| Trust Policy | Plymouth Hospitals NHS NHS Trust |
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## Cancer Operational Policy

| Date | Version |
|---|---|
| **September 2015** | **1** |

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

| **Who should read this document?** | |
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| 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. | |

| **Accountabilities** | |
|---|---|
| **Production** | Cancer Operational Manager/Head of Nursing (Cancer) |
| **Review and approval** | IPAM and Trust Board |
| **Ratification** | Chief Operating Officer |
| **Dissemination** | Cancer Operational Manager |
| **Compliance** | Cancer Operational Manager |

| **Links to other policies and procedures** | |
|---|---|
| | |

| **Version History** | | |
|---|---|---|
| **1.1** | September 2015 | Initial document |
| | | |

| Last Approval | Due for Review |
|---|---|
| September 2015 | September 2018 |

*The Trust is committed to creating a fully inclusive and accessible service.  By making equality and diversity an integral part of the business, it 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 on Trust Documents. Larger text, Braille and Audio versions can be made available upon request.**

## 1    Introduction

Plymouth Hospitals NHS Trust (PHNT) 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 PHNT 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 **Cancer Waiting Times A Guide Version 8.1**

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, including legal and regulatory background

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

The Government's document **Improving Outcomes: A Strategy for Cancer** 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 if cancer is suspected or not, 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%

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 **Cancer Waiting Times a Guide Version 8.1.**
- 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 |
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Please see glossary (Appendix 4)

| 4 | Duties |
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**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.

**Chief Operating Officer**

The Chief Operating Officer is the Executive Lead for cancer and is responsible for:

- Executive accountability for the implementation of this policy.
- Ensuring that effective processes are in place to manage patient care and treatment to meet national and local targets and standards including those included in the NHS Constitution.
- Achieving cancer access targets.
- Ensuring trust wide monitoring systems are in place to ensure compliance with this policy and avoid breaches of the targets.
- Monitoring progress against achievement of the targets and taking action to avoid any potential breaches.
- Keeping the Trust Board and Senior Management Team informed of progress in meeting cancer access target and any remedial action taken.

- 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.
- 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.

**The Director of Cancer Services**

The Director of Cancer Services is accountable to the Medical Director and Chief Operating Officer and the role includes:

- Ensuring high quality cancer services are delivered and effectively coordinated.
- Provision of clinical advice and guidance in regard to trust wide cancer issues.
- Ensuring adequate clinical and non-clinical engagement within the cancer services strategy.
- Supporting the development and implementation of protocols and pathways to ensure an effective network of high standard care for cancer patients within the cancer standards.

**Head of Nursing (Cancer)**

The Head of Nursing (Cancer) is accountable to Director of Cancer Services and Chief Nurse and the role includes:

- Implementation of cancer strategies.
- Facilitation of the delivery of cancer waits.
- Monitoring of cancer waiting times data and its quality.
- Management of cancer service team, including cancer services administration and cancer nurse specialists.
- Facilitating peer review.
- Facilitating the implementation of actions relating to national cancer patient experience survey.
- Oversight and reporting of cancer strategic plan and local issues within the Trust.

**Cancer Operational Manager**

The Cancer Operational Manager will:

- Ensure that Trust staff has access to this policy and the provision of appropriate training sessions in order for the policy to be rolled out successfully.
- Work with the individual Service Lines administrative teams in their delivery of the cancer standards and address ad-hoc problems with service lines and MDTC and 2WW office.
- Provide leadership and support to the MDT coordinators so that they provide a high quality service to the site specific MDTs.
- Monitor the overall Trust, Inter-trust and site specific cancer performance.
- Lead on national audit and data collection and monitoring of cancer data.
- Validate all breaches and ensure accurate information is uploaded to the national database.

**Cancer Services Administration Manager**

The Cancer Services Administration Manager will:

- Manage the cancer services team ensuring all key tasks are covered during staff absence – namely 2ww processing, MDT administration and cancer pathway tracking.
- Deliver training sessions to required staff groups.
- Administer the cancer waiting times online training.

- Provide in depth role related training for 2ww clerks, data collectors and MDTCs (to include knowledge of their site's pathways)
- Be accountable for 2ww referral process.

## Multi-Disciplinary Team Coordinator (MDTC)

There is a named MDTC for each MDT and with support from the MDTC Assistants the MDTCs are responsible for:

- Tracking patients on the PTL for their allocated tumour site. Due to the tight timescales involved it is not feasible to expect patients pathways to deliver themselves without intervention, it is the MDTCs responsibility to 'pull' cancer patients along their diagnostics and treatment pathways.
- Identify where interventions are not being planned within the appropriate timescale and escalating to the relevant individual where necessary when alternative action needs to be taken.
- The administrative and functioning of the individual MDT meetings including making sure patients are discussed in a timely manner at the relevant MDT meeting.
- Making sure that all the necessary clinical and non-clinical information is available to allow the patient to be discussed holistically at the MDT.
- Providing the administrative support so that there is accurate, accessible and timely treatment plans agreed by the MDT.
- Communicating and interacting with the clinician teams regarding issues relating to the patient pathway.
- Ensuring that referrals/appointments for patients on the cancer pathway are made in a timely manner.
- Receiving and processing referrals into the MDT so that they are tracked and brought to the MDT in a timely manner for discussion and planning of treatment.
- Receiving and processing referrals from Tertiary hospitals and ensuring all information required for tracking and MDT discussion is received and inputted into the correct place.
- Completing breach analysis on all patients that are treated or seen outside the targets.
- Collecting data discussed at MDT for national audits, COSD and staging.

## MDT Clinical Lead

There is a named MDT Lead for each tumour site. They are responsible for:

- Ensuring the efficient operations of the MDT in line with national cancer peer review standards.
- Reviewing breaches with service line managers.
- The tumour site specific pathway ensuring staging data is available to the MDTC for collection.

## Care Groups & Service Line Teams

Cancer Waiting Times (CWT) is integrated into the operational delivery structures. Care Group Teams are accountable to the Chief Operating Officer for ensuring delivery of CWT through their Service Lines teams

Service Lines have responsibility for:

- Ensuring that the duties, responsibilities and processes laid down in this policy are implemented with the Service Line. This includes ensuring that effective processes are in place to manage patient care and treatment that meet national, local standards and the NHS Constitution.
- Ensuring 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.

- Managing resources allocated to the Service Line with the aim of achieving access standards. 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's treatment.
- Working with other Service Line Managers 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.
- Ensuring all relevant Service Line staff are aware of this policy and receive training so that they can meet the policy requirements.

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. However, overall accountability for the communication process lies with PHNT.

Patients are responsible for ensuring that they follow the booking procedures and protocols based on the information supplied to them via correspondence and leaflets for example by attending appointments that are booked with them.

| 5 | Key elements (determined from guidance, templates, exemplars etc) |

### GP referrals for Suspected Cancer (2ww)

All suspected cancer referrals should be referred by the GP/GDP on the relevant body site proforma available on the PHNT website and submitted via choose and book 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 deliver to the relevant booking team.  Referrals received after 3:30pm will be delivered the following morning by 11am.  Referrals received after 5pm will be processed as being received the following day. Referrals will be date stamped by Cancer Services and all departments should book 14 days from this date.

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.

National guidance states that patients cannot attend (DNA) a 2ww appointment and 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.

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.


## Diagnostic Phase

All diagnostics for patients on a cancer 62 day pathway should be requested with a 2ww priority and a red 2ww sticker should be clearly displayed on the request form.

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.

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.


## MDT Meeting

Each Site specific team has regular MDTs 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.

**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.

*Cancer Treatment Patient Target List (PTL)*

A Cancer Treatment PTL is created daily by the Performance Information Team 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.

*Weekly PTL Process*

In addition a weekly PTL report is produced for each site by the relevant MDTC which includes patients who are within 4 weeks of their target or past their target, for skin it is all patients. 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, no action required

The weekly process includes escalation to mangers as below –

- Unresolved red actions are escalated to the Service Line Management Team at the end of the weekly process.
- Actions that roll over into the second week will be escalated to Service Line Managers at the beginning of the weekly process and are clearly identified on the report.
- Key themes affecting multiple patients are escalated by the MDTC to the Cancer Operational Manager, Head of Nursing (Cancer) and relevant Service Line Management Team as and when they arise.


**Clock Stops, Pauses and Adjustments**

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.

## 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.

## 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.

## 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.

## 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.

## Breach Analysis and Reporting

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.  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
- Treatment delayed for medical reasons

Breach analysis is completed by the MDTC once diagnosis of cancer is confirmed and is started once the patient is first identified as a breach (this can be before treatment has started) and updated as necessary.

Breaches over 90 days are reviewed by Director of Cancer Services and shared with Care Group Managers and the Care Group Clinical Director.

All breaches are shared with clinical, operational and management teams.

Breaches are discussed at the weekly cancer performance meeting and avoidable delays actioned and addressed by service lines.

## Weekly Cancer Performance Meeting

A weekly performance meeting will take place on a Thursday chaired by the Executive Lead for Cancer (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 will include:

- 2ww seen in 7 and 10 days
- DTT by day 31 and 42
- Imaging performance for CT, CTC, MRI and US biopsies and aspirates (7 days request to test and reporting in 2 working days)
- Endoscopy performance – OGD and Colonoscopy (7, 10, 12 and 14 days request to test)
- Pathology performance against 10 day turnaround
- 62 Day performance current and future month

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

Operational issues that affect achievement of the cancer standards should be discussed at this meeting and actions determined to minimize risk.

Breaches of cancer standards will be presented weekly by the Cancer Operational Manager.


**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) through IPAM
- included within the annual cancer quality assurance report to the Quality Assurance Committee (QAC)
- performance and breaches are allocated to each service line and  included within the monthly Service Line Dashboards
- performance and breaches are discussed at the weekly cancer performance meeting


**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 8.1**).  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.

PHNT 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. data collectors, MDTC, MDTC assistants will be undertaken as part of their orientation and training for their role. Annual assessment will be undertaken as part of the appraisal process.

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.
- Spot checks patients that do not breach any of the targets are also carried out on a monthly basis by the Cancer Admin Manager.  Three patients from two cancer sites are done each month on a rolling programme.
- The weekly PTL process includes meetings where each patient on the PTL is reviewed and checks on national guidance are applied.

## 6    Overall Responsibility for the Document

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

## 7    Consultation and ratification

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

This document is published on the Trust Wide Public Folders. The Cancer Operational Manager is responsible for holding and maintaining a master file containing a register and a signed copy of the policy, and the corresponding Equality Impact Assessment.

The Cancer Operational Manager will ensure that old versions of the policy are archived in the archive master files. Access to archived documents will be through the Document Controller.

The Document Controller will issue the policy numbers and maintain an index that will include the document's title, policy number and issue, owner, issue date and next review date.

The approvals are indicated by the front sheet of the document as is the version (i.e. issue) control.

| 8 | Dissemination and Implementation |
|---|---|

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.

| 9 | Monitoring Compliance and Effectiveness |
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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.

| 10 | References and Associated Documentation |
|---|---|

NHS Constitution

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

Cancer Waiting Times A Guide Version 8.1

http://systems.hscic.gov.uk/ssd/cancerwaiting/cwtguide8-1.pdf

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

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

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 — Appendix 1

### Core Information

| | |
|---|---|
| **Document Title** | Access Policy for Cancer Pathways |
| **Date Finalised** | September 2015 |
| **Dissemination Lead** | Cancer Operational Manager |

### Previous Documents

| | |
|---|---|
| **Previous document in use?** | No |
| **Action to retrieve old copies.** | N/A |

### Dissemination Plan

| Recipient(s) | When | How | Responsibility | Progress update |
|---|---|---|---|---|
| All staff | On publication | Email | Document Control | |
| All staff | Ongoing | Training sessions | Cancer Operational Manager | Commenced |
| | | | | |

## Review and Approval Checklist — Appendix 2

### Review

| | | |
|---|---|---|
| **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 3

| Core Information | |
|---|---|
| **Manager** | Katie Caley |
| **Directorate** | Cancer Services |
| **Date** | September 2015 |
| **Title** | Access Policy for Cancer Pathways |
| **What are the aims, objectives & projected outcomes?** | The purpose of this policy is to ensure that:<br><br>• All of our services must be available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief.<br>• Access to our services is based on clinical need.<br>• The planning and delivery of our services must be focused on patient experience.<br>• Our services must reflect the needs and preferences of patients, their families and their carers through the provision of choice wherever possible.<br>• The NHS works across organisational boundaries and in partnership with other organisations in the interests of patients and the wider population.<br>• PHNT is committed to providing the best possible value for money to deliver the most effective and fair use of finite resources.<br>• 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. |
| **Specific issues and data gaps that may need to be addressed through consultation or further research** | There is no data currently collected for gender identity or socio-economic. |

## 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 | |

| 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. |