard process Standard Operating Procedure for the management of reviewing possible Harm to Cancer patients, any cancer patients waiting 104 days or more from referral to the first definitive treatment should have a clinical harm review undertaken.

8. Monitoring and audit

Monitoring and audit are an important part of cancer management.

It is the responsibility of the Cancer Centre information team to run a regular programme of audits for data completeness and data anomalies.

Any data anomalies are highlighted to the relevant tumour site Cancer Navigator Team Leader for investigations and correction. Response to the Cancer Centre information team must occur within 24 working hours of the anomaly being raised in order not to delay the audit programme and to ensure accurate performance available at all times.

In addition, a regular data quality programme will be established to review the following:

comparative audit of data on the cancer management system and PAS

comparative audit of diagnosis code on PAS, cancer management system and healthcare records

The cancer information team will also carry out a quarterly audit to ensure that patients are being 'upgraded' at the earliest, appropriate opportunity.

9. Process for Monitoring Compliance

The process for monitoring compliance against this policy is set out on the table below.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Trust Cancer PTL Meetings	Head of Cancer Performance	Daily cancer PTL, patient level tracking and discussions which take place at the PTL meetings	Weekly	Non compliance escalated to HOOPs/DHOOPs tracked through SCR
Cancer target has not been met	Associate Director of Operations – Cancer	Breach review analysis	Monthly	Exception reporting through monthly OPC paper
Clock starts & stops on pathways in line with CWT	Head of Cancer Performance	Pre and Post upload data validation across all standards using 'Cancer Metrics KPI' SOP	Monthly	Exception reporting through monthly Cancer Board

10. Equality Impact Assessment

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

11. Supporting References, Evidence Base and Related Policies

National Cancer Waiting Times Monitoring Dataset Guidance Version 12.0 August 2023

https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/cancerwaitingtimescwt

UHL Elective Care Access Policy B3/2004

NHS Constitution for England

https://www.gov.uk/government/publications/the-nhs-constitution-for-england

12. Names of people consulted about the document:

Name	Job title
Kelly Lambert	Associate Medical Director for Cancer
Suzanne Nancarrow	Associate Director of Operations – Cancer
Jane Pickard	Macmillan Lead Cancer Nurse
Anita Parmar	Macmillan Cancer Programme Lead
Lynn Neat	Head of Elective Care Policies and Administration
Cancer Board members	General Managers, Heads of Service, Clinical Leads

Names of committees required to approve the document:	Approved on
Cancer Centre Governance Meeting	18/6/24
Clinical Cancer Board	21/6/24
Operational Management Group	26/6/24
Cancer Design Group	16/7/24
Policies and Guidelines Committee	20/8/24

13. Process for Version Control, Document Archiving and Review

Review every three years or earlier should a change in legislation, best practice or other circumstance dictate. This Policy will be available via the Document Management System.