Cancer Services Operational Policy

Date: 30th September 2015

Agenda item: 10.1, Public Board meeting

Title: Cancer Services Operational Policy

Prepared by: Natalie Wickins - Senior Delivery Manager

Presented by: Pete Adey - Operations Director

Responsible Executive: Pete Adey - Operations Director

Summary: A policy document to support the existing joint CCG and RD&E Access Policy in delivering a consistent approach to the operational management of cancer waiting times across the Royal Devon and Exeter NHS Foundation Trust, as well as defining roles and responsibilities and clarifying procedures relating to cancer on a Trust wide basis.

Actions required: The Board of Directors is requested to note and endorse the development of the Cancer Services Operational Policy and approval by the Hospital Operations Board on the 18th of September 2015, as per the 8 key priorities for Cancer published by NHS England, Monitor and the Trust Development Authority.

Status (*):

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History: N/A

Link to strategy/Assurance framework: Supports operational delivery of cancer waiting times standards.

Monitoring Information

Please specify CQC standard numbers and tick ✓ other boxes as appropriate

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Cancer Services Operational Policy
30th September 2015
1. **Purpose of paper**

1.1 For the Board of Directors to note and endorse the development of the Cancer Services Operational Policy and approval by the Hospital Operations Board on the 18th of September 2015, as per the 8 key priorities for Cancer published by NHS England, Monitor and the Trust Development Authority.

2. **Background**

2.1 Already in existence is a jointly agreed CCG and RD&E Trust Patient Access Policy which contains detail on all patient access standards and includes a section on the operational management of cancer pathways and waiting times monitoring. As part of the recently published 8 key Cancer performance improvement priorities developed by NHS England, Monitor and the Trust Development Authority it was requested that every Trust has a ratified operational policy for cancer in place to support existing patient access policies. The policy content should include the organisational approach to auditing data quality and accuracy, the Trust approach to ensuring MDT coordinators are effectively supported and have sufficient and dedicated capacity to fulfil the function effectively.

3. **Analysis**

3.1 The Cancer Services Operational Policy has been developed by the Cancer Services management team, with input from the operational Divisions and involved the appraisal and review of operational policies from other acute Trusts. The clinical oversight and agreement of the pathway review process has been completed by the Associate Medical Director for Cancer Services and agreement of the Trust Executive Medical Director. The policy was presented and approved by the Hospital Operations Board on the 18th September 2015.

3.2 This policy provides a single point of reference for the operational management of cancer pathways as well as detailing the roles and responsibilities of staff across all levels working within the provision of cancer services delivery. The policy also refers to the procedures and processes for tracking and reviewing patients throughout their cancer pathway. Peer review is not included in this policy as these processes are contained within the tumour site specific operational policies.

3.3 This policy will be implemented with immediate effect in line with national guidance. Compliance with this policy will be audited in six months' time.

3.4 The Cancer Network within NHS England South are developing a region-wide Cancer Access Policy which when ratified will need to be considered and any revisions required will need to be reflected within both the Trust Access Policy and the Cancer Services Operational Policy. Any updates or revisions will be taken to the Hospital Operations Board for ratification.
3.5 The Cancer Services Operational Policy will be an Annex of the current Trust Patient Access Policy. The full Access Policy has not been circulated as it is already operational and available on the Trust website. The Cancer Services Operational Policy is attached as Appendix 1 to this paper for information and endorsement.


4.1 None

5. Link to BAF/Key risks

5.1 BAF item: Failure to achieve operational standards for cancer waiting times. There are no known key risks as a result of implementing this policy.

6. Proposals

6.1 The Board of Directors is requested to note and endorse the development of the Cancer Services Operational Policy and approval by the Hospital Operations Board on the 18th of September 2015
# Cancer Services Operational Policy

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<td>Divisional Business Manager (Specialist Services)</td>
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<tr>
<td>Division/ Department responsible for Procedural Document</td>
<td>Specialist Services Division /Cancer Services</td>
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<td>Cancer Performance Manager</td>
<td>New policy to ensure consistent practice and clarity of roles within cancer services as well as a definition of the Trustwide role</td>
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<td>1.1 - Draft</td>
<td>26/08/15</td>
<td>Cancer Performance Manager</td>
<td>Changes in line with feedback from members of the team as well as cross referencing with further guidance.</td>
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### Associated Trust Policies/ Procedural documents:

- Individual MDT Operational Policies
- Access Policy
- Network Cancer Access Policy
- Radiology Appointments SOP
- Incident reporting, analysing, investigating and learning policy and procedures

### In consultation with and date:

Initial Circulation: Cancer Services Cluster Manager, Lead Cancer Nurse, Team Leader in the 2ww Office and Senior Delivery Manager (29/07/15)

Second Circulation (for dissemination to teams for comment): Divisional Directors, Divisional Business Managers, Head of Operational Performance, Head of Access, Associate Medical Director of Cancer Services and General Manager of the Operations Support Unit. (19/08/15)

Reviewed with the Lead for Patient Equality (17/09/15)

Reviewed at the Hospital Operations Board (18/09/15)

Reviewed by Deputy Head of Governance (21/09/15)

Reviewed by the Head of Safety, Risk & Patient Experience (23/09/15)

Reviewed by the Medical Director (23/09/15)

### Contact for Review:

Cancer Performance Manager

### Executive Lead Signature:

(Applicable only to Trust Strategies & Policies)
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1. INTRODUCTION

1.1 Cancer services is an organisation-wide service, cross cutting into the vast majority of specialist and diagnostic services. This document has been put in place to establish a consistent approach to the management of cancer waiting times across the Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as the Trust), as well as defining roles and responsibilities and clarifying procedures relating to cancer on a Trustwide basis.

1.2 The standards that NHS Providers are expected to meet are:
- 2 weeks from urgent General Practitioner (GP) referral for suspected cancer to first outpatient attendance.
- 2 weeks from symptomatic breast referral (cancer not suspected) to first outpatient attendance.
- 31 days from decision to treat to first definitive treatment for cancer.
- 31 days from decision to treat or earliest clinically appropriate date (ECAD) to subsequent treatment (surgery, drug or radiotherapy) for all cancer patients including those with a recurrence.
- 62 days from urgent GP referral for suspected cancer to first definitive treatment for cancer (31 days for suspected Children’s cancers, Testicular cancer, and Acute Leukaemia).
- 62 days from referral from NHS Cancer Screening Programmes (Breast, Cervical and Bowel) to first treatment for cancer.
- 62 days from a Consultant’s decision to upgrade the urgency of a patient (e.g. following a non-urgent referral) to first treatment for cancer.

1.3 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.

1.4 Failure to comply with this policy could result in disciplinary action.

2. PURPOSE/SCOPE

2.1 This policy relates to all patients with suspected, diagnosed or recurrent cancer and those referred via a NHS screening programme (Breast, Cervical and Bowel) and healthcare professionals who care for these patients within the Trust.

2.2 Implementation of this policy will help to ensure that:

2.2.1 Staff members are aware of the correct processes and timescales for booking and seeing 2 week wait referral patients.

2.2.2 The Trust has processes in place to ensure a consistent approach to management and compliance with the National Cancer Waiting Times Guidance (2011):.

2.2.3 There is a clear process to enable Consultants to fast track referrals where they suspect malignancy, even if this was not identified before referral to them.
2.2.5 Patients with recurrent or secondary disease will have their pathways expedited in the same way as those with primary disease.

2.2.6 When there is a suspicion of malignancy or other serious abnormality after imaging, the referrer is made aware so they can then take appropriate action.

2.2.7 GPs will receive timely information about a patient who has received a cancer diagnosis, and can then offer the appropriate support to the patient and their family.

2.2.8 Clinical and divisional teams take responsibility for their own capacity and demand, monitoring performance and develop proactive ways to meet the National Cancer Waiting Times targets in line with best practice.

2.2.9 Clinical teams take responsibility for monitoring clinical pathways in line with best practice and Strategic Clinical Cancer Network Guidance.

3. DEFINITIONS

3.1 E-referral
The electronic referral system through which GPs send referrals to the Trust.

3.2 PAS (Patient Administration System)
Hospital electronic Patient Administration System to record all referrals and activity.

3.3 Cancer Wait Times Tracker
Hospital database to record specifically all cancer related tracking activity.

3.4 Decision to Treat Date (DTT)
The date the patient and Consultant agree the treatment plan.

3.5 Cancer Waiting Times (CWT) Targets
The nationally agreed waiting times for stages of the patients pathway for suspected or diagnosed cancer.

3.6 2 Week Wait (2ww) Target
Maximum 14 days (including weekends and Bank Holidays) from the date that a 2 week wait referral is received by the Trust to the date first seen with an appropriate specialist or attendance at an appropriate diagnostic procedure.

3.7 31 Day target
Maximum 31 days from the date of DTT to the date of the first definitive treatment (i.e. surgery, radiotherapy, chemotherapy, palliative care, active monitoring). This applies to all patients with a cancer diagnosis whether primary, secondary or recurrent disease and regardless of their referral route. Patients upgraded by a Consultant and those undergoing second or subsequent treatments, are also measured against this target.

The 31 day target is also applied to subsequent treatments when there is no new decision to treat, but there has been a previously agreed and clinically appropriate delay before treatment can commence. In these cases the Earliest Clinically Appropriate Date (ECAD) is the start of the 31 days.

3.8 62-day target
Maximum of 62 days from the date that a 2 week wait referral is received by the Trust, or from a Screening Service, or the date of Consultant upgrade, to the date of
the first definitive treatment.

3.9 **MDT**
Multi-Disciplinary Team comprising those involved in treating cancer patients.

3.10 **IOG**
Improving Outcomes Guidance.

3.11 **NSSG**
Network Site Specific Groups.

3.12 **PTL Meeting**
Patient Tracking List meeting.

4. **DUTIES AND RESPONSIBILITIES OF STAFF**

4.1 **Role of the Chief Executive**
4.1.1 The overall and final responsibility for this policy in the Trust rests with the Chief Executive.

4.2 **Role of the Executive Lead for Cancer (Operations Director)**
4.2.1 Board level accountability for Cancer Waiting Times and cancer services delivery.
4.2.2 Ensuring that the Key Performance Indicators related to Cancer Waiting Times targets are achieved.
4.2.3 Delegation of responsibilities relating to provision of cancer services;
4.2.4 Effective support of managerial decisions and recommendations to ensure provision of appropriate resources.

4.3 **Role of the Associate Medical Director of Cancer Services**
4.3.1 Professional management responsibility for the Multi-Disciplinary Team leads in their roles including responsibility for delivery of Cancer Waiting Times within their tumour site.
4.3.2 Manage the medical team (tumour site and clinical leads) to ensure they proactively monitor all patients to ensure treatment in a timely manner; however if this is not achieved all patients who have breached must be reviewed weekly by MDT lead.
4.3.3 Leading on the process for mitigating harm to patients and ensuring all patients breaching their cancer wait times targets are appropriately reviewed by the clinical teams to establish if the patient has come to harm as a result of the delay.
4.3.4 Personally review the top 10% of longest waiting 62 day breaches to establish if the patient has come to harm as a result of the delay.

4.9 **Role of the MDT Lead/Tumour Site Lead**
4.9.1 Ensuring that care is given according to recognised guidelines with appropriate information being collected to inform clinical decision making and to support clinical governance.
4.9.2 Accountability for CWT delivery, breach avoidance and learning (with support from the relevant senior speciality manager).
4.9.3 In conjunction with Director of Cancer Services ensure continuity of service throughout the year including theatre timetabling and ensuring appropriate cover during periods of annual leave.

4.9.4 Reviewing patients that have been treated past their cancer wait times breach date to determine clinical learning points and to confirm if the delay led to that patient coming to harm.

4.9.5 To ensure that the multidisciplinary team meet on a weekly basis, with an agreed core team membership, records of attendance and appropriate records and care plans of cases discussed.

4.9.6 All MDT pro formas must be clinically validated on the day of the MDT meeting.

4.9.7 Accountable for breach avoidance and shared learning from historic breaches.

4.10 Role of Medical Staff Treating Cancer Patients
4.10.1 Informing the secretarial team or MDT co-ordinator about any consultant upgrades or recurrences when required to ensure that patients are tracked appropriately and treated in accordance with CWTs.

4.10.2 When a patient receives a diagnosis of cancer, the attending clinician or Clinical Nurse Specialist must ensure that this information is communicated to the patient’s GP before the end of the following working day.

4.10.3 Ensuring that patients awaiting diagnosis or treatment of a cancer are not coming to avoidable harm due to unnecessary delays. Medical staff must escalate concerns about delays through their clinical division or to the Director of Cancer Services.

4.10.4 To ensure patients are treated in an appropriate order with regards to clinical priority, with consideration given to breach dates.

4.11 Role of the CNS (keyworker)
4.11.1 Ensure information is passed to the relevant individuals and documented appropriately to promote timely management of care.

4.11.2 Act as a point of contact for administrative staff to be able to clarify clinical information on the CWT tracker.

4.4 Role of Cancer Services Management Team and Lead Cancer Nurse
4.5.1 Monitoring and overseeing of CWT data quality and validation of compliance with the CWT targets.

4.5.2 Working with clinical and divisional teams to drive forward delivery of National Cancer Waiting Times.

4.5.3 Ensuring that policies and processes relating to Cancer Wait Times are in place to support the management of cancer patients.

4.5.4 Developing, delivering and monitoring cancer training for relevant staff groups to promote the delivery of Cancer Waiting Times.

4.5 Role of Divisional Management teams and Cluster Managers
4.6.1 Working with clinical teams within the division to monitor capacity and demand for services and support performance in cancer to deliver national targets and ensure a positive patient experience.
4.6.2 Notify the cancer management team if they are unable to identify and organise additional capacity when it is required and may result in breaches.

4.6.3 Complete the initial validation of breaches for their area and provide these at the Validation Meeting. Ensure any breaches are reflected on and actions are taken where possible to mitigate further avoidable breaches, in conjunction with the clinical team.

4.6.4 Chair Patient Tracking List (PTL) meetings for their area, challenging and resolving any avoidable delays as appropriate.

4.6.5 Identifying the need for additional activity required to meet the demand.

4.6.6 Liaison with the relevant teams to ensure booked dates in the future are brought forward where possible, to prevent a breach.

4.6 **Role of Two Week Wait Office**

4.7.1 Receiving 2 week wait referrals from GP Surgeries via the NHS E-referral Service and ensuring the patients are booked appropriately, changing the appointments when needed to a more appropriate service and ensuring that any pre diagnostic procedures are booked.

4.7.2 Where the service is not on NHS E-Referral Service (Lower GI and One stop prostate) booking the appointments for the patient to see a specialist within 14 days, including starting the 18 week pathway.

4.7.3 Monitoring the outpatient clinics to ensure that all vacant slots are filled or passed back to cluster for their utilisation, thus ensuring all clinics are fully booked.

4.7.4 Managing the 2 week wait endoscopy mailbox, ensuring that patient’s demographic details are correct on PAS and adding patients to the CWT Tracker within 1 working day of receipt.

4.7.5 Managing the generic mailbox for 2 week wait queries.

4.7.6 Monitor duplicate referrals and highlight these to the GP Surgeries.

4.7.7 Email the consultant’s secretary to inform them when patients choose to cancel their 2 week wait appointments and decline to rebook.

4.7.8 Rebooking patients who have DNAd (Did Not attend) following notification from the Receptionist of the need to rebook the patient.

4.7.9 If the patient needs a diagnostic procedure rather than a Consultant appointment, an orange x-ray card will be completed and delivered to Radiology within 24 hours so an appointment can be made within 14 days.

4.7.10 Enter all referrals and appointment details online to the CWT tracker.

4.7.11 Contact any patients booked with less than 5 days’ notice by telephone where possible.

4.7.12 Liaise with the Urology Nurse Specialist to ensure that appropriate patients are booked to the prostate one stop clinic.

4.7.13 Ensure the appointment letter is delivered to Health Records to enable the notes to be pulled/prepped for the outpatient clinics.
4.7.14 Notify the relevant Slot Manager/Admin Line Manager if additional appointment capacity is required to enable the 2 week target to be met. Highlighting to the Performance & Development Manager for NHS E-Referral Service if no response is received.

4.7 Role of the Central Performance Team and Information Department

4.8.1 Monitor compliance with the Cancer Waiting Times targets in line with the Trust’s Key Performance Indicators.

4.8.2 Provide reports on high level cancer performance and patient level detail on a regular basis to the relevant internal teams, including trend data to the CCG.

4.8.3 Upload the Cancer Waiting Times data to the Open Exeter system on a monthly and quarterly basis in line with nationally directed deadlines.

4.8.4 Meet with the cancer management team regularly to discuss cancer performance.

4.8.5 Provide activity and performance forecasts to tumour sites including seasonal peaks, campaigns and developments to aid capacity planning for the future.

4.8.6 Permanently deleting incorrect records from the cancer tracker (i.e. duplicates).

4.12 Role of the MDT coordinator

4.12.1 Ensuring live recording of the MDT discussion and all outcomes are uploaded onto the Cancer Wait Times Tracker, CDM and filed in the notes as appropriate.

4.12.2 Ensuring all information and results (patient notes, referral letters, x-rays, CT and MRI scans and histopathology reports/specimens) are readily available and visible at the meeting to inform discussion.

4.12.3 To include the 62 day breach dates on agenda and proforma as applicable.

4.12.4 Ensuring any consultant upgrades identified by the clinical team during the MDT meetings are recorded on the MDT proforma.

4.12.5 Reviewing quality of data on the cancer tracker and add missing data as required in partnership with the team.

4.12.6 Attending the weekly Patient Tracking List (PTL) meeting for the relevant tumour site/s and contribute to the meeting as applicable.

4.12.7 Ensuring any cancer/suspected cancer patients on the MDT agenda are on the tracker and add records to the tracker as required.

4.12.8 Receiving cancer referral forms (ITRs) via the generic mailbox and ensuring these patients are added to the cancer tracker, CDM and that acknowledgement of receipt is provided to the referring Trust.

4.12.9 Returning treatment information for shared patients to the referring Trust within the required timescales as set out in the Network Cancer Access Policy.

4.12.10 Sending cancer referral forms (ITRs) to the relevant mailbox in the receiving Trust in line with the Network Cancer Access Policy.

4.12.11 Working with the multi-disciplinary team to ensure that appointments, investigations and treatments are booked in a timely way, ensuring that delays are avoided and breaches escalated appropriately.
4.12.12 To work with the CNS(s) and clinicians to ensure that actions are taken to ensure the smooth running of the patient pathway, e.g. entering of information onto Dendrite (clinical audit and management system) and the CWT Tracker.

4.12.13 To ensure all patients’ progress relating to the MDT is accurately recorded in a timely manner on the CWT Tracker.

4.12.14 Notify the relevant Cluster Manager if they identify delays and there are potential or actual breaches in any of the CWT targets.

4.13 **Role of the Medical Secretaries**
4.13.1 Attend the weekly Patient Tracking List (PTL) meeting and contribute to the meeting focusing on their consultants patients.

4.13.2 Ensuring work for cancer patients is prioritised, for example: typing of letters for cancer patients before non-cancer patients.

4.13.3 Updating the tracker as the patient progresses through their pathway and following up on and escalating any issues or delays appropriately.

4.13.4 Looking out for key words that may indicate a suspicion of cancer when typing letters and checking these patients are on the cancer tracker. If not, establish whether the consultant has upgraded this patient.

4.13.5 Where letters indicate a diagnostic has been requested; check to ensure this is on the radiology system and if the priority is “cancer” (the patient has been referred via the orange card process) then ensure the patient is on the tracker if appropriate.

4.13.6 Notify the relevant Cluster Manager if they identify delays and there are potential or actual breaches in any of the CWT targets.

4.14 **Role of the GP**

5. **PROCEDURES AND PROCESSES**
This section of the policy outlines the procedures to be followed to ensure that patients who are suspected of having, or who are diagnosed with, cancer receive timely and appropriate care.

5.1 **Pre-referral**
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 e-mail or Choose & Book route. Urgent referrals for suspected cancer will be made on a standard Trust pro-forma via Choose & Book or in the case of Upper and Lower GI via e-mail. Addresses and the patients preferred location to be seen will be taken into account when booking appointments at the different hospital sites; however, priority is to be given to seeing the patient within 14 days. All referrals are to a team, not to a nominated Consultant. All referrals will adhere to the guidelines for referral set out nationally.

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.
GP’s should only send two week wait referrals for patients that are available to attend an appointment within the next 14 days and also they should also inform the patients that they are being referred as a suspected cancer.

5.2 Booking 2 week wait suspected cancer referrals
5.2.1 See cancer access policy

5.3 Consultant upgrade for suspected cancer
5.3.1 See cancer access policy

5.4 31 day pathways including ECAD
5.4.1 See cancer access policy

5.5 62 day pathways
5.5.1 See cancer access policy

5.6 Tertiary referrals
5.6.1 See cancer access policy

5.7 MDT Procedure
5.7.1 The MDT co-ordinators should receive full support in the form of line management, including dedicated cross cover for planned and unplanned absence.

5.7.2 During the MDT meetings the MDT co-ordinator should also receive support of the clinical teams to enable completion of the relevant documentation and upgrades to be documented and added to the cancer wait times tracker.

5.7.3 See Multidisciplinary Team Working Guide published by the NHS Institute for Innovation and Improvement, for further guidance pertaining to the running of MDT meetings.

5.8 Rapid notification of an unsuspected diagnosis of cancer
5.8.1 This procedure applies to situations where cancer is diagnosed, where cancer was not previously clinically suspected. These situations are referred to as incidental findings in terms of cancer wait times and do not apply to patients already on an active pathway.

5.8.2 If unexpected findings indicating cancer are present on a diagnostic report, the report will be given to the secretary on the day the test is carried out, for urgent typing on the same working day. The typed report will be checked and verified as soon as possible and forwarded urgently to the referring clinician for their immediate attention.

5.8.3 The secretary will add the patient to the cancer wait times tracker as a “non 62 day” pathway with a comment to explain why.

5.9 Breach Analysis and Reporting
5.9.1 A detailed review is undertaken using the template present in Appendix 1 for every patient breaching the 31 or 62 day operational targets. This review examines in detail why the breach occurred by looking at each step in the pathway and identifying delays against our local expectations.

5.9.2 All breaches are discussed at the monthly validation meeting (see meeting structure in appendix 2). Proposed breach reasons are prepared prior to the
meeting and presented by a representative from the relevant cluster and where required discussion around potential pauses or other guidance queries is facilitated with the Cancer Services team.

5.9.3 Post validation meeting, all breaches undergo a second review from the clinical teams to ascertain whether the patient has come to any avoidable harm. See appendix 3 for the full process.

6 **PATIENT DOCUMENTATION**

6.1 **Patient Treatment Plan**

All patients must receive a copy of their treatment plan either by form of a copy of letter to GP or specific treatment plans set out with diagnosis, treatment plan and follow up.

6.2 **Treatment Summary**

All patients will receive an end of treatment summary, which will summarise care received and any follow up arrangements or requirements for the future.

6.3 **Patient records**

All patients with a Cancer Diagnosis will be identified with an orange sticker within the medical notes that informs staff of diagnosis, DTT and named Key worker.

6.4 **Written Information**

All patients will receive written information about their Cancer, their planned treatment and after care unless they have explicitly requested otherwise and this has been documented.

All patient information will be available in different formats and languages via the Patient Advice & Liaison Service (PALS office) at the Trust.

7. **ARCHIVING ARRANGEMENTS**

The original of this policy, will remain with the author (Cancer Performance Manager, Cancer Services). An electronic copy will be maintained on the Trust Intranet, P – Policies – C – Cancer. Archived electronic copies will be stored on the Trust’s “archived policies” shared drive, and will be held indefinitely. A paper copy (where one exists) will be retained for 10 years.

7.2 **PROCESS FOR MONITORING COMPLIANCE AND EFFECTIVENESS OF THE CANCER SERVICES OPERATIONAL POLICY**

8.1 **Policy Standards/ Key Performance Indicators**

Key performance indicators will be those currently in force nationally, for Cancer Waiting Times and Peer Review. These will be monitored by the Cancer Services management team and performance.

8.2 **Process for Implementation and Monitoring Compliance and Effectiveness**

Monitoring compliance with this policy will be the responsibility of the Divisional Business Manager, the Cancer Management Team & Trust Performance Team.

To monitor compliance with this policy the auditable standards will be monitored as follows:
<table>
<thead>
<tr>
<th>No</th>
<th>Minimum Requirements</th>
<th>Evidenced by</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Monthly monitoring of the achievement of waiting times targets, investigating cases</td>
<td>Submission of validated cancer wait times data/population of monthly breach</td>
</tr>
<tr>
<td></td>
<td>that fail to comply and taking action as necessary to reduce the risk of it occurring</td>
<td>agenda.</td>
</tr>
<tr>
<td></td>
<td>again.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Ensuring, through the Peer Review process, that the relevant audits have been</td>
<td>Peer review reports.</td>
</tr>
<tr>
<td></td>
<td>undertaken and action plans developed to address any areas that do not meet the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>relevant standards.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Periodic audit of a selection of notes from non-breaching cancer patients against</td>
<td>CWT audit reports and quarterly summaries.</td>
</tr>
<tr>
<td></td>
<td>information held on the Cancer Wait Times Tracker.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Weekly review of open cancer pathways through the specialty PTL. This should be run</td>
<td>Spot checks for each PTL by cancer services, twice yearly.</td>
</tr>
<tr>
<td></td>
<td>in line with this operational policy.</td>
<td></td>
</tr>
</tbody>
</table>

8.3 **Frequency**  
In each financial year, the Cancer Performance Manager will review the measures listed above to ensure that this policy has been adhered to and a formal report will be written and presented at the Cancer Services Governance Group and at the Cancer Performance Meeting for all areas.

8.4 ** Undertaken by**  
Cancer Performance Manager

8.5 **Dissemination of Results**  
At the Cancer Services Governance Group and at the Cancer Performance Meeting for all areas which are held monthly.

8.6 **Barriers**  
Any barriers to implementation will be risk-assessed and added to the risk register.

8.7 **Changes in Practice**  
Any changes in practice needed will be highlighted to Trust staff via the Governance Managers’ cascade system.

9. **REFERENCES**

- National Cancer Plan, 2010
- National Cancer Reform Strategy, 2007
- The Manual of Cancer Services, 2004
- Cancer Waiting Times (CWT) National Guidance, 2011
- The NHS Institute for Innovation and Improvement Multidisciplinary Team Guide, 2010
## APPENDIX 1: Breach Analysis Template

### Route Cause Analysis Template

<table>
<thead>
<tr>
<th>Hospital Number - Patient Name</th>
<th>Req Date</th>
<th>Date Occurred</th>
<th>Wait for Step</th>
<th>Number of Days Through</th>
<th>Target Wait</th>
<th>Comments</th>
</tr>
</thead>
</table>

- **Targets Failed**
- **Route Cause (Number and Text)**
- **Contributory Factors**
- **Lessons Learned**
- **Recommendations**
- **Shared Learning**
- **Actions Required or Reference to Existing Action**

**Total Pathway Length**

Did the patient come to harm as a result of the delay to treatment?

- Verified by: Name:
- Signature:
- Date:
APPENDIX 2: Cancer Services Meeting Structure

Cancer Services Operational Policy
Ratified by: Hospital Operations Board
Review date: 18th September 2015

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APPENDIX 3: Process for identifying and reporting avoidable patient harm when a patient has breached the 31 or 62 day cancer wait times targets.

All clinical and non-clinical staff members are aware of their duty to report concerns about possible harm to patients under the care of the Trust. They should report those concerns through the normal Trust Governance framework in line with the Trusts’ Incident reporting, analysing, investigating and learning policy and procedures (April 2015).

The administrative teams review the active patients on tracking at least weekly to ensure that they are progressing within their pathway. This is facilitated through the relevant tumour site patient tracking list meeting (PTL).

If patients with cancer breach any of their target treatment times the breaches are reviewed at the monthly Validation Meeting. These reviews ensure that the reason for breaching is known and recorded, any avoidable delays are noted and actions are taken to reduce the risk of recurrence.

A second validation is undertaken with the Clinical Teams delivering the cancer treatments when a breach has occurred. This is with the specific aim of assessing if any potential avoidable harm has occurred.

All incidents where the clinical team identify that harm has possibly occurred will be reported on the Trust Electronic Incident Reporting system (Datix) immediately or as soon as safe to do so (link via IaN).

Not all incidents need to be investigated to the same extent or depth. Categorising incidents according to the actual impact and the potential future risk to patients/visitors/staff/others and the organisation establishes the level of local investigation and causal analysis that should be carried out. These should be investigated in line with the Incident reporting, analysing, investigating and learning policy and procedures (April 2015). These should be reviewed using the Trusts’ 72 hour report template.

A decision will be made by the Chief Nurse / Chief Operating Officer, Deputy Chief Nurse or the Chief Executive as to whether any actual harm incident is a Red Incident reportable to the Commissioners as a Serious Incident Requiring Investigation (SIRI).

Where possible harm has occurred due to delays in external organisations they will be informed of the findings.

A monthly report is produced to ensure that these investigations are progressing. Any incidents where harm has occurred will be reported appropriately through the Trust’s internal systems and onto appropriate external systems.

A further review is carried out by the Director of Cancer Services of the top 10% of waiting times patients. This is to review these patients, once more, who have had the longest waits. The review is carried out to validate the earlier process, identify any previously unidentified harm from the longer wait for treatment and to identify any previously unidentified avoidable delays in the pathway.
APPENDIX 4: Open Pathway Review Process

Open Pathway Review Process

Administrative Review Process

- Breach analysis document is populated to date and added to until the patient is treated.
- Open pathway reaches operational target (excluding 2ww).
- Patients are discussed at weekly PTL meetings (breaching and non-breaching patients).
- Is the next step planned and has this been booked within agreed acceptable timescales?
  - Yes: Await next step to be completed.
  - No: Escalate to relevant team member (Capacity – cluster manager, Unknown – clinician in charge of patient).

Clinical Review Process

- Weekly clinical review of all patients with open 62 day pathways post 42 days and all 31 day patients with no TCI.
- Assessment of potential adverse clinical outcome for patient.
- Is the patient at risk of potentially coming to harm due to the delay?
  - Potential harm: Escalation to relevant divisional management team to expedite the next steps.
  - No potential harm: Continue weekly monitoring.

Patient treated (See post treatment breach process)

Any patient exceeding the below thresholds will be reviewed by the relevant Divisional Director or Associate Medical Director on a weekly basis. This information will be provided on a weekly basis by Cancer Services.

Patients on a 62-day pathway waiting over 90 days
Patients on a 31-day pathway waiting over 45 days
**APPENDIX 5: Post Treatment Breach Analysis Process**

**Post Treatment Breach Analysis Process**

1. **Patient breaches 31-day and/or 62-day Cancer Wait Times target**
2. **Relevant division to complete standard breach analysis template (1 per patient)**
3. **Cluster Manager or appropriate deputy to attend monthly Validation Meeting**
4. **The breach reason/s and any actions discussed are recorded during the Validation Meeting**

**Outstanding Actions**
- **Max 2 working days post meeting**
- **Max 1 week post meeting**

**Cluster Managers to complete all actions and submit remaining breach reasons**

**Every breach reviewed by a clinician to ascertain if there is a risk that avoidable harm has come to the patient as a result of delays in the pathway?**

**Outcome of review**
- **No Harm**
- **Possible Harm**
- **Potential Future Harm**
- **Ongoing**

**Logged on DATIX (Summary of incidents to be provided to Cancer Services)**

**Categorise incident - 72 hour report to be completed as per the Trust Incident Reporting Policy using the appropriate template**

**Decision made by Chief Nurse/Deputy Chief Nurse or Chief Executive as to whether incident is a ‘Red Incident’ or ‘SIRI’**

**Clinician to decide on monitoring strategy for the patient. Report adverse prognosis in line with harm protocol. Inform Cancer Services of outcome. Record on breach spreadsheet.**

*Review of avoidable harm may be delayed due to histology or other information not yet available*
APPENDIX 6: COMMUNICATION PLAN

COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

<table>
<thead>
<tr>
<th>Staff groups that need to have knowledge of the strategy/policy</th>
<th>All Trust staff involved in booking, tracking or treating patients with suspected or diagnosed cancer.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The key changes if a revised policy/strategy</td>
<td>N/A</td>
</tr>
<tr>
<td>The key objectives</td>
<td>This document has been put in place to establish a consistent approach to the management of cancer waiting times across the organisation as well as defining roles and responsibilities and clarifying procedures relating to cancer on a Trustwide basis.</td>
</tr>
<tr>
<td>How new staff will be made aware of the policy and manager action</td>
<td>Cancer Wait Times training E-mail cascade Through the Cancer Performance Meeting Available on Trust Intranet under Policies Trust Intranet 'Must Read'</td>
</tr>
<tr>
<td>Specific Issues to be raised with staff</td>
<td>N/A</td>
</tr>
<tr>
<td>Training available to staff</td>
<td>Further information about the CWT guidance and tracking can be gained through the formal training course “Level 1 - An Introduction to Cancer Wait Times and Tracking”. Detailed training or queries can be addressed by contacting the Trust Cancer Performance Manager.</td>
</tr>
<tr>
<td>Any other requirements</td>
<td>N/A</td>
</tr>
<tr>
<td>Issues following Equality Impact Assessment (if any)</td>
<td>1 relevant impact for people with disabilities</td>
</tr>
<tr>
<td>Location of hard / electronic copy of the document etc.</td>
<td>The original of this policy, will remain with the author (Cancer Performance Manager, Cancer Services). An electronic copy will be maintained on the Trust Intranet, Archived electronic copies will be stored on the Trust’s “archived policies” shared drive, and will be held indefinitely.</td>
</tr>
</tbody>
</table>
APPENDIX 7: EQUALITY IMPACT ASSESSMENT TOOL

<table>
<thead>
<tr>
<th>Name of document</th>
<th>Cancer Services Operational Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division/Directorate and service area</td>
<td>Specialist Services/Cancer Services</td>
</tr>
<tr>
<td>Name, job title and contact details of person completing the assessment</td>
<td>Alex Tait Cancer Performance Manager, x8362</td>
</tr>
<tr>
<td>Date completed:</td>
<td>10/09/15</td>
</tr>
</tbody>
</table>

The purpose of this tool is to:

- **Identify** the equality issues related to a policy, procedure or strategy
- **Summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **Highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. **What is the main purpose of this document?**
   
   This document has been put in place to establish a consistent approach to the management of cancer waiting times across the organisation as well as defining roles and responsibilities and clarifying procedures relating to cancer on a Trustwide basis.

2. **Who does it mainly affect?** *(Please insert an “x” as appropriate:)*
   
   Carers ☐  Staff ☒  Patients ☐  Other (please specify)

3. **Who might the policy have a ‘differential’ effect on, considering the “protected characteristics” below?** *(By differential we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)*
   
   Please insert an “x” in the appropriate box (x)

<table>
<thead>
<tr>
<th>Protected characteristic</th>
<th>Relevant</th>
<th>Not relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Disability</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Sex - including: Transgender, and Pregnancy / Maternity</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Race</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Religion / belief</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Sexual orientation – including: Marriage / Civil Partnership</td>
<td>☐</td>
<td>☒</td>
</tr>
</tbody>
</table>

4. **Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to...** *(e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)*?
N/A – this document does not affect or single out any specific groups of people.

5. Do you think the document meets our human rights obligations? ☒

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:

- **Fairness** – how have you made sure it treat everyone justly?
- **Respect** – how have you made sure it respects everyone as a person?
- **Equality** – how does it give everyone an equal chance to get whatever it is offering?
- **Dignity** – have you made sure it treats everyone with dignity?
- **Autonomy** – Does it enable people to make decisions for themselves?

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

While creating this document, key parties have been provided oversight and the opportunity to comment on the processes and wording of the policy. All feedback has been collated in an inclusive manner.

Consideration was given to disability related communication needs.

7. If you have noted any ‘missed opportunities’, or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

<table>
<thead>
<tr>
<th align="left">“Protected characteristic”:</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td align="left">Issue:</td>
<td>N/A</td>
</tr>
<tr>
<td align="left">How is this going to be monitored/addressed in the future:</td>
<td>N/A</td>
</tr>
<tr>
<td align="left">Group that will be responsible for ensuring this carried out:</td>
<td>N/A</td>
</tr>
</tbody>
</table>