Document Title:	**CANCER ACCESS AND OPERATIONAL POLICY**		
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Contributes to HSC Act 2008 (Regulated Activities) Regulations 2014(Part 3); and CQC Regulations 2009 (Part 4) **CQC Fundamental Standards of Quality and Safety:**			17
Issuing Division/Directorate:	Cancer Services		
Author/Contact: (Asset Administrator)	Nathan Hall, Interim Cancer Service Manager		
Hospital Sites: (tick appropriate box/es to indicate status of policy review i.e. joint/ independent)	✓MEHT □ BTUH □ SUH		
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Approval Group / Committee(s):	Senior Management Group	**Date:**	28th November 2019
Professionally Approved by: (Asset Owner)	Wendy Matthews: Director of Nursing Kevin Beaton: Medical Director	**Date:**	28th November 2019
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Related Trust Policies (to be read in conjunction with)	Dignity in Care Policy – Register No: 10120 Safeguarding Children and Young People – Register No: 04064 Safeguarding Adults Policy – Register No: 08034 Private Patient Policy – Register No: 12024 Patient Access Policy – Register No: 04055 Serious Incident Policy – Register No:11025 Caring for Adult Patients with a Learning Disability in the Acute Hospital Policy – Register No: 09116

Document Review History:			
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1.0	Matt Riddleston		5 January 2010
2.0	Matt Riddleston		I June 2012
3.0	Karen Hull		7th March 2016
4.0	Nathan Hall	Full review	5th December 2019

1. Purpose

- The purpose of this policy is to provide guidance and outline the rules for the management of patients on a cancer pathway and to act as an operational guide for those staff involved in the management of these pathways.
- The policy sets out the roles and responsibilities, processes to be followed and establishes a number of good practice guidelines to assist staff with the effective management of patients with suspected or diagnosed cancer.
- Patient's best interests are at the forefront of this policy. "The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals".
- 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 Guide version 10.

1.2 For patients it will ensure that**:**

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

1.3 For Clinical and Non-clinical staff it will make sure that**:**

- Teams and individuals are aware of their responsibilities for moving patients along the agreed clinical pathway in accordance with the national Cancer Reform Strategy standards as set out in Cancer Waiting Times Guide version 10
- 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 in the Somerset Cancer Register (SCR) and reported to the National Cancer Waiting Times Database within predetermined timescales

2. Aims

To ensure that all staff adhere to National Cancer Waiting Times as described in this policy in conjunction with CWT V10.

To ensure that there are robust processes and systems in place for all staff that clarifies all the essential cancer performance standards.

To ensure that patients are seen in appropriate timescales, Somerset Cancer Register and PAS is kept up to date and patients are tracked and discussed at MDT meetings within agreed timescales.

3. Scope

This policy applies to all Trust Staff involved in the care and management of cancer patients and to all patients with confirmed or suspected cancer cared for under Cancer Waiting Times Guidance as it applies to English NHS patients and as outlined in this policy.

4. Equality Impact Assessment

Mid Essex Hospital Services NHS Trust (the Trust) strive to ensure quality of opportunity for all service users, local people and the workforce. As an employer and a provider of health care, the Trust aims to ensure that none are placed at a disadvantage as a result of its policies and procedures.
(Refer to Appendix 1)

5. Definitions

The following is a list of definitions issued by the Department of Health that are used in this policy:

Active monitoring	This is where a diagnosis has been reached but it is not appropriate to give active treatment at that point in time but an active treatment is still intended/may be required at a future date.
Active waiting list	The list of patients who are fit and able to be at that point in time. The active waiting lists is also used to report national waiting time statistics
Cancelled operations / procedures	If the trust cancels a patient's operation or procedure on the day of, or after admission for non-clinical reasons – the Trust is required to rearrange treatment within 28 days of the cancelled date or within target wait time whichever is soonest.

CaRP (Cancer 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. A 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 patients categorised as requiring routine treatment. All routine patients should be seen or treated in the order they were initially referred for treatment.
CSMB	Cancer Services Management Board
CWT	Cancer Waiting Times (National Cancer Standards)
Decision to admit (DTA)	Where a clinical decision is made to admit the patient for either day case or inpatient treatment.
Decision to treat (DTT)	Where a clinical decision is taken to treat a patient as an inpatient, day case or outpatient setting.
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
ECAD	Earliest clinically appropriate date (for next stage of treatment)
EROD	Earliest Reasonable Offer Date
First definitive treatment (FDT)	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention. What constitutes first definitive treatment is a matter of clinical judgment in consultation with other as appropriate, including the patient.
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
NCG	Network Clinical Group
Outpatients	Patients referred by a general practitioner (medical or dental) or another consultant / health professional for clinical advice or treatment.
Patient Administration System (PAS)	Trust system (Lorenzo) where all patient appointments are booked and waiting lists are managed.
PTL	Patient 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.
RTT	Referral to treatment (18 week standard)

Somerset Cancer Register (SCR)	A system in which all cancer patients are tracked and monitored. SCR is also used to support our reporting processes
SCN	Strategic Clinical Network
TCI (to come in)	A proposed future date for an elective admission

6. Roles and Responsibilities

6.1 **Chief Operating Officer** is the executive lead for clinical operations and is responsible:

- Through the divisional structure including Associate Director of Operations and Divisional Clinical Directors for ensuring that effective processes are in place to manage patient care and treatment that meet national, local and NHS Constitution targets and standards
- With Associate Director of Operations and Divisional Clinical Directors for achieving cancer access targets
- With Associate Director of Operations and Divisional Clinical Directors for monitoring progress against achievement of the targets and taking action to avoid any potential breaches
- For keeping the Site Director Team and Senior Management Team informed of progress in meeting cancer access target and any remedial action taken
- For delivering operational targets for service delivery in line with the annual business plan to include national targets – including 18 weeks, cancer waiting times and all other key access targets
- For the management, communication and dissemination of the Trust Cancer Access Policy as the Responsible Officer
- For ensuring that principles of managing demand, activity, capacity and variation are embedded in service development and part of the business cases for investment and development of services

6.2 **Associate Director of Operations and Divisional Clinical Directors** for each division have overall responsibility for implementing and adherence to this policy within their division. This includes:

- Ensuring that effective processes are in place to manage patient care and treatment that meet national, local and NHS Constitution targets and standards for each specialty within the clinical division
- Managing resources allocated to the clinical division with the aim of achieving access targets. This includes having the staff and other resources available to operate scheduled outpatient clinics, patient treatment and operating theatre sessions and avoid the need to cancel patient treatment
- Ensuring capacity and demand modelling tools are updated at least yearly or as services change to ensure sufficient capacity is available to meet the needs of the patients being referred

- Working with other Associate Directors and Clinical leads 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
- Achieving cancer access targets
- Ensuring that the duties, responsibilities and processes laid down in this policy are implemented with the Division
- Ensuring all staff that need to operate this policy are aware of this policy and receive training so that they can meet the policy requirements
- Implementing effective monitoring systems within the division to ensure compliance with this policy and avoid breaches of the targets: escalate any actual or potential breaches to the Cancer Service Manager
- Implementing systems and processes that support data quality and for validating data to ensure that all reports are accurate and produced within agreed timescales
- Ensuring that any patients with learning disabilities and autism can have their special needs met in accordance with Trust Policy

Day to day operational management of this policy will be delegated to divisional operational managers and Clinical leads as set out in the governance arrangements for each clinical divisional group

6.3 Consultants are responsible for:

- Managing the patients care and treatment and working with their Associate Director of Operations and Clinical Lead and clinical colleagues to ensure that this is provided within timescales laid down in national, local and NHS constitution targets and standards
- Alerting the Associate Director of Operations any potential or actual breaches of targets
- Ensuring that any patients with learning disabilities and autism have their special needs met in accordance with Trust Policy
- Managing staff within the medical team to ensure that scheduled outpatient clinics, patient treatment and operating theatre sessions are held and avoid the need to cancel patients
- Managing waiting lists and deciding on patient admissions / treatments in line with clinical priority
- Working with colleagues to prevent the cancellation of patient admissions for non-clinical reasons and taking action to reschedule any patients so cancelled in line with timescales set out in this policy
- Communicating accurate waiting time information to patients, their families and carers and dealing with any queries, problems or complaints in line with trust policy
- Assisting with the monitoring of data quality and production of reports
- Supporting effective capacity and demand planning with specialist knowledge and pathway detail
- Managing the responsibilities of the MDT including attendance and annual leave cover

6.4 Mid-Essex Referral Centre and those staff designated to make appointments including for outpatients, diagnostic tests and treatment are:

- To receive fast track referrals, ensure that they are date stamped, and enter details on to the Trusts Patient Administration System within 24 hours
- To forward the referral when required to the appropriate consultant to assign clinical priority
- To make outpatient appointments that ensure the cancer standards are met
- To ensure all outpatient appointment offers are recorded on PAS
- To ensure cancellation reasons are recorded on PAS
- To ensure PAS is updated correctly and in a timely way e.g. as soon as practicable with any patient choice decision
- To ensure Somerset Cancer Register is updated and reflects a true and accurate record as depicted on PAS
- To refer any problems or suspected / potential breaches of policy or compliance with cancer targets to the appropriate Service or Operational Manager and copy to Associate Director of Operations for Cancer

6.5 Corporate Cancer Management Function

- Tracking patients on the PTL for the tumour site that they are responsible for coordinating
- Monitoring the PTL relevant to their tumour site to identify where interventions are not being planned within the appropriate timescale
- Escalating to the relevant individual where necessary when alternative action needs to be taken so that the patients pathway can achieve the required standard
- The administrative management and support and for the functioning of the individual MDT meetings including making sure that patients are discussed in a timely manner at the tumour site MDT meeting
- Making sure that all the necessary clinical and non-clinical information is available to allow the patient to be discussed holistically
- Planning communicating and interacting with clinicians regarding issues relating to the patient pathway
- Maintenance of and the quality of Cancer Dataset Collection
- 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
- Undertake formal breach analysis in conjunction with Service Managers and MDT clinical leads of patients at day 61 and above in the 62 day pathway

6.6 Multi-Disciplinary Team

An MDT comprises of medical and non-medical professionals who are responsible for the cancer patient's care. It includes clinicians from a variety of disciplines, the exact constituent are described for each tumour site as part of Peer Review requirements. It supports delivery of cancer standards by:

- Bringing together designated cancer specialists to discuss patient care and agreeing a treatment plan for individual patients
- Making sure care is planned according to national guidelines and to support clinical governance
- Identifying and supporting entry of patients into clinical trials
- Ensuring that any patients with learning disabilities and autism have their special needs met in accordance with Trust Policy
- Monitoring and ensuring that there is good attendance by core members of the MDT so that decision making relevant to good practice and achievement of the cancer pathway
- Supporting the collection of good quality data relevant to clinical care and service improvement
- Reviewing its performance in terms of achieving safe and timely care in line with good practice and Cancer pathways standards
- Taking responsibility for changing pathways as required and those identified as a result of audit, data collection and performance information

6.7 MDT Clinical Lead

Each tumour site will be led by a clinician who has site specific specialist knowledge of treating cancer. The clinical lead will:

- Ensure that objectives of MDT working (as laid out in National Manual of Cancer Service Standards) are met
- Ensure that designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team’s operational policies are multidisciplinary decisions
- Ensure mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent
- Ensuring that any patients with learning disabilities and autism have their special needs met in accordance with Trust Policy
- Ensure that the target of 100% of cancer patients discussed at the MDT is met
- Ensure that patient care pathways are in accordance with National Performance Standards
- Ensure that integration with SMDTs that are relevant to individual patient care is seamless

- Ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision making and to support clinical governance/audit
- Ensure that treatment decisions made in the meeting are acted on and referrals made in a timely manner.
- Overall responsibility for ensuring that MDT meeting and team meet Peer Review Quality Measures
- Ensure attendance levels of core members are maintained, in line with Peer Review Quality Measures
- Provide link to Trust CSMB, either by attendance at meetings or by nominating another MDT member to attend
- Provide link to NCG (SCN), either by attendance at meetings or by nominating another MDT member to attend
- Lead on, or nominate lead for service improvement
- Organise and chair annual meeting examining functioning of team and reviewing operational policies, and collate any activities that are required to ensure optimal functioning of the team (e.g. training for team members)
- Ensure MDT's activities are audited and results documented
- Ensure that root cause analyses are undertaken of cancer waiting time breaches in order to inform service development
- Ensure that the outcomes of the meeting are clearly recorded and clinically validated and that appropriate data collection is supported
- Ensure target of communicating MDT outcomes to primary care is met

6.8 Lead Cancer Clinician

- Responsible for ensuring high quality cancer services are delivered and effectively coordinated
- Ensuring adequate clinical and non-clinical support
- Supervising arrangement for audit and supporting delivery of uniform standards
- 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
- Ensuring the development of services and reporting of performance concern to the cancer board with implementation of action plans to resolve areas of concern
- Supporting MDT clinical leads in the preparation for peer review and in highlighting any potential concerns within a speciality for this to be reviewed and corrected

6.9 Cancer Service Manager

- Reports to Associate Director of Operations - Performance
- Provides overall reporting of Trust performance against Cancer standards

- Ensure there are sufficient governance and performance management arrangements in place to robustly support the delivery of cancer performance
- Lead on improvements to Cancer access standards
- Be the trust management representative on the cancer network group meetings
- Ensuring the policy is kept up to date and reflects national best practice guidance
- Providing expert advice on cancer pathways across the organisation, including advice from national team if required
- Ensuring trust wide compliance with the policy and carrying out spot check audits to check compliance
- Work with the individual services in their delivery of the cancer standards
- Provide leadership and support to the Cancer Waiting List/MDT Managers so that they provide a high quality service to the site specific MDTs

6.10 General Medical / Dental Practitioners and other referrers

The trust relies on GP's and other referrers, supported by local commissioners to ensure patients understand their responsibilities and potential pathway steps and timescales when being referred. This will help ensure patients are:

- Referred under appropriate clinical guidelines
- Ensure they use agreed referral proformas / protocols, provide the required clinical information and patient demographics
- Offered a choice of provider as outlined in national guidance
- Aware of the speed at which their pathway may be progressed
- In the best possible position to accept timely appointments throughout their treatment

6.11 Patients

Everyone has a role to play to ensure that the Trust is able to deliver care within the Cancer pathways

Patients also have a role to play as outlined in the NHS Constitution these include:

- Make themselves available for the two months after referral for reasonable appointments
- Attending their hospital appointment or ensuring that they contact the hospital to cancel it, giving as much notice as possible if they are unable to attend
- Managing their own health where possible
- Using the part of the service appropriate for their needs
- Being involved in the management of their treatment pathway
- Ensuring that they inform their healthcare provider of any changes in personal circumstances, particularly contact details and registered GP

6.12 All staff

- All staff are responsible for ensuring that any data created, edited, used or recorded on the Trusts information systems within their area of responsibility is accurate recorded in accordance with this policy and other trust polices relating to the collection, storage and use of data in order to maintain the highest standards of data quality and maintain patient confidentiality
- All patient referrals, treatment episodes and waiting lists must be managed on the Trust Somerset Cancer Register and all information relating to patient activity must be recorded accurately and in a timely fashion and where appropriate all requests stamped with the 2ww stamp

7. Policy Monitoring Responsibilities

- This policy will be professionally approved by the Cancer Services Management Board.
- Alterations and amendments to this policy will be approved and endorsed by Cancer Services Management Board.

8. Key Principles

- 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 clinical priority and the overseas visitor policy.
- Patients will be treated in order of their clinical need. Patients of the same or comparable clinical priority will be treated on a ‘first come first served’ principle, according to case mix.
- The process of waiting list management for patients suspected of or diagnosed with cancer will be transparent to the public and communications with patients (or parents/carers and vulnerable patients) will be timely and informative clear and concise.
- Waiting lists will be managed equitably with no preference shown on the basis of provider or source of referral.

9. Cancer Waiting Times Standards

The Cancer Waits standards are described in detail in National Cancer Waiting Times Version 10. The standards are summarised below:

Maximum 2 weeks (2ww):

- All patients referred from GP/GDP as suspected cancer will be seen within 14 days of receipt of referral **(Operational Standard of 93%)**

- All patients referred with breast symptoms irrespective of whether cancer is suspected or not, will be seen within 14 days of receipt of referral **(Operational Standard of 93%)**

Maximum one month (31 day):

- All patients that are having a subsequent treatment for cancer will receive treatment within 31 days of the decision to treat
    - Surgery **(Operational Standard of 94%)**
    - Drug Treatment **(Operational Standard of 98%)**
    - Radiotherapy **(Operational Standard of 94%)**

- All patients diagnosed as a new cancer will receive treatment within 31 days of decision to treat irrespective of treatment **(Operational Standard of 96%**

Maximum two months (62 days):

- All patients referred by their GP/GDP as suspected cancer or breast symptomatic, who are subsequently diagnosed with cancer, will commence treatment within 62 days of receipt of referral **(Operational Standard of 85%)**

- 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 of 90%)**

- All patients that are upgraded by Consultants as suspected cancer will commence treatment within 62 days of the date of upgrade **(No operational standard set)**

- All patients (31 days) from urgent GP (GMP, GDP or Optometrist) referral to first treatment for acute leukaemia, testicular cancer and children's cancers **[No separate Operational Standard – Monitored within 62 day classic]**.

Faster Diagnosis (28days):

The Faster Diagnosis Standard will initially apply to all patients referred urgently for investigation on a:

- Two week wait pathway;
- Symptomatic breast pathway; or
- Urgent screening programme pathway.

The Faster Diagnosis Standard will also apply to those cancers covered by the 31 day rare cancer standard (acute leukaemia, testicular cancer and children's cancers).

The Faster Diagnosis Standard will not apply to patients who:

- Die within 28 days of being referred and with no communication of diagnostic outcome;
- Decline all diagnostic investigations or appointments;
- Are first seen on a faster diagnosis pathway and then choose to have diagnostic tests privately before returning to the NHS for cancer treatment;
- Are ineligible for NHS funding; or
- Opt not to continue on a faster diagnosis pathway.

10. Which Patients are included in the Cancer Waiting Time Standards?

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

- Being treated within a clinical trial
- Whose cancer care is undertaken by a private provider on behalf of the NHS i.e. directly commissioned by an NHS commissioner
- Whose care is sub-contracted to another provider – including private provider – (and hence paid for) by an English NHS provider i.e. commissioned by an NHS commissioner but sub-contracted out by a commissioned provider
- Diagnosed with a second new cancer
- Without microscopic verification of the tumour (i.e. histology or cytology) if the patient has been told they have and /or have received treatment for cancer
- With any skin squamous cell carcinoma (SCC) for example: Every SCC an individual skin cancer patient has will be covered by the standards

11. Excluded from Cancer Waits

Cancer waiting times service standards are not applicable to patients

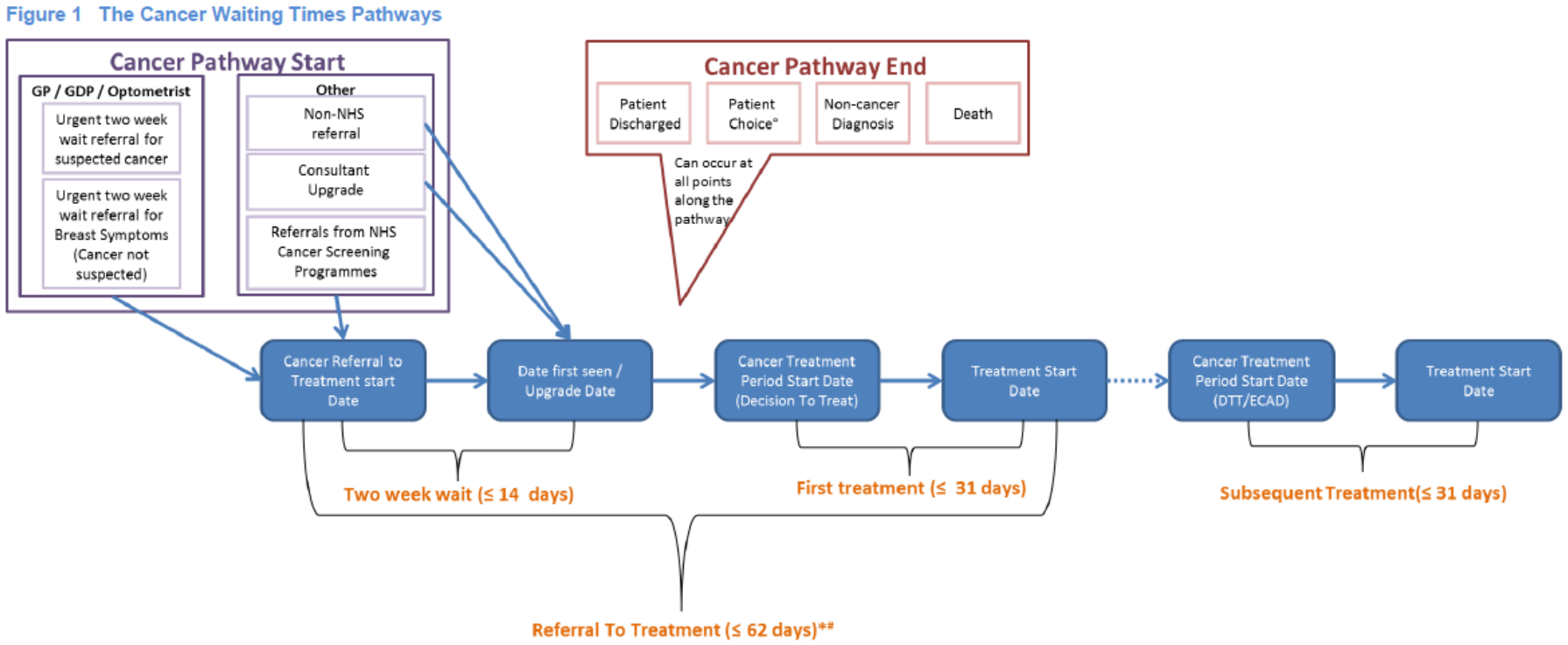
- With a non-invasive cancer ie:
    - carcinoma in situ (with the exception of breast (D05) which is included) – local systems will need to be in place to notify cancer registries of carcinoma in situ cases except for D05
    - basal cell carcinoma (BCC).

- Who die prior to treatment commencing – local systems will need to be able to flag this and forward the information to cancer registries
- Receiving diagnostic services and treatment privately. However:

    - where a patient chooses to be seen initially by a specialist privately but is then referred for treatment under the NHS, the patient should be included under the existing 31 day standards
    - where a patient is first seen under the two week standard, then chooses to have diagnostic tests privately before returning to the NHS for cancer treatment, only the two week standard and 31 day standard apply. The patient is excluded from the 62 day standard as the diagnostic phase of the period has been carried out by the private sector.
- Who refuse all reasonable offers of diagnostics or treatments, or opt to be treated outside of the NHS.

Figure 1 - The Cancer Waiting Times Pathways

12. Key Dates



*The Consultant upgrade pathway starts at the Upgrade date, not the Cancer referral to treatment start date.
This standard is ≤ 31 days for rare cancers
° Patient Choice = Patient declining any further NHS treatment or investigation
Note: this diagram does not include recurrent cancers

13. Coverage of the 2ww Standard

The two week wait standard applies to patients referred with suspected cancer from one of the following referrers:

- General Medical Practitioner (GMP)
- General Dental Practitioner (GDP)
- Optometrist

Referrals from the following also apply where they are acting on behalf of the patient's GMP in which cases the referral source should be recorded as the GP (03):

- Referral from GP with specialist interest (GPwSI)
- Clinical Assessment Service
- Walk-in centre

The standards apply to all NHS providers and private providers either where the activity is directly commissioned by an NHS England commissioner or subcontracted by an NHS provider.

Referrals for suspected recurrence of cancer:

A GP (GMP, GDP or Optometrist) can make an urgent two week wait referral for a suspected recurrence or a suspected second new primary cancer.

- the two week wait first seen and Faster Diagnosis Standard would apply
- if the urgent two week wait referral is diagnosed as a recurrence they are covered by the 31 day subsequent treatment standard
- if the urgent two week wait referral is diagnosed as a new primary the patient moves onto the 62 day pathway.

13.1 **2ww Clock start and end dates**

The two week wait start point is the receipt of the referral by the provider who will first see the patient (recorded as the cancer referral to treatment period start date). Receipt of referral is day zero.

Referrals received after a working day has finished should have the cancer referral to treatment period start date set as the date that the referral was received and not the next working day.

The two week wait end point is either when:

- the patient is seen for the first time by a consultant (or member of their team) following the referral receipt. This is recorded as DATE FIRST SEEN
- the patient is seen at a diagnostic clinic or goes 'straight to test' in a consultant-led service (unless that test is a blood test).

13.2 **Patient seen as an emergency prior to being seen following a two week wait referral.**

A telephone consultation or triage does not count as a clock stop for the two week wait standards.

Where a two week wait patient is admitted as an emergency for the same condition (i.e. related to the suspected cancer) before they are seen they should no longer be recorded against the two week wait standard, or Faster Diagnosis Standard. The emergency admission is the referral into the system and supersedes the original referral. However, the patient could be upgraded to the 62-day pathway if a consultant or authorised member of their team suspect's cancer is the cause of the admission.

13.3 **Management of DNAs & cancellations**

Patients should not be referred back to their GP after a single Did Not Attend (DNA) or cancellation. Patients should only be referred back to their GP after multiple DNAs following a clinical decision to do so.

Patients should never be referred back to their GP after an appointment cancellation unless this has been agreed with the patient – by cancelling an appointment a patient has shown a willingness to engage with the NHS

13.4 **Reasonable offer of appointment**

A 'reasonable' offer of an appointment is defined by locally agreed access policies.

Part of being reasonable means that the patient has been consulted and listened to, considering what the patient would find reasonable.

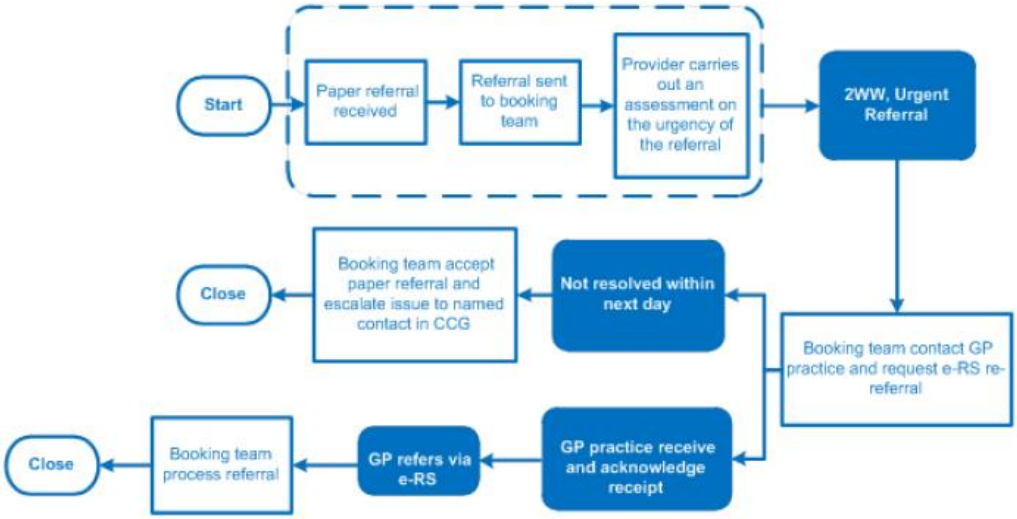
- For cancer a reasonable offer is classed as any appointment within the two week period and it is not a requirement to offer a choice of dates within this
- However it is best practice to offer the patients a choice and aim to offer the first appointment within 7 days of the referral being received. This will also assist in ensuring patients can be offered appointments within the standard over holiday and bank holiday periods
- The best interests of the patient should remain at the forefront when implementing this policy
- Patients who are unable to accept appointments within the 2 week standard **should not** be referred back to their GP/GDP/Optometrist because they are unable to accept an appointment within two weeks
- Patients **should not** be returned to their GP/GDP or Optometrist if they DNA their first appointment, they may be returned to the care of their GP after two or more DNA with agreement of their clinician
- Patients can only be referred back to their GP/GDP or Optometrist after multiple (two or more) DNA's but not after multiple appointment cancellations – by cancelling an appointment a patient has shown a willingness to engage with the NHS
- Patients **should not** be discharged if they are not immediately fit to attend appointments or tests
- Only the GP can downgrade a referral. If a consultant thinks the two week wait referral is inappropriate this must be discussed with the GP/GDP/Optometrist

- Also see adjustments which outline the adjustment possible when a patient DNA's their first appointment from the receipt of the referral to the date they rebook their appointment which is relevant to both the 2 week wait and 62 day standards.

13.5 Referrals not made via E-RS

For two week wait urgent referrals received by a route other than e-RS, referrals should not be rejected in the interests of patient safety. A patient should be offered an appointment.

A recommended process for this is included below. In the interest of patient safety, if there is no response from the GP practice within the next working day, the provider will contact the patient to make an appointment, regardless of whether they have received the e-RS referral from the GP practice or not.



13.6 Inappropriate and incorrect referrals

If a consultant thinks the two week wait referral is inappropriate this should be discussed with the GP/GDP or Optometrist. Only the referrer can downgrade or withdraw a referral.

14. Coverage of the 31 day Standard

The 31day standard applies to:

- NHS patients with a newly diagnosed invasive cancer (localised or metastatic), regardless of the route of referral
- NHS patients with a recurrence of a previously diagnosed cancer, regardless of the route of referral
- Patients who choose initially to be seen privately but are then referred for first and/or subsequent treatments in the NHS.

14.1 **31 day Clock starts**

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

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

15. Coverage of the 62 day Standard

15.1 **62 day 2ww Urgent clock start**

Clock start – refer to 2ww

15.2 **62 day Consultant Upgrade clock start**

If a consultant upgrades a patient for a first primary cancer the 62-day period starts at the CONSULTANT UPGRADE DATE. Only those upgrades that are diagnosed with cancer and go on to treatment need to be reported.

15.3 **Who can upgrade a patient?**

A consultant or an authorised member of the consultant team (as defined by local policy) can upgrade a patient if cancer is suspected. The ultimate responsibility for upgrades rests with the consultant responsible for the care of the patient who will have delegated their authority by local agreement. The upgrades could come from any part of the health service, not just from consultants and teams that most commonly see cancer patients.

15.4 **Can there be an upgrade from any source of referral?**

Yes, with the exception of the following as they are already on a cancer pathway:

- two week wait referrals for suspected cancer
- two week wait referrals for breast symptoms (not suspicious of cancer)
- urgent screening referrals.

An upgrade can occur after a MDT meeting as long as it was not the MDT meeting where the care plan that was agreed with the patient was discussed.

Upgrades are only for suspected new primaries only, not recurrences.

15.5 62 day Screening clock start

The two week wait standard does not apply to patients from the NHS national cancer screening programmes. However, it is important that clock start, the first seen activity and clock end is recorded for monitoring of the Faster Diagnosis Standard and 62-day screening standard if cancer is confirmed.

15.6 When does the Faster Diagnosis Standard and 62-day standard start for the three NHS cancer screening programmes?

The clock start (day 0) is when a referral is received by a provider in the screening pathway for further investigation after an initial screening test. Each individual screening programme is as follows:

- Breast - receipt of referral for breast screening assessment (i.e. not back to routine recall)
- Bowel (FOBT or FIT) - receipt of referral for an appointment to discuss suitability for colonoscopy with a specialist screening practitioner (SSP)
- Bowel scope – The bowel scope procedure date where participants are subject to biopsy or polyp removal or otherwise referred for a colonoscopy in the screening programme.
- Cervical - receipt of referral for an appointment at colposcopy clinic.

15.7 What is recorded as the Date First Seen for screening cases?

The date first seen for the individual screening programmes are as follows:

- breast – first attendance for breast screening assessment
- bowel (FOBT or FIT) – first attended appointment with specialist screening practitioner (SSP) to discuss suitability for colonoscopy
- bowel scope – first attendance following initial bowel scope, which could be SSP appointment or colonoscopy
- cervical – first attended colposcopy appointment

It is the responsibility of the provider commissioned for this first attendance to upload this information onto the National Cancer Waiting Times system.

16. Decision to Treat (DTT)

The DTT is the date the patient agrees a treatment plan. The date the patient signs the consent form may, depending on administrative procedures locally, take place some days after the DTT. It is advised that the meeting at which the treatment plan is agreed is classed as the DTT, not the date the consent form is signed.

Can a DTT date be changed?

Yes; if

- a patient decides they do not want the treatment originally agreed to (eg if a patient is offered surgery and is given a To Come In (TCI) date then decides they would rather have chemotherapy then the DTT is reset to when the chemotherapy is agreed); or
- due to clinical considerations after the agreement it is decided that the agreed treatment is no longer appropriate (eg pre-operative tests find complications); and
- a different treatment is discussed and agreed to, then the date of agreement for the treatment the patient goes on to have would be the new DTT and the 31-day

17. Ending the 31/62 day Pathways (Clock stops)

The 31 day & 62 day standard **stops** with first definitive treatment and this is defined as ‘an intervention intended to manage the patients disease, condition or injury and avoid further intervention. It is a matter of clinical judgement, in consultation with the patient’ For cancer waits a first definitive treatment is further defined as the start of the treatment aimed at removing or eradicating the cancer completely or at reducing tumour bulk.

The clock stops for first definitive treatment and this may differ for different treatments, for example:

- For surgical intervention it is the date the patient is admitted for surgery
- For anti-cancer drug therapy it is the date the first drug in an agreed course is given
- For radiotherapy it is the date the first fraction is given
- For active monitoring it is the date agreed with the patient
- For palliative care it is when the first contact is made with the patient
- This is not an exhaustive list and further treatments may apply under the guiding principle above
- Diagnostic procedures may also be first definitive treatments if they are undertaken with therapeutic intent e.g. the intention is to remove the tumour, irrespective of whether the margins are clear i.e. in polypectomy or excision biopsies.
- For further details (including enabling treatments) refer to CWT Version 10

17.1 Combined Treatments and Treatment Packages

For the purposes of the cancer waits dataset combined treatments are treatments of different modalities combined in a way that they must be scheduled to take place together. These should be regarded as single treatment packages.

Examples of combined treatments include:

- Chemo-radiotherapy - where radiotherapy and chemotherapy are delivered within a strict schedule so that they interact to make both treatments more effective (eg weekly 5FU during radiotherapy for rectal cancer, radiotherapy given synchronously with cycle 4 of CMF for breast cancer)
- pre-operative or intra-operative radiotherapy - where radiotherapy is given just before or during surgery to maximise the effect of both treatments.

The definition of combined treatments excludes adjuvant therapies where each treatment can be scheduled separately. (eg breast surgery followed by post-operative radiotherapy, chemotherapy for small cell lung cancer followed by consolidation radiotherapy).

17.2 Treating Metastatic Disease

Treatment of metastatic disease is almost always classed as a subsequent treatment.

The exception is treatment of metastatic disease with an unknown primary where both first and subsequent treatments can be recorded. If originally the primary is unknown, but then at a date after the metastatic disease has had a FDT the primary is diagnosed, then the treatment of the primary would be recorded as a subsequent treatment.

17.3 Subsequent Treatments & Earliest Clinically Appropriate Date (ECAD)

All subsequent treatments for primary and recurrent cancer need to have a 31 day period recorded.
A subsequent treatment could be:

- Anti-cancer treatment (curative or palliative) aimed at shrinking (or delaying the growth/spread) of the tumour/cancer
- The provision of palliation for the symptoms resulting from the tumour/cancer
- Symptomatic support by non-specialist palliative care teams where no active cancer treatment is planned
- Active monitoring (where no active or palliative treatment is appropriate).

An individual patient may receive one or a combination of these interventions

The member of the consultant team liaising with the patient about the treatment in question would set the ECAD.

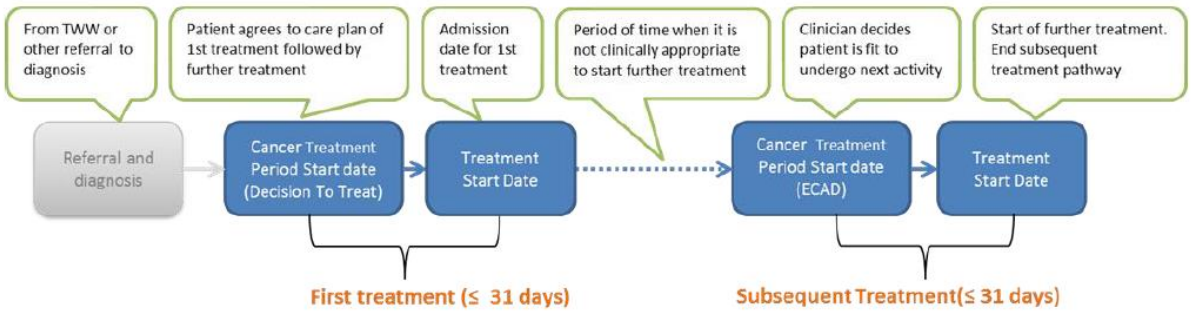
The ECAD can be with or without the presence of the patient and set at a number of points:

- at the clinical review with the patient following the preceding treatment. If it is not possible to make a decision at the review a further review could be arranged
- at the start of the preceding treatment if the patient will not be reviewed between treatments
- at the Multidisciplinary Team (MDT) meeting if it is possible to identify the likely ECADs between treatments in an agreed package
- following receipt of test results and prior to discussing with the patient if this is an appropriate date.

The patient does not have to be physically present on the date the ECAD is set as it can be set based on an earlier consultation.

The ECAD can be reviewed and changed any time up to the ECAD.

Figure 2 ECAD (patient not required to be present on ECAD date)



18. Managing Recurrences

When a patient, who has previously had cancer has a recurrent cancer diagnosis confirmed, the patient would proceed onto a 31day subsequent treatment pathway. If the cancer diagnosed was in the same location or was the same type of cancer as a previously diagnosed cancer but the cancer is classed by the clinician as a new primary then this would be a new 62-day pathway, not a recurrence eg if a patient has left breast cancer and then comes back at a later date with right breast cancer then which pathway the patient is recorded under is dependent on the clinical decision as to whether this is a new primary or not.

19. Adjustments

Waiting time adjustments are allowed in two places:

1st Outpatient appointment

- If a patient DNAs their initial out-patient appointment – this would allow the clock to be re-set from the receipt of the referral (recorded as the cancer referral to treatment period start date) to the date upon which the patient rebooks their appointment. This adjustment is relevant to the cancer two week wait and the 62-day standard.

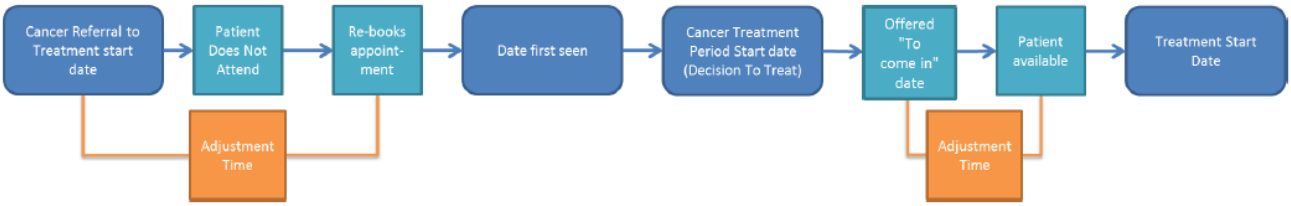
Admitted treatment

- If a patient declines an offer of admission for treatment in an in-patient (ordinary admission or day case) setting provided the offer of admission was “reasonable”. For cancer patients under the 31 or 62 day standard ‘reasonable’ is classed as any offered appointment between the start and end point of 31 or 62 day standards (i.e. any appointment within a cancer treatment period or cancer referral to treatment period). ***The adjustment would be the time between the date of the declined appointment (the offered To Come In date) to the point when the patient could make themselves available for an alternative appointment***.

For cases where the patient is unavailable for a period of time, such as a holiday, then this adjustment can be continued until the patient makes themselves available again. Any delay after that for medical suspensions or capacity issues would not be included in the adjustment.

No adjustments can be made for patients declining reasonable offers of diagnostic attendance.

Figure 3 ADJUSTMENT FOR DNA and To Come In date



20. Inter Provider Transfers

- An inter-provider transfer (IPT) occurs when a patient follows a pathway of care that involves a referral between providers
- An inter-Provider Transfer (i.e. where the patient’s pathway transfers from one provider to another for any reason) will not be recognised as a referral without receipt of the Clinical dataset and Cancer Waiting Times Datasets
    - The inter-provider Transfer ensures the timely transfer of clinical and administrative information between providers when an IPT occurs
- An inter-provider Transfer ensures patients receive appropriate assessment, diagnosis and treatment within the specified target times it is essential for referral information is sent to the provider within 24 hours of the decision to transfer
- The patient journey must be appropriately monitored, with key events communicated between all providers involved in the patient pathway

- There should be no delays in the transfer of patients and problems in the process must be escalated appropriately and in a timely manner to the relevant staff so that remedial action can be taken
- If a patients cannot be treated within the agreed 62 day performance standard the breach will be appropriately allocated between providers

21. Rare Cancers – Testicular, Children's and Acute Leukaemia

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

The Trust is committed to ensure all patients within the acute leukaemia, testicular cancer and children's cancers cohorts, who are fit and able and willing to be treated, receive that treatment within 31 days of the receipt of the initial referral into secondary care.

22. Auditing

All patients who breach the treatment targets 31 and 62 days within cancer pathway will have a breach analysis undertaken by the MDT Co-ordinators in conjunction with Service Manager and the MDT clinical lead. These will be presented at monthly divisional governance meetings.

Cancer Waiting List/MDT Managers will review cancer tracking and ensure all details are clear and entered on to Somerset Cancer Register; this will be the basis for any breach reporting

Validation of all breach pathways will occur via the cancer support manager who will provide an unbiased view of the analysis using the information on Somerset Cancer Register

Ad-hoc challenge of pathway recoding will occur via the Cancer Service Manager and will take place as part of the Cancer PTL reviews using the information on the cancer PTL

23. Resource Management

The capacity and effectiveness of the MDT team will be reviewed yearly via the Cancer Service Manager and will be reported to the CSMB regarding outcomes.

This will ensure the team is adequately resourced and supported by the cancer team and the divisional operational and clinical leads for each tumour site for the tasked required of them including review of the tumour sites covered and MDT allocation's, and vacancies and plans to resolve this.

Service Managers are responsible for ensuring demand and capacity modelling is completed and updated at least yearly or when a service change occurs to ensure adequate capacity is in place to deliver the service.

24. Performance Overview and Breach Reporting

Performance of all cancer standards are monitored by the divisional operation team and centrally by the corporate performance team.

A cancer PTL is available and updated 3 times a day for operational management of cancer pathways; this is used by the MDT Administration team and operational teams to track patients on a cancer patient to diagnosis and treatment.

All information relating to cancer treatments is logged by the MDT team on SCR to allow full tracking and validation of pathways.

During the RCA process it is identified if a delay has occurred, the MDT lead with colleagues will identify if the delay in diagnostics or treatment impacted adversely on the outcome for the patient.

All clinical harm review information….

Cancer 62 day - Clinical Harm Review

25. Cancer PTL Meetings

Cancer PTL meetings will occur weekly for each tumour site specialty, and are chaired by the Director of Planned Care and Associate Director of Performance.

Each specialty will be required to understand delays for each patient pathway and be able to provide the next steps including a plan to show how the patient will be treated before their breach date.

The specialties will also be expected to highlight upcoming capacity/clinical workforce constraints or delays within the service and what remedial action has been taken to counteract this.

Once completed, actions will be sent out via the Cancer Performance Team with specialties expected to return answers within 24 hours.

In addition to the Cancer PTL meeting, it is expected that the specialties would meet weekly with the MDT coordinators to understand any potential pathway delays and blockages.

26. Training Requirements

All non/clinical staff will have Trust induction and PAS training. All non/clinical staff involved in cancer pathways will have specific local training in relation to the implementation of this policy and Somerset Cancer Register training provided by Cancer Services, supported by the Cancer Waiting list/MDT Managers. Additional or remedial training will be provided as required.

27. Implementation and Communication

Corporate services will ensure that the Policy is available on the intranet and the Trust website together with supporting procedure notes and that staff are notified via Focus.

The Cancer Service Manager is responsible for ensuring the policy is disseminated to all divisions and cascaded.

28. References

This policy outlines the national rules as well as local policy and this includes the following:

NHS Constitution

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

Cancer Waiting Times Version 10

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

Appendix 1: Preliminary Equality Analysis

This assessment relates to: Cancer Access and Operational Policy (09124)

A change in a service to patients		A change to an existing policy	**X**	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
1. What are you proposing to change?	Full Review
2. Why are you making this change? (What will the change achieve?)	3 year review
3. Who benefits from this change and how?	Patients and clinicians
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Refer to pages 1 and 2

Preliminary analysis completed by:

Name	Nathan Hall	**Job Title**	Interim Cancer Service Manager	**Date**	August 2019