The Shrewsbury and Telford Hospital NHS
NHS Trust

Addendum to Elective Care Access Policy - Cancer Pathways

Policy Statement

This policy stipulates the way in which The Shrewsbury and Telford Hospital NHS Trust will manage patients who are waiting for an out-patient appointment, diagnostic investigation, in-patient or a day-case admission on a cancer pathway.

This policy should be used in conjunction with: Elective Care Access Policy – October 2014

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CONTENTS

1. Introduction

This document details processes relevant to access for patients on a suspected cancer pathway at The Shrewsbury and Telford Hospital NHS Trust (SaTH). It details how SaTH will approach the management of patients against national cancer waiting time targets. It is the intention of this addendum to document processes for ensuring all cancer referrals, irrespective of referral source, are handled efficiently and equitably, in line with national guidance. This document has been developed using current guidance from the Department of Health, including Cancer Waiting Times: A Guide (V8.0 2011), and other sources of best-practice. In areas where local interpretation is required, this is always in the 'spirit' of the national guidance and at all times in the patient's best interests. The overall purpose of the document is to establish a consistent approach to the management of cancer waiting times across the organisation.

2. Objectives

To ensure all staff involved in cancer waiting times management are aware of and follow the processes outlined in this document in order to provide equitable access for patients through effective cancer tracking, to enable the Trust to achieve or exceed the required access standards, taking into account national rules and guidelines.

The key principles of this policy are:

- Improve the patient experience as they move through the clinical pathways, minimising unnecessary delays where possible;
- Ensure patients receive treatment according to clinical priority in the first instance, followed by actual waiting time;
- Escalate bottlenecks in cancer-waiting-time pathways at an early stage to Operational, Centre and Executive management teams;
- Provide timely, consistent and accurate data-recording for patients on cancer waiting-time pathways.

3. Relevant Access Standards

The standards that NHS Providers are expected to meet are:
Cancer waits – 2 week wait
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – Operational Standard 93%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – Operational Standard 93%
Cancer waits – 31 days
Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers – Operational Standard 96%
Maximum 31 day wait for subsequent treatment where that treatment is surgery – Operational Standard 94%
Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – Operational Standard 98%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – Operational Standard 94%
Cancer waits – 62 days
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – Operational Standard 85%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – Operational Standard 90%
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – No Operational Standard
NHS document; Cancer Waiting Times: A Guide (Version 8, 2011)

4. Scope

This document has been designed to be a reference guide for all staff involved with cancer pathway management and sets out the standards required.

5. Duties and Responsibilities

Chief Executive / Chief Operating Officer / Deputy Chief Operating Officer (Planned Care)

The Chief Operating Officer (COO) on behalf of the Chief Executive has overall responsibility for the implementation of this policy and board level accountability for the Trust's adherence to this policy. The COO is responsible for ensuring the delivery and monitoring compliance of the cancer waiting times targets. The Deputy Chief Operating Officer for Scheduled Care will be responsible as designated by the Chief Operating Officer.

Cancer Performance Manager

The Cancer Performance Manager will ensure that all cancer services 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 services core team on this policy together with the Trust's Elective Care Access Policy. Training will also be provided to new members of the team at induction. The Cancer Performance Manager is responsible for reviewing this policy.

Cancer Performance Management Team

The management team which incorporates the Cancer Performance Manager, Deputy Cancer Performance Manager and Cancer Performance Analyst will ensure;

- that the processes outlined in this document are implemented and adhered to, without deviation by the cancer support team, on a day-to-day basis,
- will ensure that refresher training on this policy and the Trust's Elective Care Access Policy is included within the cancer support services core team annual training programme, in order to maintain skills and knowledge,

The Cancer Performance Management Team in conjunction with the Cancer Support Services Team, has a responsibility to ensure that the patient pathway is validated prior to upload to the national cancer waiting time database, demonstrating a true and accurate waiting time for each patient.

Cancer Pathway Co-ordinators

The Cancer Pathway Coordinators will ensure the accuracy of information for all patients managed against national cancer waiting time targets on the Somerset Cancer Registry Database (SCR), using information received from multi-disciplinary sources.
All Cancer Pathway Coordinators have a responsibility to ensure that they comply with the guidance in this operational policy.

Clinicians

Clinicians must agree a 'Consultant Upgrade' within the appropriate site specific multi-disciplinary team meeting if they suspect a diagnosis of cancer in order to effectively upgrade patients to the national 62-day target.

Centre and Operational Management Teams

The Centre and Operational management teams have a responsibility to ensure that adequate capacity is available for all patients added to all waiting lists to enable the Trust to achieve the required local and national cancer standards. The Centre and Operational management teams have a responsibility to ensure that their respective clinical teams have robust processes in place in order to enable cancer patients to be added to the waiting list in a timely and consistent manner.

Administrative Booking Clerks / Receptionists

The Administrative Booking Clerks / Receptionists have a responsibility to ensure that the data entered onto SEMA/SCR accurately reflects the information provided by the GP on referral, in order that patients can be tracked within the relevant national cancer time frame.

The Administrative Booking Clerks/Receptionists have a responsibility to ensure that the data entered onto SEMA/SCR accurately reflects the information provided by the clinical teams on the clinic outcome proforma.

6. Access Policy Standards

Managing the cancer pathway in line with Going Further on Cancer Waiting Times

1. Clock Starts

1.1 The clock starts for urgent suspected cancer referrals are as follows:

- Two week wait (2WW) and symptomatic breast referrals.
  - For Choose and Book referrals the clock start date is the date the UBRN is created.
  - For non-Choose and Book referrals, the date the referral received is the clock start date
- Breast screening – receipt of referral for further assessment (i.e. not back to routine recall)
- Bowel screening – receipt of referral for appointment to discuss suitability for colonoscopy with a specialist screening practitioner (SSP)
- Cervical screening – receipt of referral for appointment at colposcopy clinic

2. Timeliness of GP/GDP Referral

2.1 The patient should be referred by the GP/GDP to the Trust at the earliest opportunity. The GP has the responsibility to ensure the correct 2WW proforma is used and that all correct contact details (including a day time telephone number) are submitted on the proforma. The GP should inform the patient of the reason for referral and the need to attend an appointment within 14 days. The GP should offer the patient a copy of the two week wait information leaflet designed to be given to patients being referred on a 2WW referral.

2.2 The GP should complete the 2WW proforma and send to the referral management centres.

2.3 Receipt of the referral is day 0 for the 2WW national target.

2.4 Choose and Book Referrals. Choose and Book is the national electronic referral method for all 2WW referrals. Choose and Book is the preferred option for receiving referrals at SaTH (where the service is published).

3. Minimum Referral Dataset

3.1 The SaTH locality has agreed a standard suspected 2WW cancer referral proforma for each tumour type. It is expected that all referrals will contain the following minimum dataset:

- Date of referral
- Full name of patient
- Patient's date of birth
- Patient's gender
- Patient's full address
- Patient's up-to-date daytime contact telephone number
- Patient's NHS number
- Full clinical details on the reason for the referral in line with NICE suspected cancer referral guidance
- Referrer details (including telephone and fax number)
- Indication of whether the patient is aware of the nature of the urgency of the referral

Dental Practitioners do not use Choose and Book. These referrals are accepted by the dental practitioner referring to the NHS 2WW generic email or by faxing to the safe haven fax. E-mail address is **TwoWeekRule@NHS.net** and the safe haven fax number is 01743261333. The contact phone number if required is 01743261663.

2WW referrals from Prisons are made to the SaTH email account **TwoWeekRule@NHS.net.** Prison referrals are subject to the NHS Constitution that all patients should be seen within national waiting time targets and the Prison Service has the responsibility to ensure transport services are available.

4. Suspected cancer referrals not containing the required information

4.1 If a referral is received not containing information needed to process it, then the referring GP/GDP should be contacted immediately, thereby minimising the delay to the patient. This does not constitute a reason for making a pause to the pathway and patients should not be referred back to their GP/GDP to stop a pathway.

5. Suspected cancer referrals sent to the wrong provider

5.1 If the Trust receives a referral for a patient for a service not provided by SaTH, i.e. a referral sent to the wrong organisation, then it should be immediately forwarded to an appropriate provider by SaTH, thereby ensuring there is no delay to the patient pathway. The date of receipt is when the referral was originally received by the Trust, not the day it was forwarded onto the appropriate provider, and this does not constitute a reason for making a pause in the pathway. The GP/GDP should be contacted and advised to enable a change in the future practice. Patients should not be referred back to their GP to stop a pathway.

6. Clinically inappropriate 2WW referrals

6.1 Should the consultant consider the 2WW referral to be clinically inappropriate then this should be discussed with the referring GP/GDP. If the request to withdraw the referral as a 2WW is authorised by the referring GP/GDP then the Consultant will communicate this message back to the 2WW clerk in writing (e.g. via an e-mail). This then authorises the 2WW clerk to convert and process the referral as a non 2WW. If the referring GP chooses **not** to downgrade the 2WW referral, the GP/GDP's decision is final and no one in the Trust can convert a 2WW referral to a non 2WW referral unless with the specific agreement of the GP/GDP.

6.2 Patients seen in a SaTH clinic, considered to be an inappropriate 2WW referral will be notified to the local Clinical Commissioning Group/Health Board. The Clinical Commissioning Group/Health Board will liaise back to the referring GP to inform them of the inappropriate referral. The Clinical Commissioning Group/Health Board will provide feedback on the outcome.

7. GP Responsibility

7.1 The GP/GDP should ensure that patients, at the point of the referral being made, are informed of the importance of being seen quickly and the importance for the NHS of patients keeping appointments.

7.2 The verbal information provided to the patient by the GP/GDP will be supplemented with a patient leaflet, produced by SaTH. This leaflet will be available for GP/GDPs to give to patients during their primary care consultation at the point of the referral.

8. Administrative processes for referring and receipt of a 2WW appointment

Choose and Book Referrals:

The Trust actively encourages referring patients electronically and Choose and Book should be the primary referral method for all 2WW referrals (where the service is published). The GP/Referral Management Centre has responsibility to search for and book all 2WW appointments by choose and book software. The SaTH 2WW team monitor the 'referrals for review' work list and use the 'accept' function to complete the booking. Details can then be entered onto Trust's cancer database – the Somerset Cancer Registry (SCR). Whilst SEMA is automatically updated via Choose and Book, the 2WW staff access SEMA to make an appropriate comment so that the patient does not get cancelled. It is the responsibility of the Booking & Scheduling department to run daily checks to ensure that the data on SEMA relating to 2WW referrals is accurately replicated on SCR.

Slot Availability:

It is the responsibility of the SaTH Centres to ensure there are sufficient slots available on Choose and Book at all times. Where sufficient slots do not exist the referrer can 'defer to provider' and this transfers the responsibility for booking to SaTH. The SaTH 2WW team monitor deferred patients via the 'ASI' work list and promptly escalate to & work with the Directorates to secure the required capacity. Patients should then be contacted and the appointment booked. Details can then be entered onto the Somerset Cancer Database. Patients are to be booked in chronological order or triaged on clinical need – 'queue jumping' in order to avoid CWT TWW breaches over those patients who may have already breached their CWT target (& therefore have already waited longer) will not be permitted.

Paper Referrals:

8.1 All paper referrals should be emailed to SaTH generic 2WW email account **TwoWeekRule@NHS.net.** Upon receipt the SaTH 2WW clerks will date stamp the referral and allocate a 2WW appointment following tumour group procedures. The contact phone number if required is 01743 261663. Upon receiving a 2WW referral, the 2WW clerk will send an acknowledgement of receipt to the referring e-mail address. In the case of a GDP referral the 2WW clerk will ring the dental practitioner to confirm receipt of the referral.

8.2 It is the joint responsibilities of the Clinical Commissioning Group/Health Boards and the Trust to ensure that this procedure is reiterated to referrers.

8.3 The Patient Administration System (SEMA) is the Trust's primary source of waiting list information. Patient details must be entered onto SEMA and the Somerset Cancer Database within one working day of receipt.

8.4 Every patient should have a referral date registered on SEMA and the Somerset Cancer Database with a matching referral letter or a clear audit trail back to the original referral date and letter.

8.5 Due attention should be paid to ensure all the appropriate checks are undertaken to search for the patient on SEMA to avoid duplication of records. If the patient is already registered as a SaTH NHS Trust patient, then special attention should be taken to ensure that the same referral has not already been registered on SEMA. But equally, due attention should be given to the fact that the GP may have sent more than one suspected cancer referral for different tumour sites. In these situations, it is advised that contact is made with the referrer to clarify.

9 Suspected cancer referrals that are received elsewhere in the Trust (outside 2WW)

9.1 In the event that a paper proforma is not received directly in the Booking & Scheduling service (2WW office) [e.g. referral received in another hospital department], then it is the responsibility of the individual member of staff who opened/received the referral to date stamp it with the date the referral was received and to contact and inform the Booking & Scheduling Department (2WW office). The Booking & Scheduling Department (2WW office) will process the referral in the usual way. The Booking & Scheduling Department (2WW office) will contact the GP to inform them of the correct referral process for future reference.

10 Booking of the appointment

10.1 All 2WW referrals will be appointed by day 14 (national target). The Trust has an internal target of appointing 2WW referrals by day 7 for the following sites: Paediatric, Testicular, Brain (rare) Leukaemia, Head & Neck (neck lump), Lung, Colorectal, Urology and Upper GI (oesophageal).

11 Contacting patients to make appointments

11.1 The Booking & Scheduling Department (2WW office) will make all reasonable efforts to contact the patient to arrange their appointment. The 2WW clerk will attempt to contact the patient on at least two occasions by telephone at different times to negotiate the appointment date and time.

11.2 If a patient is trying to delay accepting an appointment within 14 days then the 2WW clerk will inform the patient that they have been referred for an urgent appointment. If the patient requests further information the 2WW clerk will advise the patient to contact their GP for further details. The employees within the Booking & Scheduling Department do not use the word 'Cancer' in their dialogue with patients.

11.3 Fixed appointment letters are not sent before either a date has been agreed, or at least two attempts to contact the patient by telephone at different times, have been made

11.4 An appointment letter will not be sent to a patient in circumstances where it is known that they will be unavailable to attend thus to induce a series of DNAs resulting in referral back to the GP/GDP. The patient will be offered an alternative appointment for the dates that they are available.

11.5 On confirmation of an appointment, the 2WW clerk will send out a confirmation letter by first class post to the patient confirming the appointment details and enclosing any relevant Trust or Network supplementary patient information leaflets.

12 Process when a patient cannot be contacted

12.1 In cases where the Trust is unable to contact the patient after numerous attempts & using a variety of communication methods (telephone, post and communication with the GP) the patient will be discharged & referred back to their GP. Should the GP then be successful in resuming communication with the patient & establish that the patient is willing to resume investigations/treatment a new referral is to be issued by the GP.

13 Patients who choose to have a beyond 'breach' appointment (1st OPA)

13.1 Where a patient chooses to have their initial appointment outside of the 14 day waiting time (this may be for a number of reasons e.g. ill health, social or other reasons), the 2WW office should record the earlier date offered within the 14 day period (on SEMA and Somerset Cancer Registry). This is to ensure that the Trust has an audit trail showing that it was able to offer the patient an appointment within the maximum national 14 day waiting time period. The 2WW clerk will follow internal escalation procedures of contacting the GP to see if the

GP can encourage the patient to attend within 14 days. If the patient still chooses to wait outside the 14 days, then these examples are escalated to the Centre Manager who reports the breach to the Executive Management Team. Details of the breach (including the reason) are recorded on the Somerset Cancer Registry by the 2WW clerks. The clock will continue to tick and the patient will be counted as a breach of the 2WW target.

13.2 The patient should not be discharged back to their GP after multiple (two or more) appointments cancellations unless they state that they no longer require the appointment. In the case of a patient stating that they no longer require an appointment, the 2WW clerk will notify the GP by phone. A note of this communication will be recorded on both the Trust's SEMA and the Somerset Cancer Registry. A discharge letter is activated by the 2WW clerk to be sent to the GP.

14 Tracking of cancer patients

14.1 On receipt of the 2WW referral in the 2WW office, the referral will be logged onto SEMA & the cancer database SCR (Somerset Cancer Registry). Once the appropriate referral information has been recorded onto SCR; responsibility to track the patient transfers from the 2WW office to Cancer Services Department.

14.2 The patient will then be tracked from the suspected cancer referral right until end of treatment (which may include several subsequent treatments) or at the point of confirming that the disease is benign. This includes recording of all appropriate appointments and treatments that the patient undertakes along their cancer pathway. This may be across any number of NHS organisations; providing SATH has had direct involvement within the patient pathway.

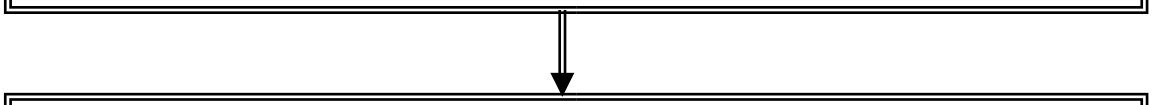
15 Management of cancellations and Did Not Attend – at any point on a cancer pathway

15.1 The following flow charts show the locally agreed pathway for patients on a cancer pathway who cancel or DNA an appointment at any point of the cancer pathway.

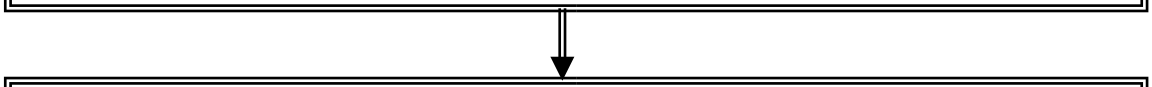
1. First Out-Patient Appointment Following a GP Referral to the Trust for a Suspected Cancer Referral (a 2WW Referral)

National guidance dictates that after a first 1st DNA, all cancer 2WW referrals have to be offered a 2nd appointment. This would allow the clock to be re-set from the receipt of the referral to the date upon which the patient rebooks their appointment.

(National Cancer Waiting Times v8.0 page 108 (4.1.6))



After a 2nd DNA of a **first OPA**, the Booking & Scheduling Team (2WW) will issue a standard letter to the GP informing them the patient has been discharged back to their care. Prior to this the Booking & Scheduling Team will check that the contact details recorded for the patient are accurate and that the patient had been effectively informed of the two appointment dates and therefore the recording of the two DNAs is accurate.



This DNA procedure also applies to patients being offered a <u>new</u> appointment following a Consultant upgrade on to a 62 day cancer pathway (provided the upgrade took place <u>before</u> the date first seen).

(National Cancer Waiting Times v8.0 page 114 (4.1.31))

2. Multiple DNAs along the Cancer Pathway: OPA / Diagnostic Tests / Admissions – all episodes

A waiting time adjustment cannot be made for DNAs at any point in a cancer pathway other than a patient DNA at their initial out-patient appointment. *(National Waiting Times Guidance Page 108 (4.1.6))*

However, a "local policy" can be agreed for referring a patient back to their GP after multiple (2 or more) DNAs. *(National Waiting Times Guidance Page 113 (4.1.22))*

Cancer patients who DNA a 2nd **consecutive** appointment at any point along the cancer pathway (including diagnostic tests) will be escalated to the Centre Manager. The Centre Manager will contact the clinical team to request a clinical review to ascertain as to whether it is clinically appropriate / responsible to discharge this patient back to the GP.

The clinical team must decide what clinical action is required and either re-appoint the patient or discharge back to the care of the GP. Only with this clinical authority can the patient be discharged.

If the clinical team decide to discharge patient from clinical care then the clinical team must write to the GP; with a copy to the patient, informing them of this.

Should the GP subsequently wish to re-enter the patient (after discussion with the patient) then a new cancer referral must be submitted initiating a new clock.

If the Clinical Team decides to offer a further appointment, the appropriate co-ordinator can record this and the clock will continue from the original referral date and no adjustment will be made.

The Clinical team must ensure that the Cancer Pathway Co-ordinator is informed of the action required.

3. Cancellations of Appointments at Any Point Along a Cancer Pathway (Outpatient Clinics, Diagnostic Tests, Admissions) – all episodes

The national cancer guidance on cancellations is that cancellations do not remove patients from a cancer pathway – 'by cancelling an appointment a patient has shown a willingness to engage/stay in contact with the NHS and it would not be appropriate to refer these patients back to their GP unless this was discussed and agreed with them as the most appropriate course of action'
(National Waiting Times Guide version 8, 4.1.6, page 108).

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A patient can therefore only be discharged back to the GP after **multiple (two or more)** cancellations with their (the patients) agreement.

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The Directorate Manager will coordinate who is the best person to contact the patient to establish the reason for the **multiple cancellations** and ask the patient if they no longer wish to proceed with their investigations/treatment and wish to be discharged back to their GP.

Should the patient stipulate that they are currently unwell and therefore that is the reason for their multiple cancellations the patient **must not be** encouraged to accept referral back to their GP. If, however, the patient clearly states that they no longer wish to proceed with investigations/treatment & agrees to be discharged the Directorate Manager must:

- Coordinate communication of this to the Consultant so the Consultant can write a discharge letter to the GP with a copy to the patient
- Ensure the Cancer Tracker is informed so the Cancer Pathway can be closed

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If the patient does not agree to be discharged then the Directorate Manager will contact the GP (CNS if appropriate) to request GP/CNS assistance to encourage the patient to keep future appointments.

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At all stages, all actions **must** be recorded in the cancer Tracking Notes on the Somerset Cancer Registry for governance and audit purposes. It is the Centre Manager's responsibility to ensure this is recorded.

16 Pathway adjustment for admitted pathway

16.1 A patient has to be offered a 'to come in' (TCI) date for admitted care (ordinary admission or day case) within the 31 or 62 day period. If the offer of admitted care is declined, an adjustment can be made from the date the declined appointment would have been to the point when the patient could make themselves available for an alternative TCI.

17 Reasonableness – outpatient and admitted treatment

17.1 Cancer waiting times are too short for the usual Trust definition of reasonable offer (3 weeks' notice and choice of 2 dates) to apply. NICE guidance says that an offer was reasonable if "there was a sufficient amount of notice and the provider took account of personal circumstances".

17.2 The Trust will not offer inpatient treatment dates which they know a patient cannot attend, so as to induce a pause to the patient pathway, or to induce a series of DNAs and potential subsequent referral back to the patient GP/GDP.

18 Consultant upgrades

18.1 A Consultant must upgrade a patient onto a cancer pathway should there be a suspicion of a cancer diagnosis.

18.2 An upgrade onto a cancer pathway can be made at any point of a patient pathway as long as it is before the decision to treat (DTT) date is confirmed with the patient.

19 Patient medical fitness

19.1 If a patient is not immediately fit for the diagnostic/treatments needed, then an adjustment cannot be made. The national operational standards for the 14 day, 31 day and 62 day targets takes this into account and therefore, patients are required to remain on their cancer pathways and <u>not</u> be referred back to the GP/GDP, placed on a pending list, moved between cancer pathways or moved solely onto an 18 week pathway.

20 Stepping patients off a cancer pathway

20.1 If the patient cannot 'guarantee' attendance for tests or treatment within a certain timescale then they remain on the cancer pathway.

20.2 A patient can only be 'downgraded' from a cancer pathway by a cancer clinician after clinical review. The cancer pathway coordinator needs a form of written communication from the clinician to this effect with stipulated criteria as to why the patient is being 'downgraded' and then the coordinator will close the patient's cancer pathway.

20.3 *<u>Exceptions</u>*: The only exceptions exist where the patient declines all further treatments or investigations. In this situation, the clinician should liaise with the patient's GP/GDP and discharge the patient back to their GP/GDP who will discuss with them directly what the obstacles are which are preventing them from undertaking these investigation(s).

21 Patient 'Thinking Time'

21.1 Where a patient has requested thinking time prior to making a decision to proceed with a treatment option, the clock will continue to tick.

21.2 The patient's clock will continue to tick during this period and must not be paused / adjusted, even if the patient requires longer to make a decision.

22 Active monitoring / surveillance

22.1 Active monitoring / surveillance (in terms of cancer waits) can be used where a diagnosis has been reached but it is not appropriate to give any active treatment at that point in time but an active treatment is still intended/may be required at a future date.

22.2 The patient is therefore monitored until a point in time when they are fit to receive or it is appropriate to give an active treatment. The patient would have to agree that they were choosing to be actively monitored for a period of time rather than receive alternative treatment.

22.3 Active monitoring stops the clock for a cancer waiting time target.

22.4 Active monitoring will not be used while waiting for a diagnosis to be confirmed or staging to be completed; neither will it be used to allow for thinking time or to address capacity issues that mean the proposed active treatment would not be available in 31/62 days.

23 Inter Provider Transfers (IPTs) and breach allocation

23.1 Nationally, where a patient's care is provided by the Trust and another provider organisation and the patient is on a 62 day cancer pathway, both providers share responsibility for ensuring that their respective parts of the dataset are uploaded and for ensuring that the 62 day waiting time service standard is met.

23.2 Whilst the Department of Health (DoH) does not plan to set a national cut-off point by which referrals to a treating provider should be received (and after which time the treating provider does not need to share a breach), there is a locally agreed process, that all Tertiary Provider Transfers should take place by day 42 or less of the patient pathway (all breaches will remain shared).

24 Tertiary Alert forms

24.1 Where a patient's care is transferred from one provider to another during their diagnostic or treatment pathway a tertiary alert form should be sent by the referring Trust as a mechanism by which the receiving Trust is forewarned of a likely transfer.

24.2 The site specific cancer pathway coordinator from the referring hospital is responsible for ensuring that the tertiary alert form is sent when the patient has been informed of the onward referral.

25 'To Come In' (TCI) booking cards and diagnostic test request forms

25.1 All TCI cards and diagnostic test request forms should be marked with a "red dot", if it is suspected that the patient has cancer/ is on a cancer pathway". This will allow staff in the relevant areas to prioritise these patients to ensure that the individual portions of the pathway are delivered in a time that allows achievement of the waiting time target overall.

25.2 Individual tumour pathways should identify the turnaround times for diagnostic tests and reporting timeframes, this is to make sure that the entire pathway is 62 day compliant and also so that the cancer pathway coordinators are clear at what point to escalate a patient as being 'off trajectory'.

26 Patients admitted as emergency

26.1 Where a patient is admitted as an emergency for the same condition as their 2WW referral (i.e. related to the suspected cancer) before they are seen, they should no longer be recorded against a two week wait standard. The emergency admission is the referral into the system and effectively supersedes the original referral. This patient would then be tracked as a 31 day target. However, such a patient could be upgraded onto the 62 day period if a Consultant or authorised member of their team suspect's cancer is the cause of the admission.

26.2 Patients who are admitted as an emergency for a different condition, continue with their existing pathway for the 2WW referral.

27 Subsequent treatment

27.1 Subsequent treatment starts a 31 day cancer clock from decision to treat date or earliest clinical appropriate date - and ends when definitive treatment is delivered. Definitive treatment could be:

- An anti-cancer intervention aimed at shrinking a tumour or delaying the growth or spread of the cancer
- Provision of palliation for the cancer symptoms
- Active monitoring (if no other treatment is appropriate)
- Symptomatic support by non NHS palliative care services

28 Earliest Clinical Appropriate Date (ECAD)

28.1 The earliest clinically appropriate date applies to patients whose treatment plan involves a sequence of more than one treatment modality, but where further decision to treat dates are not applicable. It can be either:

- A pre-determined date, set by the clinician responsible for the patient's care when it is anticipated that the patient will be fit to start the next stage of the care pathway.
- A date set during a clinical review or on receipt of test results, when it is anticipated the patient will be fit to start the next stage of the care pathway.
- An ECAD date can be changed once it is set, but only if the date has not passed. ECAD starts a 31 day cancer clock.

29 Family history referrals

29.1 Family history clinics are for asymptomatic patients and are therefore excluded from all monitoring and reports.

30 Overseas visitors and private patients

30.1 Patients who choose initially to be seen privately but are then referred for first or subsequent treatment will be monitored on the 31 day cancer pathway for first definitive treatment or subsequent treatment.

30.2 Patients who receive their initial treatment from a private provider but then seek subsequent treatments through the NHS would be classed as subsequent treatments (even if it is the first one they had on returning to the NHS).

30.3 Please refer to the relevant sections in the Patient Access Policy (found on the Trust Intranet) for guidance on how to identify, record and manage overseas visitors and private patients.

7. Cancer Performance and Reporting

1. The Cancer Services Team will complete weekly cancer Patient Treatment Lists (PTLs) within Somerset Cancer Registry to enable Multidisciplinary Teams to treat patients within the cancer waiting time standards.

2. It is the responsibility of the Centre Manager to ensure that their centre coordinator meets with the cancer pathway coordinator on a weekly basis to monitor performance and resolve any pathway delays where possible (or escalate where appropriate).

3. The Cancer Team will produce monthly performance reports which show the Trust's performance against the national cancer waiting time operational standards by tumour type. This report will be published to the Trust Board.

4. The Cancer Team will also provide a detailed breakdown, by tumour site, of performance against the national cancer operational standards to the quarterly Site Specific Operational Team meetings. Breaches and significant trends will be discussed at these meetings.

5. Cancer performance is presented at the weekly PTL Meeting which Centre Managers are required to attend. Directorate Managers are to discuss all patients at risk of breaching for the current reporting month and to raise issues present or future which are likely to impact on performance.