University Hospitals of Leicester NHS
NHS Trust

Cancer Access Policy

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CONTENTS

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

This is a new policy. Previously, content was included within the Access Policy for Elective Patient Care B3/2004

KEY WORDS

Cancer, pathway, RTT, 62, 31, 2ww, 2 week wait,

1 INTRODUCTION AND OVERVIEW

1.1 The University Hospitals of Leicester (UHL) are committed to ensuring that patients receive treatment in accordance with the NHS Constitution, national objectives and targets, including Improving Outcomes: A Strategy for Cancer 2011 and the more recent Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020. This policy takes into account guidance from the Department of Health and NHS England.

1.2 The purpose of this policy is to outline the rules for the management of patients on a cancer pathway and to act as an operational guide for those staff involved in the management of these pathways.

1.3 It sets out the roles and responsibilities, processes to be followed and establishes a number of good practice guidelines to assist staff with the effective management of patients with suspected or diagnosed with cancer.

1.4 This policy and its associated documents are further supported by the Next Steps approach to ensuring cancer services are delivered to patients in a timely manner, ensuring patients are aware of their next step in their pathway, where and when that will be with the aim being to deliver this within 7 days where appropriate. This policy sets out how patients on cancer pathways are managed in line with the National Cancer Waiting Times Targets.

1.5 For clinical and non-clinical staff it will make sure that:

- Teams and individuals are aware of their responsibilities for moving patients along the agreed clinical pathway in accordance with Going Further on Cancer Waits GFOCW 6.3 and Cancer Waiting Times Guide version 11.0.
- Clinical support departments adhere to and monitor performance against agreed maximum waiting times for tests/investigations in their department
- Everyone involved in the cancer pathway has a clear understanding of their roles and responsibilities
- Accurate and complete data on the Trust's performance against the National Cancer Waiting Times is recorded on the Somerset (SCR) Cancer Database and reported to the National Cancer Waiting Times Database (NHS Digital) within predetermined timescales

1.6 For patients, it will ensure that:

- Patients with suspected cancer and/or with a confirmed cancer diagnosis receive treatment in accordance with the cancer standards relevant to their cancer pathway, taking into account that they may choose to wait longer or clinically be unable to be seen or treated within these time frames
- Patients are treated according to clinical priority and those with the same clinical priority are treated in chronological order

2 POLICY SCOPE

2.1 This policy applies to all UHL staff involved in the care and management of cancer patients.

2.2 This policy applies to all NHS England patients with confirmed or suspected cancer cared for under Cancer Waiting Times Guidance. The policy will be applied consistently and without exception across the Trust. This will ensure that all patients are treated equitably and according to their clinical need and is inclusive of military patients.

2.3 Non-NHS patients including overseas visitors are not covered by this policy and should be managed according to clinical priority and the overseas visitor policy.

3 DEFINITIONS AND ABBREVIATIONS

3.1 **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.

Active Monitoring will commence when a decision is made (and agreed with the patient) that it is clinically appropriate to start a period of monitoring, possibly whilst the patient receives symptomatic support, but without any specific or significant clinical intervention at this stage.. It is not to be used for thinking time.

During Active Monitoring the patient will remain under the care of a Consultant although the GMP/GDP will be updated with the progress of their patient.

3.2 **Active Waiting List -** The list of patients who are fit and able to be admitted at that point in time. The active waiting lists is also used to report national waiting time statistics

3.3 **Cancelled operations / procedures -** If the trust cancels a patient's operation or procedure on the day of, or after admission for non-clinical reasons – the Trust is required to rearrange treatment within 28 days of the cancelled date or within target wait time whichever is soonest.

3.4 **Cancer Pathway Navigator -** Multi-Disciplinary Team Co-ordinator managed by the Cancer Centre delivering services to the tumour groups

3.5 **Communication and Referral Protocol (CaRP) –** CaRP form is designed to be completed 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.

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

3.7 **CWT -** Cancer Waiting Times

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

3.9 **Decision to treat (DTT) -** When the patient is informed of a clinical decision to treat a patient as an inpatient, day case or outpatient setting.

3.10 **Did Not Attend (DNA) -** Patients who have agreed or been given reasonable notice of their appointment / treatment and who without notifying the Trust fail to attend

3.11 **DoH -** Department of Health

3.12 **ECAD -** Earliest clinically appropriate date (for next stage of treatment)

3.13 **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 judgment in consultation with other as appropriate, including the patient

3.14 **Multi-Disciplinary Team (MDT) -** 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, the exact constituent are described for each tumour site as part of Peer Review requirements

3.15 **Outpatients -** Patients referred by a general practitioner (medical or dental) or another consultant / health professional for clinical advice or treatment

3.16 **PAS -** Trust system where all patient appointments are booked and waiting lists are managed.

3.17 **PTL** - Patient Tracking List, a report used to ensure the maximum waiting time targets are achieved by identifying the patient wait time along that pathways and patients who are at risk of being treated outside the pathway requirements

3.18 **Peer Review/QSIS -** An annual assessment specific to each specialty against national standards

3.19 **Somerset Cancer Registry -** Tracking and cancer data collections system for all suspected cancer/confirmed cancer patients within the Trust

3.20 **TCI (to come in) -** A proposed future date for an elective admission

4 ROLES

4.1 Chief Executive

The Chief Executive is ultimately accountable to the Trust Board for ensuring that effective processes are in place to manage patient care and treatment that meet national, local and NHS Constitution targets and standards and for achieving these targets

4.2 Chief Operating Officer

The Chief Operating Officer is the executive lead for clinical operations supported by the Deputy Head of Performance - Cancer (DHOPC) and is responsible:

a) Through Clinical Management Groups (CMG) and the Cancer Centre Management Team for ensuring that effective processes are in place to manage patient care and treatment that meet national, local and NHS Constitution targets and standards

b) With Clinical Management Groups for achieving cancer access targets

c) For implementing Trust wide monitoring systems to ensure compliance with this policy and avoid breaches of the targets

d) With Clinical Management Groups for monitoring progress against achievement of the targets and taking action to avoid any potential breaches

e) For keeping the Trust Board and Senior Management Team informed of progress in meeting cancer access target and any remedial action taken

f) For delivering operational targets for service delivery in line with the annual business plan to include national targets – including 18 weeks, cancer waiting times and all other key access targets

g) For conducting a capacity and demand review Trust wide

h) For the management, communication and dissemination of the Trust Cancer Access Policy as the Responsible Officer

i) For ensuring that principles of managing demand, activity, capacity and variation are embedded in service development and part of the business cases for investment and development of services

4.3 Clinical Management Groups

The Clinical Management Groups, including the Service Managers, General Managers, Deputy Head of Operations and Head of Operations have overall responsibility for implementation and adherence to this policy within their CMG. This includes:

a) Ensuring that effective processes are in place to manage patient care and treatment that meet national, local and NHS Constitution targets and standards for each specialty within the CMG

b) Managing resources allocated to the CMG with the aim of achieving access targets. This includes having the staff and other resources available to operate scheduled outpatient clinics, patient treatment and operating theatre sessions and avoid the need to cancel patient treatment

c) Working with other CMG Directors and CMG Clinical Directors to provide a joined-up approach to implementing this policy and achieving the cancer access targets, particularly around outpatient and operating theatre capacity and availability of diagnostic services

d) Achieving cancer access targets

e) Ensuring that the duties, responsibilities and processes laid down in this policy are implemented with the CMG

f) Ensuring all staff that need to operate this policy are aware of this policy and receive training so that they can meet the policy requirements

g) Implementing effective monitoring systems within the CMG to ensure compliance with this policy and avoid breaches of the targets: escalate any actual or potential breaches to the DHOPC.

h) Implementing systems and processes that support data quality and for validating data to ensure that all reports are accurate and produced within agreed timescales

4.4 Consultants

Each Consultant is responsible for:

a) Managing the patients care and treatment and working with their Clinical Management Groups and clinical colleagues to ensure that this is provided within timescales laid down in national, local and NHS constitution targets and standards

b) Alerting the Clinical Director of any potential or actual breaches of targets

c) Managing staff within the medical team to ensure that scheduled outpatient clinics; patient treatment and operating theatre sessions are held and avoid the need to cancel patients

d) Managing waiting lists and deciding on patient admissions / treatments in line with clinical priority

e) Working with colleagues to prevent the cancellation of patient admissions for non-clinical reasons and taking action to reschedule any patients so cancelled in line with timescales set out in this policy

f) Communicating accurate waiting time information to patients, their families and carers and dealing with any queries, problems or complaints in line with Trust policy

g) Assisting with the monitoring of data quality and production of reports

4.5 2WW Booking Centre

Staff designated to make appointments including for outpatients, diagnostic tests and treatment will for a patients first episode following a 2WW referral will:

a) Fast track referrals via e-referral for all tumour groups and enter details on to the Trusts Patient Administration System (PAS) within 24 hours
b) Input 2ww referrals on to SCR within 24 hours
c) Ensure all capacity constraints are flagged to the relevant CMG within 24 hours of processing the referral
d) For Breast and Skin, ensure all outpatient appointment offers are recorded on PAS.
e) For all other tumour groups where responsibility for booking the appointment sits with the CMG, to ensure all offers are recorded on SCR.
f) For responsible tumour groups, ensure cancellation reasons are recorded on PAS, otherwise the responsibility sits with the CMG
g) For responsible tumour groups, ensure PAS is updated correctly and in a timely way e.g. as soon as practicable with any patient choice decisions
h) Refer any problems or suspected / potential breaches of policy or compliance with cancer targets to the appropriate CMG Manager and the DHOPC.
i) Ensure all 2WW first outcomes are processed within 48 hours, where a DNA or cancellation has taken place, to ensure the next appointment is offered within 7 days escalating to the CMG Manager and DHOPC where non-compliance is identified.

4.6 CMG Operational Managers

The appropriate management (Service Managers and General Managers) within the CMGs will:

a) Maintain an up to date and accurate waiting list annotating where necessary so that patients who are being treated within the cancer pathways are clearly identified

b) Work closely with Cancer Pathway Navigators to ensure accurate patient pathways are recorded, escalating to the DHOPC where standards are below expected levels.

c) Ensure patients are given reasonable notice taking account of patient choice as outlined in the current national cancer waiting times guidance.

d) Ensure that all admission offers are recorded on PAS for purposes of adjustment.

e) Ensure weekly PTL meetings are held, with all patients reviewed down to a minimum of 1 month ahead for Upgrades, 62 day and screening pathways.

f) Ensure all escalations raised for delays greater than 7 days for all pathways are acted upon and escalated via the weekly PTL meetings.

g) Prepare for and attend monthly breach/performance review meetings with the DHOPC, identifying avoidable/unavoidable delays and any remedial action required.

h) Work closely with the lead clinicians for cancer and the Cancer Pathway Navigators to ensure any clinical delays/decision making is timely.

4.7 Cancer Pathway Navigators

As a minimum, to ensure:-

a) all patients on an active suspected and/or confirmed cancer pathway are managed in line with local and national pathway protocols and Cancer Waiting Times Guidance
b) MDT referrals are placed on the next available MDT (subject to MDT Lead approval), MDT Agendas are sent out as per local requirements, closed down within 24hrs and MDT outcomes are sent to the referring clinician/GP.
c) All patients on an active pathway are tracked a minimum of once every 7 days and where delays are evident, to escalate those to the appropriate service and/or CMG Management Team.
d) To ensure all data items relating to Cancer Waiting Times and COSD are collected for each patient for a complete record on the cancer information management system
e) Support and attend weekly tumour site PTL meetings with the CMG management team
f) Conduct weekly data validation for Cancer Waiting Times and COSD requirements as directed.

4.8 Multi-Disciplinary Team (MDT)

MDT meetings for each tumour will take place a minimum of once a week, where the MDT falls on Bank Holiday alternative arrangements will be made for MDT provision by the MDT Clinical Lead.

The appropriate core members must be in attendance as per the individual tumour site operational policy in line with the NHS England Quality Surveillance Indicators. Only patients who require an MDT opinion should be discussed, particularly noting the MDT is not for a clinical discussion of benign pathology or a radiology review meeting. A referral into an MDT does not constitute a transfer of care and unless stated by the receiving MDT, the ownership of the patient remains with the referring clinician or index tumour site unless agreed.

4.9 Lead Cancer Clinician

a) Ensure clinical standards are at the forefront of everything we do

b) Ensure high quality cancer services are delivered and effectively co-ordinated

c) Support the development and implementation of protocols and pathways to ensure a high standard of care for cancer patients within the cancer standards

d) Support CMGs with clinician engagement and appropriate challenge

e) To provide clinical input required for review of breach cases where required

f) Lead on the harm review process for all patients diagnosed with cancer treated over 104 days in line with the SOP Cancer Clinical Harm Review Process (Appendix 1)

4.10 Deputy Head of Performance – Cancer

a) Ensure overall operational efficiency of the Cancer Centre

b) Ensure adherence to CWT Guidance

c) Lead for the Recovery Action Plan for Cancer for UHL, ensuring appropriate escalation where risks/non delivery is identified

d) Ensure all patients on a Cancer PTL are actively tracked

e) Ensure application of the pathway escalation policy is adhered to by all applicable staff within UHL

f) Lead on the quality of cancer services data and data upload

g) Lead for the RCA and thematic review of 62 day breaches

h) Lead on the reporting of cancer performance and backlog data to the Trust Executive, NHSI, NHSE and the CCG performance board

i) Work with the Cancer Network to ensure best practice for the management of cancer pathways is shared

j) Support policy users with issues around interpretation and application of this policy. Where any matter cannot be resolved, escalate to the Director of Operations for resolution.

4.11 All Staff

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

All patient referrals, treatment episodes and waiting lists must be managed on the Trust's PAS system and all information relating to patient activity must be recorded accurately and in a timely fashion.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS

Cancer patients will be prioritised according to national guidance. Patients will be treated in order of their clinical need. Patients of the same or comparable clinical priority will be treated on a 'first come first served' principle, according to case mix.

The process of waiting list management for patients suspected of or diagnosed with cancer will be transparent to the public and communications with patients (or parents/carers and vulnerable patients) will be timely and informative clear and concise.

Waiting lists will be managed equitably with no preference shown on the basis of provider or source of referral.

This policy sets out how patients on cancer pathways are managed in line with the National Cancer Waiting Times Targets and includes information on:

National Cancer Waiting Times Targets		Implementation
Maximum 2 weeks from:	• Urgent GP or GDP referral for suspected cancer to first outpatient attendance • Referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment	Which patients are included What starts the clock What stops the clock Clock adjustments Patient choice Escalation Points
Maximum one month (31 days) from	• Decision to treat to first definitive treatment • Decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is: ➢ Surgery ➢ Drug treatment ➢ Radiotherapy	Which patients are included What starts the clock What stops the clock Clock adjustments Patient choice Escalation Points
Maximum two months (62 days) from	• Urgent GP or GDP referral for suspected cancer to first definitive treatment (62 day classic) • Urgent referral from NHS Cancer Screening Programme (breast, cervical and bowel) for suspected cancer to first definitive treatment • Consultant upgrade of urgency of a referral to first treatment	Which patients are included What starts the clock What stops the clock Clock adjustments Patient choice Escalation Points

5.1 Cancer Waiting Time Standards

The Cancer Wait standards are described in detail in "Going Further on Cancer Waits" (GFOCW). The standards are summarised below:

5.1.2 Maximum 2 weeks from:

- Urgent GP or GDP referral for suspected cancer to first outpatient attendance – **operational standard of 93%**

- Referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment - **operational standard of 93%**

5.1.3 Maximum one month (31 days) from:

- Decision to treat to first definitive treatment – **operational standard 96%**
- Decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is:

  - Surgery – **operational standard 94%**
  - Drug treatment – **operational standard 98%**
  - Radiotherapy – **operational standard 94%**

5.1.4 Maximum two months (62 days) from:

- Urgent GP or GDP referral for suspected cancer to first definitive treatment (62 day classic) – **operational standard 85%**
- Urgent referral from NHS Cancer Screening Programme (breast, cervical and bowel) for suspected cancer to first definitive treatment – **operational standard 90%**
- Consultant upgrade of urgency of a routine referral to first treatment – **local standard 86%**

5.2 Which patients are included in the Cancer Waiting Time Standards?

5.2.1 Cancer waiting time service standards are applicable to patients cared for under the NHS in England with ICD codes C00-C97 (excluding basal cell carcinoma) and D05 (all carcinoma in situ – breast) this includes those patients:

- Being treated within a clinical trial
- Whose cancer care is undertaken by a private provider on behalf of the NHS i.e. directly commissioned by an NHS commissioner
- Whose care is sub-contracted to another provider – including private provider – (and hence paid for) by an English NHS provider i.e. commissioned by an NHS commissioner but sub-contracted out by a commissioned provider
- Diagnosed with a second new cancer
- Without microscopic verification of the tumour (i.e. histology or cytology) if the patient has been told they have and /or have received treatment for cancer
- With any skin squamous cell carcinoma (SCC) i.e. each SCC an individual skin cancer patient has will be covered by the standards, not just the first

5.2.2 In terms of specific standards it should be noted that:

The **two week wait standard** applies to patients urgently referred with suspected cancer or any patient with breast symptoms where cancer is not suspected.

The **31 day first and subsequent standards** apply to:

- NHS patients with a newly diagnosed invasive cancer (localised or metastatic).
- NHS patients with a recurrence of a previously diagnosed cancer.

- NHS patients with a new diagnosis of cancer or a recurrence regardless of the route of referral – this will include patients who may be diagnosed with cancer during routine investigations or while being treated for another condition – incidental finding.
- Patients who choose initially to be seen privately but are then referred for first / subsequent treatments with the NHS.

The **two month 62 day standard** applies to patients who are referred:

- Through the two week wait referral route by their GP/GDP with suspected cancer.
- Urgently from any of the 3 national cancer screening programmes (breast, cervical, bowel).
- Then upgraded by a consultant or authorised member of consultant team because cancer is suspected.
- On suspicion of one cancer but diagnosed with a different cancer.

5.3 Which patients are excluded from monitoring under these Standards?

Any patient:

- With a non-invasive cancer i.e. carcinoma in-situ (with the exception of breast D05)
- Basal cell carcinoma
- Who dies prior to treatment commencing
- Receiving diagnostic services, second opinions and/or treatment privately, however:-

However where a patient chooses to be seen privately initially but is then referred for treatment under the NHS, the patient should be seen under the 31 day standard with a start date from the date the Trust accepts clinical responsibility for the patient.

Where a patient is seen under the 2 week standard, then chooses to have diagnostic tests privately before returning to the NHS for cancer treatment only, then the 2 week and 31 day standards only apply and the patient is excluded from the 62 day standard as the diagnostic phase was carried out in the private sector

If the patient does not have an NHS number they are excluded from monitoring purposes at a national level but should still receive treatment under the principles of this policy.

5.4 When does the 2 week wait clock start and stop?

5.4.1 The 2 week wait clock starts on the receipt of the referral to the Trust and this can be direct from the GP/GDP or via E-Referrals in which case the start is the conversion of the UBRN/date of receipt of referral.

- Receipt of the referral is day 0
- Referrals received after normal working hours

5.4.2 The 2 week wait clock stops when the patient is first seen by a consultant (or member of team) or in a diagnostic clinic following receipt of referral

- If cancer is excluded at the first visit or diagnostic then the 62 day pathway is also ended and the patient is either discharged or managed on a routine 18 week pathway
- If cancer is not excluded then the patient continues to be monitored on a 62 day pathway

5.5 Management of two week wait – reasonable offers / DNA / cancellations / downgrades

a) The best interests of the patient should remain at the forefront when implementing this policy.

b) For cancer, a reasonable offer is classed as any appointment within the two week period and it is not a requirement to offer a choice of dates within this. The offer of dates ideally provides 48 hours notice. However, it is best practice to offer the patients a choice and aim to offer the first appointment within 7 days of the referral being received. This will also assist in ensuring patients can be offered appointments within the standard over holiday and bank holiday periods.

c) All GPs must check patients are available before referral, and consider deferring if not.

d) Where patients cancel 2 or more first attendance appointments, the 2WW office and/or service should discuss with the GP whether a withdrawal of the referral is appropriate due to lack of engagement. Only if the GP agrees, should the pathway be ended at this point.

e) Patients should not be returned to their GP/GDP if they DNA their first appointment; they may be returned to the care of their GP/GDP after two consecutive DNAs to facilitate further management of the patient.

f) Patients should not be discharged if they are not immediately fit to attend appointments or tests.

g) Only the GP/GDP can downgrade the referral, a consultant who feels the referral does not meet the agreed criteria must discuss this with the GP/GDP and ask them to withdraw it.

h) Adjustments are possible when patients DNA their first appointment from the receipt of the referral to the date they rebook their appointment which is relevant to both the 2 week wait and 62 day standards.

i) Any referrals inadvertently sent to the wrong organisation should be forwarded without delay via the Referral Gateway (a process which informs the GP)

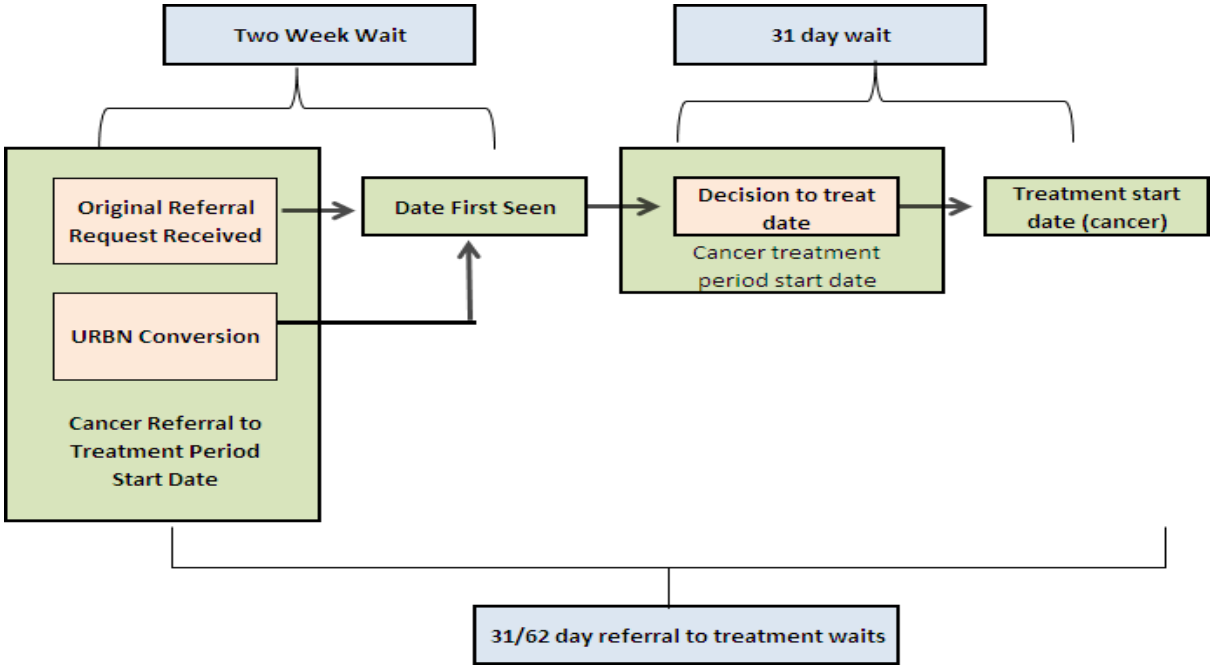
j) UHL will not offer ‘Two Week Rule’ appointments where it is not commissioned to do so.

k) All referrals from GPs will only be accepted on a PRISM form to ensure the patient is commenced on the correct pathway; any referrals received in other formats will be returned to the GP and only processed when received in the correct format.

l) Incomplete PRISM referrals not meeting the minimum dataset/criteria will be referred back to the GP Practice via telephone from the 2WW office.

5.6 Management of urgent referrals for suspected cancer on to a 62 day pathway

The period for this service standard is as follows with the periods for 2 week wait and 31 day treatment standards marked



5.7 When does the 62 day clock start?

- The starting point for the 62 day standard is the receipt of the referral either direct from GP/GDP or if via e-referral UBRN conversion
- The receipt or conversion of referral is day 0 in the 62 day period

5.8 When does the 62 day clock stop?

The 62 day clock stops when first definitive treatment is started and this may differ for different treatments, for example:

- For surgical intervention it is the date the patient is admitted for surgery
- For anti-cancer drug therapy it is the date the first drug in an agreed course is given or in the case of Prostate patients, where the hormone prescription is given to the patient and confirmed in writing/SCR entry from a member of the clinical team
- For radiotherapy it is the date the first fraction is given
- For active monitoring
- For non-specialist palliative care and specialist palliative care
- The 62 day clock stops if all treatment is declined

Enabling treatments can be classed as first definitive treatment and stop the 62 day clock. Agreed enabling treatments that are classed as first definitive treatment as noted in current Cancer Waiting Times Guidance.

Other enabling treatments can only mark the end of the 62 day period where the patient is having these prior to surgery within the same admitted care spell (admission).

The list of enabling treatments that can stop the 62 day clock is deliberately limited to ensure that there is not an unnecessary delay before active intervention / treatment is initiated

In some instances patients may refuse all reasonable offers of diagnostic tests, this in effect means that they have opted out of the 62 day pathway, and therefore the Trust is unable to deliver the standard. If the patient is not prepared to cooperate this ends the 62 day pathway. If at a later stage the patient chooses to have the tests and is subsequently diagnosed with cancer, a new 31 day clock would be started.

Reasonable offer of diagnostics is defined as not less than 24 hours' notice.
Refusal of all reasonable offers is defined as:

- Any 2 or more DNA of appointments
- Any 2 or more occasions where declines and cancellations have caused a delay.

5.9 Tertiary Referrals for Cancer

5.9.1 The Trust shares a number of pathways with other providers in the East and North of England Region and works in line with the Inter-Provider Transfer Policy (R-3). The policy has been developed to support the inter-hospital transfer of patients on cancer pathways. The policy applies to all patients covered by the 62 and 31 day cancer waiting times targets that require transfer between hospitals for specialist multidisciplinary team discussion (SMDT), diagnosis/ staging, treatment, and follow up.

5.9.2 Once a decision to refer a patient on a cancer pathway has been made the referral letter and a minimum dataset CaRP form, extracted from SCR, will be transferred via NHS.net to the relevant Trust within **24 hours of the decision** (Monday to Friday). (NB. the letter can follow after CaRP but no more than 24 hours later)

5.9.3 Should a patient be referred to another Trust for treatment on a 62 day pathway and breach the 62 day cancer waiting times standard, then for **national performance** the breach is shared between the first seen Trust and the treating Trust i.e. 0.5 shared accountability each. If more than two hospital trusts are involved in the cancer pathway, the breach is still shared equally between the first seen and treating Trusts.

5.10 Reallocation of Breaches

NHS England produced guidance in April 2016 on reallocation of breaches will be reported nationally on NHS Digital. All breaches of the 62 day standards will be subject to reallocation as set out in the table below

Scenario	Referral timeframe	Total timeframe	Allocation
1	> 38 days	< 62 days	100% of success allocated to the treating provider
2	< 38 days	< 62 days	50% of success allocated to the referring provider and 50% allocated to the treating provider
3	< 38 days	>62 days	100% of breach allocated to the treating provider
4	> 38 days	> 62 days, but treating trust treats within 24 days	100% of breach allocated to the referring provider
5	> 38 days	> 62 days and treating trust treats in >24 days	50% of breach allocated to the referring provider and 50% allocated to the treating provider

5.11 Management of Screening Referrals on a 62 Day Pathway

The extended 62 day standard relates to the three national cancer screening programmes only:

- The national breast screening programme
- The national bowel screening programme
- The national cervical screening programme

5.12 When does the 62 day clock start for screening referrals?

For the individual screening programmes, the clock starts on the receipt of the referral (day 0) as follows:

- Breast - the receipt of the referral for further assessment (i.e. not routine recall)
- Bowel - the receipt of referral for appointment to discuss suitability for colonoscopy
- Cervical - on receipt of referral for appointment at colposcopy clinic

Note the 2 week wait standard does not apply to 62 day screening patients, but if they DNA their first appointment an adjustment can be made.

5.13 Management of consultant upgrades on a 62 day pathway start and end points

5.13.1 The clock starting point for this 62 day period is the date on which the consultant (or authorised clinician) decides to upgrade the patient.

5.13.2 The clock end point would be first definitive treatment as defined in section 5.8.

5.13.3 The number of patients ‘upgraded’ is monitored monthly and is communicated via the Cancer Performance Dashboard and managed via the daily PTL.

5.13.4 If a cancer diagnosis is ruled out then the patient should either be discharged or continue on an 18 week RTT pathway

5.14 Management of 31 day standard clock starts and amendments

The starting point for this standard is the date the patient agrees a plan for their treatment.

- This should be either a face to face consultation or telephone consultation
- This should be recorded at the time the decision is made and not retrospectively
- It should be noted that signing of the consent form by the patient may often occur after they have agreed their treatment plan and therefore this is not the decision to treat date
- If the patient subsequently changes their mind about their treatment plan for example they have agreed surgery but decide they would instead prefer chemotherapy then the decision to treat date can be amended to the new decision however the 62 day period would continue unchanged
- If a patient has seen a consultant in the private sector and the decision to treat is made there and they subsequently decide to have treatment at the Trust, the decision to treat date is the date that the trust accepts the referral even if it is with the same consultant

5.15 Management of 31 day standard clock stops and first definitive treatments

5.15.1 The 31 day standard stops with first definitive treatment and this is defined as ‘an intervention intended to manage the patients disease, condition or injury and avoid further intervention. It is a matter of clinical judgement, in consultation with the patient’ For cancer waits a first definitive treatment is further defined as the start of the treatment **aimed at removing or eradicating the cancer completely or at reducing tumour bulk.**

5.15.2 The 31 day clock stops for first definitive treatment and this may differ for different treatments, for example

- For surgical intervention it is the date the patient is admitted for surgery
- For anti-cancer drug therapy it is the date the first drug in an agreed course is given
- For radiotherapy it is the date the first fraction is given
- This is not an exhaustive list and further treatments may apply under the guiding principle above
- Diagnostic procedures may also be first definitive treatments if they are undertaken with therapeutic intent e.g. the intention is to remove the tumour, irrespective of whether the margins are clear
- Enabling treatment listed in section 5.8 would also stop the 31 day clock

5.16 What happens when a treatment option is not available within the 31 day or 62 day period?

The 62 day or 31 day clock cannot be stopped or paused due to the treatment option agreed with the patient not being available within the period for capacity or other reasons, for example if a patient is offered a choice of treatment options and chooses to have robotic surgery and there is no capacity within the period the clock would continue to tick.

5.17 When to use Active Monitoring

5.17.1 This is where a diagnosis of cancer has been reached but it is not appropriate to give any active treatment at that point, but active treatment is still intended / may be required at a future date.

5.17.2 The patient is monitored during the intervening time until they are fit to receive or it is appropriate to proceed with treatment. A patient would have to agree that they are choosing to be actively monitored for a period of time rather than receive alternative treatment; it should be an **informed choice** to be monitored rather than receive treatment and **should not** be used for thinking time. The monitoring period is determined by the clinician and communicated to the patient; the GP/GDP is informed via letter of this period.

- For example a patient is offered a range of treatments and wants to take a couple of weeks to think about it – this is not active monitoring unless specific to Prostate cancer patients where CWT v11 should be referenced.
- However if a patient has a prostate tumour that is not causing significant problems and they decide not to pursue active treatment but to be monitored this would be active monitoring

This option cannot be used if a cancer diagnosis is not confirmed.

5.18 When does the clock start for the 31 day standard for subsequent treatment?

The starting point for this 31 day period is either:

- The decision to treat date, i.e. the date the patient agrees a treatment plan for first or subsequent treatments within a cancer care plan

Or

- The earliest clinically appropriate date (ECAD) where there is no new decision to treat, but there has previously been agreed and clinically appropriate period of delay before the next treatment can commence. This might not be the start of subsequent treatment itself, but could be the next activity that actively progresses a patient along the pathway for that treatment to take place, examples of this would be:
- A patient with rectal cancer who is to have radiotherapy then surgery, the patient would not be clinically fit for surgery until six weeks later, so the ECAD would be set for six weeks after the radiotherapy is complete
- A patient with breast cancer who is to have surgery then radiotherapy, the patient who not be fit for radiotherapy planning until they can lift their arm above their head – the ECAD would be set for when they are fit for radiotherapy planning

The ECAD can be set at a number of points

- Clinical review with the patient following the preceding treatment for example review post-surgery, if it is not possible for example the patient has not healed sufficiently then a further review would be required
- At the start of the preceding treatment if the patient will not be reviewed between treatments
- At MDT meeting if it is possible to identify the likely ECADs between treatments in a package
- Following receipt of test results and prior to discussing with the patient if this is an appropriate date
- The ECAD can be changed **provided the date has not passed**, for example if on review the patient is not fit enough to proceed to the next treatment. Should however the patient be reviewed after the ECAD and found to be unwell the original date would stand.

5.19 When does the 31 day subsequent treatment clock stop?

The 31 day subsequent treatment clock stops for first definitive treatment and this may differ for different treatments, for example (exactly same as 31 day/62day clock stops)

- For surgical intervention it is the date the patient is admitted for surgery
- For anti-cancer drug therapy it is the date the first drug in an agreed course is given
- For radiotherapy it is the date the first fraction is given

5.20 Management of Recurrence

5.20.1 A recurrence is classed as a subsequent treatment, this would be when a patient has been diagnosed and treated for a primary cancer, and been informed that they are disease free, and then the cancer reoccurs in the same site.

5.20.2 These patients are monitored against the 31 day standard, irrespective of route of referral. However it is considered best clinical practice for GPs/GDPs to contact the Trust to ensure that the patient is seen as soon as possible/

5.20.3 If a patient on a 62 day pathway is diagnosed with a recurrence, as they have had first definitive treatment at some point in the past they are removed from the 62 day pathway and managed on a 31 pathway only.

5.21 Management of Metastatic Cancer

5.21.1 Treatment of metastatic disease is almost always classed as a subsequent treatment. The exception would be treatment of metastatic disease with an unknown primary and in this instance both first and subsequent treatments can be recorded.

5.21.2 If the primary cancer is identified after the metastatic disease of an unknown primary was treated, treatment of the primary cancer would be classed as a subsequent treatment on a 31 day pathway.

5.21.3 If a new primary cancer is identified with metastatic disease, and the metastatic disease is treated first, this should be recorded as a subsequent treatment and would therefore not stop a 62 day clock. Treatment of the primary is classed as

first definitive treatment and this stops the 62 day clock as this standard is for new primary cancer only.

5.22 When are adjustments to cancer waiting times allowed?

5.22.1 Adjustments to the waiting time are allowed as below with the supporting SOP – Downgrading Patients from a 62 to a 31 day pathway supporting the administration of adjustments:

- If a patient DNA's their initial outpatient appointment – in this instance the clock can be re-set from the receipt of the referral to the date the patient re-books their appointment and this adjustment applies to both the 2 week wait clock and the 62 day clock.
- If the patient is unable to attend **any** first appointment within 14 days, the Trust should inform the GP of the situation and advise the clock will be re-started from when the patient is available, rather than cancelling the referral and asking the GP to re-refer as in the spirit of the overarching Cancer Waiting Times Guide Version 9 October 2015 rules (4.1, 4.1.1 and 4.11).
- If a patient declines a reasonable offer of **admission** for treatment in this instance admission means admitted care and would not apply to treatment in an outpatient setting. In cancer guidance a reasonable means an offer within the applicable standard e.g. within 31 or 62 days. The adjustment can be applied from the date of the declined treatment to the point when the patient makes themselves available for an alternative appointment.

5.22.2 Whilst **reasonable** in terms of cancer guidance means a date offered within target, every effort should be made to offer patients a choice of dates with as much notice as possible where this is practicable.

5.23 How to Manage Step Downs

5.23.1 Step down is a term used at the Trust to indicate that cancer has been excluded and the patient can be removed from a 62 day pathway. It is essentially the "stepping down" of the urgency or the "stepping off" of the cancer pathway.

Examples include:

- Cancer treatment completed
- Cancer treatment not required
- Patient declines treatment
- Patient deceased

5.23.2 The decision to step down a patient must be a clinical decision and can only be made on or after the date first seen. Those patients stepped down are <u>not</u> subject to any performance indicators other than the Two Week Wait standard although they may go on to a Referral To Treatment pathway

5.23.3 If a clinician has made the decision to exclude cancer this can be communicated in a number of ways:

- Clinical letter
- Email to cancer tracking team
- PTL Meeting
- MDT Discussion

5.23.4 It is important that the patient is informed of the decision at the earliest opportunity by the clinician responsible for the patient's care

5.23.5 If it is not clear from any of the above that cancer has been excluded or further diagnostics are being pursued, then the cancer tracking team will request a "step down" from the clinician responsible for the patients care by emailing both the consultant and the secretary (depending on working practices) as set out in the step down process contained within the standard operational procedure

5.23.6 Responses to requests should be received within 2 working days to avoid delays on the pathway – Please note that the clock continues to tick while the tracking team awaits these responses and therefore if further diagnostics are required, pathway delays occur whilst awaiting the "next step" instructions

5.24 How to manage patient cancellation, choice and engagement – all standards

5.24.1 Not all patients can and should be treated within the timeframes outlined in national policy and the cancer standard thresholds are set to reflect this. The SOP – Downgrading patients from a 62 to a 31 day pathway provides further detail around the operational management within UHL in addition to the following:-

- Some patients may state in advance that they are unavailable for **inpatient** treatment for example they have a holiday booked, and it would therefore be inappropriate for the trust to offer them an appointment in the knowledge that they would not be able to attend. In this instance it is it is possible to add a clock pause from the earliest reasonable offer (date within target) that could have been offered to the patient until the date they are available for treatment.
- Patients may agree a date for **inpatient** treatment and then cancel this in advance, in this instance the patient should be rebooked within target as the clock is still ticking. Should they decline the new offer within target then a patient pause can be added from the earliest reasonable offer given as part of the rebooking process.
- Some patients may DNA their admission for treatment, in this instance a **clock pause cannot** be added, and the patient should be contacted and the reason for the DNA ascertained and offered a further treatment date in target. If however they DNA a second time then this should be discussed with the clinical team and agreement reached as to whether it is appropriate to discharge the patient back to the care of their GP/GDP. It is good practice to ensure that patients who DNA cancer appointments or admissions for treatment are contacted and their reasons or fears discussed. It is **not acceptable** to continue to offer dates to patients who DNA twice without making contact with them, ideally contact should be made by one of the clinical team so that they can provide further advice or reassurance.

5.24.2 Refusal - In some instances patients may refuse all reasonable offers of diagnostic tests, this in effect means that they have opted out of the 62 day pathway, and therefore the Trust is unable to deliver the standard. If the patient is not prepared to cooperate this ends the 62 day pathway. If at a later stage the patient chooses to have the tests and is subsequently diagnosed with cancer, a

new 31 day clock would be started. Reasonable offer of diagnostics is defined as not less than 24 hours' notice. Refusal of all reasonable offers is defined as either 2 or more consecutive DNA of appointments or 2 or more consecutive occasions where declines and cancellations have caused a delay.

5.24.3 Pre-Operative - patients who do not follow pre-operative guidance, provided this was clearly communicated, or attend for their treatment in an intoxicated state, and cannot be treated should be recorded as DNA, as per national guidance. This would include patients who have not followed nil by mouth instructions. Every effort should be made to rebook the patient and to provide support to enable their compliance. If however this situation occurs for a second time then this should be escalated to the clinical team and agreement reached as to whether it is appropriate to discharge the patient back to the care of their GP/GDP, following discussion with the GP/GDP. It is good practice to ensure that patients who cannot be admitted for treatment as described above are provided with advice or reassurance to enable their compliance. It is **not acceptable** to continue to offer dates to patients who cannot be admitted for treatment as described above.

5.24.4 In some instances a patient may be offered a treatment date outside of the standard for example due to capacity, but then it is possible for example additional lists have been provided to offer them an earlier date within the standard which they refuse. In this instance a pause **cannot** be added, as the patient has not declined a reasonable offer. It is however always good practice to offer earlier appointments if it is possible to do so.

5.25 Management of patient choice – treatment options and clinician choice

5.25.1 Options - patients may be offered a range of treatment options; if this is the case then a treatment date for any of these must be offered within target, it is not possible to add a pause to the clock because there is insufficient capacity to treat the patient within the standard. It is also **unacceptable** not to discuss clinically appropriate options because there is insufficient capacity to treat the patient within the standard. This includes robotic and other complex treatment options

5.25.2 **Thinking Time -** Patients may be offered a range of treatments and may wish to have 'thinking time'.

For example, if a patient has been offered invasive surgery and they want to take some time to think about this before confirming they wish to go ahead with the surgery this is thinking time not active monitoring; allowing a patient time to consider options is good clinical practice and patient thinking time will not jeopardise a provider's performance against the standards because it has been taken into account in the operational standards that have been set (i.e. the operational standards have been set at a level that allows for a proportion of patients breaching due to thinking time). The time taken will depend on a range of issues and be agreed by the patient and the clinician

5.25.3 Patients may be offered a range of treatment options, but ask about another treatment option that they have heard about. If on reflection it is clinically appropriate to offer this option, then a pause can be added from the admission date that would have been offered to the date the patient makes themselves available for a further appointment.

5.25.4 Patients have the right to treatment with a clinician that they trust. If they are offered a choice of clinician's and choose one of these, but for example they are

on leave and there is not capacity to treat the patient within the standard then a pause cannot be added.

5.25.5 If however the patient is offered treatment with only one consultant and they ask to be treated by another and it is not possible to offer an appointment within the standard, then it is possible to add a pause as the patient has declined a reasonable offer of admission. The pause can be added from the date of the reasonable offer to the date the patient makes themselves available

This also applies if they choose an alternative clinician to the one offered and they are on leave, but not if the offered clinician is on leave

5.26 Management of Rare Cancers (Testicular, Children's, Acute Leukaemia)

5.26.1 Referrals for suspected testicular, children's cancers and acute leukaemia have a specific 31 day standard from receipt of referral to first definitive treatment.

6 EDUCATION AND TRAINING REQUIREMENTS

The CWT elements of effective cancer pathway management is covered within the E-Learning Module available to all staff within UHL and will be reviewed on an annual basis.

7 PROCESS FOR MONITORING COMPLIANCE

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

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Cancer Action Board Meetings (CAB)	Deputy Chief Operating Officer	Daily cancer PTL, patient level tracking and discussions which take place at the CAB meetings	Weekly	Non compliance escalated to HOOPs/DHOOPS tracked through the Cancer Information System
Cancer target has not been met	Deputy Head of Performance (Cancer) & General Manager for the tumour site	Root cause analysis/breach review analysis	Monthly	Exception reporting through monthly Cancer performance paper
Clock stops on all pathways in line with CWT Rules	Deputy Head of Performance (Cancer)	Pre Upload and Post upload data validation for all breaches across all standards using reporting from NHS Digital and the Cancer Information System	Monthly	Exception reporting through monthly Cancer performance paper

8 EQUALITY IMPACT ASSESSMENT

8.1 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.

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

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

Going Further on Cancer Waits (GFOCW) Version 6.3

Cancer Waiting Times Guide Version 9 October 2015

http://systems.hscic.gov.uk/ssd/cancerwaiting/documentation

Access Policy for Elective Patient Care B3/2004

NHS England National Cancer Breach Allocation Guidance 2016

NHS Constitution
http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 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.

Appendices

Appendix 1 – SOP Cancer Clinical Harm Review Process