Name of Policy: Cancer Services Operational Policy

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This policy supersedes all previous issues
## Version Control

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Cancer Service Operational Policy

1 Introduction
It is recognised that cancer is an organisation-wide service, cross-cutting into the majority of specialties and diagnostic services. Achievement of the national cancer waiting times (CWT) standards is considered by patients and the public to be an indicator of the quality of cancer diagnosis, treatment and care NHS organisations deliver. The NHS Constitution also sets out patient rights in access to the current maximum waiting times for cancer care.

The Trust is committed to achieving quality cancer services for patients and sustaining these targets (DoH Cancer Waiting Times Guidance 2011, V8).

Delivering timely cancer pathways is crucial for the following reasons:

- Despite improving survival rates, cancer is the fourth leading cause of death in the UK;
- Patients continue to present late to their GP with their symptoms, resulting in delayed referral;
- There is variation in 2 week wait (2WW) referrals across the country suggesting that GPs are not always identifying suspicious symptoms;
- Once a patient has been referred, they want to be told “It’s not cancer” as soon as possible or have their treatment planned in a timely manner;
- Where the diagnosis is cancer, a speedy diagnostic pathway is critical for 62 day compliance.

2 Policy scope
This policy outlines the way in which Gateshead Health NHS Foundation Trust will manage adult cancer pathways for patients who are waiting for an out-patient appointment, diagnostic investigation, in-patient or a day-case admission on a cancer pathway.

The policy applies to all members of staff working within Gateshead Health NHS Foundation Trust who are involved in facilitating cancer pathways.

This policy should be used in conjunction with the Patient Access (Waiting List / Waiting Times) Policy OP12 v6 and cancer guidance for upgrading patient onto a 2ww pathway; Guidance for Upgrading Non 2 week wait patients to a 62 day Cancer pathway ‘Improving the care of all patients with suspected cancer referred outside the 2 week wait’ 2013. (Appendix 1)

3 Aim of policy
The overall purpose of the document is to establish a consistent approach to the management of cancer pathways that are at the point of;

- Diagnosis of cancer unconfirmed (cancer suspected);
- Diagnosis of cancer confirmed.

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 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 Directorate management teams;

• Provide timely, consistent and accurate data-recording for patients on cancer waiting-time pathways.

Using a pathway approach to managing cancer services primarily benefits patients but also will benefit the organisation by;

• Helping to manage the cancer standards (at tumour site level);
• Identifying any hidden waits;
• Allows organisations to track patients correctly;
• Identifying any specialty specific issues; and
• Provides an opportunity to deliver more sustainable and timely services.

4 Duties (roles and responsibilities)

4.1 Board of Directors – responsible for ensuring that the Trust meets the national access targets as a requirement of its license. Will receive a report at each meeting of the board from the Director of Strategy and Transformation that provides assurance on the approach being taken to ensure the Trust is and remains compliant with its obligations.

4.2 Director of Strategy and Transformation - Executive Lead for national access targets (including cancer). Responsible for ensuring reporting arrangements to the board of directors are robust and demonstrate a timely response to emerging issues. Will act on behalf of the Chief Executive to hold associate directors and their teams to account for the delivery of national access targets and contractual access measures. Will provide the Board of Directors with a report at each meeting that demonstrates how the Trust is and plans to remain compliant with its obligations.

4.3 Associate Director – accountable to the Chief Executive for delivery of national access targets and contractual access measures. Will ensure that systems and processes are in place within and across the business unit to support the delivery of the access targets. Will hold their clinical and management teams to account for the delivery of access targets. Responsible for working with colleagues in other business units and corporate teams to ensure seamless pathways of care. Will ensure the financial consequences are addressed in the development and implementation of improvement plans.

4.4 Service Line Managers – accountable to the Associate Director for delivery of national access targets and contractual access measures in the service lines. Will ensure that systems and processes (e.g. IMAS demand and capacity tool) are in place within and across service lines to support the delivery of the access targets. Will hold their clinical and support teams to account for the delivery of access targets.
Responsible for working with colleagues in other business units and corporate teams to ensure seamless pathways of care. Will ensure the financial consequences are addressed in the development and implementation of improvement plans.

4.5 **Head of Performance** – responsible for providing clinical business units (Associate Directors and Service Line Managers) with analysis of the information they require to undertake their responsibilities. To achieve this will work closely with the corporate information team to ensure that timely information reports are provided that meets the needs of the service.

4.6 **Head of Information** – responsible for providing the Head of Performance and clinical business units with the information they need to ensure that the Trust can meet its contractual responsibilities to deliver national and local access targets.

4.7 **Head of Cancer Services** – responsible for providing the clinical business units (Associate Directors and Service Line Managers) with service information from the cancer systems and providing support in understanding the issues raised. Will work in collaboration with cancer teams to identify ‘best pathway/timeline’s and raise discussion regarding actual or potential delays for action with SLM.

4.8 **Lead Cancer Clinician (Trust)** – is a named designated lead with overall responsibility for ensuring high standards of cancer clinical care across the organisation, in a timely manner. Has responsibility for facilitating delivery of the cancer waiting time’s performance, and has a professional management responsibility for the cancer MDT clinical leads delivery of site specific tumour cwt.

4.9 **Clinicians** - All clinicians must ensure that before adding a patient to the waiting list for a cancer treatment, the patient is fit, ready and able to come into hospital for their procedure. When assessing patients if clinicians wish to upgrade patients to the national 62-day target they should follow the guidance provided; **Guidance for Upgrading Non 2 week wait patients to a 62 day Cancer pathway 2013.** *(Appendix 1)* Clinicians are not able to ‘step down’ a patient from a GP 2ww referral pathway unless previously discussed with the referring GP and an agreement reached. This must be recorded in the form of a letter to GP and documented within the clinical notes. The Cancer Tracking Team must be informed of this decision.

Cancer waiting times guidance v9

*Two week wait referrals can only be ‘downgraded’ by the GP - if a consultant thinks the two week wait referral is inappropriate this should be discussed with the GP and the GP asked to withdraw the two week wait referral status – a GP should not be asked to downgrade a patient (or withdraw the referral) simply because they are unavailable to accept an appointment within two weeks;*

4.10 **Cancer MDT Clinical Lead** - must ensure that MDT patient discussions are carried out with reference to the individual patient timelines. Patient’ pathways that are seen to be ‘behind schedule’ (flagged amber or red against target in timeline) must be considered by all core members of the MDT and escalation procedures implemented where necessary in relevant departments (i.e. diagnostics). Review of actual
timelines should ascertain whether there is emerging themes over a period of time and therefore a need for service improvement. If service improvement is a consideration the lead clinician should involve the service SLM and Head of Cancer to work collaboratively to address issues and agree actions. The cancer MDT clinical leads are responsible for ensuring that pathway timelines are reviewed at least annually to verify they reflect the most up to date diagnostic pathway in line with meeting the 62 day target.

4.11 **Cancer Multidisciplinary Team Members** – will ensure they use individual patient pathways as part of the clinical discussion. Clinicians are therefore responsible for knowledge of the patient target dates and that their individual patient discussions are carried out with reference to the patient timeline reports. Patient’s pathways that are seen to be ‘behind schedule’ (flagged amber or red against target in timeline) must be considered and actions put in place by the responsible clinician (named consultant) to appropriately expedite appointments or treatment as necessary. Where delays are within the diagnostic pathway the radiology core member must work in collaboration with the responsible consultant to agree actions. All MDT members have a responsibility to ensure that they comply with the guidance in this operational policy.

4.12 **MDT Cancer Co-ordinators** - will ensure the accuracy of information for all patients managed against national cancer waiting time targets on the Dendrite Cancer Database, using information received from cancer waiting times, multi-disciplinary meetings and interrogation of multiple systems. The MDT co-ordinators will ensure they use the individual patient timelines when retrieving target information, preparing information for the weekly cancer target meeting and identify any delays for escalation. All MDT co-ordinators are responsible for producing a timeline report for inclusion and discussion at the weekly cancer MDT meetings. All MDT co-ordinators have a responsibility to ensure that they comply with the guidance in this operational policy.

4.13 **Cancer Nurse Specialists** – it is acknowledged that cancer nurse specialists groups may work slightly different (e.g. some will work independently in clinic and review 1st seen 2ww patients, while others may not meet individual patients until post a cancer diagnosis and thereafter at key points in the pathway). All cancer CNS’ must however, ensure during such contacts that they refer to individual patient cancer waiting times information and patient timelines to inform any planning of care taking into consideration specific target dates. All cancer CNS’ have a responsibility to ensure that they comply with the guidance in this operational policy.

4.14 **Cancer Pathway Coordinators (trackers)** - will ensure the accuracy of information for all patients managed against national cancer waiting time targets on the Dendrite Cancer Database (system used for cancer tracking), using information received from cancer waiting times, interrogation of multiple systems and multi-disciplinary sources such as cancer MDT outcomes. The cancer tracking team will ensure they use the individual patient timelines for tracking purposes, with the aim of ‘pulling’ cancer patients through the pathway. The tracking team are also responsible for preparing tracking information for the weekly cancer target meeting and identify any delays for escalation and subsequently follow the escalation process. All Cancer Pathway
Coordinators have a responsibility to ensure that they comply with the guidance in this operational policy.

4.15 **The Information Department** - in conjunction with the Cancer Services Team and Outpatient team, the Information Department has a responsibility to check data quality/accuracy prior to the weekly PLT submission to UNIFY and upload to the national cancer waiting time database to ensure that the patient pathway information demonstrates a true and accurate waiting time for each patient. All information department staff have a responsibility to ensure that they comply with the guidance in this operational policy.

4.16 **Administration staff (supporting the cancer pathway in business units e.g. waiting list managers, secretarial roles, radiology/endo)** - will ensure the accuracy of information for all patients managed against national cancer waiting time targets input on the Dendrite Cancer Database, using information received from multi-disciplinary sources. The administration staff will ensure they use the individual patient timelines when reviewing patient pathways and prepare updates for the weekly cancer target meeting identifying any delays that have been escalated and actions taken to bring pathway back on track. All administration staff have a responsibility to ensure that they comply with the guidance in this operational policy.

4.17 **Out-patient Administrative Clerks / Receptionists (inclusive of diagnostics admin)** - have a responsibility to ensure that the data entered onto Medway 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 Outpatient administrative clerks / receptionists have a responsibility to ensure that the data entered onto Medway accurately reflects the information provided by the clinical teams on the clinic-outcome proforma. Validation of 2ww data is the responsibility of the Outpatient administrative teams. All administration staff have a responsibility to ensure that they comply with the guidance in this operational policy.

5 **Definitions**
Cancer Waiting Times standards monitor the length of time that patients with cancer or suspected cancer wait to be seen and treated in England. These were first introduced through the NHS Cancer Plan (2000) and extended in the Cancer Reform Strategy (2007). A review of the standards in 2010 led to endorsement in *Improving Outcomes: A Strategy for Cancer (2011)* that they would be retained.

**Operational standards**
The measures and the operational standards are:

- **Two weeks** from urgent GP referral for suspected cancer to first appointment (93%);
- **Two weeks** from referral for breast symptoms (whether cancer is suspected or not) to first appointment (93%);
- **62 days** from urgent GP referral for suspected cancer to first treatment (31 days for children's cancers, testicular cancer, and acute leukaemia) (85%);
- **62 days** from urgent referral from NHS Cancer Screening Programmes (breast, cervical and bowel) to first treatment (90%);
• **62 days** from a consultant's decision to upgrade the urgency of a patient (e.g. following a non-urgent referral) due to a suspicion of cancer to first treatment (no operational standard set);
• **31 days** from diagnosis (decision to treat) to first treatment for all cancers (96%);
• **31 days** from decision to treat/earliest clinically appropriate date to second/subsequent treatment (surgery or radiotherapy) (94%);
• **31 days** from decision to treat/earliest clinically appropriate date to second/subsequent treatment (anti-cancer drug therapy, e.g. chemotherapy) (96%).

6 Whole system management of the cancer pathways

*Note; the next section on ‘management of referrals’ is in part a summary of the full process, for full information reference should be made to the [Patient Access Policy OP12 v6](#).*

6.1 **Standardisation of suspected cancer referrals** – GP’s will be encouraged to clearly identify referrals which are suspicious of cancer by use of standardised tumour specific referral proforma examples of these can be viewed within [Patient Access Policy OP12 v6](#).

6.2 **Management of Referrals** - Patients who are referred with suspected cancer must be seen within 14 days of the receipt of referral. At the point of referral the GP/referrer will undertake to ensure that the patient is aware for the reason for referral and that they are available to attend an appointment. All such patients must receive a booked appointment. The Referral and Booking Management Centre will ensure patients are offered a choice of appointments. All referral letters will be sent directly to the Referral and Booking Management Centre for date stamping and registration on Medway (referral contract), however it is recognised that it may be appropriate for some referrals to be sent directly to individual Clinicians/Services. In these circumstances the receiving department must follow the same process to ensure patients appear on the appropriate reports for tracking and compliance with targets. *Appendix 2* demonstrates flowcharts of the process in place for both paper referrals and electronic referrals through NHS e-Referrals Service. NHS e-Referral Services enables patients to fully book directly into Consultant’s outpatient clinics at the time the decision to refer is made (i.e. at the GP practice). Patients can also book at a later date via The Appointments Line (TAL) or on-line via the HealthSpace website. If there are any issues regarding capacity, the appropriate Service Line Manager, Waiting List managers and Associate Director will be notified via the Daily 2ww Cancer Status Notification Report. The report will be sent daily by the Referral and Booking Centre showing all 2ww referrals with appointments booked over 14 days (including reasons for delay) and patients still awaiting appointments and whether there is capacity to book these at the time of generating the report. Information in full relating to patient access should be checked via [Patient Access Policy OP12 v6](#).

6.3 **Booking of appointments** - All outpatient appointments will be managed on PAS. Diagnostic elements of the pathway will be booked in the appropriate systems; Radiology in Carestream RIS and Endoscopy procedures within Endosoft. Confirmation letters will be generated via the appropriate booking system and all will include a pre-registration form and service/appointment specific patient information leaflets where required.
6.4 **Reasonable offers** - For urgent appointments (2ww suspicious of cancer or upgraded referrals) to be deemed reasonable patients must be verbally offered 2 appointments within 14 days of receipt of the referral within a minimum of 24 hours’ notice.

6.5 **Cancer delay reasons** – as above the patient will be offered an appointment on a minimum of 2 different dates. If the patient refuses choices offered this will be should be recorded as per national definitions (*Cancer Delay Reasons Definitions Appendix 3*).

6.6 **Unavailability of clinic slots** - Where patients cannot be allocated an appointment or where slots are no longer available within the NHS e-Referral Service within the agreed waiting time, due to unavailability of clinic slots, this will be notified to the appropriate Service Line Manager, Waiting List Manager, Associate Director as they occur using the Daily 2ww Cancer Status Notification Report. The Service Line Manager or nominated person will take the appropriate action to ensure the additional capacity is made available.

6.7 **Patients who ‘do not attend’ (DNA’s) or ‘cannot attend’ (CNA’s) an outpatient appointment** - Patients who have been referred via the two week wait suspicious of cancer route and subsequently DNA or CNA are managed in accordance with the processes outlined within the *Patient Access Policy OP12 v6*. This policy also advises management of patients who fail to attend on 2 occasions - resulting in a referral back to the GP. It is the responsibility of the Service Line Managers to monitor DNA’s and CNA’s and contact patients as outlined in the policy. Standardised letters will be used for the groups described above and can be viewed in the appendices of the above referenced policy.

6.8 **Agreed clinical pathways** – each tumour site specific team has an agreed ideal pathway for patients (*pathway timelines*) this takes into account the most likely tests and investigations and identifies target timescales to ensure the national access targets are met (see appendix 4 for example of tumour site timeline/pathway). Wherever possible an ICE request should be made immediately at the patient’s outpatient appointment and should be marked priority 2ww so that the Radiology department is alerted to the urgency. Set within the timelines are key trigger points that are traffic light coded RED AMBER GREEN, these points act as an indicator for escalation within individual pathways and are used within the weekly cancer meeting. All members of the team (clinical and non-clinical) have a responsibility to ensure these standards are adhered to other than where there is a good clinical reason to work outside the pathway and associated timescales. (*Timeline example Appendix 4*)

6.9. **Tracking cancer patient pathways** - the tracking team locate information by interrogation of multiple systems and multi-disciplinary sources (such as cancer MDT outcomes, CNS*) to retrieve information/data relevant to the cancer pathways this is then entered into the Dendrite Cancer Database system. As a minimum the information system used for cancer patients collects data on key milestones such as;
- first outpatient appointment
• key diagnostic test or tests
• diagnosis
• decision to treat
• multi-disciplinary team (MDT) discussion
• transfer to another provider; and
• treatment itself (or decision not to treat)

The cancer tracking team will use the individual patient pathway timelines for tracking purposes, with the aim of ‘pulling’ cancer patients through the pathway. 2ww patient data is imported x 3 per week by the Information Department and tracking takes place on a daily basis for each individual tumour site. The patients on the tumour site specific timeline list show all patients currently on a 31 or 62 day pathway and allows filtering by tumour site. This enables tracking staff to see clearly where each patient is in their cancer pathway, what next step(s) each patient is awaiting and the deadline by which it needs to be done. Clear traffic light coding (RED AMBER GREEN) enables clear visual identification of which patients are currently at risk of missing a milestone on their pathway.

MDT coordinators also support tracking by the timely entry of data retrieved from weekly cancer MDT meetings and admin staff across the Trust also play an important part by directly entering pathway information onto the database, this reduces time and resources spent looking for information which may not be readily available on systems. The tracking team are also responsible for preparing PTL tracking information for the weekly cancer target meeting and will identify any delays for escalation and subsequently follow the escalation process (Cancer Tracking SOP - Appendix 5)

6.10 Cancer Reports - The timeline report is kept up to date by daily tracking of all patients’ on a cancer pathway. All staff (clinical and non-clinical) supporting cancer pathways will have access to the timeline reports which will support delivery of the targets; it is the responsibility of those staff to regularly access cancer timelines. Access to the timelines can be sought through business intelligence reporting systems in Medway.

• Weekly cancer MDT members will receive a hard copy report at the meeting from the MDT coordinator and this should be used in individual patient discussions.
• The weekly PTL cancer meeting will use the report to effectively track and escalate patients.
• Each service will use this report to prepare for the meeting in advance.
• Unresolved PTL issues will be identified and reported to the appropriate services SLM for immediate action. (Delivering cancer Waiting Times; a good practice guide October 2015).

6.11 MDT meetings – the core team will discuss individual patient cases listed with reference to the timeline report as part of the clinical discussions.
• All clinicians involved with a patient’s pathway are responsible for the knowledge of the individual patient target date and that their contribution to the actual
patient pathway takes into account the milestones within the timeline when planning diagnostics or treatment.

- The MDT coordinator will prepare for the weekly meetings by, listing each patient inclusive of target breach dates.
- A timeline report will be accessed just prior to the meeting to reflect the most updated position of each patient.
- The MDT coordinator will ensure all members present receive a copy of this report to aid discussions.

- Patient’s pathways that are seen to be ‘behind schedule’ (flagged amber or red against target in timeline) must be carefully considered and actions put in place by the responsible clinician (named consultant) to appropriately expedite appointments or treatment as necessary.
- Where delays are within the diagnostic pathway the radiology core member must work in collaboration with the responsible consultant to agree actions.
- It is the responsibility of the MDT coordinator to record outcomes from the MDT directly into Dendrite and post the meeting guarantee that distribution of list is carried out.

*(MDT SOP appendix 6).*

### 6.12 Cancer 62 Day Patient Tracking List (PTL) – this is produced each week for submission in accordance with the guidelines provided by NHS England *(Appendix 7).*

The data is extracted from the CTWT element of Dendrite and split out into the various waiting time elements that the return requires. In addition the confirmed treatments from the previous week are provided (from Dendrite data) with reasons given for any breaches that have occurred. The completed return and its supporting information are then sent to colleagues in Performance and Cancer Tracking who check and agree the figures before submission to UNIFY2. Any discrepancies/DQ issues are discussed and actioned as appropriate prior to submission. The PTL is shared with the business units for discussion/action from the weekly cancer target meeting.

### 6.13 Cancer PTL weekly target meetings – a weekly cancer PTL meeting is held with all key stakeholders from the business units (e.g. waiting list managers/radiology endo admin staff).

- It is an expectation that a lead or a named deputy will attend every week.
- Prior to the meeting all staff will have worked through their PTL/timeline report and identified patient pathways that require expediting or escalation.
- It is an expectation that processes will already have been commenced pre the meeting to address issues raised *(Terms of Reference appendix 8).*
6.14 **Escalation Process** – there are several standard operating procedures in place to address the 14 and 62 day cwt target in relation to pathway bottlenecks. The several areas addressed take into account the differences between surgery and medicine (e.g. theatre capacity) but also site specific tumour groups that operate a hub and spoke service level agreement (e.g. Head and Neck).

- The escalation processes are the responsibility of each business unit to adhere to and provide the necessary action in response to delays to prevent missed pathway milestones.
- The Associate Directors and SLM’s are responsible for addressing any recurrent themes identified through escalation and providing necessary action plans to address issues *(Escalation SOP Appendix 9)*

6.15 **CWT Live Dashboard** - to support the Information department’s vision of “live data as soon as you need it”, the development of an auto populating Cancer dashboard (using a product called Microsoft Reporting Services with links in to the Trusts SQL server data warehouse displaying the live position) in relation to the 14, 31 & 62 day cwt target is available. The dashboard displays a ‘known’ position by cancer type - showing the ‘state of play’ in relation to activity that has occurred as well as a planned position which links in to the timeline data and utilises the planned activity dates which, when combined with the actual activity, presents the most likely cancer target position. The dashboard conditionally highlights the combined percentages, which allows the user to quickly focus on the key areas of concern. All staff (clinical and non-clinical) supporting cancer pathways will have access to the cwt dashboard which will support delivery of the targets; it is the responsibility of those staff to regularly access the dashboard.

6.16 **Cancer Data** - Data quality is the responsibility of all involved in the care pathway including clinical staff. Data quality is checked on a weekly basis as part of the cancer outcomes data set information that is required. MDT coordinators also support data quality and accuracy checks. Monthly data quality checks are carried out by the Information Department and subsequent further checks are also carried out with other Trusts where there are shared pathways prior to the national upload to Open Exeter for cwt data. *(DQ SOP Appendix 10)*

6.17 **62 day target breach RCA procedure** - Due to the nature of a patient’s clinical symptoms there will be occasions where it has not been possible to avoid a breach. If this occurs:

- On commencement of treatment it is the responsibility of the senior trackers to complete a breach report for all 62 day breaches, this will be sent to the appropriate SLM who will discuss with the clinical lead any further information and agree sign off before return to the cancer team.
- The RCA process must be supported by the departments involved in the pathway (such as radiology and pathology, or the chemotherapy, surgical and radiotherapy service as appropriate).

- It is the responsibility of the Head of Cancer to discuss shared breach information with other providers and agree reasons/codes for delays
• Breach reasons will be uploaded onto the national cancer waiting time’s system (Open Exeter) by the Information Department.  
(Standard operating procedure for RCA completion (Appendix 11)

6.18 **RCA procedure for ‘Near Miss’** - Improving the 62 day performance has led to the implementation of the 8 key priorities (Appendix 12). Requirements are that further analysis to support this is necessary and therefore a root cause breach analysis will be completed for each pathway not meeting the current standards (i.e. failing the 85% standard).  
The process will be;  
• Performance team identify site specific tumour groups not meeting the standards  
• SLM is responsible for review of the last ten patient breaches and near misses (defined as patients who came **within 48 hours** of breaching)  
• Initial RCA preparation for this group of patients will be carried out by the senior trackers (standardised template with demographics, CCG and 1st seen appointment info completed)  
• It is the responsibility of the SLM’s to complete the RCA with the relevant data and analyse any issues or themes.  
• It is the responsibility of the SLM to produce an improvement plan for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling, describing a timetabled recovery trajectory for the relevant pathway to achieve the national standard.

6.19 **Improvement Plans**  
To support the delivery of national and local contractual access targets documented improvement plans may be required. These will cover the following areas:  
• Analysis of the problem – each service line will undertake a root cause analysis to understand why it is at risk of going off track (or has already breached);  
• Action plan – following analysis of the problem a series of actions targeted at the cause of the problem will be identified with clear timescales for delivery and clearly identified management leads. Where there are cross business unit issues to be addressed the service line manager for each service will work together to resolve the issue. A joint, agreed action plan for improvement will be produced;  
• Timetable for delivery – each action plan will make clear the timetable for delivering each component of the action plan but will also forecast using available data and information the timetable for returning to the required level of performance;  
• Risks assessment – each improvement plan will be risk assessed to inform the Trust about the level of concern held by the service line;  
• Monitoring progress – the performance team will work with the business unit and service line to track performance to ensure that the milestones agreed are being delivered. In cases of the most serious concern weekly escalation meetings may be held until such time as the programme is delivered. Where milestones are not delivered the Director of Strategy and Transformation will discuss concerns with the Chief Executive.

6.20 **Backstop policy (104+ day)**-  
**Background**
The Going Further on Cancer Waiting Times operational standards have been designed to take in to account the practicalities of managing very complex diagnostic pathways, patients who are temporarily clinically unfit for cancer treatment, and those who choose to defer their diagnosis or treatment for personal reasons.

For these reasons, some patients may have a recorded waiting time in excess of 62 days, which is both accurately reported and is clinically directed in the best interests of the patient concerned.

It is also recognised that a small proportion of patients will have a recorded waiting time of more than 104 days for this reason i.e. 6 weeks beyond a breach of the 62 day standard. The exact approaches to managing patients with a long waiting time, both proactively and retrospectively, require clarification so that avoidable non-clinical factors can be identified and separated from clinically appropriate management, and patient choice.

The ‘backstop’ 104+ day policy aims to ensure that the cancer operational standards, performance management and reporting arrangements act as a tool to improving access times for all cancer patients.

6.20.1 **Process for managing long waiting cancer patients** -

**What is a long waiting time?**

- Generally, waiting time of over 62 days from urgent referral to treatment is classified as a long wait.
- For the purposes of this part of the policy document however, long waiting times means those in excess of 104 days (the backstop measure).
- Patients classified as “long waiters” are expected to form a minority of cases breaching the operational standard.

*Some patients will have a legitimate long waiting time for cancer diagnosis and treatment, for either choice or medical reasons. The operational standard for delivery of cancer care within 62 days of urgent referral was set at 85%, to take account of these cases.*

6.20.2 **Identifying patients with a long waiting time** -

- The PTL and patient timeline reports will identify any patient waiting over 62 days, inclusive of those at day 104 +
- These patients will also be highlighted to business units and performance teams through the weekly PTL cancer target meeting and overseen by RTT to monitor actions and delivery.
- Proactive tracking of cancer patients will continue after a breach has occurred (by the provider responsible for the patient’s care, and also following any patient transfer to another provider), for the purposes of either the delivery of treatment, or diagnostic tests and investigations.

6.20.3 **Reporting of cancer patients with a long waiting time** -

- The Trust Board will receive routine regular reports on cancer waiting time’s performance. These reports show performance against each of the cancer operational standards and where required action plans identifying measures being taken to improve and sustain cancer performance.
• The reports will identify the number of patients with a long waiting time inclusive of those at 104+ days
• Where required the Trust Board will be able to see outcomes of individual root cause analysis (RCA) in relation to the cancer pathway/s concerned, and may request further forms of exception reporting as required by local circumstances.
• Collaborative working with the Clinical Commissioning Group will be maintained through performance meetings to discuss exception reports, any themes identified within the RCAs and any cancer improvement plans.

6.20.4 **RCA for long wait patients (104 + days)** –
• It is the responsibility of the senior tracker(s) to begin an RCA at day 62 and complete as soon as possible after the patient receives their cancer treatment.
• The RCA process will be supported by the departments involved in the pathway (such as radiology and pathology, or the chemotherapy, surgical and radiotherapy service as appropriate) and any additional information added.
• The Head of Cancer/Lead Cancer Nurse will oversee the RCA process.
• Any RCA for 104 + days will be reviewed via an appropriate clinical harm review involving the Lead Cancer Clinician and Head of Cancer (see process below).
• Any RCA identifying a delay/s which caused the breach, then the breach will be reported on as “avoidable” and, where a thematic issue is identified this will be the responsibility of the SLM to address via an Improvement Plan.

6.20.5 **Shared pathways RCA for long wait patients (104 + days)** –
• In the case of shared pathways, the Trust will work with other providers involved in the patients care to participate in the RCA. Separate RCA process for long wait patients will not be undertaken by individual providers. These will be discussed between the senior cancer management.
• The Trust will agree at an early stage which trust will lead on the RCA. *(Normally, the treating Trust would lead the RCA, or, if the delay reason is very clear and attributable to the actions/inactions of a provider then they should lead the process).*
• Consideration for early escalation to Trust Boards and Commissioning Clinical Leads, should a Serious Incident (SI) likely to have occurred (see sections below).
• Where any provider in shared pathways is concerned that a RCA should have been undertaken or potential harm event investigated in line with this guidance, then the Medical Director or Lead Cancer Clinician should contact their counterpart at the earliest opportunity.

6.20.6 **Process for potential clinical harm reviews (104 + days)** -
Where an individual patient with a confirmed cancer diagnosis has waited over 104+ days, there will be a clear, transparent process in place to identify if the extended delay has caused harm to the patient. Therefore in addition to a ‘62 day target’ RCA, long wait patients (over 104+ days) with a confirmed cancer diagnosis will have a clinical harm review undertaken as follows;

- The senior tracker(s) to begin an RCA at day 62 and complete as soon as possible after the patient receives their cancer treatment.
- Weekly review is undertaken of patients at 104+ days with Head of Cancer at cancer team meeting.
- Patient records obtained and placed with completed RCA after treatment commences.
- A clinical harm review panel will be convened monthly to review all RCA for 104+ days involving the Lead Cancer Clinician, Head of Cancer with the lead for appropriate site specific tumour group invited to assess if any clinical harm has occurred due to the delay.
- A decision will be made within this group as to whether clinical harm has occurred and recorded on the RCA.
- The RCA documentation and review will be recorded within the Ulysses system as part of the Quality Team.
- If either a single delay or a sequence of delays can be shown to have resulted in a serious harm event for the patient concerned, or the available evidence suggests that this may have been the case, then the Trust/s where such delays occurred will follow their policy for investigating and reporting the case as an SI - (report per Incident Reporting Policy – Datix Policy RM04).
- If a SI investigation commences due to the outcome above the Trust will follow its escalation process (STeIS) through to the senior clinical lead at the relevant CCG.

Considerations to take into account with these reviews are

- Where there was a medical reason for the patient to wait for cancer treatment then there should be clear evidence that the patient pathway has been reviewed at regular intervals.
- A serious communication breakdown or administrative error in a patient pathway may also be considered as a SI. This would depend on the overall circumstances and the actual/potential consequences of the error/s concerned.

6.20.7 Regional review

- CQRG’s will work with the Regional teams to ensure that themes are captured and support provided where serious concerns are highlighted in providing timely care to patients.

7. Training

To ensure compliance with this policy all staff involved in cancer pathways will be trained by the Cancer Information Team to a standard level, this will be tailored if and where necessary to the individual’s responsibilities. Refresher training can be accessed directly by discussion with the cancer team at any time. However, both new starter and refresher
programmes will be provided on a regular basis. Associate Directors/SLM’s are responsible for ensuring their staff are fully trained and receive appropriate refresher training.

8 Monitoring compliance with the policy

**Internal Structure for monitoring**
To support the management of the access target agenda a structure has been put in place that allows for a timely response to emerging concerns. This is described below.

![Diagram showing the structure of monitoring compliance with the policy]

**External**
All cancer waiting times standards are monitored through the National Cancer Waiting Times Monitoring Dataset (NCWTMDS) which is an information standard applicable to all cancer services. Data is submitted to Open Exeter NHS England.

Regular external audit is performed by KPMG which samples a range of cancer waiting times targets and subsequent patient pathways. This process is managed through the information department working in collaboration with the cancer tracking team.

9 **Equality and diversity**
The 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 in relation to their protected characteristics.

10 **Consultation and review**
Development of this policy involved the relevant departments that are cross cutting to cancer services, (cancer services, information department and outpatient leads).

11 **Implementation of policy (including raising awareness)**
This policy will be implemented in accordance with OP27 “Policy for the development, management and authorisation of policies and procedures.
All members of staff will be informed via e-mail and presentation/discussion through regular cancer and RTT meetings.

12 **References**
Cancer Waiting Times Guidance (DoH)
NHS Operating Framework 2011-12
Delivering Cancer Waiting times; a good practice guide. (NHS England)

13 **Associated documentation**
- Patient Access Policy OP12 v6 (2014)
- Guidance for Upgrading Non 2 week wait patients to a 62 day Cancer pathway ‘Improving the care of all patients with suspected cancer referred outside the 2 week wait’ (2013).
- National Cancer Waiting Times Monitoring Dataset Guidance Version 9.0 (October 2015)
Guidance for Upgrading Non 2 week wait patients to a 62 day Cancer pathway

‘Improving the care of all patients with suspected cancer referred outside the 2 week wait’

INTERNAL CONSULTANT REFERRAL FOR SUSPECTED CANCER
INTERNAL CONSULTANT REFERRAL FOR SUSPECTED CANCER

Purpose

The purpose of this policy is to describe the process for Consultants (or core members of the MDT team) to upgrade or transfer patients to access the 62-day systems and pathways as outlined in the National Cancer Waiting Times Guidance.

The aim is to improve the pathway of care for all suspected cancer patients and not just those referred via the two week wait system.

Introduction

The National Cancer Plan set out goals to reduce delays and improve the patient experience. The Cancer Waiting Time targets (31/62) went live on Jan 1st 2006.

It was clear from the outset that some of the changes put in place to allow fast tracking of suspected cancer ‘two week wait’ patients would lead to a two tier system that would disadvantage patients with cancer diagnosed via a different referral pathway.

The Cancer Reform Strategy (Dec 2007) outlines the requirements to upgrade non 2-week wait referrals to improve equity in care for patients with suspected cancer.

In order to be compliant with the new national guidance Consultants (or other core members of the MDT) will be able to upgrade non 2-week wait patients whom they are suspicious of cancer to a fast track pathway. The upgrade can take place at various points in the pathway but must be before the point of a decision to treat (figure 1)

Upgrades may take place under the following circumstances:

1. MDT - Upgrades
   As of January 2009 all patients diagnosed with cancer discussed in the MDT can be upgraded onto the 62-day pathway.

Principles

- Consultants (core members of MDT) are able to upgrade or transfer patients (in accordance with clinical guidelines for suspected cancer) to the 62 day pathway at 1st MDT discussion

- The Lead clinician for the MDT will ensure data is captured by the MDT co-ordinator who completes excel spread sheet.

- It is the MDT Co-coordinators responsibility to information share the data with the cancer trackers within 24hrs of the decision, and also to update the dendrite cancer database with the UPGRADE type completed. It is the cancer tracker(s) responsibility to validate this information within CWT or when notification received.
• Patients will access fast track diagnostics and site specific pathways and will be monitored by proactive tracking. Escalation procedures will be in line with criteria used to escalate 2ww referrals within the tracking process.

2. GP Referral - Upgrades
Routine letter sent to appointments bureau. Suspicion of cancer identified by Consultant on receipt of GP letter. (this group of patients are identified via the information provided in the GP letter by the consultant)

Principles

• Consultants (core members of MDT) will mark the letter as ‘Urgent Upgrade' suspicious of cancer – letters are returned to appointments bureau via the courier service.

• The 62 day target will start from receipt of the letter back to the Cancer Appointments Bureau (post consultant upgrading). The letters will have a turnaround time of 24 hours (as per standard practice in courier service) These patients will follow the timescales of the 2ww cancer pathway with regards to investigation requests, results and on diagnosis of cancer “decision to treat” and treatment.

• It is the responsibility of the consultant to ensure that the subsequent pathway remains on a fast track priority. Further appointments and investigations will be as per 2ww urgent rule in accordance with site specific timelines.

• The appointments clerk is responsible for marking the patient as Upgraded within PAS and therefore the pathway will follow and be monitored via the 62 day target within Dendrite CWT. An appointment will be offered to this patient ASAP but not outside 14 days of receipt of upgraded referral to the appointments bureau.

• (NB currently this is done in free text of PAS and appointments clerks are notifying cancer trackers of upgrades, this will change when final processes are agreed and changes can be made to PAS to flag these patients for dendrite).

• The Consultant (core member of the MDT) will inform the GP of the upgrade via clinic letter or MDT outcome.

• The cancer trackers will identify such patients, validate information received within Dendrite cancer database and continue monitoring as per 62 day cancer process. (Patient details, date of the internal consultant referral, Consultant decision to refer, date the referral received by the Cancer Appointments Bureau).

• The patients’ pathway will be tracked and navigated by the MDT and cancer tracker.

This group of patients are identified via their first outpatient appointment / following a diagnostic test / whilst an inpatient, with suspected cancer. Investigation requests, results
and on diagnosis of cancer “decision to treat” and treatment will be as for 2 week wait referral patients.

**Principles**

**Outpatient presentations**

- At outpatient appointment patient identified as ‘suspicious of cancer’ Consultants (core members of the MDT) will **upgrade patient to 62 day target**. *(other members of team should discuss first with consultant/core member of team suspicion)*

- If non-core MDT members see a patient, it is their responsibility to refer urgently to Lead Clinician of the appropriate MDT a core MDT member who will then upgrade the patient as appropriate.

- The out patients appointment slip must be stamped using the red ‘**upgrade 62 day target**’ stamp

- It is the clinic admin staff who will be responsible for checking all clinic slips and ‘**upgrading**’ patients on PAS. This will be completed within 24 hours of patient attending clinic.

- The Consultant will inform the GP of the upgrade via the clinic letter

- Patient details, date of the referral, Consultant decision to refer, date the referral received by the clinic slip will be validated within Dendrite by the cancer tracker.

- Subsequent investigations must be marked with a 2ww “urgent” and patients will then access the diagnostic pathway as per fast track 2ww rules and in accordance with the site specific timeline.

- Patients will be tracked and pathway navigated via the MDT’s and cancer trackers.

- The patient will be reviewed by the relevant MDT

**Diagnostic Presentations** -

- please refer to Policy for Rapid Notification of Unsuspected Cancers

**Internal Referral** -

- Urgent referral to appropriate cancer specialist c/o appropriate site specific team. Patient should be presented to MDT and decision made to upgrade. Data will be captured by MDT
co-ordinator and recorded within CWT as ‘upgrade’ and the cancer trackers informed. (e.g. presentation at A&E)

In Patient Presentations

- In patient investigation flagged as ‘suspicious’ - as above refer to policy for Rapid Notification of unsuspected Cancers

- Patients under c/o appropriate site specific team present to MDT for discussion and recording of upgrade decision. Data will be captured by MDT co-ordinator and recorded within CWT as ‘upgrade’ and the cancer trackers informed.

- Under c/o non cancer specialist - Urgent referral to appropriate cancer specialist c/o appropriate site specific team. Patient should be presented to MDT and decision made to upgrade. Data will be captured by MDT co-ordinator and recorded within CWT as ‘upgrade’ and the cancer trackers informed.

The Cancer Services Information Team

- The cancer information team (inclusive of MDT co-ordinators) are responsible for the collection of cancer waiting times data, validation of data surrounding the upgraded patient pathway, monitoring via the appropriate site specific timelines, and the escalation process where necessary.
1st OPA:
Suspected cancer identified

Diagnostic tests:
Suspected cancer identified

GP Letter:
Suspected cancer identified

Upgrade patient identifying this on the clinic slip via red stamp ‘upgrade 62 day target’

Refer to Notification of Unsuspected Cancer Policy

Requests for investigations marked 2ww urgent cancer

GP informed

Requests for investigations marked 2ww urgent cancer

Staging investigations marked 2ww urgent cancer

Patient tracked and navigated within site specific timeline Patient added to MDT

Treatment within 62 days
Management of GP 2ww Referrals

1. Received into Referral & Triage Management Centre
2. Paper referral received by Trust - via email, fax, courier
3. Referral data stamped and registered on PMS (within 6 hours of receipt)
4. Referral data scanned into EPM (within 6 hours of receipt)
5. Referral scanned into WorkFlow Module
6. Clinician triage within 24 hours of receipt
7. Specialist will identify nominated deputy to carry out this process in the absence of the relevant clinician
8. Referral & Triage Management Centre receive urgent referral from non-whanau within 24 hours
9. Patient contacted by telephone and offered choice of appointment (2 alternative within 14 days)
10. Confirmation letter generated from system in use (PMS)
11. Correspondence for patients residing at HVMP must be sent to relevant Prison &/or the Medical Officer
12. Patients requiring an interpreter will be sent a letter in both English and the required language according to interpreting & translation service policy (DN 22)
13. Patients requiring an interpreter will be sent a letter by post and interpreter booked (DN 22)

Management of Referrals - Paper 11/19/2015

Cancer Services Operational Policy v1
Cancer Delay Definitions

The reason why a delay occurred between the CANCER REFERRAL TO TREATMENT PERIOD START DATE and the DATE FIRST SEEN, when the PRIORITY TYPE of the SERVICE REQUEST was National Code 3 'Two Week Wait'.

This is the reason why the Health Care Provider was unable to provide an APPOINTMENT DATE within the service standard of two weeks.

National Codes:

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<th>Description</th>
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<tr>
<td>01</td>
<td>Clinic cancellation</td>
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<tr>
<td>02</td>
<td>Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this PATIENT)</td>
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<td>03</td>
<td>Administrative delay</td>
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<td>04</td>
<td>Referral not received within 24 hours (Retired 1 July 2012)</td>
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<tr>
<td>05</td>
<td>PATIENT unavailable (the PATIENT has declined the opportunity to be seen within two weeks prior to any APPOINTMENT being offered)</td>
</tr>
<tr>
<td>06</td>
<td>PATIENT declines (the PATIENT declines all APPOINTMENT dates offered within two weeks)</td>
</tr>
<tr>
<td>07</td>
<td>PATIENT cancellation (the PATIENT cancels their booked APPOINTMENT)</td>
</tr>
<tr>
<td>08</td>
<td>PATIENT care not commissioned by the English NHS (waiting time standard does not apply)</td>
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<tr>
<td>09</td>
<td>Other reason</td>
</tr>
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<td>10</td>
<td>Other reason (Retired 1 July 2012)</td>
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Notes:

- National Code 03 ‘Administrative delay’ should not be used to record delays linked to a ‘Did Not Attend’ (DNA) event where a waiting time adjustment has been entered into the PATIENT record.
- If National Code 08 ‘Other reason’ is used, further detail must be recorded for the precise cause of the delay, within DELAY REASON COMMENT (FIRST SEEN).
- National Code 08 ‘PATIENT care not commissioned by the English NHS (waiting time standard does not apply)’ should only be used in instances where the non-English administration has commissioned a two week wait service, i.e. the PRIORITY TYPE of the SERVICE REQUEST was National Code 03 'Two Week Wait', but the PATIENT was not seen within two weeks. This is to allow for different commissioning arrangements to be supported by local administrative and clinical systems.

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## Timeline Example

### Cancer Timeline Report - Lung Patients

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<th>Name</th>
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<th>Target Treatment Date</th>
<th>Current T DO (Est. Start)</th>
<th>TP1 4 DAY 1 (PET Scan)</th>
<th>TP2 5 DAY 2 (PET Scan)</th>
<th>TP3 6 DAY 3 (PET Scan)</th>
<th>TP4 7 DAY 4 (PET Scan)</th>
<th>TP5 8 DAY 5 (PET Scan)</th>
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<th>TP8 11 DAY 8 (PET Scan)</th>
<th>TP9 12 DAY 9 (PET Scan)</th>
<th>TP10 13 DAY 10 (PET Scan)</th>
<th>TP11 14 DAY 11 (PET Scan)</th>
<th>TP12 15 DAY 12 (PET Scan)</th>
<th>TP13 16 DAY 13 (PET Scan)</th>
<th>Comments</th>
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<th>Confirmed Cancer</th>
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### Appendix 4

Cancer Services Operational Policy v1
## Name of Standard
**Operating Process:** CTWT Tracking / Timelines Data Entry completion procedure

## Effective From:
01/01/2015

| Date Ratified | 01/01/15 |
| Ratified      | Cancer Service’s |
| Review Date   | 01/01/17 |
| Sponsor       | Carolyn Harper |
| Expiry Date   | 01/01/18 |

## Version Control

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Background

Timeliness were introduced to the Trust in 2014, this was to enable cancer trackers, MDT co-ordinators & secretaries to update patients information in Dendrite in a timelier manner, to deliver the cancer waiting time’s targets.

The cancer tracking team with the support of the MDT coordinators use the individual timelines (Box 1) for tracking purposes. The aim is to be able to highlight patients that need ‘pulling’ through the cancer pathway. Identifying clearly where each patient is in their cancer pathway, what are the next step(s) for each patient, and the deadline by which it needs to be done?

All the information can be found by the interrogation of multiple systems, multi-disciplinary sources, the MDT outcomes and information from the CNS’s. The Information is then entered into the Dendrite Cancer Database system and the timelines.

Timelines are also used to detect bottle necks in pathways; this raises early awareness with Service Level Managers.

Purpose of the Procedure

To define the methodology of completing dataset fields into Dendrite CTWT timelines.

How to open up timelines once in CTWT.

Procedure

1. Log into CTWT as normal and select appropriate timeline.

2. Once the timeline page is open fill in the appropriate fields, remember to fill in any planned dates, and then go back to complete once the procedure/investigation has gone ahead.

3. Keep the comment box up to date with any new info form letters etc.

4. Please run time line 3 x weekly, updating your consultant’s pts.

(Box1)
1 To open timeline click on below and select appropriate timeline.
2 Once timeline page is open fill in the appropriate fields, remember to fill in any planned dates, and go back to complete the actual date once the procedure/investigation has gone ahead.

3 Keep comment box up to date with any new information from letters etc.,
Name of Standard Operating Process: Standard Operational Procedure Breast MDT

Effective From: 01/01/2015

Date Ratified 01/01/15
Ratified Cancer Service’s
Review Date 01/01/17
Sponsor Carolyn Harper
Expiry Date 01/01/18
Withdrawn Date

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The Breast MDT is held on a Monday at 8.30am in the breast seminar room. This procedure describes how to prepare all relevant lists and defines administration required for Breast Multi-disciplinary Team Meeting.

1. Breast list sent by email on Wednesday PM.
2. Print off a copy for MDT meeting.
4. Email list on NHS NET (Cancer services) to – Royamarley@NHS.NET & Louise.mills2@NHS.NET
5. Check on Medway for appointments during the next week (surgery patients only – 1st group on list). Make a note of these on the list.
6. Print off a copy of attendance list

**Friday:**
1. Additions to list are emailed on Friday. Print a copy and add to back of original list.
2. Copy and paste to end of original list and save as before.
3. Email list as before on NHS NET.
4. Friday pm print out current and up-to-date timelines.
Monday:  
**MDT Room – Breast Screening**  
1. Log into Dendrite.  
2. Distribute timelines to core members of MDT.  
3. Click on View Group Members  
4. In the drop down menu click on ‘Breast surgery patients’. A list of patient’s names will appear. Click on the relevant patient to be discussed and the proforma will appear.  
5. Update proforma as instructed by Breast MDT team & fill in keyworker info.  
6. Once complete LOCK each proforma.  
7. Once surgery list is complete follow procedure for viewing group members and update ‘Breast discussion patients’ then ‘Breast core biopsy patients’.  
8. When MDT complete on Dendrite click on Edit Group Members. Click on each Breast group then Remove all. This clears the lists ready for next week.

**Bowel Screening Office:**  
**Printer settings – QE-BSU-BOWEL-SSP-LJ4300DTN on Highland.**  
- Print off Surgery proforma – Open up one of the proforma from the surgery group - Multi print - BreastSurgeryMDTmulti letter – 1 blue - for oncologist/1 green – 1 for Gateshead patients, 2 for Mr Pervaz patients - STGH. (2 copies for STGH nurse. Print any BENIGN patients in this group individually if info on 1st page of proforma only.  
- Print all Mr Pervaz proforma from remainder of list (x2 copies if patient has cancer, x1 copy if benign) – print 1st page only unless info on 2nd page etc. – green (give to STGH nurse in nurses office). This applies to any additional requests from STGH nurse for info for other BCN’s.  
- Print off 1 copy of patient’s proforma (green paper) who have been referred for Surgical options/Mastectomy and give to Breast nurses.  
- **File Surgery proforma only in notes – not Mr Pervaz’s** - reception/clinic prep etc.  
- Blue copies to Oncology clinic.

1. Run report on Dendrite – Breast MDT outcomes. Sort into alphabetical order by surname. Save in Breast outcomes and Email to Roya Marley/Louise Mills/CHS Cancer Services team @ Sunderland on NHS mail. Email a copy to Claire Wipat on Outlook.  
2. Complete CTWT/COSD field updates  
3. Run a report from Dendrite for Breast updates. Copy and paste into BREASTCTWTTEMPLATE in MDT coordinators folder, Breast lists & outcomes. Print a copy for updating on CTWT. No need to save document. Update CTWT/COSD.  
4. Scan attendance list and save in MDT Coordinators folder. Update Breast attendance spreadsheet.  
5. Update Breast MDT workloads.  
6. Check NHS mail (Cancer services) – if you have queries for breast proforma from Mandy Pinkerton @ Spire she will require the latest MDT proforma. Print off and email to yourself then forward to her. Her email is mandy.pinkerton@spirehealthcare.com

**Items to take to MDT**  
**Attendance Register.**  
**MDT List.**  
**Timeline reports**
Appendix 7

Information Department - 62 day cwt PTL submission guidance

62 DAY PTL

The patients on the 62 day pathway are all patients who are referred via an urgent referral for suspected cancer from a GP or GDP (two week wait) where cancer has not been excluded. A two week wait patient only comes off the 62 day pathway when a cancer diagnosis is excluded. Where a Trust refers a 62 day patient to another Trust for treatment, the patient should be removed from the referring Trust’s 62 day PTL and added to the receiving Trust’s PTL. In such cases, the patients start date on the 62 day pathway remains the same (i.e. the patient must still be treated within 62 days of the original GP referral).

Patients on 62-day target list (e.g. not received first treatment)

For those patients on the 62-day pathway we focus on the following categories:

1. Those that have not yet had a decision to treat.
2. Those that have had a decision to treat, but not a date for first treatment.
3. Those that have had a decision to treat, have a date for first treatment, but that date will not prevent a breach.

Patients treated within last 7 days (and no longer on 62 day target list)

4. Number of patients treated in the last seven days that were not within the target time.
5. Number of patients treated in the last seven days within the target time.

Line-by-Line Description: Patients on 62-day target list

Definition

1. Those that have not yet had a decision to treat are defined as all two week wait patients who are in the diagnostic phase of the pathway. Some of these patients will be diagnosed with cancer and some will have a non-cancer diagnosis.

Information to be collected

- Number of patients without decision to treat who will breach target within 15-28 days.
- Number of patients without decision to treat who will breach target within 8-14 days.
- Number of patients without decision to treat who will breach target within 1-7 days.
- Number of patients whose breach date has already passed (but have not yet received first treatment) of which:
- Number of patients who passed their breach date during the last seven days.

**Definition**

2. Those that have had a decision to treat but not **had** a date for first treatment.

3. Those that have had a decision to treat, **have** a date for first treatment the **date of which** will not prevent a breach.

   [2. + 3. Added together]

   In both cases, where treatment dates are past the breach date the treatment date should be re-arranged to be within target (subject to appropriate clinical exceptions).

**Line by line description: Patients treated within last 7 days**

**Information to be collected**

4. Number of patients treated in the last seven days that were not treated within the target time.

5. Number of patients treated in the last seven days within the target time.
Terms of Reference
Cancer PTL Target Meeting

The role and purpose the meeting;
The cancer PTL target meeting should be held weekly on a Wednesday and chaired by a senior cancer tracker. The purpose of the meeting is to ensure;

- that we monitor and manage all patients waiting on the cancer pathways
- we identify pathway ‘exceptions’ – were the patients is waiting too long at each step of the pathway
- we identify potential breaches and discuss the potential management of the pathway
- to escalate any issues / delays identified within the patients pathway
- to have addressed any minor issues
- that the waiting list co-ordinators are sufficiently prepared for the referral to treatment meeting on a Friday

Membership;
It is expected that there is attendance from;
Cancer Manager or deputy
Senior cancer tracker
Medical waiting list co-ordinator
Surgical waiting list co-ordinator
Radiology appointments co-ordinator
Endoscopy appointment co-ordinator
MDT co-ordinators
Gynae-oncology tracker
Where the above is unable to attend there is an expectation that a nominated deputy will attend in their place.

Outcomes
- All attendees of the meeting will action patient level issues from meeting and follow their local escalation standard operational procedures.
- Cancer tracking team will provide weekly meeting report for services to highlight issues raised in meeting.

Standard Operational Procedure
Escalation Process – Medicine

The report is live (within 1 hour) so is able to be looked at and updated at any time.
Each secretary is responsible for updating the information for their allocated Consultants patients.

1. Secretaries to compile a report from the timelines for specific consultant / group of patients (i.e. Lung, Upper GI)
2. Secretaries to check for the information needed on the timelines and update where possible. (dates of Scans, outpatient appointments and outcomes of tests and OPA’s)
3. If no information available and secretaries have tried to get an update form the consultants, then escalate to Assistant Administration Managers by Tuesday morning, prior to Wednesday Cancer Targets meeting.
4. Assistant Administration managers to email consultants. If no response escalate to Service Line Managers
5. If still no response then Service Line Managers to escalate to Associate Directors

**Wednesday Cancer Targets Meeting (Assistant Administration Managers)**

1. Review Timelines
2. If information ‘unavailable’ from the systems/letters email consultants
3. If no reply to email – bleep consultants (Friday morning)
4. If no reply bleep Consultants again on Monday morning, if still no reply by close of play Monday escalate to Service Line Managers
5. Once information received update dendrite and Timeline immediately

**Standard Operational Procedure**

**Escalation Process – Medicine – Capacity**

**No capacity for 2 week wait**

1. Capacity issue identified for 2 week wait patients
2. Review patients and aim to try and move slots around to accommodate the 2 week wait
3. If no movement available liaise with Consultants to provide an extra clinic
4. Inform Service Level Manager for sign off
5. If unable to put extra clinic on escalate to Service Level Manager
Standard Operational Procedure – Surgery

2 week wait capacity issues

7. Waiting List manager is responsible for monitoring current capacity against referrals for 2 week wait patients, using reports provided by Information. It is judged that there are capacity issues at any point if either:
   a. There is insufficient capacity to offer any 2ww patient an appointment within 2 weeks OR
   b. There are TAL issues on Choose & Book.

8. Waiting list manager reviews existing booked patients and clinic format and aims to try and move slots around to accommodate the 2 week wait patients. In the event of any undue obstacles being experienced when attempting to move patients or change clinic format, escalate to the Service Line Manager.

9. If despite efforts to move patients, capacity issues remain, Waiting List Manager to liaise with consultants, secretaries and outpatient department to identify options to increase capacity of existing clinics or to provide additional clinics.

   Waiting List Manager has the authority to agree additional / changes in clinics that do not:
   a. Incur additional expenditure (e.g. WLI for Surgeon)
   b. Create breaches of other quality standards (e.g. 18 weeks)
10. Service Line Manager does not need to be informed about the detail of attempts to make these arrangements but is required to sign-off any arrangements that will incur additional expenditure (e.g. WLI payments) or cause breaches of other quality standards, (e.g. 18 weeks).

11. Waiting List Manager briefs Service Line Manager in weekly meeting about such arrangements that are successfully made, or escalates to them immediately in the event that additional capacity is not forthcoming and capacity issues remain.

12. Service Line Manager makes attempts to secure additional capacity, liaising with Clinical Director, Associate Director and others as required.

13. In event that all such attempts are unsuccessful, Service Line Manager alerts Performance & Cancer teams of likely capacity breaches.
Standard Operational Procedure – Surgery

Potential breaches due to lack of theatre capacity

1. Consultant secretary identifies that patient cannot be listed for surgery within target date. Secretary alerts Waiting List Manager. Secretary liaises with consultant to identify options to bring forward theatre date for that patient, including:
   a. Postponing planned surgery of already listed patients,
   b. Sharing operative work with other consultant colleagues,
   c. Possible dates and requirements for additional theatre lists.

2. If additional theatre lists are considered, Consultant Secretary contacts Theatre Modernisation Manager to identify if theatre capacity can be matched with surgeon and anaesthetist availability.

3. Arrangements can be agreed between Consultant Secretary, Waiting List Manager and Theatre Modernisation Manager in the event that the above steps resolve the situation without:
   a. Incurring additional expenditure (e.g. WLI for Surgeon or Anaesthetist)
   b. Creating breaches of other quality standards (e.g. 18 weeks)
   c. Cancellation of other consultant’s theatre lists
   d. Changing arrangements for patients who have already had their surgery cancelled once or who have submitted a complaint or PALS concern about their surgical date.

4. Waiting List Manager briefs Service Line Manager in weekly meeting about such arrangements that are successfully made, or escalates to them immediately for decision in the event identified options will entail one or more of 3a-d.

5. Where matter is not resolved, Service Line Manager reviews options, liaising with Clinical Director, Associate Director and others as required.

6. In event that all such attempts are unsuccessful, Service Line Manager alerts Performance & Cancer teams of likely future capacity breaches.
Standard Operational Procedure

Escalation Process – Surgery

The report is live (within 1 hour) so is able to be looked at and updated at any time. Each secretary is responsible for updating the information for their allocated Consultants patients.

1. Secretaries to update Timelines as soon as information is available
2. Secretaries to check for the information needed in the timelines and update where possible. (dates of Scans, outpatient appointments and outcomes of tests and OPA’s)
3. If no information available and secretaries have tried to get an update from the consultants, then escalate to waiting list manager and/or Administration manager prior to Wednesday Cancer Targets meeting.
4. Waiting list manager and/or Administration manager to email consultants. If no response escalate to Service Line Managers
5. If still no response then Service Line Managers to escalate to Associate Directors

Wednesday Cancer Targets Meeting (Waiting List Manager)

1. Review Timelines
2. If information ‘unavailable’ from the systems/letters email consultants
3. If no reply to email – bleep consultants (Friday morning)
4. If no reply bleep Consultants again on Monday morning, if still no reply by close of play Monday escalate to Service Line Managers
5. Once information received update dendrite immediately
Standard Operational Procedure

Escalation Process – Head & Neck

The report is live (within 1 hour) so is able to be looked at and updated at any time. Each secretary is responsible for updating the information for their allocated Consultants patients.

1. Secretaries to update dendrite and timeline as soon as information is available
2. Secretaries to check for the information needed on the report and update where possible. (dates of Scans, outpatient appointments and outcomes of tests and OPA’s)
3. If no information available and secretaries have tried to get an update form the consultants, then escalate to waiting list manager and/or Administration manager prior to Wednesday Cancer Targets meeting.
4. If no response by Friday escalate to Service Line Managers
5. If still no response then Service Line Managers to escalate to Associate Directors

Wednesday Cancer Targets Meeting (Waiting List Manager)

6. Review Timeline
7. If information ‘unavailable’ from the systems/letters email ENT secretaries
8. If no reply to email escalate to Waiting list manager
9. If no reply contact secretaries again on Monday morning, if still no reply by close of play Monday escalate to Service Line Managers
10. Once information received update dendrite immediately
Standard Operational Procedure

Escalation Process –Head & Neck- Capacity

No capacity for 2 week wait

1. Capacity issue identified for 2 week wait patients
2. Review patients and aim to try and move slots around to accommodate the 2 week wait
3. If no movement available liaise with CHS for consultant ability to provide an extra clinic
4. Inform Service Level Manager for sign off
5. If unable to put extra clinic on escalate to Service Level Manager
6. Service Level manager to escalate to Associate Director
### Name of Standard Operating Process:

CTWT Data Quality Review procedure

### Effective From:

01/01/2015

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Background

This procedure was introduced to identify incomplete or anomalies to Individual patient entries on CTWT that prevent patients being uploaded to CTWT. The identified patients are required to be amended to enable the patient entry to be included in the monthly upload of CTWT information.

Purpose of the Procedure

To define the methodology of reviewing CTWT Data Quality files supplied by Information Division.

Procedure

Information Sharing

1. Two Files are received from Information department, one for 1st Treatment errors, second for sub treatment errors. These indicate the NHS numbers and details of the issue which is causing the record to fail being uploaded to CTWT Open Exeter System

2. Each patient is checked and the issue resolved. Missing NHS numbers are resolved by Information department.

3. Information department is emailed when completed and informed if an issue cannot be resolved (i.e., waiting on further information being received).
Name of Standard Operating Process: Root Cause Analysis completion procedure (RCA)

Effective From: 01/01/2015

| Date Ratified | 20/03/15 |
| Ratified      | Cancer Service’s |
| Review Date   | 20/03/17 |
| Sponsor       | Carolyn Harper |
| Expiry Date   | 20/03/18 |
| Withdrawn Date|            |

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Background

Breach tolerances are provided by the national cancer waiting time standards and are to take into account patients who choose to wait longer for their treatment, for whom waiting longer is clinically appropriate, or where pathways include a complex diagnostic element. Due to the nature of a patient’s clinical symptoms there will be occasions where it has not been possible to avoid a breach. If this occurs:

- A breach report (root cause analysis – RCA) will be completed for all breaches on commencement of treatment
- This will be sent to the appropriate SLM who will discuss with the appropriate clinical lead any relevant further information, potential pathway issues and sign off. This should then be returned to the cancer team (RCA Fig. 1),
- It is the responsibility of the Head of Cancer to discuss shared breach information with other providers and agree reasons/codes for delays
- Breach reasons are uploaded onto the national cancer waiting times system (Open Exeter).

‘Near Miss’ RCA procedure

Improving the 62 day performance has led to the implementation in 2015 of the 8 key priorities. It is necessary therefore to introduce further analysis for site specific groups who do not meet the standards therefore;

- A root cause breach analysis will be carried out for each pathway not meeting current standards, reviewing the last ten patient breaches and near misses (defined as patients who came within 48 hours of breaching).
- RCA preparation for this group of patients will be carried out by the senior trackers
- It is the responsibility of the SLM’s to add the relevant data and analyse issues and themes.

Purpose of the Procedure

To define the methodology of Completing Root Cause Analysis (RCA) documentation for CTWT Breaches.

Procedure

Information Sharing

1. Use Excel. Open up the Breach report file to identify the patient’s requiring a Root cause analysis. (Cancer Services drive – Operational folders – Breach report.)

2. Use Excel. Open up the “1 NEW PATHWAY REPORT” file (Location – Cancer Services drive – Operations folder – PCT completed Breach reports)

3. Using the identified Patient details in the breach report create a Root cause analysis worksheet for that individual and rename the file using the protocol (NHS no. patients 1st Initial and surname, Priority of referral, indication if shared or full breach, Tumour Type, Month of breach, initials of person completing the RCA)

4. Complete the header details then go to main section of report.
5. Identify and record in the main section all interventions in chronological order. Details to record include referral date, outpatient clinics, MDT’s, investigation requests date, date of investigation and date of investigation report. Also include a very summary of the outcomes from all of these. If there are any delays in the pathway these need to be included at the relevant point.

6. Complete the bottom section of the report.

7. Save file

8. On selected monthly Target date all reports are sent to Service level managers for review, comments.

(Fig.1)

Appendix 12

Cancer Waiting Time Standard: Eight Key Priorities

- The Trust Board must have a named Executive Director responsible for delivering the national cancer waiting time standards.
- Boards should receive 62 day cancer wait performance reports for each individual cancer tumour pathway, not an all pathway average.
- Every Trust should have a cancer operational policy in place and approved by the Trust Board. This should include the approach to auditing data quality and accuracy, the Trust approach to ensure
MDT coordinators are effectively supported, and have sufficient dedicated capacity to fulfil the function effectively.

- Every Trust must maintain and publish a timed pathway, agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Clinical Network for the following cancer sites: lung, colorectal, prostate and breast. These should specify the point within the 62 day pathway by which key activities such as OP assessment, key diagnostics, inter-Provider transfer and TCI dates need to be completed. Assurance will be provided by regional tripartite groups.

- Each Trust should maintain a valid cancer specific PTL and carry out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance. The Trust is to identify individual patient deviation from the published pathway standards and agree corrective action.

- A root cause breach analysis should be carried out for each pathway not meeting current standards, reviewing the last ten patient breaches and near misses (defined as patients who came within 48 hours of breaching). These should be reviewed in the weekly PTL meetings.

- Alongside the above, a capacity and demand analysis for key elements of the pathway not meeting the standard (1st OP appointment; treatment by modality) should be carried out. There should also be an assessment of sustainable list size at this point.

- An Improvement Plan should then be prepared for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling, describing a timetabled recovery trajectory for the relevant pathway to achieve the national standard. This should be agreed by local commissioners and any other providers involved in the pathway, taking advice from the local Cancer Clinical Network. Regional tripartite groups will carry out escalation reviews in the event of non-delivery of an agreed Improvement Plan.