Derby Teaching Hospitals NHS
NHS Foundation Trust

TRUST POLICY FOR THE CANCER CENTRE OPERATIONAL POLICY

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Executive Lead Signature	Medicine and Cancer Divisional Director

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CANCER CENTRE OPERATIONAL POLICY

1. Introduction

Derby Teaching Hospitals NHS Trust is committed to ensuring that patients receive treatment in accordance with the NHS Constitution, national objectives and targets, including Improving Outcomes: "A Strategy for Cancer."

This policy sets out the Trust's local policy associated with meeting the cancer standards and takes into account guidance from the Department of Health. It is designed to ensure efficient and equitable handling of referrals in line with national waiting time guidance relating to cancer pathways and should be used in conjunction with the Trust's Patient Access Policy: http://flo/documents-forms/document-search/?q=access+policy.

Patients' 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 Going Further on Cancer Waits (GFOCW). See for the latest version. http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx.

2. Purpose and Outcomes

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

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

  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 Going Further on Cancer Waits GFOCW 6.3 and Cancer Waiting Times Guide version 8.0.S:\Oncology\Rehabilitation and Cancer\Cancer Centre\Inter_Provider

TransferPolicies\East_Midlands_Clinical_Network-_IPT_V2_April2015.docx.

- 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 Infoflex and reported to the National Cancer Waiting Times Database (Open Exeter) within predetermined timescales.

3. Scope

This policy applies to all PHT 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.

'In the event of an infection outbreak, flu pandemic or major incident, the Trust recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, staff should take advice from their manager and all possible action must be taken to maintain on-going patient and staff safety'

4. Definitions Used

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

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	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.
CSC	Clinical Service Centre
CWT	Cancer Waiting Times
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	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.
Infoflex	A system in which all cancer patients are tracked and monitored. Infoflex is also used to support our

	reporting processes.
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 Co-ordinator	Multi-Disciplinary Team Co-ordinator
Outpatients	Patients referred by a general practitioner (medical or dental) or another consultant / health professional for clinical advice or treatment.
PAS (Patient Administration System)	Trust system where all patient appointments are booked and waiting lists are managed.
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.
TCI (to come in)	A proposed future date for an elective admission

5 Quick Reference Guide

The Policy sets out the guidance that must be followed for all patients on cancer pathways, and includes information on :

1. Purpose
2. Definitions
3. Policy Overview
4. Cancer Waiting Times
5. Roles and Responsibilities
6. Cancer Centre

6. Policy Overview

6.1 Referrals

When a GP sees a patient and suspects that the patient may have cancer, the Acute Trust is obliged to see that patient within 14 days from receipt of referral; if the patient meets the nationally agreed criteria and the referral was received through the agreed fax or Choose & Book route. Urgent referrals for suspected cancer will be made on a standard Trust pro-forma via Choose & Book or faxed to a central referral team.

A patient referred via their GP/GDP on a two week wait referral proforma, which is completed correctly, cannot be downgraded by the receiving consultant. If the consultant feels that this is an inappropriate referral, he/she needs to communicate with the GP/GDP and the GP/GDP needs to re-issue the referral in an appropriate form and withdraw the two week wait referral.

All patients referred under the two week wait rule, referred via an NHS screening programme or upgraded by a Consultant, will count as potential 62 day wait patients. A Consultant (or an authorised member of the consultant team) can upgrade a non-two week wait referral at any point on or before the MDT date; this patient will then become a 62 day wait, from the date the consultant upgrades the patient, and the 62 day standard applies.

All new, recurrences and subsequent cancer treatments with an agreed treatment plan are counted under the 31 day wait rule.

Some patients will follow a difficult clinical pathway and will take longer to diagnose and agree a treatment plan. Within any patient pathway there should be no delay caused by administrative processes.

PTL

Consultants and General Managers, or deputy for each speciality, are responsible for ensuring that patients on the 31 and 62 day pathway do not breach the target. A Patient Tracking List (PTL) weekly snapshot, produced from Infoflex, will be sent out weekly by the Cancer Centre Team and will include all patients that are currently on day 29 of the cancer tracking pathway and do not have a treatment start date.

Escalation

The MDT Co-ordinators will track the patients on a daily basis from Day 0 of the pathway and alert the relevant General Manager or deputy of any delays or problems, via agreed escalation processes. It is the responsibility of the MDT Co-ordinator to ensure that they have explored all avenues in bringing a clinic or diagnostic test appointment or TCI forward and liaised with the CNS or Clinician to prevent a breach occurring.

If the General Manager or deputy for the speciality is unable to resolve the potential breach then he/she will inform the Cancer Centre and confirm at the weekly PTL and escalation meeting.

Breaches/Root Cause Analyses

All breaches are investigated and a root cause analysis document will be completed for each one, in accordance with the agreed Root Cause Analysis (RCA) process. This will be in a table format identifying how many days each part of the pathway took, identify any avoidable or an avoidable delays and will be signed off by the Consultant with a reason for the breach. A collated summary of all breaches will be presented at the Cancer Programme Board monthly.

- All 2ww referrals will be automatically uploaded onto Infoflex from Lorenzo and all patients will be classified as potential cancer until proven otherwise. Any referrals from other routes for patients (new diagnosis, recurrence, subsequent or tertiary) will be identified by the MDT Coordinator and added to Infoflex.

- A live tracking list of patients will be maintained by the MDT Co-ordinators on Infoflex. They will be responsible for regularly tracking these patients, updating Infoflex in a timely manner and ensuring the operational policy is followed.

Radiological Investigations

Radiology investigations for suspected cancer patients will be indicated on the request form by ensuring the two week wait priority is chosen. Radiology booking clerks will then allocate an appointment within 14 days. If an appointment cannot be booked within 14 days or has been identified by the MDT Coordinator as being booked outside of this timescale then the agreed escalation policy will be activated to identify capacity.

Endoscopy Investigations

Endoscopy investigations for suspected cancer patients will be indicated on the request form as a two week wait. The Endoscopy booking clerks will then allocate an appointment within 14 days. If an appointment cannot be booked within 14 days or has been identified by the MDT Coordinator as being booked outside of this timescale then the agreed escalation policy will be activated to identify capacity

Unexpected Findings of Cancer

Unexpected findings of cancer will be dealt with according to the Trust's radiology and pathology agreed procedures, ensuring that patients are notified to and identified at the MDT meeting.

Tertiary Referrals

Referrals to another Trust for treatment count, for waiting times purposes, as shared activity. Due to the nature of the case it is likely that these patients may have followed a complex diagnostic route and are at higher risk of breaching.

MDT Co-ordinators will ensure that notification of a referral is emailed on the tertiary referral alert, following the agreed Trust process and form S:\Oncology\Rehabilitation and Cancer\Cancer Centre\East Mids Strategic Clinical Network\Inter-Provider Transfer Policy\East Midlands Clinical Network- IPT V16 July2015 NOV2015.pdf to the named Generic email address. This will be done within one working day of the MDT meeting where the transfer was agreed. This is to ensure that the receiving Trust is aware of target dates.

For those cases where a decision is made in between MDT meetings the Consultant or CNS should inform the MDT Co-ordinator so that a notification can be sent.

- Clinicians should ensure that the clinical referral is dictated, typed and emailed to the treating Trust within 2 working days of the MDT meeting where the transfer was agreed. This is to ensure that referrals are dealt with promptly and do not get delayed or lost in the post. Tertiary referrals should be made by day 42 under the EMSCN inter provider Transfer guidance (see appendix for link) to give the treating Trust time to see the patient, plan and book their treatment with the 62 days.

- Those patients who require diagnostic tests will be actively monitored by the MDT Co-ordinator to ensure their appointment will allow enough time to treat the patients if required.
- Wherever possible patients should be given their next date for hospital attendance before they leave their appointment to avoid administrative delays.
- All patients with a suspected diagnosis of cancer referred via the 2 week wait route or any other route will be tracked on Infoflex until either a non-malignant diagnosis is made or, if cancer diagnosis is confirmed, they receive their first and subsequent treatments and are discharged. At any point in the patient journey - as soon as a patient has cancer excluded by a clinician, this will be dictated by a clinician in a clinical letter and entered onto Infoflex by the MDT Co-ordinator thus ensuring an auditable process.

- **All** cancer patients should be noted or discussed by an MDT

Reasonable Notice

According to 'Cancer Waiting Times – A Guide V8.0', a reasonable offer is classed as any appointment within the two week period for the 14 day standard. 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.

Submission of Information to Open Exeter

The Cancer Data Information Manager or Deputy will ensure that all two week wait and cancer treatment data is submitted on a weekly basis, in accordance with the National reporting requirements to the national cancer waiting times system (Open Exeter) and will follow the agreed weekly and monthly processes for sharing current and confirmed performance reports, ensuring that all Business Units and Board reports are well informed.

6.2 Cancer Waiting Time Standards

The Cancer Waits standards are described in detail in *"Going Further on Cancer Waits"* (GFOCW).

The standards are summarised below:

Maximum 2 weeks from:

- Urgent GP or GDP referral for suspected cancer to first outpatient attendance – **Operational standard of 93%**
- Referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment - **Operational standard of 93%**.

Maximum one month (31 days) from:

- Decision to treat to first definitive treatment– **operational standard 96%**
- Decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is:
  - Surgery – operational standard 94%
  - Drug treatment – operational standard 98%
  - Radiotherapy – operational standard 94%

Maximum two months (62 days) from:

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

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) i.e. Every SCC an individual skin cancer patient has will be covered by the standards

In terms of specific standards it should be noted that:

- The **two week wait standard** applies to patients urgently referred with suspected cancer or any patient with breast symptoms where cancer is not suspected.
- The **one month 31 day first and subsequent standards** apply to:
  - NHS patients with a newly diagnosed invasive cancer (localised or metastatic)
  - NHS patients with a recurrence of a previously diagnosed cancer
  - NHS patients with a new diagnosis of cancer or a recurrence regardless of the route of referral – this will include patients who may be diagnosed with cancer during routine investigations or while being treated for another condition – incidental finding
  - Patients who choose initially to be seen privately but are then referred for first / subsequent treatments with the NHS.
- The **two month 62 day standard** applies to patients who are referred :

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

Which patients are excluded from monitoring under these standards?

Any Patient:

- With a non-invasive cancer i.e. carcinoma in-situ (with the exception of breast D05)
- Basal cell carcinoma
- Who dies prior to treatment commencing
- Receiving diagnostic services and treatment privately
  - However where a patient chooses to be seen privately initially but is then referred for treatment under the NHS, the patient should be seen under the 31 day standard with a start date from the date the Trust accepts clinical responsibility for the patient.
  - Where a patient is seen under the 2 week standard, then chooses to have diagnostic tests privately before returning to the NHS for cancer treatment only, then the 2 week and 31 day standards only apply and the patient is excluded from the 62 day standard as the diagnostic phase was carried out in the private sector.
  - Patients who decide to have private treatment
  - If the patient is a prisoner – prisoners are not monitored under the standard as they do not have NHS numbers, however they should still receive treatment under the principles of this policy working in close liaison with prison authorities to expedite treatment whilst taking into account the specific transport and escort requirements necessary.

2 Week Wait Clock Starts

- The 2 week wait clock starts on the receipt of the referral to the Trust and this can be direct from the GP/GDP or via Choose & Book, in which case the start is the conversion of the UBRN (the patient attempts to make an appointment).
- Receipt of the referral is day 0.

- Referrals received after normal working hours e.g. 17:00 hrs should still be classed as the being received that day and recorded as such.

2 Week Wait Clock Stops

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

- If cancer is excluded at the first visit or diagnostic then the 62 day pathway is also ended and the patient is either discharge or managed on a routine 18 week pathway

- If cancer is not excluded then the patient is continued to be monitored on a 62 day pathway

2 Week Wait – Reasonable Offers / DNA / Cancellations / Downgrade

- 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.

- Patients should not be returned to their GP 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 should not be returned to their GP after a single cancellation, they should only be returned to the care of their GP after two or more cancellations when this has been agreed with the patient – cancellation of the appointment should be seen as assumed willingness to attend.

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

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

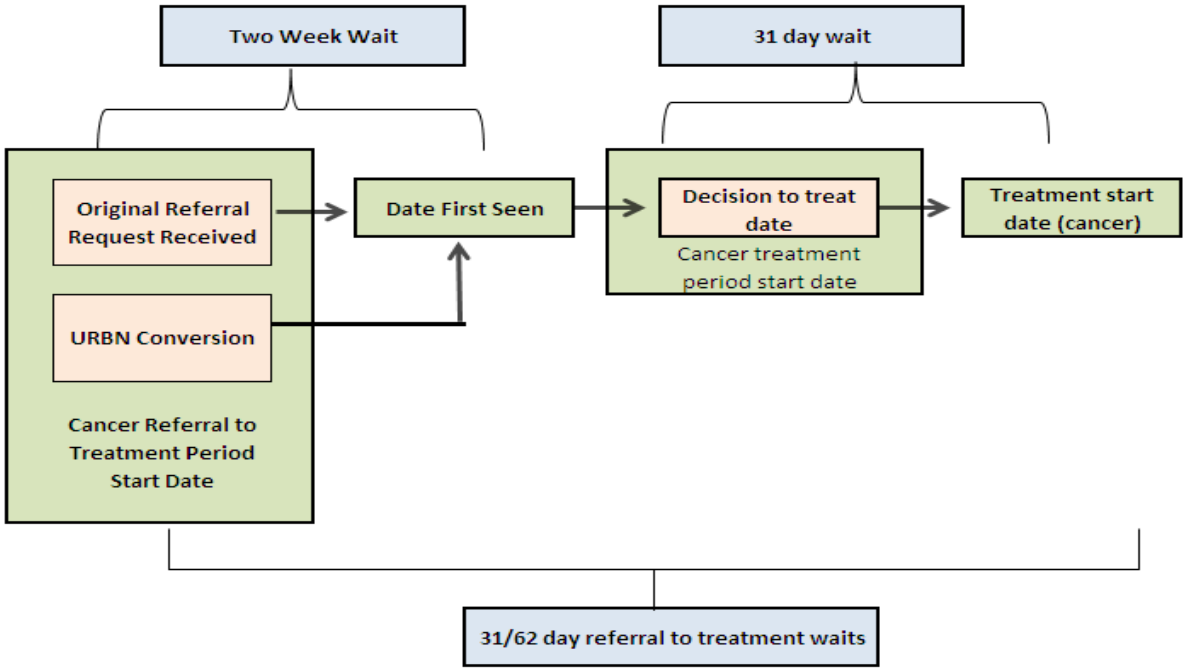
- Also see **a section 28 adjustment - which outlines** the adjustment possible when patient DNA their first appointment from the receipt of

the referral to the date they rebook their appointment which is relevant to both the 2 week wait and 62 day standards.

Urgent Referrals for Suspected Cancer on to a 62 Day Pathway

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

Standard 62 day Pathway (Appendix1)



62 Day Clock Starts

- The starting point for the 62 day standard is the receipt of the referral either direct from GP/GDP or if via choose and book URBN conversion.
- The receipt or conversion of referral is day 0 in the 62 day period

62 Day Clock Stops

- The 62 day clock stops when first definitive treatment is started and this may differ for different treatments, for example :
- For surgical intervention it is the date the patient is admitted for surgery
- For anti-cancer drug therapy it is the date the first drug in an agreed course is given
- For radiotherapy it is the date the first fraction is given
- In some instances enabling treatment can be classed as first definitive treatment and stop the 62 day clock and examples of this are :

- Colostomy for bowel obstruction
- Insertion of an oesophageal stent
- Non-small cell lung cancer stent
- Ureteric stenting for advanced ovarian cancer
- Other enabling treatments can only mark the end of the 62 day period where the patient is having these prior to surgery within the same admitted care spell (admission)

- In some instances patients may refuse all diagnostic tests, this in effect means that they have opted out of the 62 day pathway, and therefore the Trust is unable to deliver the standard. If the patient is not prepared to cooperate then this ends the 62 day pathway. If at a later stage the patient chooses to have the tests and is subsequently diagnosed with cancer, a new 31 day clock would be started.
- The list of enabling treatments that can stop the 62 day clock is deliberately limited to ensure that there is not an unnecessary delay before active intervention / treatment is initiated.

Screening Referrals on a 62 Day Pathway

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

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

Screening Referrals 62 Day Clock Starts

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

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

Note the 2 week wait standard does not apply to 62 day screening patients, but if they DNA their first appointment an adjustment can be made (see DNA section 27)

Consultant Upgrades on a 62 Day Pathway Start and End Points

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

The clock end point would be first definitive treatment as defined in section 15

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

31 Day Standard Clock Starts and Amendments

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

- This should be either a face to face consultation or telephone consultation.
- 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.

31 Day Standard Clock Stops and First Definitive Treatments

The 31 day standard stops with first definitive treatment and this is defined as ‘an intervention intended to manage the patient’s 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 31 day clock stops for first definitive treatment and this may differ for different treatments, for example

- For surgical intervention it is the date the patient is admitted for surgery
- For anti-cancer drug therapy it is the date the first drug in an agreed course is given
- For radiotherapy it is the date the first fraction is given
- This is not an exhaustive list and further treatments may apply under the guiding principle above.
- Diagnostic procedures may also be first definitive treatments if they are undertaken with therapeutic intent e.g. the intention is to remove the tumour, irrespective of whether the margins are clear.
- Enabling treatment listed in section 15 would also stop the 31 day clock.

Treatment Option not Available within the 31 Day or 62 Day Period

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

Active Monitoring

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

The patient is monitored during the intervening time until they are fit to receive or it is appropriate to proceed with treatment.

This must be agreed with the patient; it should be an **informed choice** to be monitored rather than receive treatment and **should not** be used for thinking time.

For example a patient is offered a range of treatments and wants to take a couple of weeks to think about it – this is **not active monitoring.**

However if a patient has a prostate tumour that is not causing significant problems and **they** decide not to pursue active treatment but to be monitored this **would be** active monitoring.

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

31 Day Standard For Subsequent Treatment Clock Start / ECAD

The starting point for this 31 day period is either:

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

The ECAD can be set at a number of points

- Clinical review with the patient following the preceding treatment for example review post-surgery, if it is not possible for example the patient has not healed sufficiently then a further review would be required.
- At the start of the preceding treatment if the patient will not be reviewed between treatments
- At MDT meeting if it is possible to identify the likely ECADs between treatments in a package
- Following receipt of test results and prior to discussing with the patient if this is an appropriate date.

The ECAD can be changed **provided the date has not passed**, for example if on review the patient is not fit enough to proceed to the next treatment. Should however the patient be reviewed after the ECAD and found to be unwell the original date would stand.

31 Day Subsequent Treatment Clock Stops

The 31 day subsequent treatment 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

Specialist Palliative Care

Some patients will require symptomatic and supportive care provided by the specialist palliative care team and this might be first or subsequent treatment. The start date for this treatment is assessment of the patient by the specialist team.

Recurrence

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

These patients are monitored against the 31 day standard, irrespective of route of referral.

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

Metastatic Cancer

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

- If the primary cancer is identified after the metastatic disease of an unknown primary was treated, treatment of the primary cancer would be classed as a subsequent treatment on a 31 day pathway.
- If a new primary cancer is identified with metastatic disease, and the metastatic disease is treated first, this should be recorded as a subsequent treatment and would therefore not stop a 62 day clock. Treatment of the primary is classed as first definitive treatment and this stops the 62 day clock as this standard is for new primary cancer only.

Adjustments to Cancer Waiting Times

Adjustments to the waiting time are allowed in two places:

- If a patient DNA their initial outpatient appointment – in this instance the clock can be re-set from the receipt of the referral to the date the patient re-books their appointment and this adjustment applies to both the 2 week wait clock and the 62 day clock.

- If a patient declines a reasonable offer of admission for treatment in this instance admission means admitted care and **would not apply** to treatment in an outpatient setting. In cancer guidance a reasonable means an offer within the applicable standard e.g. within 31 or 62 days. The adjustment can be applied from the date of the declined treatment to the point when the patient makes him/herself available for an alternative appointment.

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

Patient Cancellation, Choice and Co-operation – All Standards

Not all patients can and should be treated within the timeframes outlined in national policy and the cancer standard thresholds are set to reflect this.

- Patients who cancel their appointment, even if it is on the day of the appointment, must not be recorded as a DNA. The appointment should be re-booked within the standard e.g. within 14 days of the 2 week standard. It is therefore important to agree the date and provide as much notice as possible of the appointment to encourage patient compliance. It is also good practice to offer a date within 7 days of the receipt of the referral to allow for patients who do cancel to be offered a further appointment within the standard. (See section 12).

- Patient choice: patients may decline a treatment but then change their minds, provided the decision to decline all treatment was an informed choice then this would end the clock, if they change their mind subsequently a new 31 day clock would be started for the subsequent treatment.

- Some patients may state in advance that they are unavailable for treatment for example they have a holiday booked, and it would therefore be inappropriate for the trust to offer them an appointment in the knowledge that they would not be able to attend. In this instance it is it is possible to add a clock pause from the earliest reasonable offer (date within target) that could have been offered to the patient until the date they are available for treatment.

- Patients may agree a date for treatment and then cancel this in advance, in this instance the patient should be rebooked within target

as the clock is still ticking. Should they decline the new offer within target then a patient pause can be added from the earliest reasonable offer given as part of the rebooking process.

- Some patients may DNA their admission for treatment, in this instance a **clock pause cannot** be added, and the patient should be contacted and the reason for the DNA ascertained and offered a further treatment date in target. If however they DNA a second time then this should be discussed with the clinical team and agreement reached as to whether it is appropriate to discharge the patient back to the care of their GP. It is good practice to ensure that patients who have DNA cancer appointments or admissions for treatment are contacted and their reasons or fears discussed. It is **not acceptable** to continue to offer dates to patients who have DNA twice without making contact with them, ideally contact should be made by one of the clinical team so that they can provide further advice or reassurance.

- Some patients may refuse all diagnostic tests, in this instance they have in effect taken themselves off a 62 day pathway and the clock is stopped see section 15.

- Patients who do not follow pre-operative guidance, provided this was clearly communicated, or attend for their treatment in an intoxicated state, and cannot be treated should be recorded as DNA, as per national guidance. This would include patients who have not followed nil by mouth instructions. Every effort should be made to rebook the patient and to provide support to enable their compliance.

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

Patient Choice – Treatment Options and Clinician Choice

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

- Patients may be offered a range of treatment options, but ask about another treatment option that they have heard about. If on reflection it is clinically appropriate to offer this option, then a pause can be added

from the admission date that would have been offered to the date the patient makes him/herself available for a further appointment.

- Patients have the right to treatment with a clinician that they trust. If they are offered a choice of clinician's and choose one of these, but for example they are on leave and there is not capacity to treat the patient within the standard then a pause cannot be added.

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

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

Rare Cancers (Testicular, Children's, Acute Leukaemia)

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

6.3 Roles and Responsibilities

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 clinical operations and is responsible:

- Through clinical service Centre (CSC) General Managers and Chiefs of Service 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 General Managers and Chiefs of Service for achieving cancer access targets.

- For implementing trust wide monitoring systems to ensure compliance with this policy and avoid breaches of the targets.

- With General Managers and Chiefs of Service for monitoring progress against achievement of the targets and taking action to avoid any potential breaches.

- With General Managers and Chiefs of Service for managing any actual breaches in achieving targets.
- For keeping the Trust Board 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 conducting a capacity and demand review trust wide
- 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.

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:

- Make sure that objectives of MDT working (as laid out in Manual of Cancer Services) are met.
- Make sure the MDT is managed 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.
- Have in place mechanisms to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent.
- Take overall responsibility for ensuring that their MDT meeting and team meet peer review quality measures.
- Make sure attendance levels of core members are maintained, in line with quality measures.
- Ensure that a target of 100% of cancer patients discussed at the MDT is met.
- Provide the link to network and other relevant specialty groups, either by attendance at meetings or by nominating another MDT member to attend.

- Lead on, or nominate lead for service improvement.
- Organise and chair an annual meeting, examining the functioning of the team and reviewing operational policies and collate any activities that are required to ensure optimal functioning of the team (for example training for team members).
- Ensure MDTs' activities are audited and results documented.
- 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.
- Work alongside the MDTC and Cancer Management team to ensure that patients are progressed as quickly as possible through their pathway and in line with national performance targets.

Lead Cancer Clinician:

Will Support the development and implementation of protocols and pathways to ensure an effective network of high standard care for cancer patients within the cancer standards and is :

- 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.

Cancer Lead Nurse:

The Cancer Lead Nurse is responsible for ensuring each Clinical Nurse Specialist (CNS) and Allied Health Professional (AHP) Lead is familiar with this policy,

- Ensuring compliance with Peer Review Measures
- Enforcing the National Cancer Patient Experience Survey (appendix4)
- Identify any nursing/AHP Professional resource issues arising from the above and alerting relevant managers of these to ensure that remedial action is taken

Cancer Business Unit General Manager

The Cancer Business Unit General Manager has overall responsibility for implementing and adherence to this policy. 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 Cancer Centre.

- Supporting the Lead Clinician and Lead Nurse for the Cancer Centre in engaging Managers and Clinicians in the complex agenda relating to Cancer Pathways, audit and Peer Review across the Trust, including supporting those teams in service transformation and the preparation of annual work plans, operational policies and service reports for Peer Review, inclusive of both national and local priorities

- Ensure there are sufficient governance and performance management arrangements in place to of Cancer performance robustly support the delivery.

- Lead on improvements to Cancer access standards.

- Managing resources allocated to the cancer centre with the aim of achieving access targets.

- Working with other General Managers and Service managers to provide a joined-up approach to implementing this policy and achieving the cancer access targets.

- Achieving cancer access targets.

- Ensuring that the duties, responsibilities and processes laid down in this policy are implemented with the Cancer centre.

- Ensuring all staff that are required 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 Cancer centre to ensure compliance with this policy and avoid breaches of the targets: escalate any actual or potential breaches to the Divisional Director.

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

Day to day operational management of this policy will be delegated to the Cancer centre manager as set out in the governance arrangements.

General Managers and Service Managers (Other Business Units)

The General Manager of each specialty will have overall responsibility for implementing and adherence to this policy within their Business units. 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 their Business unit.

- Managing resources with the aim of achieving Cancer 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.

- Working with other General Managers and to provide a joined-up approach to implementing this policy and achieving the cancer targets, particularly around outpatient and operating theatre capacity and availability of diagnostic services.

- Achieving cancer targets.

- Ensuring that the duties, responsibilities and processes laid down in this policy are implemented with the Business unit.

- 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 Business unit to ensure compliance with this policy and avoid breaches of the targets: escalate any actual or potential breaches to the Lead Cancer 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

Cancer Centre Manager:

Monitors the overall Trust, Inter-trust and site specific cancer performance.

The Cancer Centre Manager is also responsible for:

- Working with and Supporting the General Manager and Divisional Director in directing, guiding and leading the Cancer Centre Team in the overall management of the Service Line and for developing strategic plans and performance management frameworks to ensure delivery of all key activity, quality and financial targets.

- Working with and Supporting the General Manager & Divisional Director in engaging Clinical Managers and Clinicians in the complex management agenda relating to Cancer Pathways and audit across the Trust, including the preparation of annual business plans and service improvements to support the development of capacity and capability to deliver both local and national priorities.

- Supporting the Lead Clinician and Lead Nurse for the Cancer Centre in engaging Managers and Clinicians in the complex agenda relating to Cancer Pathways, audit and Peer Review across the Trust, including supporting those teams in service transformation and the preparation of annual work plans, operational policies and service reports for Peer Review, inclusive of both national and local priorities.

- Ensuring that all Cancer Centre core team staff involved in cancer pathway tracking are aware of this policy and the importance of following the procedures. Training will be provided to the Cancer Centre core team on this policy together with the Trust's Access Policy. Training will also be provided to new members of the team at induction.

- Working with individual Business Units in their delivery of the cancer standards

- Providing leadership and support to the MDT Co-ordinators so that they provide a high quality service to the site specific MDTs.

- Monitor the overall Trust, Inter-Trust and site specific cancer performance.

- Ensuring the operational management teams and waiting list managers have accurate timely reports that enable them to manage their patients according to this policy

- Providing reporting that enables teams to proactively manage patients and avoid breaches.

- Quality assuring and producing accurate performance management data for use by trust managers and for reporting data to external sources.

- Ensuring reporting reflects national best practice.

- Reviewing this policy.

- Provide leadership and support to the MDT coordinators so that they provide a high quality service to the site specific MDTs Capturing and recording all data from the minimum dataset on the Infoflex database in an accurate, timely and relevant manner.

- Uploading data to the national database within set timescales.

- Collaborating with Multidisciplinary teams, clinical and managerial teams to ensure that patients are seen, diagnosed and treated within minimum cancer waiting times targets.

- Providing reports to provide assurance and information for clinical and managerial teams to help them Ensuring all suspected and diagnosed patients are actively tracked through their cancer pathways, until they

have received their first definitive or subsequent treatment or until a non-diagnosis of cancer is indicated by a clinician who must be auditable.

- Prioritise their capacity.
- Provide overall knowledge with regards to cancer waiting times guidance.
- Leading on cancer specific meetings and processes; Cancer Programme Board, PTL Meeting, Escalation Meeting, Root Cause Analyses.
- Leading on national cancer audit data submissions.
- Leading on the Peer Review process

Deputy Cancer Centre Manager:

The Deputy Cancer Centre Manager is responsible for:

- Supporting the Cancer Centre Manager in the day to day duties and the above objectives.
- Ensuring that the processes outlined in this document are implemented and adhered to, without deviation, by the cancer centre MDT Co-ordinators and administrative team on a day to day basis.
- Ensuring refresher training on this policy and the Trust's Access Policy is included within the Cancer Centre core team annual training programme, in order to maintain skills and knowledge.
- Supporting the Cancer Centre Manager in the day to day duties and the above objectives
- Acting as a key link to Public Health England and the host of organisations for National Mandatory Cancer audits.
- To promote dissemination of data and early awareness of any changes to COSD and audit data sets.
- Work closely with IT Services and ensure Infoflex is developed to meet national and local requirements.

Cancer Centre Audit /Team Leaders:

The Cancer Centre Audit /Team leaders are responsible for:

- Complying with the guidance of this policy.
- Providing general guidance on cancer waiting times queries.

- Identifying and correcting data quality issues and ensuring this informs MDT Coordinators training, assessment and performance management processes.
- Leading on COSD and MDT Specific audits for their teams.
- Preparing weekly and monthly reports on latest and confirmed cancer performance but tumour site.
- Ensuring that the patient pathway is validated prior to upload to the national cancer waiting times database, demonstrating true and accurate waiting time for each patient.
- Preparing adhoc reports from data collected on the Infoflex database.
- Line managing MDT Coordinators, including appraisals, training, assessments and performance managing.
- Planning and allocating weekly cancer centre staff work plan, ensuring that MDT Meetings and patient tracking has adequate cover according to resources available.
- Liaising with other Trusts on shared patients to ensure that information is shared and provide/receive assurance that patients are treated within the appropriate timescales.
- Liaise with the Trust's IT department
- Contribute to the Cancer Centre's Peer Review process.

Multi-disciplinary Team Co-ordinators are responsible for:

Complying with the guidance of this policy:

- 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

- Provide administrative support so that there is accurate, accessible and timely recording of the treatment plan agreed by the MDT
- Planning communicating and interacting with clinicians regarding issues relating to the patient pathway
- Maintenance of and the quality of the Cancer Data Collection.
- Ensuring that referrals/appointments for patients on the cancer pathway are made in 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
- Ensuring that the data entered into the tracking system for cancer patients (Infoflex) is accurate and timely.
- Identify and expedite referrals/appointments/admissions for patients on the cancer pathway so that they are made in timely manner
- Follow escalation processes and escalate to the relevant individual when alternative action needs to be taken so that patients can be seen/treated within timescales and according to agreed clinical pathways.
- Communicate and interact with clinicians regarding issues relating to the patient pathway
- Take responsibility for the administrative management and support and for the functioning of the individual MDT meetings including:
- Ensuring that patients are added as requested and as per agreed pathways to the MDT meeting in a timely manner
- Ensure that all the necessary clinical and non-clinical information is available to allow the patient to be discussed holistically
- Providing administrative support so that there is accurate, accessible and timely recording of the treatment plan agreed by the MDT
- Receive and process referrals into the MDT so that they are tracked and brought to the MDT in a timely manner for discussion and planning of treatment.
- Prepare and attend a weekly PTL meeting, record and circulate actions (in line with agreed policy
- Prepare relevant sections of root cause analyses
- Provide cross cover for absences of colleagues

- Action tertiary referral alerts to ensure they fit into the above processes

MDT Assistants:

MDT Assistants have a responsibility to ensure that they:

- Comply with the guidance of this policy
- Track all patients up to 14d for the tumour site they are responsible for assisting; monitor the work list relevant to their tumour site
- Follow agreed processes to use hospital, systems and reports to identify relevant patients Chase and record attendances and outcomes of patient's first appointments/STT appointments
- Identify and expedite referrals /appointments/admissions for patients on the cancer pathway so that they are made in timely manner
- Take responsibility for the administrative preparation for the MDT;
- Ensuring that patients are added as requested and as per agreed pathways to the MDT meeting in timely manner
- Ensure that all necessary clinical and non-clinical information is available to allow the patient to be discussed holistically
- Receive and process referrals into the MDT so that they are tracked and brought to the MDT in a timely manner for discussion and planning of treatment
- When required attend and support the MDT Coordinators at MDT Recording of minutes
- Minute taking at departmental team meetings
- Minute taking at MDT operational meetings
- Minute taking at Ad-hoc meetings
- Provide cross cover for absences of colleagues

All Consultants:

Each consultant is responsible for:

- Managing the patients care and treatment and working with their General Manager and colleagues to ensure that this is provided within timescales laid down in national, local and NHS constitution targets and standards.

- Alerting the General Manager of any potential or actual breaches of targets.
- 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.

Multi-Disciplinary Teams:

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.
- 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.

- **Outpatient booking administrators 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 Trust's Patient Administration System (PAS) within 24 hrs

- 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 decisions.

- To refer any problems or suspected / potential breaches of policy or compliance with cancer targets to the appropriate Service or Business Manager and General Manager.

Waiting List Administrators:

All secretarial and waiting list officers are required to support the guidance in this policy and:

- To maintain an up to date and accurate waiting list annotating where necessary so that patients who are being treated within the cancer pathways are clearly identified.

- To work closely with MDT Co-ordinators to ensure when a decision to admit is made in clinic, the clinic attendance date is recorded on PAS and the decision to admit date is correctly recorded, and all MDT treatment decisions are accurately recorded.

- To ensure all patient contact details with any additional information required is correctly.

Director of ICT Services is responsible for:

- The management of the hospitals computerised information systems and IT training team.

- Providing IT training for all staff required to operate this policy.

- To ensure patients are given reasonable notice taking account of patient choice as outlined in this policy section 13 and 19 and national cancer guidance.

- To ensure that all admission offers are recorded on PAS.

Head of Information Services:

Representatives of the Trust IT and Information department will work with the Cancer Centre primarily through, but not limited to, the Cancer Informatics Steering Group:

- Ensure the Operational Management and Clinical teams have accurate timely reports that enable them to manage their patients according to this policy via SharePoint.
- For providing reports that enable teams to proactively manage patients and avoid breaches.
- For quality assuring and producing accurate performance management data for use by trust managers and for reporting data to external sources.
- Ensuring reporting reflects national best practice and Governance requirements
- Develop a shared vision and approach to issues impacting on the cancer informatics, fostering good teamwork between Cancer, IT and Information.
- Develop relationships to ensure cancer information requirements are aligned to the wider Trust strategies and policies.
- Ensure a formal route for consideration and discussion of cancer informatics risk management and information governance.
- Populate shared area with weekly and other relevant Cancer reports
- Dedicated data Analyst
- Dedicated development officers (Infoflex)

Commissioners:

The Trust relies on GPs 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.

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:

- 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.

All Staff:

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

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

Other Trusts:

The Cancer Centre will adopt a continual process to engage with other Trusts for the benefit of streamlining pathways for patients. This should include:

Reviewing and improving shared pathways

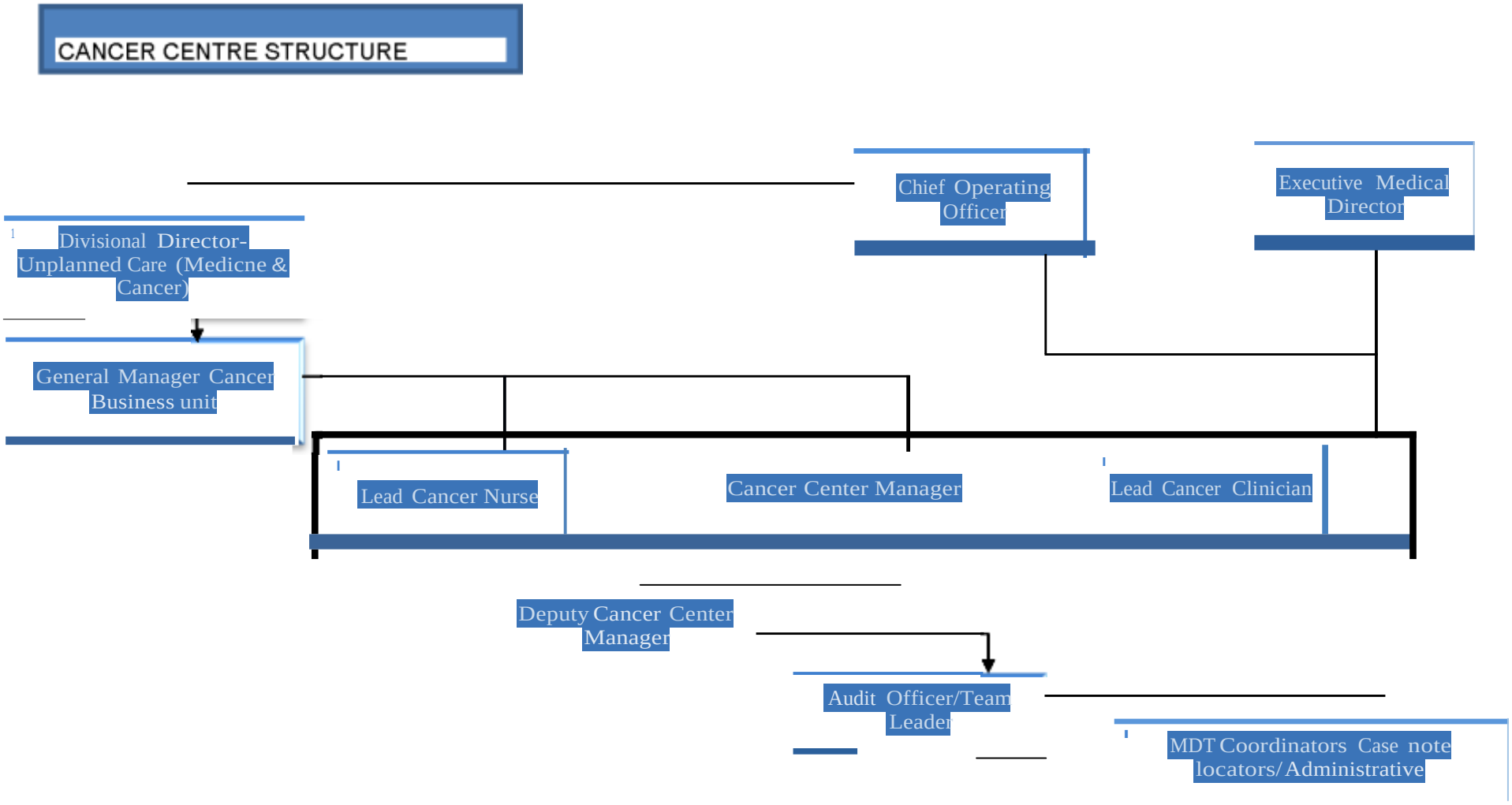
- Reviewing and ensuring an effective process for the transfer of patient referrals between Trusts
- Consistent, accurate and timely sharing of relevant shared patient data on suspected or diagnosed cancer pathways

- Reviewing shared breaches on an ongoing basis to ensure a process of continual learning
- Scheduled meetings to identify and embed how information and minutes are shared/stored.
- Comply with Interprovider Transfer guidance. S:\Oncology\Rehabilitation and Cancer\Cancer Centre\East Mids Strategic Clinical Network\Inter-Provider Transfer Policy\East Midlands Clinical Network- IPT V16 July2015 NOV2015.pdf

6.4 The Cancer Centre:

The Cancer Centre is responsible for:

- Ensuring all suspected and diagnosed patients are actively tracked through their cancer pathways, until they have received their first definitive or subsequent treatment or until a non-diagnosis of cancer is indicated by a clinician
- Capturing and recording all data from the minimum dataset on the Infoflex database in an accurate, timely and relevant manner.
- Uploading data to the national database within set timescales.
- Collaborating with multidisciplinary teams, clinical and managerial teams and other trusts to ensure that patients are seen, diagnosed and treated within minimum cancer waiting time targets.
- Providing reports to provide assurance and information for clinical and managerial teams to help them prioritise their capacity.
- Provide overall knowledge with regards to cancer waiting times guidance.
- Leading on cancer specific meetings and processes; Cancer Programme Board, PTL Meeting, Escalation Meeting, Root Cause Analyses.
- Leading on national cancer audit data submissions.
- Leading on the Peer Review process.


CANCER CENTRE STRUCTURE
Chief Operating Officer
Executive Medical Director
Divisional Director- Unplanned Care (Medicne & Cancer)
General Manager Cancer Business unit
Lead Cancer Nurse
Cancer Center Manager
Lead Cancer Clinician
Deputy Cancer Center Manager
Audit Officer/Team Leader
MDT Coordinators Case note locators/ Administrative

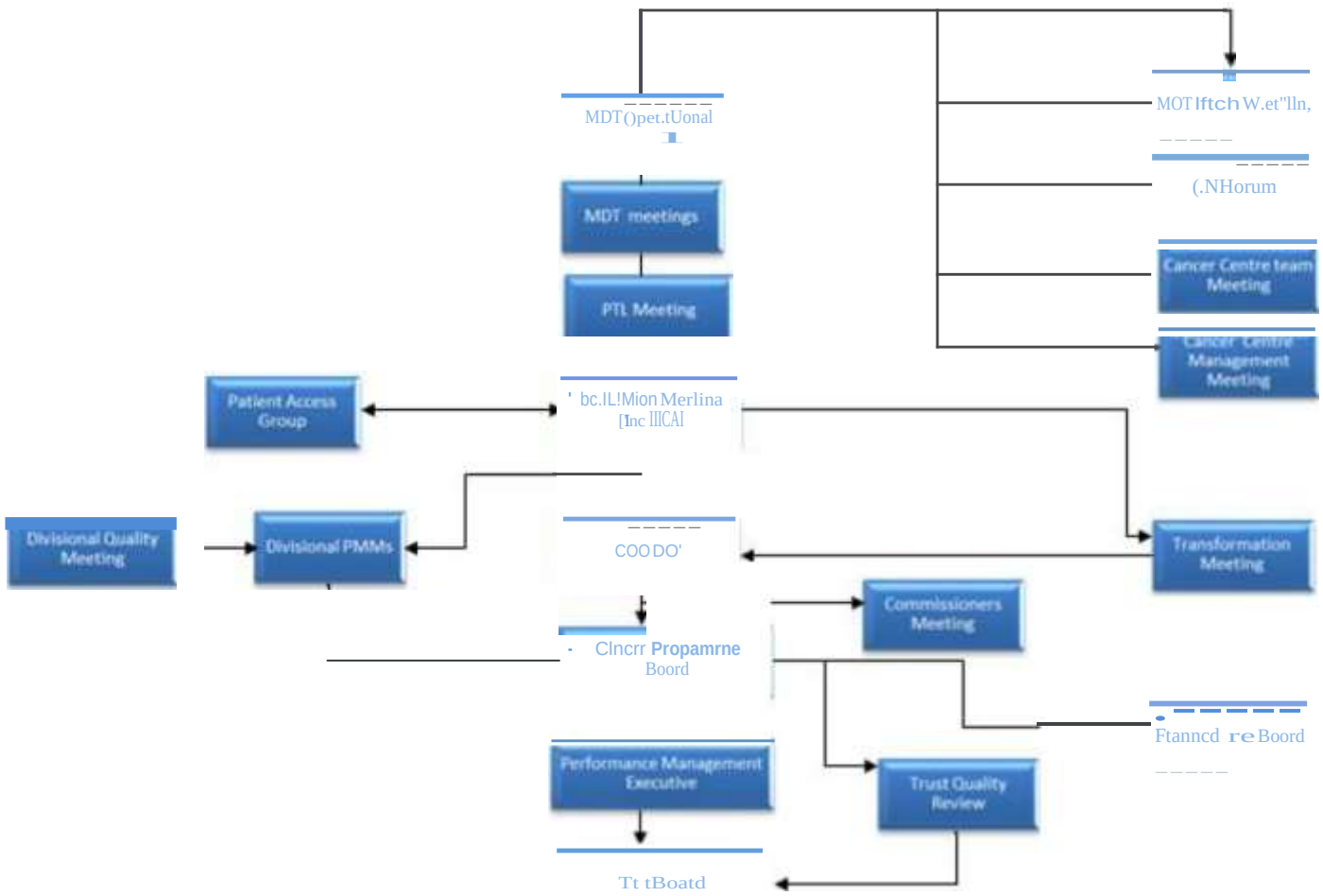
Meetings Purpose and Structure

The key Regular meetings to support the delivery of this Cancer Centre Operational Policy are outlined below.

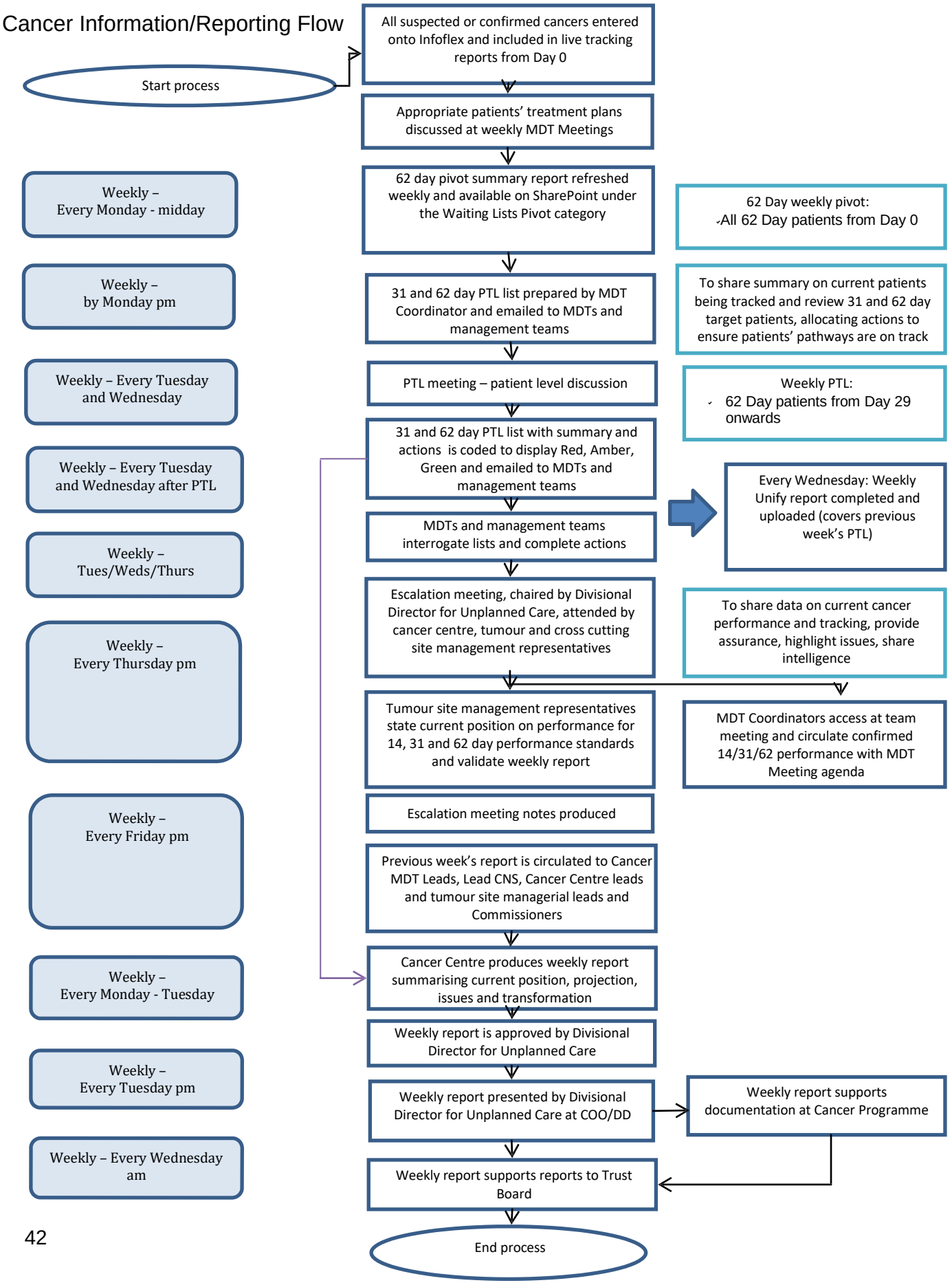
Meeting Name	Chair	Approved at	Approval Date	Review Date
MDT Leads Meeting	Cancer Lead Clinician	MDT Leads Meeting	22.09.14	22.09.15
Cancer CNS and AHP Forum	Lead Cancer Nurse	Cancer CNS and AHP Forum	22.09.14	22.09.15
Cancer Centre Transformation	Cancer Transformation Lead	Transformation Meeting	28.07.14	28.07.15
PTL Meeting	Cancer Centre Manager	Escalation Meeting	16.05.14	16.05.15
Escalation Meeting	Divisional Director	Escalation Meeting	15.03.14	15.03.15
Informatics Meeting	General Manager	Escalation Meeting	22.09.14	22.09.15
Cancer Programme Board	Medical Director	Cancer Programme Board	01.09.14	01.09.15

In addition the Cancer Centre team will meet regularly to review the management and training of the Cancer Centre team and to ensure that this Operational Policy and Standard Operating procedures for the service are maintained and up to date.

CANCER CENTRE REPORTING AND MEETING STRUCTURE



Monitoring and Projection Reports



PTL Process:

Daily	Weekly	Monthly	Quarterly	Annually
Live tracking✓	**Summary and patient level detail ✓**	**Confirmed Performance✓**	**Confirmed Performance✓**	**Confirmed Performance✓**
Infoflex: *14 Day ✓* *31 Day ✓* *62 Day ✓*	*62 Day - All patients on pathway ✓* *31 Day – All patients on pathway ✓*	*14 Day ✓* *31 Day ✓* *62 Day ✓*	*14 Day ✓* *31 Day ✓* *62 Day ✓*	*14 Day ✓* *31 Day ✓* *62 Day ✓*
	Current Performance Position ✓	**Breach Summary**		
	14 Day ✓ *31 Day ✓* *62 Day ✓*	*14 Day* *31 Day (RCA)* *62 Day (RCA)✓* *Overall Summary*		
	Waiting List position	**Performance Trend**	**Performance Trend**	**Performance Trend**
	14 Day *31 Day ✓* *62 Day ✓*	*14 Day ✓* *31 Day ✓* *62 Day ✓*	*14 Day ✓* *31 Day ✓* *62 Day ✓*	*14 Day ✓* *31 Day ✓* *62 Day ✓*
	Breach Projection ✓			
	31 Day ✓ *62 Day ✓*			

Consultants and General Managers or deputy for each speciality are responsible for ensuring that patients on the 31 and 62 day pathway do not breach the target. A Patient Tracking List (PTL) weekly snapshot, produced from Infoflex, will be sent out weekly by the cancer centre team and will include all patients that are currently on day 29 of the cancer tracking pathway and do not have a treatment start date. N.B. Patients are tracked from Day 0 on their pathway and the weekly PTL snapshot is for patients on Day 29 onwards of their pathway.

This snapshot report supports the PTL meeting and is a patient level discussion meeting and the agreed PTL process should be followed

The post PTL meeting report containing the minuted actions required for each patient is distributed to clinical and managerial teams and is used to form the assurance reports presented by individual business units at the weekly Escalation meeting.

Tumour site	Patients on 62 Day PTL Tracking	With diagnosis	On track (Green)	Require actions to save (Amber)	Will breach (Red)
Urology					

Root Cause Analysis (RCA) Process:

At the point of the confirmed breach the RCA timeline will be Imitated and distributed to the Assistant General Manager/Service Manager for the relevant Business unit and the Cancer Centre Manager to enable to the RCA to begin. The RCA tracker will form part of the monitoring of this process.

<table>
<tr><th colspan="8">RCA Tracker</th></tr>
<tr><th>Process Start</th><th>Within first 2 days</th><th>Week 1</th><th>Week 2</th><th>Week 3</th><th>Week 4</th><th>Before Month Close</th><th>Monthly</th></tr>
<tr><td rowspan="2">Likely or certain breach identified from Tracking/Clinical Pathway reference/PTL/Tertiary alert</td><td rowspan="2">MDT Coordinator to initiate/completes RCA document, stage 1, and emails to Cancer Centre Manager</td><td>Cancer Centre Manager checks RCA and emails to: General Manager, Named Consultant, MDT Lead, Lead CNS</td><td>GM to completes stage 2 and 3 of RCA document:
a) Agree reason statement for RCA breach
b) Agree actions to provide assurance that similar breaches would be avoided</td><td>GM to send agreed RCA to Cancer GM and Cancer Centre Manager</td><td>GM presents summary of breach at next Escalation meeting Return to Cancer Centre Manager to include in upload data</td><td>Cancer centre clear to upload to Open Exeter System</td><td>Cancer Centre Manager prepares breach summary report for Cancer Programme Board Group</td></tr>
<tr><td></td><td></td><td></td><td>Cancer Centre Manager converts to pdf and send completed copy to tertiary centre
If tertiary referral, Tertiary organisation agrees or feeds</td><td></td><td></td></tr>
</table>

All breaches are investigated and a root cause analysis document will be completed for each one in accordance with the agreed Root Cause Analysis (RCA) process. This will be in a table format identifying how many days each part of the pathway took, identify any avoidable or unavoidable delays and will be signed off by the Consultant with a reason for the breach, clarity on if harm has occurred due to the breach taking place, and what learning has been identified. A collated summary of all breaches will be presented at the Cancer Programme Board monthly as displayed below.

Ne ona l Data- Fully Validated

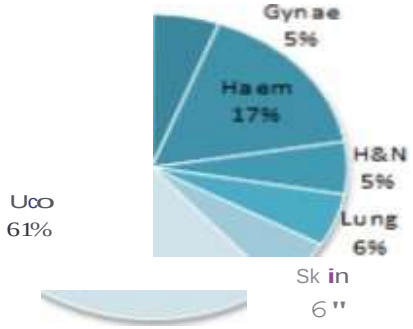
Derby Teaching Hospitals r1!L
NHS Foundation Trust

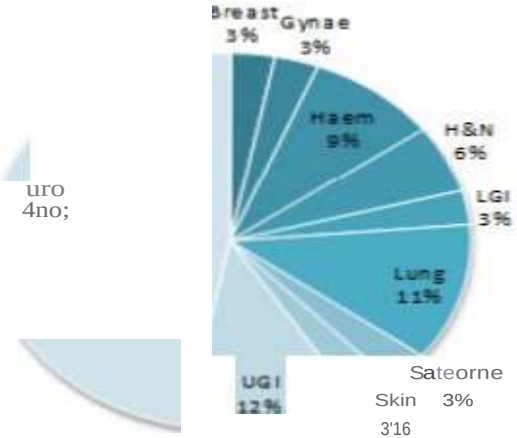
34

Total 62 Day Breach Patoients

18

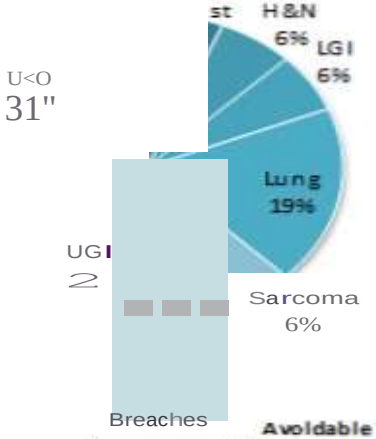
Avoidable Breaches





16

unavoidable Breaches



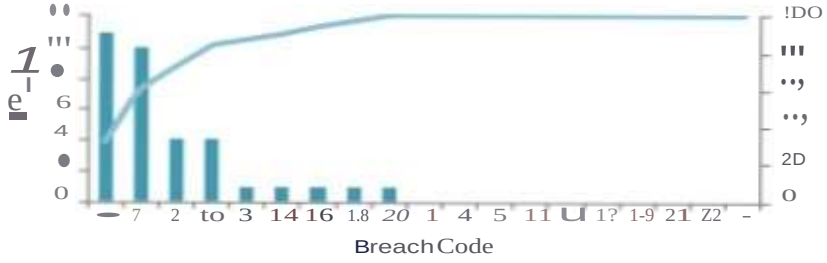
3

3" Referrals after Day 62

1

3" Referrals after Day 42

Parao Analysis of 8..--.m R•soru



	Avoidable
PreV'ious Perform•nce	12
Current Perform•nce	18
Variance	6
Year to D•t• (Jul)	44
33	
34	
1	
99	

Cancer Tracking Process

- 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 .
- Provide administrative support so that there is accurate, accessible and timely recording of the treatment plan agreed by the MDT.
- Planning, communicating and interacting with clinicians regarding issues relating to the patient pathway.
- Maintenance of and the quality of the Cancer Data Collection.
- Ensuring that referrals/appointments for patients on the cancer pathway are made in 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.
- Ensuring that the data entered into the tracking system for cancer patients (Infoflex) is accurate and timely.

Patients will **only** be removed from Cancer tracking once a clinical letter or other auditable correspondence has been given by the managing clinician.

The Policy is **NOT** to copy and paste from other systems to Infoflex i.e. radiology (table top) when removing patients from tracking.

Tumour site task	Detail
Tracking/PTL	⌄ Run tracking work lists for tumour site. Checking and update Infoflex with next steps on patient pathway ↙↗OP outcomes ↙↗Scans attended and results ↙↗Biopsy results ↙↗Next step known ⌄ Review 2ww referrals/STT on relevant tumour sites and update next check date ⌄ Liaise with CNSs, Consultants, booking clerks, secretaries and managers to expedite patient journeys, escalating any issues identified (refer to escalation processes) ⌄ Check treatments started against weekly treatment reports, updating Infoflex: ↙↗Radiotherapy/brachytherapy ↙↗Chemotherapy ↙↗Surgery ↙↗Hormone therapy ⌄ Identify newly diagnosed cancer patients and recurrences by checking weekly histology report ⌄ Identify newly diagnosed cancer patients and recurrences by checking outcomes from clinic, endoscopy, flexible cystoscopy clinic attendances etc. ⌄ Send and receive tertiary alerts, identifying next steps, expediting and escalating as required ⌄ Update cancer status on Infoflex as appropriate ⌄ Preparation, presentation and distribution of weekly PTL. Attend PTL meeting, undertake any actions post meeting

MDT Meetings	⌄ Create care plans on Infoflex ⌄ Create list for discussion at MDT, by scheduling appropriate patients (i.e. following biopsy/investigations/staging – varies by tumour site) and requests ⌄ Distribute provisional discussion list ⌄ Distribute final list ⌄ Prepare history, relevant investigations, data ahead of the meeting ⌄ Check case notes present for discussion, collect inpatient case notes just before MDT & return directly after MDT ⌄ Attend MDT meeting - capture data, record outcomes, print patient summary and file in case notes ⌄ Attendance list - ensure completed at MDT Meeting and update Infoflex ⌄ Return Case notes to clinic if after MDT or return case notes to cancer offices for return to file ⌄ Upload MDT patient summaries to ICM ⌄ Update tracking/PTL with MDT outcomes, setting next check dates ⌄ Liaise with other MDTs regarding transfer of patients ⌄ Distribute minutes/update tertiary centres ⌄ Work with MDT Lead and Lead CNS to prepare agenda for MDT Operational meetings once/twice p.a. Attend and minute the meetings

Data	Capture/update cancer waits data for weekly upload/applying CWT rules (verifying when uncertain) • Record breach reasons/prepare stage one of root cause analysis of breaches • Capture/update national audit data for monthly upload • Capture/update Cancer Outcomes & Services Data (COSD) for monthly upload • Respond to reports from Cancer Centre Audit Officer requesting data quality checks/amendments • Liaise with tertiary centres for updated data Update Infoflex with Patient Pathway ID amendments Run adhoc data queries
Provision of cover	Provide cover to other tumour sites as required to cover annual leave/sick leave

Induction and Training of MDT Co-ordinators:

Co-ordinators will have Trust induction and PAS training. All Cancer Centre staff involved in cancer pathways will have specific local training in relation to the implementation of this policy, and Infoflex training will be provided by ICT trainers, supported by the lead MDT coordinator. Additional or remedial training will be provided as required or requested by the lead MDT coordinator and/or cancer manager. (Appendix 6)

- An e-learning assessment will be carried out on initial training and refresher training will be carried out annually via an e-learning package.
- Standard operating procedures.
- Workbook assessment tool.
- A Tumour site specific MDT guide will provide specific training

Information Governance:

The Cancer Centre will comply with all Trusts and statutory requirements for the protection of Patient Records and corporate information. The Cancer Management will carry out periodic review of procedures for data flows and exchange of information with other centres to ensure that best Practice is met.

Internal Audits:

The Cancer Centre leadership team on a monthly basis ensure that internal audits of 10 Patient Records are audited to provide Audit assurance to the Trust Board.

Monitoring Responsibilities:

This policy will be formally approved by the Cancer Assurance Group and the Cancer Steering Group. Alterations and amendments to this policy will be approved and ratified by these bodies. Issues around interpretation and application of this policy will be initially resolved by Head of Performance where any matter cannot be resolved at this level it will be escalated to the Cancer Steering Group and Chief Operating Officer for resolution or referred to the National Team for advice. Compliance with this policy will be monitored as outlined in section 19 Monitoring Compliance and Effectiveness.

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 are 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.

Training Requirements

All clinical service centre staff will have Trust induction and PAS training. All Clinical Service Centre staff involved in cancer pathways will have specific local training in relation to the implementation of this policy and Infoflex training will be provided by ICT trainers, supported by the lead MDT coordinator. Additional or remedial training will be provided as required or requested by the lead MDT coordinator and/or cancer manager.

7. References and Associated Documentation

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 (latest version) – go further with cancer waits
http://www.nwlcn.nhs.uk/Downloads/Cancer%20Intelligence/Going%20Forward%20on%20Cancer%20Waits%20A%20Guide%20Version%208.0.pdf

Trusts Joint Access Policy
http://flo/documents-forms/document-search/?q=access+policy

8. Equality Impact Statement

Derby Teaching Hospitals NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy has been assessed accordingly

Our values are the core of what Derby Teaching Hospitals NHS Trust is and what we cherish.
They are beliefs that manifest in the behaviours our employees display in the workplace.
Our Values were developed after listening to our staff. They bring the Trust closer to its vision to be the best hospital, providing the best care by the best people and ensure that our patients are at the centre of all we do.
We are committed to promoting a culture founded on these values which form the 'heart' of our Trust:

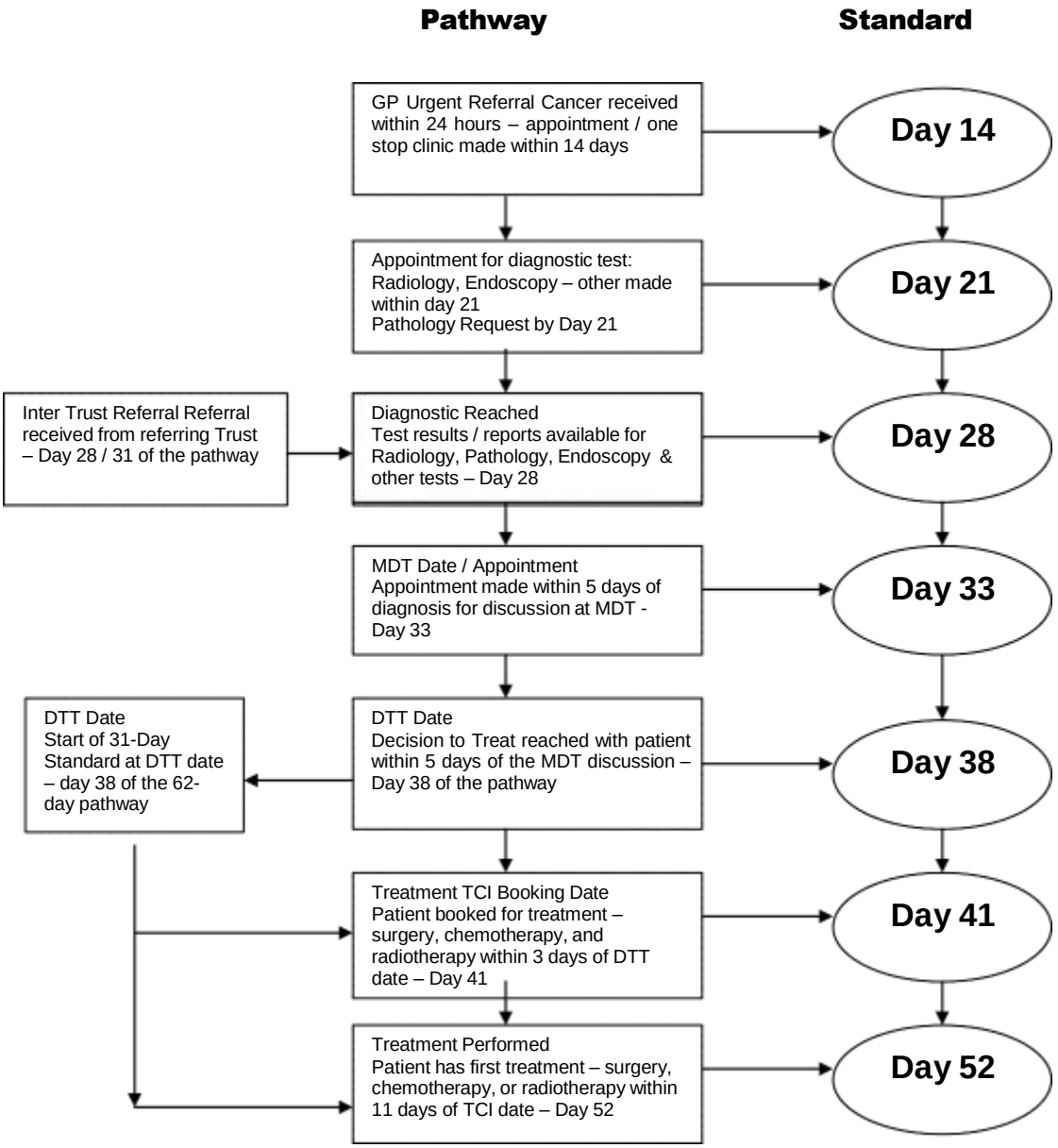
Putting Patients first
Right first time
Investing our resources wisely
Developing our people
Ensuring value through partnership

This policy should be read and be implemented with the Trust Values in mind at all time.

9. Appendices

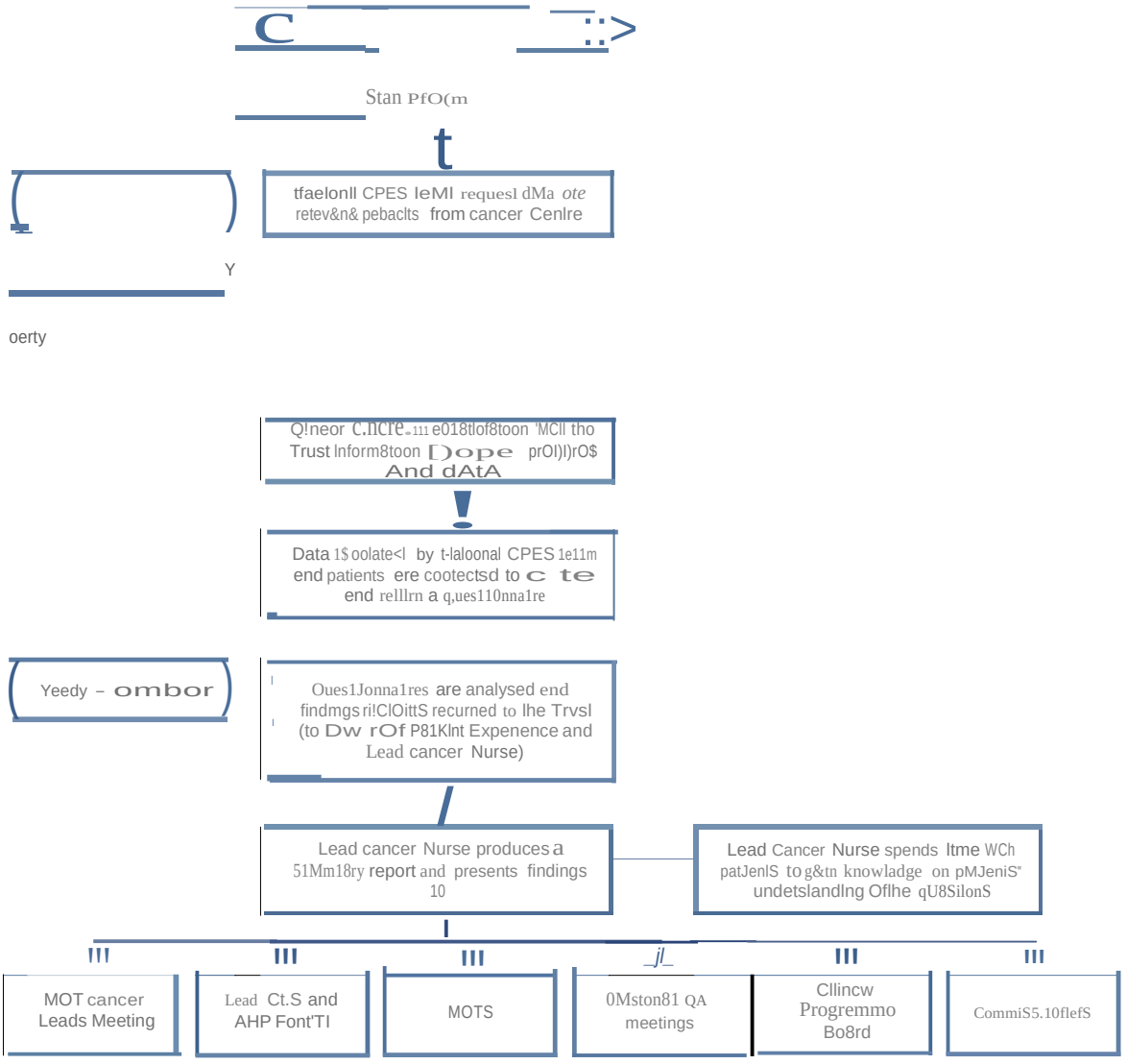
Appendix 1

Derby Teaching Hospitals Generic Pathway Standards



National Cancer Patient Experience Survey (CPES) Process

How the surveys used to inform strategy and improve quality



Action Planning:

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Appendix 3

MDT Coordinator Induction Programme V0.3

From d.!ly one onwardi:

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- MOT teams lead, CNS, radiOlO&ISt,.patholOitst
- Support•ne staft Olv▫soona Assistant General Ma011,ers, secretaroes &adm nsupport,.cll nlcstaff

- elop lc.nowted&e of tumour site specific data , IT systems-detailed knowledae of lnfoflex and cancer wlllbnallmes &Vidance references

elop lc.nowted&e of tumours te specifc pathways, includn, inter•TI'\Ist.,as required

REFERRAL

INVESTIGATIONS

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MOT O SCUSSIOH

1ST TREATMENT

SUBSEQUENT TRfATh1EHT

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  MOT-observations
  MD'" Coordln11tor roleobservatoons
- Data enuv – PPl Onr Code

2nd 4 Weeks

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- Data entry – dlatnos▫spanel{next check dates
- lntroduce concept of escalation
- lntroduction to MOT meetint prepara onJcare plans

- Treatments processes
- Data enuy – trutrnents
- Mock MDT Meeti"lf terminoloay
- MD'" tqUI J)mef'lt
- Revis t cancerw llbntt•mes pathwe vs11nd performance standards (as.ntroduced1n 1"4 ks)

Weea 10 -12

- MOT .1eetm.a (Minutes/Outcomes)

As ent

- Workbook
- Specla hstassessment
- Peer/Tr!liner assessment

Assessment

On-going Assessments