Trust Policy

University Hospitals Plymouth NHS Trust

Cancer Operational Policy

Issue Date	Review Date	Version
November 2018	Extended to January 2022	2.1

Purpose

To inform staff of the key principles for managing patients on a cancer pathway.

Who should read this document?

All Staff who deal with patients who are on a cancer pathway.

Key Messages

It is imperative that all members of staff understand the 'rules' that govern the management of patients who are on a cancer pathway. This is primarily to ensure that no patient is unnecessarily disadvantaged. It is every member of staff's responsibility to ensure that these rules are applied equitably.

Core accountabilities	
Owner	Trust Cancer Manager
Review	Trust Board
Ratification	Chief Operating Officer
Dissemination (Raising Awareness)	Cancer Operational Manager
Compliance	Cancer Operational Manager

Links to other policies and procedures

Version History		
1	September 2015	Initial document
2	November 2018	Updated
2.1	October 2021	Extended to January 2022

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available in Document Library – UHPT Trust Documents. Larger text, Braille and Audio versions can be made available upon request.

Contents

1 Introduction

University Hospitals Plymouth (UHP) is committed to ensuring that patients receive treatment in accordance with the NHS Constitution, national objectives and targets.

This policy sets out the Trusts local policy associated with meeting the cancer standards and takes into account guidance from the Department of Health and has been agreed with local commissioners. This policy is designed to ensure efficient and equitable handling of referrals in line with national waiting time guidance relating to cancer pathways. This policy also describes how UHP manages and reports performance relating to cancer waiting times.

Patient's best interests are at the forefront of this policy. The timescales within which cancer patients are treated is a vital quality issue and key indicator of the quality of cancer services offered at the Trust. In doing so, the Trust must meet the national Cancer Reform Strategy standards as set out in the **National Cancer Waiting Times Monitoring Dataset Guidance (version 9.0)** and the **Addendum to the National Cancer Waiting Times Monitoring Dataset Guidance v9.0**.

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

This policy should be used in conjunction with PHNTs Access Policy for Planned Care Services and any relevant APNs relating to the booking of patients.

2 Purpose

This 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. Cancer patients will be prioritised according to national guidance. Non-NHS patients including overseas visitors are not covered by this policy and should be managed according to the overseas visitor policy and clinical priority.

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.

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

Patients will be added to the waiting list if there is a real expectation that they will be treated and are willing to make themselves available for treatment.

The standards are set with tolerances as there are reasons why some patients will be treated outside the standards, these include –

- Patients for whom it is not clinically appropriate to be treated within the cancer standard.
- Patients who may choose to wait longer for one or more elements of their care.
- Patients who are not medically fit.
- Patients whose diagnosis is complex

NHS England's document **Improving Outcomes: A Strategy for Cancer** (2015) confirmed that cancer waiting times remain an important issue for cancer patients and that the NHS should continue to ensure that cancer services are delivered to patients in a timely manner. The standards that NHS Providers are expected to meet are:

2 week wait

- All patients referred by a GP/GDP as suspected cancer will be seen within 14 days of receipt of referral – operational standard 93%
- All patients referred with breast symptoms irrespective of whether cancer is suspected will be seen within 14 days of receipt of referral – operational standard 93%

62 day standard

- All patients referred by their GP/GDP as suspected cancer, who are subsequently diagnosed with cancer, will commence treatment within 62 days of receipt of referral – operational standard 85%
- All patients referred by their GP/GDP as suspected cancer, who are subsequently diagnosed with children's cancer, testicular cancer or acute leukaemia will commence treatment within 31 days of receipt of referral – no separate operational standard (monitored within 62 day standard)
- All patients referred from screening programmes (bowel, breast, cervical) as suspected cancer who are subsequently diagnosed with cancer, will commence treatment within 62 days of receipt of referral – operational standard 90%
- All patients that are upgraded by Consultants as suspected cancer who are subsequently diagnosed with cancer, will commence treatment within 62 days of the date of upgrade – No operational standard currently

31 day standard

- All patients diagnosed as a new cancer will receive treatment within 31 days of decision to treat irrespective of treatment – operational standard 94%
- All patients that are having a subsequent treatment for cancer will receive treatment within 31 days of the decision to treat –
    - Surgery – operational standard 94%
    - Drug treatment – operational standard 98%
    - Radiotherapy – operational standard 94%

28 day faster diagnosis standard

- This is a new standard that will be fully introduced and have an operational target from April 2020. Data collection begins from April 2018 and becomes mandatory from April 2019.
- The standard will initially apply to all patients referred urgently for investigation on a two week wait, symptomatic breast or screening referral.
- The standard 'clock' starts on receipt of the referral by the provider who will first see the patient.
- The 'clock' 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.

This policy is applicable to patients cared for under Cancer Waiting Times, this is defined as activity with ICD codes C00 – C97 (excluding basal cell carcinoma) or D05 (breast carcinoma in situ). This includes patients:

- Treated as part of a clinical trial
- Whose cancer care is undertaken by a private provider on behalf of the NHS
- Whose care is sub contacted to another provider and paid for by an English NHS Trust
- Diagnosed with a second new cancer
- If the patient has been told they have cancer and/or has been treated for cancer

Patients excluded from the cancer waiting times standards are any patient:

- With a non-invasive cancer i.e. carcinoma in situ (with the exception of breast)
- Diagnosed with a Basal cell carcinoma

- Who dies before treatment can begin
- Who declines treatment
- Who refuses to undergo diagnostic tests that would give a definitive diagnosis of cancer are excluded from the 62 day standard but if they are subsequently diagnosed they will monitored under the 31 day target
- Receiving diagnostic and treatment privately unless the patient chooses to be seen privately but is then referred for treatment under the NHS. If a patient is seen under the 2 week wait and then chooses to have diagnostic tests privately but returns to the NHS for further treatment they will monitored against the 31 day treatment standard only

For patients this policy will make sure that people:

- Suspected to have cancer and/or with a confirmed cancer diagnosis receive treatment in accordance with the cancer standards relevant to their cancer pathway and according to their choice.
- Are treated according to clinical priority and those with the same clinical priority are treated in chronological order.

For clinician and non-clinicians this policy will make sure that:

- Teams and individuals are aware of their responsibilities for moving patients along the agreed clinical pathway in accordance with the national Cancer Reform Strategy standards as set out in **National Cancer Waiting Times Monitoring Dataset Guidance (version 9.0)**
- 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 Somerset Cancer Registry and reported to the National Cancer Waiting Times Database (Open Exeter) within predetermined timescales.

3 Definitions

Please see glossary (Appendix 3)

4 Duties

4.1 Chief Operating Officer

The Chief Operating Officer is the nominated Board Member with responsibility for cancer within the Trust

4.2 Care Group /Service Line / Cancer Managers

- To ensure the proactive management of patients on the cancer pathway and to ensure milestones in the journey are met.
- To ensure all staff within teams are conversant and compliant with national and this policy. This includes ensuring that effective processes are in place to manage patient care and treatment that meet national, local standards and the NHS Constitution.
- To respond to escalation emails as laid out in this policy and act to resolve any delay in the pathway for cancer patients.
- To ensure the diagnostic services meet the targets laid out in this policy and monitor performance at cancer performance meetings.
- To review and validate breaches/root cause analysis and ensure robust action plans are in place and monitored.

- To ensure clinical review of harm is undertaken for patients with cancer treated over 104 days from referral.
- Ensure the clinical service runs smoothly and patients are seen within internal waiting time standards, there is sufficient capacity to meet demand and that clinicians adequately prepare patients for the next step of the pathway.
- Ensure all relevant Service Line staff are aware of this policy and receive training so that they can meet the policy requirements.

4.3 Cancer Clinicians

- To ensure proactive management of patients on a cancer pathway to ensure milestones are met.
- To respond in a timely manner to requests regarding cancer pathways and next steps e.g. admin/review within agreed internal timeframes.
- Work closely with and support the MDT coordinators to enable them to support the team and enable patients to be seen within target.
- Review breach analysis/root cause analysis.
- Undertake 104 day clinical review of harm as appropriate.

4.4 Multi-Disciplinary Team Coordinator (MDTC)

- To ensure all patients on a 62 day pathway – 2ww, upgrades and screening - are tracked daily for the cancer huddle sites (Urology, Colorectal, UGI, Lung, Head & Neck and Gynaecology) and at least twice weekly for all other sites.
- To ensure all patients that have made a decision to treat are tracked and escalated where necessary at least once a week.
- To facilitate the process of ensuring clinical teams action the next key event in the patients pathway within the pathway timescales
- To facilitate the process of ensuring patients on a 62 day tertiary pathway are managed in accordance with the South West Cancer Access Network Policy.
- To complete/start breach analysis on all patients that are treated or seen outside the targets as soon as they are aware that a patient will breach and in line with the monthly reporting to Trust Board (by 5th working day of the following month).

All staff are responsible for ensuring that the principles of this policy are followed.

Individual management teams are responsible for ensuring that this policy is applied in all cases and that the appropriate infrastructure is in place to enable delivery.

Clinical Commissioning Groups are responsible for facilitating effective communications with referring practitioners.

5 Key Elements

5.1 GP referrals for Suspected Cancer (2ww)

Patients referred via the 2ww can choose to attend an appointment outside the 2 week target. The tolerance set nationally takes into account the number of patients who may choose to wait longer than 14 days but to try and reduce the number of patient choice breaches patients should be offered as many dates as possible within the 14 day period.

Patients cannot be referred back to the GP because they are unable to accept an appointment within the 2 week standard. A referral can only be downgraded with the consent of the referring GP. Therefore if a Consultant, on reviewing the proforma, considers the referral should be downgraded they should contact the GP for agreement. Once this has been done iPM should be updated and Cancer Services should be informed.

Patients may cancel appointments and should be re-appointed within 14 days if possible but otherwise should be booked into the next available slot that the patient can attend. National guidance states that patients should not be referred back to the GP after multiple cancellations unless this has been agreed by the patient. However, it is good practice to let the GP know that a patient has deferred appointments, as they may wish to either contact the patient or possibly downgrade the referral. Patients that cancel multiple times resulting in a wait of more than 6 weeks should be referred to the specialty team for clinical advice.

Patients who do attend (DNA) a 2ww appointment should be re-appointed within 14 days of the DNA. Patient's that DNA twice can be referred back to their GP if clinically appropriate.

The first appointment following a 2ww referral can be an outpatient appointment with the relevant specialist or a diagnostic test where a direct to test pathway has been agreed. It can also be a nurse led clinic where the triage makes an active decision about which is the appropriate next step, such clinics needs not be face to face.

If a patient is admitted as emergency following their 2ww referral but before they are first seen for the same reasons as their 2ww referral than the 2ww referral should be closed and the patient tracked from their emergency referral. If the emergency admission is for another condition then the 2ww referral remains open and should be booked as soon as the patient is fit to attend, where possible the patient should be seen by the appropriate specialist while they are admitted to save time.

5.2 Stops, Pauses and Adjustments

The operational standard applied to the 62-day standard takes account of the volume of patients likely to defer appointments or be unfit at stages of their pathway. There is therefore no clock pause for these reasons and patients cannot be downgraded to a 31-day only pathway for these reasons:

- For multiple cancellations, the patient should be contacted by the specialty team rather than just giving multiple re-appointments. Patients may not understand the details of the test being requested, or may be anxious and require reassurance. If the patient does not wish to proceed then they should be referred back to their GP.
- If a patient refuses proposed diagnostic tests that may diagnose cancer, they have effectively removed themselves from the 62-day pathway. If they agree at a later stage they should then be monitored against the 31-day standard only.

The 31 day and 62 day pathways end when:

- treatment starts
- a patient is given a non-malignant diagnosis
- a patient refuses treatment

Patients given a non-malignant diagnosis will revert to the standard 18 week referral to treatment pathway.

Pauses and adjustments can only be applied to cancer pathways in the following circumstances –

- When a patient DNAs their first appointment following a GP referral for suspected cancer (2ww) or following a screening referral. In this circumstance the clock start is reset to the date of the DNA. DNAs in all other parts of the pathway will not pause or restart the clock.
- If a patient is waiting for inpatient or day-case treatment and the patient declines an offered date for treatment provided that the offered date is within target. An adjustment can be made from the date that the patient declines to the date the patient is available for treatment. An adjustment can also be made if the patient volunteers, before a treatment date is offered and accepted that they are unavailable for treatment for a

certain amount of time. Any patient unavailability should be recorded on the waiting list.

5.3 Reasonable Offers

All patients offered an outpatient (new and follow-up), diagnostic appointments or offers for admission should be given reasonable notice -

- All appointments/admission offers made face to face or over the telephone which the patient agrees to are deemed to be reasonable.
- For appointments booked by letter only there should be 7 days' notice from the date of the appointment letter. All bookings for patients on a cancer pathway should ideally be booked by telephone or face to face.

5.4 Patient thinking time

It is good practice to allow patients a period of thinking time prior to considering treatment. Where this is short, there is no clock pause and pathways need to take account of this and be able to accommodate a reasonable period for the patient to consider options. If a longer period of thinking time is agreed, it may be appropriate to agree Active Monitoring as a treatment and therefore a clock stop. For this to be applied a monitoring plan must be agreed with the patient, documented and actioned. It is not acceptable to use Active Monitoring to avoid breaches where the agreed thinking time is reasonable or another treatment is unavailable.

5.5 Active Monitoring

This could be either a first or subsequent treatment where the intention is for long term surveillance where the decision had been taken to monitor the progress of the disease. For example, a slow growing tumour where there is not an immediate problem and it is clinically appropriate to step back and monitor the situation until an active intervention is more appropriate.

Treatment starts when this is discussed, documented and agreed with the patient.

5.6 Earliest Clinically Appropriate Date (ECAD)

An ECAD is the earliest date that it is clinically appropriate for the next treatment in a patient's cancer pathway. The activity may not always be the start of the treatment itself but could be the next appointment which deals with the planning of that treatment. When determining an ECAD, only patient issues should be considered and not local capacity constraints. Examples would be:

- Patient with rectal cancer is to have radiotherapy then surgery – after the radiotherapy the patient is not expected to be clinically fit for surgery for 6 weeks so the ECAD would be set for 6 weeks after radiotherapy is complete
- Patient with breast cancer is to have surgery then radiotherapy – the patient would not be fit for planning radiotherapy until they are able to lift their arm over their head – ECAD would be set for when the patient would be fit for radiotherapy planning to start.

An ECAD can be reviewed and changed as long as the date has not passed. If an ECAD is set but on patient review or prior to the ECAD the patient is clinically not able to progress to the next treatment the ECAD can be changed to a later date.

If the patient is unwell after the ECAD then the ECAD cannot be reset and a wait time adjustment will not apply.

5.7 Tertiary Referrals

A new approach to monitoring inter-provider transfers began for all 62 day pathways in July 2018. This new approach will provide a more transparent view of where delays in the pathway are being experienced so that providers can work together to address issues. This is intended to ensure consistency across the country and promote collaboration between providers.

Inter-provider transfers should be recorded when the responsibility for care is formally transferred. The date that a referral request is received by the provider will mark the point at which the inter-provider transfer is made. The allocation of patients for performance is 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

5.8 Referrals by Consultant Upgrade

Patients not referred via 2ww or screening can be upgraded on to a 62 day referral to treatment pathway, the clock starts at the point of upgrade and ends with treatment or a non-cancer diagnosis. A patient can be upgraded at any point in their pathway but should be before a decision to treat has been made.

The process for upgrading a patient is -

- Cancer is suspected following triage / OPA / diagnostic test
- An “Internal upgrade referral form” is emailed directly to Cancer Services or ring the Cancer Services Team with the relevant information.

Information required to upgrade a patient –

- Name of patient
- Hospital number
- DOB
- Confirm suspect cancer and site
- Name of doctor and name of consultant

- Confirm on which stage of pathway ie..diagnostic, OPA

6 Local Guidance and Process

6.1 Suspected Cancer Referral (2WW)

All suspected cancer referrals should be referred by the GP/GDP on the relevant site proforma available on the UHP website and submitted via the NHS e-Referral service or via email to the Cancer Services Team. If an incomplete referral proforma is received Cancer Services will contact the GP to get the additional information required, the referral must not be returned to the GP or delayed for this reason.

Cancer Services will process all referrals the same day and email to the relevant booking team. Referrals received after 4pm will be processed the following working day by 10am.

Receipt of referral is day zero, referrals received after a working day has finished will have the referral received date set as the date that the referral was received and not the next working day.

6.2 Diagnostic Phase

All diagnostics for patients on a cancer 62 day pathway should be requested with a 2ww priority that should be clearly displayed on the request form or selected as the priority when requesting electronically.

All tests should be made for the earliest available appointment and agreed with the patient. It is expected that for patients on a cancer 62 day pathway the wait from request is no longer than 7 days, this includes inpatient diagnostics.

6.4 MDT Meeting

Each Site specific team has a regular MDT to discuss the patient pathway in line with NICE guidance and Cancer Peer Review Standards.

The agenda is administered by cancer services and shared with imaging and pathology at set agreed times to enable them to review prior to the MDT meeting.

Breach dates are added to the agenda where there is a target date; if there is no current target N/A will be inputted.

6.5 PTL Tracking and Escalation

MDTCs track patients from referral to first treatment and from Decision to Treat (DTT) to treatment for all subsequent treatments. To enable this there are individual site specific pathways and internal standards to enable tracking, and escalating as appropriate. Please contact Lead Clinician or Cancer Services for individual cancer pathways.

A Cancer Treatment PTL can be created at any time using an online reporting tool which pulls information from the Somerset Cancer Register (SCR) in to a list by cancer site holding key information on the patient's cancer pathway. This PTL includes all patients on an active cancer pathway who are awaiting their first treatment. It includes tracking comments which the MDTC updates regularly providing detailed information on what is currently happening on the patient's journey, any outstanding actions and escalation that has taken place.

All patients that have made a DTT for a subsequent treatment are on another PTL which is tracked as above by the MDTC.

6.6 The Cancer PTL Huddle

A cancer PTL huddle takes place throughout the week for the following cancer sites – Urology, Colorectal, Upper GI, Lung, Head & Neck and Gynae – to review patients on referral to treatment cancer pathways. These meetings focus on these sites as they are the pathways that significantly affect the ability of the Trust to achieve the 62 day standard.

Cancer services will create and send out the cancer PTL huddle report highlighting any patient that needs action in red indication the Service Line that needs to action and feedback at the huddle.

Service line Managers (SLM) are expected to attend to ensure delays can be addressed immediately.

6.7 Daily Long Waiter Report

A daily report of all patients on an active cancer referral to treatment pathway that have waited longer than 62 days is produced by the Cancer Services Team. Any patients requiring action will be highlighted in red and the specialty that needs to action will be added. This report is emailed out to all managers and responses are made by email to the Cancer Services Team to include on the patients tracking.

6.8 Weekly PTL

For those sites not included within daily huddle and for all 31 day patients a weekly PTL report is produced for each site by the relevant MDTC. This report is updated by the MDTC to show any actions required by the service line administration teams. Individual reports for pathology, imaging and oncology are created pulling together the actions from all cancer sites. The report is colour coded so it can be easily filtered for patient's requiring action as follows –

- Red – patient requires action
- Yellow – patient progressing through pathway and does not require action
- Green – patient is booked in target for treatment or has been removed from the cancer pathway
- Purple – patient is a confirmed breach that cannot be resolved e.g. confirmed cancer already past their target date when DTT is made.

The weekly process includes escalation to managers at the end of the weekly process. Key themes affecting multiple patients are escalated by the MDTC to the Cancer Operational Manager.

6.9 Internal Targets

Pathway	Waiting Time	Action
First Appointment (2 week national standard)	7 – 14 days	All service lines should ensure they have enough capacity to meet demand and achieve 7 days for first appointment. This will allow a patient to have two offered appointments within 14 days.
Telephone triage (urology and	48 hours	Where possible patients should be referred straight to test either direct

colorectal)		from referral or following telephone triage
Follow up appointments	7 days (85%)	Request to appointment
Radiological investigations exams	7 days (85%)	Request to exam : with the exception of CTC – 10 days due to prep
Radiological Reporting	2 working days	
Pathology	7 - 10 days	Plan to improve performance from 10 to 7 days or less
Endoscopy OGD	7 days	Request to test
Endoscopy colonoscopy/double	10 days	Request to test
MDT	Next available MDT	Dependant on cut-off date for requests. An emergency decision can be made outside an MDT.

6.10 Escalation

Single events of delays should be monitored, where there is continued breach of standards SLM should raise these within Care Group and upload to the Trust cancer action plan with robust plans for recovery. The issue should also be added to the Service Line risk register.

Escalation will occur when there is a potential or actual breach of the internal and external standards. MDTC will alert support managers in the first instance and subsequently if unresolved to Cancer Managers and Service lines Managers either through the daily huddle or by email. If unable to be resolved within 48 hours the SLM and/or Cancer Managers should escalate to Care Group Managers (CGM). If unable to be resolved CGM and/or Cancer Services should escalate to Chief Operating Officer.

Each service line has responsibility for managing their cancer patients on the pathway and should have their own internal escalation process.

6.11 Breach Analysis

A detailed review of every breach is undertaken by the MDTC and validated by the Cancer Operational Manager. This review is detailed on a standard template detailing each step of the pathway so that delays can be easily identified and the reasons recorded (see Table 1). Breaches are allocated an overall reason as per the cancer waiting time's dataset –

- Administrative delay
- Clinic cancellation
- Complex diagnostic pathway
- Delay due to recovery after an invasive test
- Diagnosis delayed for medical reasons

- Elective cancellation
- Elective capacity inadequate
- Out-patient capacity inadequate
- Health care provider initiated delay to diagnostic test or treatment planning
- Patient choice

All breaches of the 62 day referral to treatment target will have a breach analysis produced by the MDT Coordinator which will be reviewed by the Cancer Operational Manager on a monthly basis. This includes all steps in a patient's pathway and shows the wait for each step, an example is shown below. All breach analysis and a blank template are saved on the Cancer Services drive in the below location. MDTCs should start a breach analysis for all patients diagnosed with cancer that we know are going to breach and all those over 62 days on the PTL unless the reason for the delay is a single clear issue. Delays for patients over 62 days on the PTL should be added to the tracking comments so they are clearly displayed on all PTLs.

Breach Analysis Example:

Cancer Services - Breach Analysis

Plymouth Hospitals NHS
NHS Trust

Name:		**Tertiary Referral:**	**No**	**2ww target date:**	
Hospital No:		**1st seen Trust:**	**PHT**	**62 day target date:**	29/06/2017
Cancer Site:	Urology - Prostate	**Treating Trust:**		**31 day target date:**	
2nd Cancer Site:		**Diagnosis:**		Prostate T3a N0 M0	

Day in Pathway	Number of days wait	Stage in Cancer Pathway	Date	Comments / Plan
0	0	Referral	28/04/2017	
12	12	OPA	10/05/2017	TRUS biopsy performed
14	2	Biopsy reported	12/05/2017	
21	7	MDT	19/05/2017	Surgery / RT
32	11	OPA	30/05/2017	
33	1	Bone Scan Requested	31/05/2017	
59	26	Bone scan - patient choice	26/06/2017	Patient Away 10/06/17 - 25/06/2017
68	9	Patient Contact	05/07/2017	
91	23	OPA with surgeon	28/07/2017	Patient making treatment choice
95	4	Patient Contact	01/08/2017	Wants surgery
98	3	Surgery - RALP	04/08/2017	
Total days wait	98			

SCR Delay Reason (select from list)	Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this patient)
SCR Delay Reason Comment	TRUST : 11 days for OPA following MDT; 23 days for OPA with surgeon following patient contact. Patient also delayed bone scan as they were away (25 days) and took time considering surgery (4 days).

Over 104 days	**No**	**Date of Review**		**Reviewed By**	
Questions Considered					
Review Comments					

6.12 104 Day Breaches

All breaches over 104 days are added to DATIX, the Trust's incident system, by Cancer Services. Any that are due to factors that are avoidable are assigned to the specialty of the MDT lead for review. The MDT lead can then record against the incident if harm was caused by the extended wait for treatment. Any that are deemed to have caused harm will move to the formal incident process for reviewing incidents. In those circumstances a full Serious Incident Root Cause Analysis will be performed. Adding the incidents to DATIX also enables summary reporting of the breaches.

Process for reviewing 104 day breaches

In the absence of national definition the Director of Cancer Services has provided the following information to review patients for harm to all MDT members –

Clinical harm has occurred if the disease stage has increased during the 104 + days, or if the patient's performance status has deteriorated to the point that the ideal treatment option is no

longer possible. Evidence of this can be with clinical documentation, imaging or histo path results.

Remember that evidence of clinical harm will trigger a risk and incident process which will involve duty of candour to the patient and a root cause analysis. Clearly this is appropriate if harm has been done, but there needs to be evidence. It can be a distressing process for the patient and relatives.

- Service Line will receive a notification from cancer services that a DATIX has been raised and this will also appear on the Service Line dashboard.
- Service Line to review for clinical evidence of patient harm e.g. notes, MDT outcomes, diagnostic reports etc.
- Service Line complete relevant sections on DATIX form (SBA(R)R Investigation Section)

Monitoring of completed reviews and escalation process

- Monitored by monthly performance report (Risk and incident team RIT) through to Quality Governance and Learning Group Report to Care Group Governance teams
- Monthly cancer performance report of completed reviews through cancer performance meeting (monthly)
- Clinical harm suspected – follow incident management policy
- Tertiary referrals – review of harm undertaken – if harm suspected and delay attributed by referring trust – DATIX changed to external Trust and RIT informed who will notify relevant organisation

6.13 Cancer Performance Review Meeting

A weekly performance meeting will take place chaired by the Chief Operating Officer and attended by

- Clinical Director for Cancer
- Head of Nursing (Cancer)
- Cancer Operational Manager
- Deputy Performance Information Manager
- Service Line Managers – representation from Surgery, Imaging, and Pathology will attend weekly, other service lines will attend as and when required.

A standard data pack will be produced for this meeting by the Performance Information Team for discussion and includes for example diagnostics, cancer site specific performance and long waiter report

Other data will be provided by Performance Information as and when required by the meeting agenda.

6.14 Cancer Waiting Times Performance Reporting

Cancer Waiting Times performance against all standards will be:

- reported monthly to the Trust Board and to the NEW Devon CCG (Western Locality)
- included within the annual cancer quality assurance report to the Quality Assurance Committee (QAC)
- allocated to each service line and included within the monthly Service Line Dashboards

6.15 Data Quality

In order to ensure reported performance is consistent and comparable across providers the measurement and reporting of cancer waiting times is subject to a set of rules and definitions (**Cancer Waiting Times A Guide Version 9**). It is important that there is a consistent approach to the interpretation and implementation of national guidance to allow comparison between cancer sites, time periods and other providers.

UHP has a centralised Cancer Services Team that sits as a corporate function within the organisation, the benefits of this include –

- Assurance of adherence to rules, protocols and standard operating procedures
- Ability of staff to share knowledge and experience
- Clearer lines of responsibility
- Consistency across tumour sites
- Clearer escalation pathways

Cancer Waiting Times training is available on request for all staff across the Trust, bespoke training is also provided for teams as required. Annual online training will be available for teams directly involved in cancer pathways.

Training for cancer service staff e.g. MDTC, MDTC assistants will be undertaken as part of their orientation and training for their role.

Data quality reports will be run and actioned within the Cancer Services Team –

- Weekly report to check any 2ww referrals that have not resulted in an attendance. This ensure no one has been missed but also that the national guidance has been applied for patients that DNA or cancel their appointments.
- Missing and mismatched data for the cancer waiting time's dataset is run monthly direct from the Somerset Cancer Registry. Some local reports have also been set up to look at common DQ issues with the cancer waiting times data and these are also run monthly and actioned by the MDTCs.
- Monthly check at patient level between the patients uploaded to Open Exeter as part of the national reporting schedule and the patients we have been reporting locally as part of the cancer waiting times reporting. All mismatches are investigated by the Cancer Operational Manager and actioned appropriately, if any issues with the local reporting mechanism are identified these are also changed.
- All breaches are analysed by the MDTC and then validated by the Cancer Operational Manager. During this process all data from the cancer waiting time's dataset is double checked along with interpretation of the national guidance.

7 Overall Responsibility for the Document

The Cancer Operational Manager has overall responsibility for the co-ordination, dissemination and implementation and review of this document.

8 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be reviewed by the TME and ratified by the Chief Operating Officer.

Non-significant amendments to this document may be made, under delegated authority from the Chief Operating Officer, by the nominated owner. These must be ratified by the Chief Operating Officer.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes.

9 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document owner will be responsible for agreeing the training requirements associated with the newly ratified document with the named Chief Operating Officer and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

After approval and publication the Cancer Services Team will run and co-ordinate mandatory training sessions, to familiarise staff with the policy. The sessions will also enable staff to ask questions about the use of the policy.

The process of tracking compliance will be monitored by the Cancer Services Team.

10 Monitoring Compliance and Effectiveness

Monitoring and compliance will be carried out by the Cancer Services Team. Please refer to the Data Quality section of Key Elements section for full details.

11 References and Associated Documentation

NHS Constitution

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

National Cancer Waiting Times Monitoring Dataset Guidance (version 9.0)

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

Addendum to the National Cancer Waiting Times Monitoring Dataset Guidance v9.0

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

South West Cancer Access Policy Version 10

http://www.swscn.org.uk/wp/wp-content/uploads/2018/11/SW-SCN-Cancer-Access-Policy-v10_FINA.pdf

NHS Digital website's cancer waiting times page which links to useful documentation and guidance:

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

Achieving World Class Outcomes – A Strategy for England 2015 - 2020

http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

NICE 2ww referral guidance

http://www.nice.org.uk/guidance/ng12

Dissemination Plan and Review Checklist | Appendix 1

Dissemination Plan	
Document Title	Cancer Operational Policy
Date Finalised	November 2018
Previous Documents	
Action to retrieve old copies	N/A

Dissemination Plan

Recipient(s)	When	How	Responsibility
All Trust staff		Vital Signs	Information Governance Team
All staff	Ongoing	Training sessions	Cancer Operational Manager

Review Checklist		
Title	Is the title clear and unambiguous?	
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	
	Does the style & format comply?	
Rationale	Are reasons for development of the document stated?	
Development Process	Is the method described in brief?	
	Are people involved in the development identified?	
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	
	Is there evidence of consultation with stakeholders and users?	
Content	Is the objective of the document clear?	
	Is the target population clear and unambiguous?	
	Are the intended outcomes described?	
	Are the statements clear and unambiguous?	
Evidence Base	Is the type of evidence to support the document identified explicitly?	
	Are key references cited and in full?	
	Are supporting documents referenced?	
Approval	Does the document identify which committee/group will review it?	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	
	Does the document identify which Executive Director will ratify it?	
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	
	Does the plan include the necessary training/support to ensure compliance?	
Document Control	Does the document identify where it will be held?	
	Have archiving arrangements for superseded documents been addressed?	
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	
	Is there a plan to review or audit compliance with the document?	
Review Date	Is the review date identified?	
	Is the frequency of review identified? If so is it acceptable?	
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	

Equalities and Human Rights Impact Assessment | Appendix 2

Core Information	
Date	November 2018
Title	Cancer Operational Policy
What are the aims, objectives & projected outcomes?	The purpose of this policy is to ensure that: • All of our services must be available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief. • Access to our services is based on clinical need. • The planning and delivery of our services must be focused on patient experience. • Our services must reflect the needs and preferences of patients, their families and their carers through the provision of choice wherever possible. • The NHS works across organisational boundaries and in partnership with other organisations in the interests of patients and the wider population. • PHNT is committed to providing the best possible value for money to deliver the most effective and fair use of finite resources. • All services are accountable for supplying adequate and suitable capacity to meet the needs of their patients
Scope of the assessment	
This assessment covers the impact the project will have on the workforce (clinicians, admin staff and others) and patients.	
Collecting data	
Race	There is no evidence to suggest there is a disproportionate impact on race. However, data collection of those affected by the policy will be monitored via workforce data, untoward incidents and complaints on DATIX and feedback via other routes such as surveys.
Religion	There is no evidence to suggest there is a disproportionate impact on religion. However, data collection of those affected by the policy will be monitored via workforce data, untoward incidents and complaints on DATIX and feedback via other routes such as surveys.
Disability	There is no evidence to suggest there is a disproportionate impact on disability. However, data collection of those affected by the policy will be monitored via workforce data, untoward incidents and complaints on DATIX and feedback via other routes such as surveys.
Sex	There is no evidence to suggest there is a disproportionate impact on sex. However, data collection of those affected by the policy will be monitored via workforce data, untoward incidents and complaints on DATIX and feedback via other routes such as surveys.
Gender Identity	There is currently no data collected for this area; however, will be monitored via workforce data, untoward incidents and complaints on DATIX and feedback via other routes such as surveys.

Sexual Orientation	There is no evidence to suggest there is a disproportionate impact on sexual orientation. However, data collection of those affected by the policy will be monitored via workforce data, untoward incidents and complaints on DATIX and feedback via other routes such as surveys.
Age	There is no evidence to suggest there is a disproportionate impact on age. However, data collection of those affected by the policy will be monitored via workforce data, untoward incidents and complaints on DATIX and feedback via other routes such as surveys.
Socio-Economic	There is currently no data collected for this area; However, data collection of those affected by the project will be monitored via workforce data, untoward incidents and complaints on DATIX and feedback via other routes such as surveys
Human Rights	There is no evidence to suggest that there is a disproportionate impact on human rights regarding this policy. However, data collection of those affected by the project will be monitored via workforce data, untoward incidents and complaints on DATIX and feedback via other routes such as surveys
What are the overall trends/patterns in the above data?	No trends or patterns have been identified at this stage

Involving and consulting stakeholders				
Internal involvement and consultation				
External involvement and consultation				
Impact Assessment				
Overall assessment and analysis of the evidence	Reasonable adjustments for training, equipment and information will be made available upon request. Consideration will be given to those staff that have special requirements during the implementation of the system.			
Action Plan				
Action	**Owner**	**Risks**	**Completion Date**	**Progress update**
Monitoring of systems for feedback of impacts	Cancer Operational Manager		Ongoing	
Specific issues and data gaps that may need to be addressed through consultation or further research				

GLOSSARY | Appendix 3

PHNT	Plymouth Hospitals NHS Trust
Active Monitoring	Where it is clinically decided to start a period of monitoring in secondary care without clinical intervention or diagnostic procedure at that stage.
Active Waiting List (elective waiting and elective planned)	The list of elective patients who are fit and able to be treated at that point in time. The active waiting list is also used to report national waiting time statistics.
Cancelled operations/procedures	If the trust cancels a patients 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.
CaRP (Communication and Referral Protocol form)	A CaRP form is designed by the cancer network to be completed when a patient's care is transferred between NHS trusts. The form provides information on the current pathway status of a patient, including the referral and breach dates.
Chronological order (in turn)	The general principle that applies to booking patients in order. All patients should be seen or treated in the order they were initially referred for treatment unless clinically more urgent.
CWT	Cancer Waiting Times
Decision to treat (DTT)	Where a clinical decision is taken to treat a patient and the patient agrees to the treatment plan.
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.
DoH	Department of Health

Elective Admission/elective patients	Inpatients are classified in two groups, emergency and elective. Elective patients are so called because the Trust can 'elect' when to treat them.
Elective Planned	Patients admitted having been given a date or approximate date at the time that the decision to admit was made. This is usually part of a planned sequence of clinical care determined mainly on clinical criteria.
Elective Waiting List	Patients waiting elective admission.
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 of clinical judgement in consultation with others as appropriate, including the patient.
Incomplete pathways	Patients either on an admitted, non-admitted or diagnostic pathway still waiting for treatment.
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.
MDT Coordinator	Multi-Disciplinary Team Coordinator.
PTL	Primary Targeted 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.
Peer Review	An annual assessment specific to each specialty against national standards.