The Royal Wolverhampton NHS Trust

OP03
Cancer Operational Policy

Contents

Attachments Appendix

1.0 Policy Statement (Purpose / Objectives of the policy)

This policy sets out The Royal Wolverhampton NHS Trust (RWT) operational policy for the management of cancer pathways and associated clinical and non-clinical information required in association with patient whom a referral is made with a suspicion of cancer through to the treatment for cancer.

It details how the organisation will approach the management of patients to optimise access and ensure a high quality of care is provided including compliance with the national Cancer Waiting Times (CWT) targets, Cancer Outcome Service Database (COSD). It has been developed using current guidance from the Department of Health (2015), including Cancer Waiting Times "National Cancer Waiting Times Monitoring Dataset Guidance – Version 12.0" August 2023 and COSD "Cancer Outcomes and Services Dataset Version 10.0.3" April 2024, NHS Long term Plan.

The overall purpose of the policy is to give a consistent approach to the management of cancer waiting times and associated information across the organisation.

The key objectives are to:

- Ensure all staff are aware of all the CWT standards,
- Provide effective cancer tracking to support the Trusts delivery of CWT targets,
- Improve the patient's experience as they move through the clinical pathways by minimising unnecessary delays where possible,
- Maintain information required on a national and local level to support the delivery of Cancer Care within the organisation.

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict-of-Interest Policy is to be considered the primary and overriding Policy.

2.0 Acronyms

BPTP	Best Practice Timed Pathway
COSD	Cancer Outcomes and Services Dataset
CWT	Cancer Waiting Times
DTT	Decision to Treat
DNA	Did Not Attend
ECAD	Earliest Clinically Appropriate Date
ERS	Electronic Referral System
FDS	Faster Diagnosis Standard
FDT	First Definitive Treatment
HNA	Holistic Needs Assessments
IPT	Inter-provider Transfer
LWBC	Living With and Beyond Cancer
MDT	Multi-Disciplinary Team
NDRS	National Disease Registration

	Service
OPA	Outpatient Appointment
PIFU	Person Initiated Follow Up
PTL	Patient Tracking List
RTT	Referral To Treatment
RCA	Root Cause Analysis
SCR	Somerset Cancer Register
TNM	Tumour, Node, Metastasis
TOR	Terms of reference

3.0 Accountabilities

Whilst overall accountability rests with the Chief Executive and the Board of Directors, responsibility for adhering to the Policy sits with all staff who manage or support the management of patients on cancer pathways. Patients who are being monitored for a pre-cancerous condition are not included within the policy.

Operational implementation, delivery and monitoring of the policy reside with: -

- Group Management and Clinical Teams
- Trust Operational Management Team
- Cancer Services Team
- Patient Access Team
- MDT Lead Clinicians
- Cancer Lead Clinician
- Lead Cancer Nurse

The success of this Policy is dependent on a range of individuals being involved in its implementation.

4.0 Cancer Waiting Times (CWT)

4.1 The CWT Targets

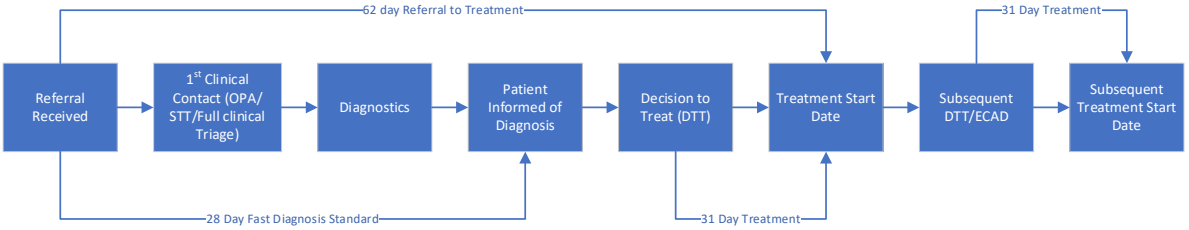
Following a consultation on the CWT standards, NHS England have reduced the number of CWT targets that Trusts are accountable for delivering. Whilst the national targets no longer include the referral to 1st appointment target of 14 days, the organisation have elected to monitor this target for internal information only.

Cancer Waiting times Standard	Description	Compliance Target
14 days	Internal only target – Maximum of 14 days from receipt of referral to the patient having 1st appointment	93%
28 Day - Faster Diagnosis Standard (FDS)	Maximum four weeks (28 days) from receipt of urgent GP (or other referrer) referral for suspected cancer, breast symptomatic referral or urgent screening referral, to point at which patient is told they have cancer, or cancer is definitively excluded.	75%
31 Day Treatment Standards	Maximum 31 days from Decision To Treat (DTT)/Earliest Clinically Appropriate Date (ECAD) to Treatment of cancer.	96%
62 Day Treatment Standards	Maximum 62-day from receipt of an urgent GP (or other referrer) referral for urgent suspected cancer, breast symptomatic referral, urgent screening referral or consultant upgrade to First Definitive Treatment (FDT) of cancer.	85%

4.2 Patient Pathway

A patient's pathway will be monitored within the Somerset Cancer Register (SCR) database, from point of referral until cancer is definitively excluded, or the patient receives a first definitive treatment for cancer. Should the patient require subsequent treatment, this will also be monitored from the point at which the decision to treatment is made.

Below demonstrates the patients journey against the prospective CWT standards.



Individual tumour sites have received a nationally agreed Best Practice Timed Pathway (BPTP) to support the management of patients from the point of referral through diagnostics to the ending of the 28 Day FDS standard.
Best Practice Timed Pathway - West Midlands Cancer Alliance (wmcanceralliance.nhs.uk).

4.3 Summary of the Cancer Rules

4.3.1 Clock Starts

The point at which each target commences (clock start day 0) is defined below.

28 Day FDS and 62 Day

- Receipt of an urgent suspected cancer referral – the referral must be sent via Electronic Referral System (ERS) or Rego (for referrals from General Dental Practitioner) with a fully completed urgent cancer referral form.
- Receipt of a referral for breast symptoms (where cancer is not suspected)
- Referral from NHS cancer screening:-

    - **Breast:** receipt of referral for further assessment (i.e. not back to routine recall);
    - **Bowel:** receipt of referral for an appointment to discuss suitability for colonoscopy with a Specialist Screening Practitioner
    - **Cervical:** receipt of referral for an appointment at colposcopy clinic.

- Triage from an abnormal direct access diagnostic (Lung Pathway)

62 Day (Consultant Upgrade Pathway)

- Point of escalation of a suspected cancer from any other source, including:
- The clinical team identify a suspicious of cancer following routine/ urgent appointment/ diagnostics, The pathway should be started at the earliest opportunity and cancer services informed.
- Abnormal results reported through the internal cancer suspicious report received into cancer service from radiology or pathology services. These patients will be escalated to the clinical team for confirmation that a cancer pathway is required.
- Suspicion of cancer following routine/urgent referral for another condition
- Patient previously DNA'd or cancelled multiple appointments whilst on a cancer pathway, but unable to discharge care back to the GP due to clinical urgency.
- Patient transfers from Private/non-NHS care into NHS

- Referral into a cancer MDT on suspicion of or with a new confirmed cancer (where a decision to treat has not yet been made)

31 Day

- The point at which the patient and a clinician agree a planned cancer treatment (DTT) for first and subsequent treatments.
- A DTT for subsequent treatment
- An ECAD for a subsequent treatment

If a patient's treatment plan changes, the DTT can be changed, e.g. if a patient had originally agreed to have surgery but then changed their mind and opted for radiotherapy instead.

An ECAD date can be reviewed and changed up until a point that it is clinically appropriate to start further treatment. This date must clearly communicated with the patient and documented within the patient's notes.

4.3.2 - Clock Stops

A patient's CWT pathway can be stopped at multiple points along the clinical pathway without the patient being discharged from the clinical service. In the situation where a non-cancer diagnosis is made but clinical input is still required the

patient will be managed through the Trusts' Patient Access policy and against the national 18-week (RTT) standard.

The point at which each target ends (clock stop) is defined below.

28 Day FDS

- First appointment, where a patient has been informed of their diagnosis prior to referral.
- Point of decision to treat prior to diagnosis (i.e. skin cancers)

28 Day FDS and 62 Day

- Where a patient is admitted as an emergency for the same condition before they have had their first appointment (the emergency admission supersedes the original referral, and the patient should be upgraded to a new 62 Day pathway)
- Communication of a non-cancer diagnosis to the patient
- Communication of a diagnosis of a new primary cancer including Cancer of an Unknown Primary (CUP)
- Patient to have interval scans/tests.
- Patient requests to transfer to a private or non-NHS provider for any element of the cancer pathway
- Patient failed to attend or cancels twice for 1st clinical appointment, including face to face and 'straight to test' appointments.
- Patient fails to attend or cancels a clinical appointment twice consecutively following 1st attendance (See above for clock starts in this situation)
- Patient declines all diagnostic tests.
- Death of patient

62 Day

- Confirmed cancer with a decision not to treat (i.e. patient declines treatment or is unfit for active treatment)

31 Day and 62 Day

- Delivery of first definitive treatment; including enabling treatment as set out within the cancer waiting time document.
- Placing a patient with a confirmed cancer diagnosis onto active monitoring
- Referral of patient into palliative care with no other active treatment

31 Day

- Delivery of subsequent treatment

4.3.3 – Waiting Time Adjustments

- **1st clinical appointment**

If a patient DNAs their 1st clinical appointment or attendance at diagnostic appointment, e.g. endoscopy, the clock start date can be reset to the date when the patient agrees the new appointment (not the new appointment date).

- if a patient declines admission for an inpatient or day case procedure due to social reasons (i.e. due to holiday or work commitments), the clock can be paused from the date offered to the date the patient is available providing the offer of admission was 'reasonable'. Reasonable Offer. An offer will be deemed to be reasonable, if 48 hours' notice is given.
- If a patient makes themselves unavailable for treatment for a set period of time, the clock can be paused from the date of the earliest reasonable appointment that the Trust would have been able to offer to the date that the patient becomes available.
- If a patient is offered a choice of treatments but asks about another treatment (i.e. requests a second opinion), the clock can be paused from the date of the earliest reasonable appointment that the Trust would have been able to offer for the initial treatment options to the date that the patient makes themselves available for a further appointment.
- Where it is deemed clinically essential to treat another medical condition before treatment for the cancer can be given (after a DTT the cancer has been made), the clock can be paused from the point at which it is confirmed that the patient requires treatment for the other condition, to the point at which the patient is deemed clinically fit to proceed with their cancer treatment. This includes treatment for COVID and Influenza.
- Where a patient opts for egg harvesting prior, the clock can be paused from the point at which the patient is seen by the egg harvesting service and agrees to the procedure until eggs are harvested.

If a treatment is to be delivered in an outpatient setting, such as an outpatient procedure or radiotherapy, a pause **cannot** be applied.

Any pause must be supported by clear documentation in the cancer management system and PAS, or other relevant clinical system. The Trust will ensure that admission dates offered to the patient are recorded.

31 day – subsequent treatment - In some circumstances, it may be appropriate for the clinician to set an ECAD which is when a patient needs to recover following their FDT. An ECAD can be adjusted but only if the date has not passed. The 31-day clock start date should be the same as the ECAD date for these patients.

For a more detailed breakdown of the cancer rules please see the latest CWT Guidance, which can be found on the NHS Digital website:
Cancer Waiting Times (CWT)

4.3.4 Referral Management

All administration tasks relating to the cancer suspicious patient will be managed by the cancer referral hub, it is the responsibility of the team to ensure that all referrals are process within 1 working day of receipt. Following the processing of referral the cancer referral hub will escalate capacity issues to the service delivery teams.

All referrals that are received via a teledermatology management system will be entered onto SCR system, in the situation that the teledermatology triaging resulted in the patient being clinically discharged from the cancer pathway, the SCR record will be updated to reflect this outcome, this includes the closure of the 26-day FDS

on the day the clinical triage was completed.

The first appointment can be a full clinical triage delivered by either a nurse or consultant, an outpatient appointment or for an investigation relevant to the referral, i.e. 'straight to test'.

Where required information is not included as part of the referral (i.e. missing test results), the Cancer Referral Centre Team will contact the relevant GP surgery by phone within 48 hours of receipt of referral to obtain this. The appointment will be provisionally booked for a patient whilst information is being obtained to ensure there is no delay to the pathway. Should the required information not be received within a reasonable timeframe the referral will be returned to the GP for further action and re-referral if appropriate. Should the cancer referral hub receive a blank referral form this will not be accepted by the organisation and returned to the refer for completion and re-referral if appropriate.

Should the trust request and receive mutual aid for 1st Clinical appointments, the referrals will be transferred via ERS to ensure that there is continuity for the patient pathway and the receipt date from the GP is maintained.

4.3.5 Managing Inter Provider Transfers (IPTs)

The National CWT Monitoring Dataset Guidance Version 12.0 defines an IPT as the formal transfer of responsibility of care from one healthcare provider to another. A transfer can only be accepted where the agreed minimum dataset is received, if this information is not received, it is the organisation responsible to return the trust within 24 hours ensure there is clear indication for the reason of return.

This section includes the minimum dataset specification for standard IPT referrals using NHS England's '*IPT - Minimum Clinical Data Checklist'* and the West Midlands Cancer Alliance's '*Inter Provider Transfer of Care Allocation Policy*' as guidance.

Tumour site specific checklists will be used to specify requirements for each tumour site pathway and MDT in the locality.

All IPTs must include the minimum dataset specified below in order to be formally recorded as an IPT:

- NHS number
- Referral form clearly indicating the reason for referral: - MDT discussion only or treatment.
- Clinical referral letter, cancer waiting time and pathway information, BMI, medical history, and medication, if applicable
- Histology slides and report
- Staging and radiological images and report
- Assurance that the patient is aware of the referral
- Referring Trusts root cause analysis for all breached referrals
- Local IPT proforma, if applicable.

Where the patient has been discussed at MDT and the decision is made to return the patient back to the referring Trust for continuation of care, a tertiary proforma/

documentation needs to be completed containing a copy of the MDT discussion and outcome.

4.3.5.1 IPT Breach Allocation

Previously, IPT patients on a 62-day pathway were reported as a shared (0.5) treatment on performance reports, irrespective of when their formal transfer of care took place. Performance reporting is based on the originating trust referring by day 38 of the patient's 62-day pathway and the receiving trust treating within 24 days of the inter provider transfer.

The table below summarises the pathway allocations for inter provider referrals.

	38 day referral time frame	24 day treatment time frame	62 day total time frame	Referring Trust allocation	Treating Trust allocation
1	Success	Success	Success	0.5 compliant pathway	0.5 compliant pathway
2	Success	Breach	Success	0.5 compliant pathway	0.5 compliant pathway
3	Breach	Success	Success	0	1.0 compliant pathway
4	Success	Breach	Breach	0	1.0 breach
5	Breach	Success	Breach	1.0 breach	0
6	Breach	Breach	Breach	0.5 breach	0.5 breach

5.0 Clinical Harm Review

It is the Trusts responsibility to ensure that a pathway review is completed for all patients who wait longer than 104 days to receive cancer treatment. The process of undertaking these reviews is outlined within the Trusts Cancer Services – 104 day harm review process (appendix 2). These reviews take place to identify if a patient has come to either clinical or psychological harm as result of the time they have waited for treatment.

For patients who have received care across 2 or more organisations', the responsibility of the harm review will be allocated as per the CWT breach allocation rules. Where this is a shared breach, it is the overarching responsibility of the treating Trust to complete the harm review.

Review of clinical and psychological harm enables the Trust to identify where pathway delays have affected patient outcomes and what steps need to be taken to avoid causing clinical harm.

6.0 The Cancer Outcomes and Services Dataset (COSD)

COSD is the national standard for collecting cancer data in the NHS to support national cancer registration and analysis at local, regional and national level. The standard covers all patients diagnosed with or receiving cancer treatment within the NHS.

The Trust is mandated to submit a monthly return to the National Disease Registration Service (NDRS) from a number of systems, including SCR and Pathology systems . The dataset incorporates a number of generic items, including data surrounding referrals, diagnosis and treatment, along with additional site specific data items to support the National Cancer Audit Programme.

Performance is monitored monthly against the ascertainment and data completeness of 3 key data items:

- Performance Status
- Staging (TNM, or other site specific)
- Clinical Nurse Specialist (CNS) Indicator / Holistic Needs Assessment (HNA) status

Site specific data quality/ housekeeping reports are produced to ensure data completeness and to support validation prior to submission. These reports are produced during the first week of every month, for patients diagnosed the previous month, and shared with the clinical services.

6.1 Living with and Beyond Cancer (LWBC)

The Living With and Beyond Cancer initiative fulfils the NHS Long Term Plan commitments to personalised care which includes HNA, holistic care planning and a post treatment person initiated follow up (PIFU) pathway where appropriate.

Within COSD requirements, data is reportable for assessments offered, assessment completion date and assessment point of pathway for both HNAs and care planning activities and number of patients moved onto a PIFU pathway. This data is subjected to monthly national upload.

HNA's need to be offered during key points of the patient journey, this includes:

- Point of diagnosis
- Start and end of primary treatment
- Point of a reoccurrence being identified
- Subsequent treatments
- Palliative care.

7.0 MDT Meetings

MDT Meetings are an integrated team approach to health care in which medical, nursing, and allied health care professionals consider all relevant treatment options and develop collaboratively an individual treatment plan for each patient.

The organisation following the internal MDT terms of reference (Appendix 3) however it is the responsibly of the MDT/ Cancer lead for the individual Tumour site, to ensure that their TOR is reflective of the site's requirements and the development of the Standards of Care in line with West Midlands Cancer Alliance MDT Streamlining documentations.

8.0 Data Quality and Peer Review

8.1 Data Quality

Cancer Services run monthly data quality reports, these will include reports for COSD submission and internal data completeness reports.

Internal data quality monitoring will include: -

- Named Consultant
- First appointment dates
- Referral type for Breast referral
- 1st appointment type
- Missing diagnosis
- Missing CWT flag
- Tertiary referral – outgoing
- Tertiary referral – incoming
- Sub referral type
- Duplicate Referrals

Cancer Service with the support of operational teams will complete validation audits monthly prior to CWT upload (5-6 week after month end). This validation will include all patients who pathway is completed within month.

8.2 Peer Review

Peer review is an annual process co-ordinated by Cancer Services. As part of the preparation the Cancer Information team will provide a standardised information pack to each tumour site by the second week of the new financial year.

Number of referrals – and referral source
Number of Diagnoses
Number of Tertiary referral
Number of Tertiaries treated
Surgeon Workload
MDT Discussion Data
MDT Attendance
CNS Contact Data – Including HNAs and treatment summaries
Chemotherapy treatments – by treating site
CWT Compliance
PTL size – 62 day only

9.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	Yes – No
2	Does the implementation revenue resources of this policy require additional	Yes - No
3	Doe the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments	

10.0 Equality Impact Assessment

An equality analysis has been carried out and it indicates that:

Tick	Options
✓	A. There is no impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.
	B. There is some likely impact as identified in the equality analysis. Examples of issues identified, and the proposed actions include: • • •

11.0 Maintenance

This policy will be reviewed yearly to ensure alignment with national guidance and local learning and improvement.

12.0 Communication and Training*

This policy will be disseminated after each review by the Trust Cancer board and Cancer recovery meeting. Wider dissemination for all staff will be achieved through management cascade, team briefing, training, all user bulletins and governance forums. All managers have a responsibility to ensure that staff are informed of new and reviewed policies.

Education sessions will be provided with the support of the Intensive Support Team.

13.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee
Validation Audit	Head of Cancer Services	Sample review of patient submitted for cancer waiting times including non-breaching patients	Bi-monthly	Team Meetings
Duplicate Referrals	Head of Cancer Services	Housekeeping Checks to ensure all duplicate referrals within Somerset are reviewed	Monthly	MDT Co-Ordinator meeting
Escalation Policy	Directorate Manager	Internal audit of escalation policy within cancer services	Annual	Cancer Recovery board
Cancer Improvement Plan	Head of Cancer Services	Tumour site breakdown of actions to improvement all cancer targets	Monthly	Cancer Recovery Group
Cancer services Update	Head of Cancer Services	Update on current performance and challenged Cancer sites	Monthly	QSAG/ Trust Board
104 Harm review - report	Lead cancer nurse/ Clinician	Overview of all cancer patient who waited longer than 104 day for treatment and associated harm	Quarterly	QSAG

14.0 References - Legal, professional, or national guidelines

NHS England (2015) Cancer Waiting Times: A Guide (Version 9)
Available from:
http://systems.digital.nhs.uk/ssd/cancerwaiting/documentation

NHS England (2018) Addendum to the National Cancer Waiting Times Monitoring Dataset Guidance v9.0
Available from:
https://digital.nhs.uk/binaries/content/assets/website-assets/data-and-information/data-collections/cancer-waiting-times/addendum-to-national-cancer-waiting-times-monitoring-data-guidance-v9.0.pdf

National Cancer Waiting Times Monitoring Dataset Guidance v10
Available from:
http://systems.digital.nhs.uk/ssd/cancerwaiting/documentation

NHS England (2023) National cancer waiting times monitoring dataset guidance V12
NHS England » National cancer waiting times monitoring dataset guidance

National Cancer Waiting Times Monitoring Dataset Guidance V12.0 (england.nhs.uk)

West Midlands Inter Provider Transfer of Care Allocation Policy (V11 April 2019)
Available from:
https://www.england.nhs.uk/midlands/clinical-networks/west-midlands-clinical-network/our-networks/cancer/resources/

NHS Digital (2018) NHS e-Referral Service: Guidance on System Availability and Business Continuity
Available from:
https://digital.nhs.uk/services/nhs-e-referral-service/document-library

NHS England (2016) National breach allocation guidance
Available from:
https://www.england.nhs.uk/wp-content/uploads/2016/03/cancr-brch-allocatn-guid-2016.pdf

BPTP and Clinical pathways for Tumour sites
Available from:

Best Practice Timed Pathway - West Midlands Cancer Alliance (wmcanceralliance.nhs.uk)

Clinical Guidelines and Pathways - West Midlands Cancer Alliance (wmcanceralliance.nhs.uk)

Part A - Document Control

<table>
<tr><td>Policy number and Policy version:

Policy No. OP03

V2.0</td><td>Policy Title

Cancer Operational Policy.</td><td colspan="2">Status:

Final</td><td>Author: Head of Cancer Services

Chief Officer Sponsor: Chief Operating Officer</td></tr>
<tr><td rowspan="8">Version / Amendment History</td><td>Version</td><td>Date</td><td>Author</td><td>Reason</td></tr>
<tr><td>1.0</td><td>Nov. ‘19</td><td>Helen Milward- Directorate Manager – Cancer Services</td><td>Implementation of Policy</td></tr>
<tr><td>1.1</td><td>Feb. ‘21</td><td>Helen Milward- Directorate Manager – Cancer Services</td><td>Minor updates made to policy</td></tr>
<tr><td>1.2</td><td>April ‘23</td><td>Helen Milward- Directorate Manager – Cancer Services</td><td>Extension</td></tr>
<tr><td>1.3</td><td>Sept. ‘23</td><td>Helen Milward- Head of Cancer Services</td><td>Extension</td></tr>
<tr><td>1.4</td><td>Feb. 2024</td><td>Head of Cancer Services</td><td>Extension</td></tr>
<tr><td>2.0</td><td>May 2024</td><td>Head of Cancer Services</td><td>Review</td></tr>
<tr><td colspan="5">Intended Recipients: This policy is aimed at all staff who are engaged in the management, administering and treatment of patients with suspected and diagnosed cancer.</td></tr>
<tr><td colspan="5">Consultation Group / Role Titles and Date: Cancer Recovery board 9 April 2024</td></tr>
<tr><td colspan="2">Name and date of Trust level group where reviewed</td><td colspan="3">Trust Policy Group – 5 May 2024</td></tr>
<tr><td colspan="2">Name and date of final approval committee</td><td colspan="3">Trust Management Committee – 31 May 2024</td></tr>
</table>

Date of Policy issue	June 2024
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	May 2027
Training and Dissemination: Through induction / local training	
To be read in conjunction with: Access Policy and relevant standard operating procedures referred to in this policy.	
Initial Equality Impact Assessment (all policies): Completed Yes **Impact assessment (as required): Completed No** If you require this document in an alternative format e.g., larger print please contact Policy Administrator 8904	
Monitoring arrangements and Committee	

Document summary/key issues covered.

This policy details the standards and processes relating to the management and monitoring of patients on a cancer pathway and the management of patients against national cancer waiting time targets.

The overall purpose of the document is to establish a consistent approach to the management of Cancer Waiting Times across the organisation and to ensure that all staff involved in caring for patients on a cancer pathway, follow Trust policy to provide equitable access for patients.

The key issues that are covered in this policy are:

- To ensure all staff are aware of all the Cancer Waiting Times standards
- Provide effective cancer tracking to enable the Trust to achieve or exceed the required access waiting time standards
- Improve the patients 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 Times pathways at an early stage to the specialty management teams
- Provide timely, consistent and accurate data-recording for patients on cancer waiting-time pathways

Key words for intranet searching purposes	

17.0 Appendix 1

The Royal Wolverhampton Hospitals NHS
NHS Trust

CANCER SERVICES ESCALATION SOP

CANCER SERVICES DEPARTMENT

1. Introduction

This Standard Operational Policy (SOP) is to ensure appropriate escalation if there is a delay in a cancer patient's pathway. Cancer Services, diagnostic services and Directorates are all responsible for ensuring that cancer patient pathways delays are avoided or minimized.

It is the intention of this SOP to ensure that any likelihood that a patient's pathway will fail to meet a cancer waiting times target is escalated at the earliest opportunity. It is designed to ensure problems are resolved at the earliest opportunity and at the lowest level and that a Divisional Manager is informed of any failure in the system.

2. Escalation areas

- Fast Track - Capacity
- Radiology
- Pathology
- Oncology
- Directorates

3. Escalation Levels

Escalation Level	Raised By	Raised To	Timescales
1	Cancer Services	Directorate Team	3 days to response
2	Cancer Services	Group Manager	2 days to response
3	Cancer Services	Divisional Manager	2 days to response

4. Escalation Reasons

In order to ensure that patients are treated within 31 and 62 day targets, patients must be managed in line with the following timescales. Escalation will be made whenever these timescales are not being achieved (or are unlikely to be achieved) at any stage of the patient's cancer pathway.

- **All investigations will be undertaken with seven days of request. This includes radiology, endoscopy and biopsies.**
- **All reporting of investigations will be undertaken within five days of the investigation being completed.**
- **All outpatient clinic letters will be made available to the Fast Track team within 2 working days of an appointment.**
- **Any patient whose pathway does not achieve the 28 day faster diagnosis target will be escalated.**

All escalations will be documented with the individual patient tracking comments, to include: action taken, level of escalation and date (e.g. "Awaiting letter escalation level 1 12.12.2018").

5. Fast Track Escalation

For each site, an escalation report must be produced by the Fast Track team and sent daily to the directorate as per the escalation plan below.

Outstanding Capacity	Days Since referral	Escalation levels
0-10	1	Level 1
11-50	5	Level 2
50+	8	Level 3

6. Diagnostic Escalation

Radiology

Escalation reports to be sent from cancer services twice a week – Radiology to respond within 24 hours. These reports are to include all patients awaiting diagnostics to be booked or reported. If a patient is waiting outside of the standard time, it will then need to be escalated as per the below plan.

Booking of radiology tests	≤ 5 days	Standard
	5 – 10 days	Radiology department Level 1
	>10 days	Radiology department level 2 + referring directorate level 1/2
Reporting of radiology tests	≤ 7 days	Standard
	7-10 days	Radiology department Level 1
	>10 days	Radiology department level 2 + referring directorate level 1/2

Pathology

Daily escalation reports to be sent from Cancer Services. The information will be a report of sample received that has come from a patient who is on a cancer suspicious pathway. If, however, a report is not received within 7 days of biopsy, it will be escalated as per the below plan.

Reporting of histology	≤ 7 days	Standard
	7-10 days	Pathology department Level 1
	>10 days	Pathology department level 2 + referring directorate level 1/2

Endoscopy

Escalation requirements when endoscopy test is not the 1st appointment. If a patient is waiting outside of the standard time, it will then need to be escalated as per the below plan. Escalation will be to the endoscopy directorate and referring directorate's management team.

Booking of endoscopy tests	≤ 7 days	Standard
	5 – 10 days	Level 1
	10 -15 days	Level 2
	>15 days	Level 3

Management of DNA's

All patients referred to a diagnostic service should have their appointment booked within the above timescales. If the patient DNA's their 1st diagnostic procedure, the patient should be automatically rebooked within 2 weeks. Should the patient DNA for a 2nd time the diagnostic booking team must contact the referring consultant for advice as to whether the patient needs to be rebooked.

Following the patient's 2nd DNA, the diagnostic booking team must inform the cancer tracking team and the patient will be removed from cancer monitoring; should a cancer subsequently be found, the patient will then be added to Somerset as an upgrade.

7. Oncology Escalation

Daily escalation reports to be sent from Cancer Services, as well as a twice weekly meeting between Cancer Services and the oncology team to discuss all patients awaiting oncology plans. If the patient is waiting outside the standard time it will be escalated as per the below plan.

Booking oncology OPA	≤ 7 days		Standard
	8 – 14 days		Level 1
	14 -21 days		Level 2 + Directorate Level 1/2
	22 day +		Level 3
Booking of oncology treatments	62 days target	By day 62	Standard
		Over day 62	Level 1
	31 day target	By day 31	Standard
		Over day 31	Level 1

8. Directorate Escalation

Clinical letters of patient on a cancer suspicious pathway	≤ 2 days	Standard
	3 – 4 hours	Level 1
	5 – 6 days	Level 2
	>7 days	Level 3
MDT follow up appointments	≤ 7 days	Standard
	8 - 10 days	Level 1
	11-12 days	Level 2
	<12 days	Level 3
Without a diagnosis	By day 21	Level 1
	By day 25	Level 2
	Over day 28	Level 3 – Breach

9. Thinking Time

A patient can request thinking time following a discussion with the clinical team. The CNS must contact the patient as per the escalation plan below. Notes of the conversation must be recorded on Clinical Web Portal.

Days since request	Escalation levels
3	CNS to contact patient
5	CNS to contact patient
7	CNS to contact patient and discuss clinical review appointment.

17.0 Appendix 2

The Royal Wolverhampton Hospitals NHS Trust

CANCER SERVICES
MDT Terms of Reference

CANCER SERVICES DEPARTMENT

RWT Cancer MDT Terms of Reference

1. Purpose

The terms of reference sets out the aims and describes the processes and responsibilities of the clinical teams for treatment planning MDT.

2. Introduction

The MDT provides specialist knowledge for the care and treatment plan for patients with a malignant diagnosis from the within RWT and the local referral networks.

3. Aim

The overall aim of the multidisciplinary cancer meeting is to enable a formal mechanism for multidisciplinary input into treatment planning and ongoing management and care of patients with cancer. The multidisciplinary team provides advice to the referring clinician. Treatment decisions are the responsibility of the primary clinician responsible for the patient.

4. Objectives of MDT meeting

4.1 The MDT is committed to achieving high standards of care and patient outcomes.

- Implementation and compliance with Improving Outcomes Guidance
- Work to follow agreed NICE Quality Guidelines and agreed EAG pathways.
- Collection of high quality data.
- Analysis of data and regular audit.
- Involvement in local, national and international research studies.
- To undertake service improvement and service redesign where required.
- Providing comprehensive information to patients and relatives.

4.2 Specific Roles of the MDT:

- To provide expertise knowledge in the management and delivery of an efficient diagnostic and treatment pathway for patients with a cancer diagnosis
- To provide rapid access to expertise and opinion.
- The MDT will discuss patients from within RWT and externally if and where RWT is seen to be the specialist centre.
- The team will provide expert input into paediatric teenage and young adult patients (TYA) with cancer and will work in conjunction with paediatric and TYA MDTs as required.

5. Operational Guidelines

5.1 MDT membership, attendance and quoracy

It is recognised that all clinicians involved in treating cancer patients should be an active member of an MDT, but that not all extended members need to be present at every meeting or for the whole of the meeting.

One individual from each core specialist group must be present for the meeting to be quorate. Quorum-

- Consultant surgeon with a specialist knowledge within the tumour site
- Consultant Radiologist

- Consultant Clinical Oncologist.
- Consultant Medical Oncologist
- Consultant Pathologist
- CNS/navigator
- MDT co-ordinator.

(Roles and responsibility - Appendix 1)

All MDT attendees are required to sign the attendance register and ensure the Lead and MDT Co-ordinator is aware who is attending at remotely.

There is an expectation that clinician wishing to have a patient discussed will either be present within the MDT meeting or a fully completed proforma (Appendix 1) will be sent to ensure all clinical information is provided and confirmation of the question that is needed to be answered by the MDT team.

When specific clinical needs have been identified by the referrers which require specific skills and targeted input, the chairperson/Lead/MDT Co-ordinator will invite the appropriate staff member(s) to attend that meeting eg Learning Disability CNS.

5.2 Meeting Structure

Meetings should be held weekly (at a minimum) at the same time and place. The duration and frequency of meetings will be determined by each MDT meeting based upon size of site/number of cases requiring discussion.

All MDT will facilitate a hybrid working model to enable both face to face and e-MDT attendance. Meeting room facility must meet the requirements of the MDT (i.e. access and display of radiology images, pathology slides, videoconferencing etc)

5.3 Referral into MDT

The referring clinician must send all referral details to MDT Co-ordinator no later than [3 days] prior to the meeting. This is to facilitate prioritisation of presentations and to ensure adequate time for investigation results to be prepared for the meeting.

The referring clinician must ensure radiology is made available for the meeting, particularly private films. The administrative MDT support may be able to facilitate this when provided with relevant information to source radiology images/pathology.

The MDT list will be circulated [2 days] prior to the meeting.

Clinicians to review list prior to MDT and advise of any patients who do not require an MDT discussion.

All patients must be made aware that their case will be presented at the multidisciplinary team meeting for discussion and consent to this process. Consent may be either verbal or written and it must be noted in the patient's clinical health record and/or on the multidisciplinary meeting referral form.

Late inclusions to the agenda are acceptable. In this instance, it is the responsibility of the presenting clinician to ensure all late additions have appropriate clinical results available to the meeting. All late inclusions will be agreed by MDT Lead or lead CNS.

5.4 Patients to be discussed

- All newly diagnosed patients

- Review patients either with a newly diagnosed or recurrent/ progression of cancer

5.5 MDT list will include:

- Information required for patient presentation:
  - Patients name
  - DOB, Hospital number
  - Referring Clinician
  - Comprehensive clinical summary
  - Test results
- Any urgent patients – clinical team must ensure all information is available in this situation of an urgent/ late additional.

5.6 Outcome Summaries

Real-time electronic completion of the MDT outcomes must occur during the meeting and observed by clinicians to allow immediate validation of accuracy of notes.

The MDT Lead must ensure full clinical sign off of MDT notes within 24 working hours of the MDT.

6. Governance and internal Quality review

1. There must be annual audits to look at treatment decisions compared to MDM/SMDM recommendations. It is recommended that if the decision to treat deviates from the recommendation, this should be re-discussed at the MDM and documented.
2. MDTs must conduct Annual Quality reviews to demonstrate compliance with relevant key performance indicators and quality measures as outlined within the cancer access policy.
3. MDTs must have operational business meetings (minimum twice a year) to review the MDT workload (activity, performance, outcomes), patient experience, trial recruitment, root cause analysis and harm reviews from 62 and 104 day breaches as well as incorporating peer review sharing and learning from best practice and updates from new treatments/guidelines.

Appendix 1 - Roles and responsibilities

Role of the MDT Lead

- Keeping meetings to the agenda
- Ensuring all visiting members are appropriate to the meeting and where required exclude attendees
- Ensuring there is appropriate representation in the meeting to enable a comprehensive recommendation to be made
- Commencing and facilitating discussions
- Prompting the full range of input into discussions if it is not forthcoming
- Summarising the discussion and inviting further input before moving to the next case
- Negotiating resolution of conflict
- Promoting mutual professional respect among all team members.
- The Chair and Deputy Chair positions will be appointed annually. If the Chair or Deputy Chair is unable to attend, the Chair will arrange a proxy to chair the meeting.

Role of MDT co-ordinator and parameters of responsibility

- The MDT co-ordinator is responsible for delivery of an effective and efficient administration service for the MDT with the support of the MDT team and in collaboration of the MDT lead.
- The MDT co-ordinator will ensure MDT provisional and final lists are set within the agree timescales for the MDT.
- The MDT co-ordinator is the point of contact and key facilitator for the MDT. They will confirm that all imaging and results are available for the meeting, (with the exception of late additions).
- MDT co-ordinator responsible for documenting the minutes in real time during the MDT. They will be assisted by the clinician for the responsibility of the patients care and the chairman of the meeting.
- MDT co-ordinator will be responsible for ensuring the minutes of the MDT are disseminated to the clinicians involved in the patient's care.
- MDT co-ordinator responsible for ensuring all clinical dataset requirement that are discussed within the MDT are accurately reflected within Somerset (SCR)
- MDT co-ordinator will ensure that all MDT minutes are reflected within clinical Web Portal in a timely manner – this action required clinical sign off of all MDT minutes.

Appendix 2 – Link to relevant proforma

The Royal Wolverhampton Hospitals NHS
NHS Trust

Cancer 104-Day Harm Review Process

Contents

1. Overview

Name of Process	Cancer 104-day Harm Review
Trust/local Strategic Objectives (as applicable) **Risks title and number**	NHS England has defined standard cancer waiting times for access to healthcare. The time taken to provide definitive treatment following the diagnosis of cancer is 62 days from the date of referral of suspected cancer referral to the first definitive treatment. The Cancer 104 day harm review scrutinises all patients that have taken more than 104 days to receive definitive treatment. The review takes into consideration the practicalities for managing complex diagnostic pathways requiring multidisciplinary and often multi-organisational input, those patients that may experience an unexpected event and become unwell, and those who choose to delay investigations or treatment or not to have treatments. The review looks at each individual patient pathway that exceeds 104 days to understand where the delays occurred, whether these delays were unavoidable or not and whether the delay resulted in clinical or psychological harm. The Trust then looks to learn from the process to improve cancer pathways ensure pathways deliver cancer care in a timely manner in line with National targets.
Purpose/Remit	To a deliver a streamlined and protocolised process to ensure that all patient who have potentially come to harm due to the time they have waited for cancer treatment. This process will look at the patient pathway focusing on both physical and psychological harm. The protocolised pathway will mean that not all patients will be required to go through full clinical review and validation. If, however following the protocol the patient is identified as having potential harm, the trust Governance process will be initiated, and the Cancer Service team will raise a datix for potential harm.
Responsibilities	. The key responsibilities are: 1. The Cancer services department will identify the patients who have received treatment within the relevant time period and have waited more than 104 days from referral to treatment. 2. Following the identification, Cancer Services will analyse the patient pathways, to review all patients treated after 104 day for cancer. 3. Following the agreed protocols, patients who required further clinical/ physiological review will be identified. 4. Where patients have been identified as potential clinical harm, the MDT team will undertake a full clinical review of the pathway using the guidance definition to clinically determine whether harm caused. 5. Where patients have been identified as potential psychological harm, the MDT team will review the patients to understand where there were gaps in the patient holistic contacts and support. 6. Where patients have been identified as potential psychological harm, with the supervision of the lead nurse, an additional patient contact will be completed to understand if the patient requires any additional support and if there feel they received the psychological and holistic support needed. 7. MDT Teams will feedback on the outcome of the reviews. 8. To identify and escalate any risks identified to the Trust. 9. To ensure that appropriate subsequent action is taken where a breach in the Cancer care pathway is believed to have caused physical or psychological harm, in line with trust governance processes 10. To identify and share learning identified from Cancer harm reviews undertaken (as appropriate) using the Trust communication mediums eg Making it Better Alert, Risky business and learning framework. 11. Harm review report is to be written 12. Clinical Cancer Clinician and Lead Cancer nurse to present finding and report to QSAG meeting quarterly as requested. The pathway is reviewed in detail utilising timelines, and all available data and information. The review identifies delays within the pathway and consequent harm. The reviews may highlight areas for service improvement.

	The 104-Day Harm review considers all patients who have a new cancer diagnosis and are on a cancer pathway, and in whom the time taken to deliver the treatment has exceeded 104 days. The report reviews all such patients and makes a judgment on whether the significant time delay in performing investigations, arriving at a pre-treatment cancer stage and the time taken to treatment has resulted in significant progression of the cancer in stage and prognosis, and or psychological harm. The review draws information from the respective electronic medical records (RWT Clinical Web Portal), the Somerset Cancer Registry System (SCR) and results of any investigations and assessments made during the care of the patient. The review may also draw specialist opinion from the respective Cancer Pathway Lead to arrive at a conclusion on whether clinical harm or psychological harm has occurred. The review makes judgement on whether the significant time taken to deliver the cancer care was a result of unavoidable or avoidable delays in the respective cancer pathway for the patient.
Definitions	To Interpretation of delay and Consideration of levels of harm caused should be based on the following definitions: **Severe harm:** If there is a delayed diagnosis due to investigations falling outside of agreed Cancer Operational Policy (OP03 Cancer Operational Policy – 22.01.2020) and there is progression of cancer stage from referral to treatment. It was deemed that there was a missed opportunity to treat the cancer. Removal of wrong limb or organ, unexpected permanent lessening of body functions. If a death occurs whilst on the waiting list. If an unexpected death occurs within 30 days of treatment. **Moderate harm:** If during the timeline review it is noted or considered that there is a substantial increase in symptoms, increase in medication or treatments that would not be expected to be seen in their typical pathway and may have been avoided if the time line was reduced due to the delays for investigations in pathway **Psychological harm:** This will be reviewed and considered if there is evidence that the patient has experienced symptoms severe enough to warrant intervention by specialist psychological/psychiatric services. Psychological harm will be identified following Health Needs Assessments undertaken with Clinical Nurse Specialists at specific milestones: at time of diagnosis, commencement of treatment, end of treatment and if recurrence. **Prolonged psychological harm**: Psychological harm which the service user has experienced or is likely to experience, for a continuous period of at least 28 days. **Avoidable Delays** Delays that a patient experiences that are a consequence of the organisation adding a significant length of time to carry out investigations or treatments in the absence of any unplanned or unexpected events or incidents experienced by the patient, are deemed to be avoidable **Unavoidable Delays** Delays that a patient experiences that are a consequence of an unplanned or unexpected event or incident that result in a significant time to carrying out investigations or treatment are deemed unavoidable delays. Patients may also choose to prioritise other commitments or events in preference to hospital investigations or treatment leading to delays and these are also deemed unavoidable delays. **Complex Pathway** Pathways that deviate from the national/ local agreed pathway
Authority &	The Trust Board previously has agreed to establish the Cancer 104 Day Harm Review Group

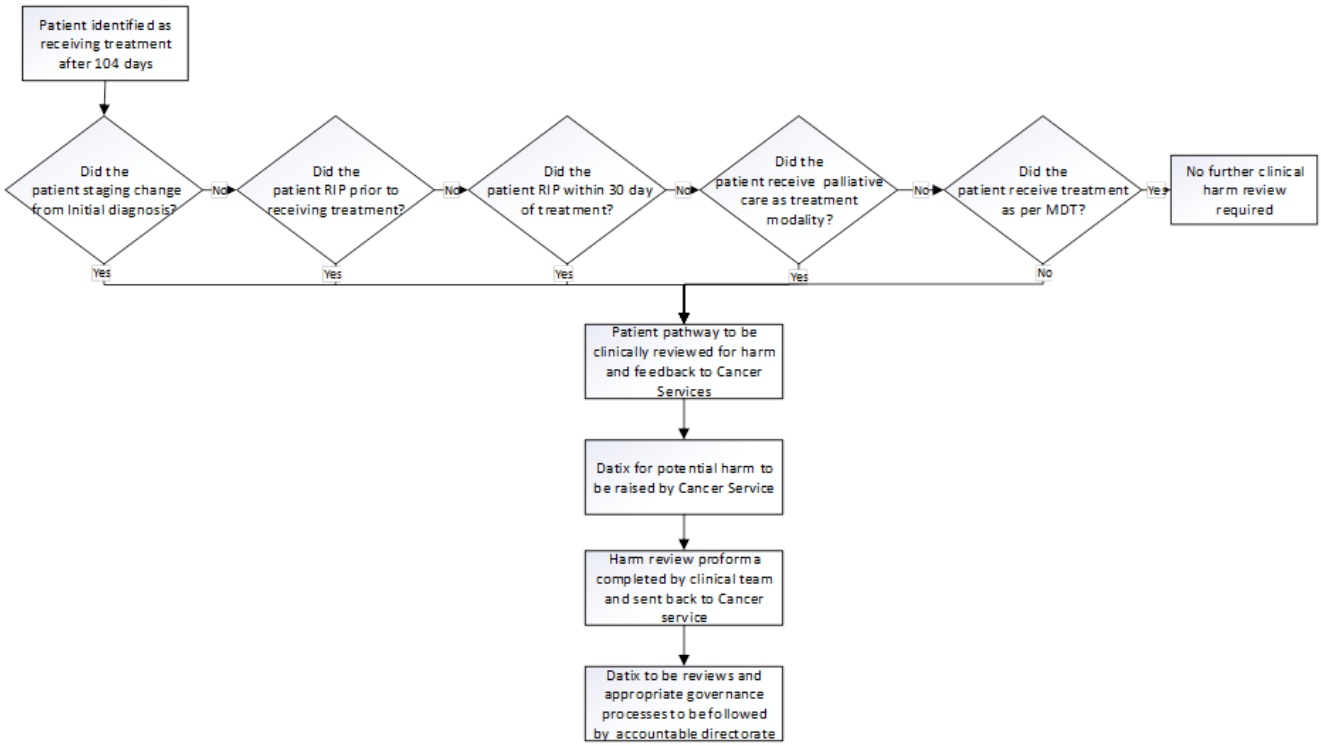
<table>
<tr><td>Accountabilities</td><td>which has advisory powers outlined in the original Terms of Reference v 3 August 2018.</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Reporting Arrangements</td><td>The Process is accountable to QSAG. A report of the meeting will be submitted quarterly basis and presented as required to the QSAG by the Trust Lead Cancer Clinician or Trust Cancer Lead Nurse who shall draw to the attention of the issues that require disclosure to the QGAC or full Board, or require executive action.

QSAG Reporting timescales.
<table>
<tr><td>Pathway completion</td><td>Report to QSAG</td></tr>
<tr><td>Q1</td><td>August</td></tr>
<tr><td>Q2</td><td>November</td></tr>
<tr><td>Q3</td><td>Feb</td></tr>
<tr><td>Q4</td><td>May</td></tr>
</table>
Any patient who requires a clinical review that RIP within 30 days of treatment will also review within the service M and M review.</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Membership</td><td>Trust Lead Cancer Clinician
Trust Lead Cancer Nurse
Head of cancer services
External Reviewer or ICB Representation Clinical Commissioner or delegated representative
Tumour Site MDT lead
Tumour Site Cancer CNS</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Frequency</td><td>There will be a monthly review of patient treated after 104days with a quarterly report submitted to QSAG. The monthly review will be in line with CWT submissions.</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Administrative support</td><td>Cancer Services</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Standards worked to</td><td>Cancer Waiting Times Good Practice Guides and relevant national publications</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Subgroup reports</td><td>Cancer Recovery Meeting</td></tr>
</table>

2. Clinical Harm – Protocol and Process

Full clinical review and validation of the patient pathway will only be required for patients where: -

- There has been a progression with the patient staging from initial diagnosis.
- The patient RIP prior to receiving treatment.
- The patient RIP within 30 days of treatments
- The patient only treatment was palliative care/ Best support care.
- The patient received a different treatment plan to that agreed within original MDT.

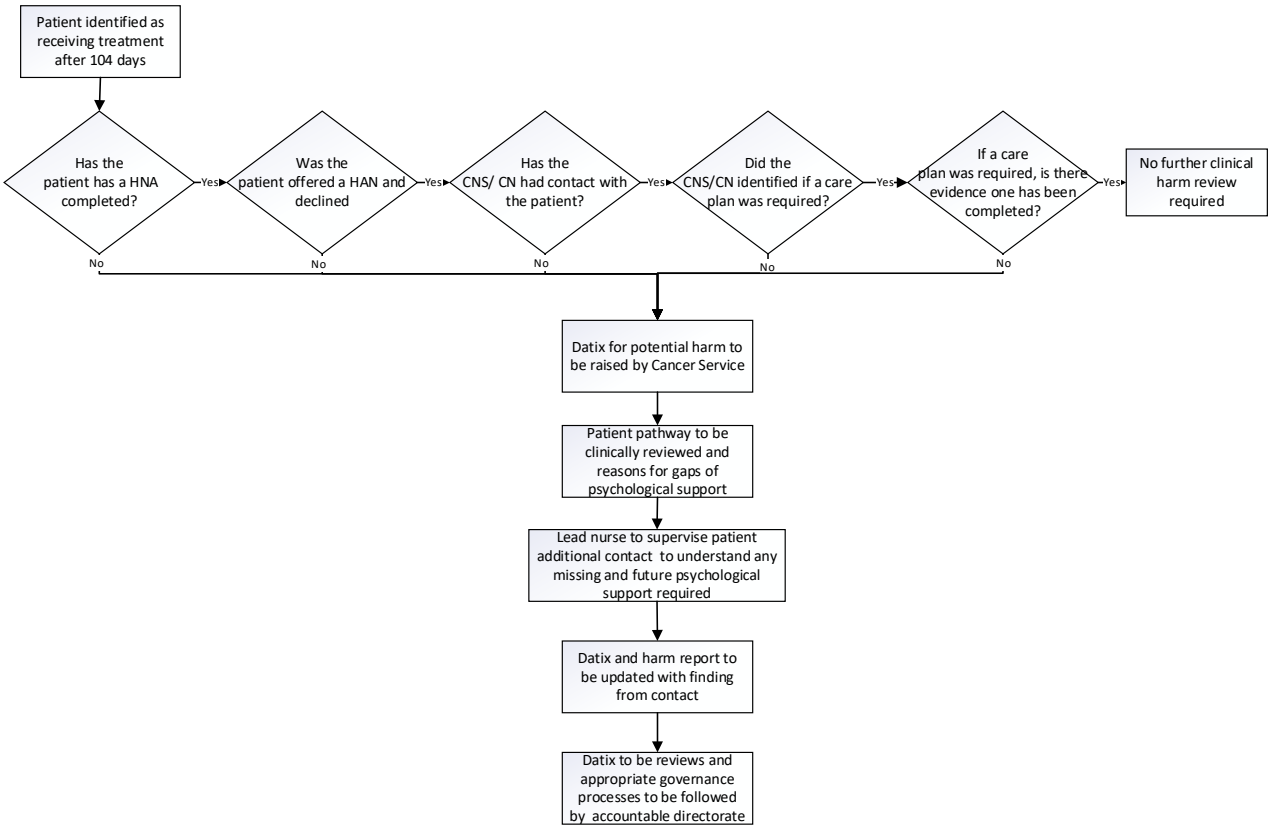


Clinical harm review Process

3.Psychological Harm – Protocol and Process

Full clinical review and validation of the patient pathway will only be required for patients where:-

- A HNA has not been completed.
- A HNA has not been offered and declined by the patient.
- The CNS/CN have not been in contact with the patient.
- The CNS/CN have not identified if a care was or was not required by the patient.
- If a care plan was required there is no evidence that one was completed.



Psychological Harm review Process

Date Approved	
Date Review	