Cancer Operational and Escalation Policy for Monitoring of Cancer Standards

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Executive Lead: Robert Peet, Chief Operating Officer

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<td>1.1</td>
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<td>Sarah Dawson, Cancer Services Manager</td>
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For more information on the status of this document, please contact: Sarah Dawson, Cancer Services Manager

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Audience: Cancer Steering Board

All staff across the health economy involved in the commissioning, referral and management of patients on a 14/31/62 day pathway

Interested members of the public, patients and their carers who may/or may not have experience of the cancer pathway.
Executive summary

The policy describes how the Trust manages access to the cancer pathways and ensures fair treatment for all patients. This document is intended for used by all staff in the local health economy dealing with patients on a cancer pathway.

The NHS Constitution 2010 provided patients with legal entitlements with regards to their waiting times for treatment from 1st April 2010. All patients should receive high quality care without any unnecessary delay. Patients can be expected to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, will be able to receive treatment more quickly. Organisations’ performance is monitored across all waiting time pledges.

The policy is not intended to replace local and departmental operational policies and procedures but act as a framework to support them. It will be reviewed regularly to ensure that it accurately reflects changing local, regional and national priorities.

The over-riding principle is that of getting all cancer patients treated and not keeping them waiting. The process for managing the cancer pathways must be transparent to the public.
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See also: Any relevant trust policies/guidelines or procedures
1. Introduction

1.1 Ashford and St Peter’s Hospitals Foundation Trust (ASPH) is committed to ensuring that all cancer patients receive treatment in accordance with the NHS Constitution, the national cancer strategy, national and regional objectives and targets. ‘Improving Outcomes: A Strategy for Cancer’ confirmed that cancer waiting times remain an important issue for cancer patients and the NHS should continue to ensure that cancer services are delivered to patients in a timely manner. There are a number of government pledges on waiting times set out in the Handbook to the NHS Constitution that NHS providers are expected to meet:

1.1.1 A patient’s right to be seen by a specialist within a maximum of 2 weeks from GP referral for urgent referrals where cancer is suspected.
1.1.2 A maximum 2 week wait to see a specialist for all patients referred for the investigation of breast symptoms, even if cancer is not initially suspected.
1.1.3 A maximum 1 month (31 day) wait from an urgent GP referral for suspected cancer to first treatment for acute leukaemia, testicular cancer and children’s cancers.
1.1.4 A maximum of 1 month (31 day) wait from decision to treat to first definitive treatment for all cancers.
1.1.5 A maximum 31-day wait for subsequent treatment where the treatment is surgery.
1.1.6 A maximum 31-day wait for subsequent treatment whether the treatment is a course of radiotherapy.
1.1.7 A maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer regimen.
1.1.8 A maximum two month (62 day) wait from urgent referral for suspected cancer to first treatment for all cancers.
1.1.9 Maximum 62 day wait from referral from an NHS screening service (Breast, Cervical and Bowel) to first definitive treatment for cancer.
1.1.10 Maximum 62 day wait for first definitive treatment following a Consultants decision to upgrade the priority of the patients (all cancers).

1.2 The overall aim of the policy is to ensure patients are treated in a timely and effective manner, specifically to improve the quality of the patient experience and allow patients to maximise their right to patient choice in the care and treatment they need.

2. Scope

2.1 This policy relates to all patients with suspected, diagnosed or recurrent cancer and those referred via an NHS screening program (Breast, Cervical or Bowel) and healthcare professionals and administration staff who care for these patients within Ashford and St Peter’s Hospitals NHS Foundation Trust.

3. Purpose

3.1 The purpose of the policy is to ensure the Trust has procedures and protocols in place for the management of all patients on a cancer pathway and that all healthcare professionals and administrative staff, who care for and manage pathways for patients with suspected or diagnosed cancer understand their responsibilities and duties in achieving the Going Further On Cancer Waits (GFOCW) targets.
3.2 This policy ensures that individual patient cases are managed in a way that supports good clinical practice and is fully consistent with the fundamental principles of the NHS.

4. Definitions

4.1 The 31 day standard application

4.1.1 NHS patients with a newly diagnosed invasive cancer with ICD 10 codes C00-C97, excluding basal cell carcinoma (localised or metastatic) as well as all breast patients diagnosed with carcinoma in situ, ICD10 code D05.

4.1.2 NHS patients with a recurrence of a previously diagnosed cancer, as above.

4.2 The 62 day standard application

4.2.1 Referred under the two week rule referral route by their General Practitioner (GP) or General Dental Practitioner (GDP) with suspected cancer.

4.2.2 Referred to a specialist due to breast symptoms, irrespective of whether cancer is suspected.

4.2.3 Referred where cancer is suspected from any of the three national cancer screening programs, Breast Cervical or Bowel.

4.2.4 A patient upgraded by a Consultant or authorised member of their clinical team because cancer is suspected.

4.2.5 Referred on suspicion of one cancer but with incidental diagnosis of a different cancer.

4.2.6 Patients remain on the 62 day pathway until they have been informed that cancer has been excluded. Patients excluded from the 62 day pathway will then continue on the 18 week pathway and will be managed in accordance with the Trusts Joint Access Policy.

5. Duties and responsibilities

5.1 General principles

5.1.1 Responsibility for cancer waiting times will be integrated throughout the organisation.

5.1.2 The specialty/tumour site management team is responsible for ensuring the clinical service runs efficiently; there is sufficient capacity to meet demand, clinicians adequately prepare patients for each step of their cancer pathway.

5.1.3 The cancer core team is responsible for ensuring that MDT coordinators escalate any identified capacity issues to the service, that cancer patient tracking is undertaken in a conscientious and timely manner and concerns are escalated to speedy resolution by the tumour site management team.

5.2 Specific roles and responsibilities

5.2.1 Chief Executive - The overall responsibility for this policy in the Trust rests with the Chief Executive who is ultimately accountable to the Trust Board for ensuring that effective processes are in place to manage cancer patient pathways that meet national, regional, local and NHS Constitution targets and standards and for achieving those standards.
5.2.2 **Executive Directors** - The Trust Executive team is responsible for ensuring effective delegation of responsibilities within their areas of responsibility and effective support of their managers’ decisions and recommendations in terms of the provision of appropriate resources.

5.2.3 **Lead Cancer Clinician** - Designated clinical lead with an overall responsibility for ensuring high standards of cancer clinical care across the organisation in a timely manner, leading the development of the cancer strategy with director, managerial and clinical support. Has professional management responsibility for the Multi Disciplinary Team (MDT) clinical leads in their roles as such, responsible for delivery of CWT within their tumour site.

5.2.4 **Lead Cancer Nurse** - Has co-responsibility for facilitating the delivery of CWT. To develop the cancer nursing strategy, includes a lead role in coordinating peer review.

Has direct/direct/professional line management responsibility for cancer specialist nurses within the organisation who in turn have a role to play in supporting patients through their cancer pathways in a timely manner.

5.2.5 **Cancer Services Manager** - The Cancer Services Manager will ensure that all cancer services core team staff involved in cancer-pathway tracking are aware of this policy and the importance of following the procedures. Training will be provided to the cancer services core team on this policy together with the Trust’s Access Policy. Training will also be provided to new members of the team at induction.

Is accountable for ensuring that the patient pathway is validated prior to upload to the national cancer waiting time database, demonstrating a true and accurate waiting time for each patient.

Generally responsible for ensuring that the cancer services team is sufficiently resourced and trained to carry out their duties to the standards required by this policy for the anticipated volume of patients.

Responsible for reviewing this policy.

5.2.6 **Cancer Data and Performance Manager** - Ensures that the processes outlined in this document are implemented and adhered to, without deviation by the cancer pathway coordinating team, on a day-to-day basis.

Has a joint responsibility to ensure that the patient pathway is validated prior to upload to the national cancer waiting time database, demonstrating a true and accurate waiting time for each patient.

Will ensure that refresher training on this policy and the Trust’s Access Policy is included within the cancer services core team annual training programme, in order to maintain skills and knowledge.

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

5.2.8 **MDT Clinical Lead** - A named lead from the MDT assigned for each of the tumour sites (as per peer review requirements). Accountable for CWT delivery, management of the PTL (including data quality and completeness), breaches avoidance and learning (with support from the relevant senior specialty manager, e.g. service manager).

5.2.9 **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.

Clinicians must complete an ‘upgrade’ form if they wish to upgrade patients to the national 62-day target or alternatively request the patient is upgraded on SCR.

Clinicians must sign a ‘step down’ form, if they believe it is clinically appropriate to step the patient off a national cancer 62-day pathway.

5.2.10 **Divisional Management Teams** - The Divisional management teams have a responsibility to ensure that adequate capacity is available for all patients added to all waiting lists to enable the Trust to achieve the required local and national cancer standards, responding in accordance with the escalation policies.

The Divisional management teams have a responsibility to ensure that their respective clinical teams have robust processes in place in order to enable cancer patients are added to the waiting list in a timely and consistent manner.

5.2.11 **Out-patient Administrative Clerks / Receptionists** - The outpatient administrative clerks / receptionists have a responsibility to ensure that the data entered onto PAS 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 IPM / PAS accurately reflects the information provided by the clinical teams on the clinic-outcome pro forma.

5.2.12 **Senior Information Analyst (Cancer)** - The Senior Information Analyst (Cancer), in conjunction with the Cancer Services Team, has a responsibility to ensure that the patient pathway is validated prior to upload to the national cancer waiting time database, demonstrating a true and accurate waiting time for each patient.

5.2.13 **AD Performance** - The AD of Performance will support and oversee the performance management of the Trust’s performance commitments, ensuring appropriate performance management systems are in place at corporate and local level to support the efficient and effective management of the Trust’s divisions. The post holder will also support the Associate Directors of Operations, Head of Informatics, and Service Managers to identify performance and potential performance issues and ensure appropriate recovery and/or mitigation plans are in place.
6. Governance

6.1 Data quality checks

Clean data is crucial for effective pathway management and critically important prior to mandatory upload to the National Cancer Waiting Times database.

6.1.1 SCR data quality reports
The integrated data quality reports within SCR will be fully utilised to allow data conflicts to be flagged and resolved in good time. These checks will be run in good time ahead of data submission to Open Exeter.

The Cancer Data and Performance Manager will see that the running of these reports is undertaken weekly by the relevant MDT co-ordinator. The outputs and actions required will be reviewed as a standing item at the weekly cancer PTL meeting.

6.1.2 DQ spot audits
A programme of spot check audits will be undertaken of what is contained in the hospital record versus what is entered into SCR and PAS. These validation checks also act as a tool to identify where staff training and supervision may be required and will highlight any divergence form national rules guidance.

The Cancer Data and Performance Manager will oversee this audit programme which will select two specialties to every two months. The outputs and actions required will be reviewed at the Cancer Board.

6.2 Managing conflicts of interest

6.2.1 The organisation will adhere to best practice governance principles around avoiding conflicts of interest in the case of self-reporting performance data. There will be a separation of duties and responsibility in respect of personnel undertaking the following:

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<td>Cancer Services Manager; Trust performance management framework</td>
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<tr>
<td>Breach reporting</td>
<td>Cancer Services Manager; MDT Leads; Cancer Board</td>
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6.3 Board assurance/reports

6.3.1 Cancer performance will be included in the monthly Trust Board and Financial Management Committee reports. Performance will be reported at specialty level.
7. Operational processes

7.1 General principles

7.1.1 All patients with suspected or diagnosed cancer will be managed in line with NHS cancer targets.
7.1.2 Due to the tight timescales involved, the organisation will operate systems and processes designed to ‘pull’ cancer patients along their diagnosis and treatment pathways.
7.1.3 All relevant patients will be added to the Somerset Cancer Registry Database (SCR) which will hold full and comprehensive records for each patient.
7.1.4 Patients will be tracked against the appropriate local and national standards and any bottlenecks or pathway breaches will be actioned and/or escalated as appropriate.
7.1.5 Compliance/breaches of target will be reported in line with national reporting guidance.

7.2 Receiving referrals

7.2.1 All referrals are to be made using standardised cancer referrals proformas and issued to the ASPH appointment centre.
7.2.1 On receipt of referral, the Appointment Centre Red Team will record on PAS the patient details, the date that the referral was sent and the date that the referral was received and they will send a fax confirmation of receipt of referral to the relevant referring GP/GDP.
7.2.2 Cancer referrals will be categorised as the appropriate priority type and will be listed on the Somerset A1 list indicating a TWR first appointment is required.
7.2.3 If the referral form is incomplete or clearly does not meet the national criteria, this will be immediately returned to the GP/GDP, by the Two Week Wait Clerk, for amending.
7.2.4 If the referral does not meet national guidance, it can only be downgraded following discussing and agreement between the GP and specialty Consultant. If agreement is reached this must be clearly documented in patient’s notes. If no discussion or agreement patient must still be seen within 14 days.
7.2.5 All TWR referrals other than Breast, Dermatology, Urology, Gynaecology and Chest will be sent for triage by the relevant consultant team which will determine the most appropriate clinic for the first appointment and whether the patient is suitable for straight-to-test diagnostics. This process will be undertaken within 24 hours of the receipt of referral.

7.3 Adding patients to SCR

7.3.1 Referral details for all patients referred to ASPH by their GP/GDP as a suspected cancer (all tumour groups) and all symptomatic breast referrals will automatically transfer from PAS to SCR once the first appointment has been attended.
7.3.2 For pathways commencing with a ‘straight to test’ (STT) diagnostic, other than endoscopy the Cancer Services team will manually enter the patient demographics and STT appointment details into SCR.
7.3.3 If at any stage a Consultant triggers the 62 day upgrade process, the Clinical Office team or Cancer Services team will notify the appointment centre of the need to change the priority type and this pathway will be added to the A2 list.
7.3.4 Any new additions to the elective waiting list for patients with suspected or diagnosed with new or recurrent cancer will be reviewed at the weekly PTL meeting.

7.3.5 Patients undergoing subsequent treatment for cancer (and therefore recordable against the 31 day target) will be highlighted at the relevant MDT meeting. It will be the responsibility of the relevant MDT co-ordinator to ensure that the details of any subsequent treatment are added to SCR.

7.4 Booking first appointments

7.4.1 All referrals should be considered as being referred to a team, not to an individual consultant.

7.4.2 The first appointment booking process will commence following any relevant triage from the consultant team.

7.4.3 Priority will be given for the patient to be seen within 14 days. The Trust has an internal ‘stretch’ target of 7 days and aims to offer patients a first appointment within 7 days. For further details please refer to Trust joint access policy

7.4.4 Each specialty is responsible for agreeing the booking rules for their service with the two week wait office. This will be regularly reviewed by the Directorate management teams to ensure that adequate provision is made to accommodate demand.

7.4.5 For outpatient clinic appointments, the Appointment Centre Red Team will identify a potential date and telephone the patient to agree the appointment date and time. Written details will be sent to the patient to confirm the appointment.

7.4.6 For STT endoscopy appointments, the Endoscopy booking office will identify a potential date and telephone the patient to agree the appointment date and time. Written details will be sent to the patient to confirm the appointment.

7.4.7 For STT Imaging appointments, the Imaging booking office will identify a potential date and telephone the patient to agree the appointment date and time. Written details will be sent to the patient to confirm the appointment.

7.4.8 The Trust commits to seeing patients at their first appointment as soon as possible and within a maximum of 14 days; to assist with this commitment, the booking of all first appointments should follow recommended booking guidance where appropriate.

7.5 Diagnostic investigations (Imaging and Endoscopy)

7.5.1 Wherever possible a request should be made immediately at the patient’s outpatient appointment (or following triage in the case of STT) and should be marked priority 2ww so that the Imaging/Endoscopy department is alerted to the urgency.

7.5.2 Patients requiring radiological/endoscopic investigations will be actively monitored by the MDT Co-ordinator to ensure their appointment will allow enough time to treat the patients if required.

7.5.3 Investigations for suspected cancer patients will be clearly indicated on the relevant request form, preferably by use of the appropriate green ‘TWR’ sticker.

7.5.4 Imaging/Endoscopy booking clerks will then allocate an appointment within a maximum of 14 days. The departments will work to the Trust’s internal stretch target of 7 days wherever possible.

7.6 Tertiary Referrals

7.6.1 MDT Co-ordinators will ensure that notification of a referral is sent to the receiving organisation within 24 hours of the MDT meeting or clinic at which a referral is decided. A copy of the clinic letter or MDT proforma will be sent to the appropriate
department. The MDT Coordinator will record the date the referral is sent on SCR and update at weekly PTL meeting any patients referred over day 42.

7.6.2 Referrals will be sent via the SCR E tertiary referral form as soon as this function is available on SCR.

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

7.6.4 Clinicians should ensure that the clinical referral is dictated, typed and faxed to the treating Trust within 2 working days of the MDT meeting where the transfer was agreed. This is to ensure that referrals are dealt with promptly and do not get delayed or lost in the post.

7.6.5 All tertiary referrals should be made by day 42 to give the treating Trust time to see the patient, plan and book their treatment with the 62 days. The Trust has an internal 'stretch' target of day 35 for tertiary referrals and is currently awaiting national guidance of agreed day of referral within a breach reallocation policy.

7.6.6 ASPH must seek confirmation of receipt of referrals from the tertiary centre and review these at weekly virtual PTL meetings with partner organisations. The inter-provider transfer date is the date when the provider due to receive the patient receives the transfer request for the patient. This will not necessarily be the date when the patient files/records are received, as stated in NCWT Guide Version 9.0.

8. Escalation processes

8.1 Outpatient first appointment capacity

8.1.1 If the Appointment Centre anticipates that an appointment cannot be made inside the relevant internal waiting time standards, this will be escalated to the relevant Service Manager or deputy within 24 hours.

8.1.2 All escalations should be emailed in the first instance with copies to the #Cancer Services mailbox.

8.1.3 The Service Manager or deputy will acknowledge the escalation within 24 hours.

8.1.4 The specialty management team are expected to ensure that all avenues have been considered to give the patient an appointment with a maximum of 6 days after the receipt of the referral.

8.1.5 If an appointment cannot be secured within 14 days, the relevant Service Manager or deputy will be responsible for informing the ADO no later than 4 days following receipt of the referral, to allow time to consider alternative arrangements for that patient.

8.1.6 All escalations will be monitored by the MDT Coordinator or MDT Support Coordinator daily via the A1 list which will be sent out to Service Managers and their teams via email. The A1 list will be summarised and submitted by the Cancer Services Manager for review at the weekly Trust Performance Committee.

8.2 STT diagnostic capacity – Endoscopy

8.2.1 If the date of the test is 15 days or more from the request date this should be escalated to appropriate Service or deputy.

8.2.2 If an appointment cannot be secured within 14 days, the relevant Service Manager or deputy will be responsible for informing the ADO no later than 4 days following receipt of the referral, to allow time to consider alternative arrangements for that patient.
8.2.3 All escalations will be monitored by the MDT Coordinator or MDT Support Coordinator daily via the A1 list which will be sent out to Service Managers and their teams via email. The A1 list will be summarised and submitted by the Cancer Services Manager for review at the weekly Trust Performance Committee.

8.3 STT diagnostic capacity – Imaging

8.3.1 If an appointment cannot be booked within 14 days of the request date then the booking clerk needs to escalate this to the relevant Service Manager or deputy.

8.3.2 If an appointment cannot be secured within 14 days, the relevant Service Manager or deputy will be responsible for informing the ADO no later than 4 days following receipt of the referral, to allow time to consider alternative arrangements for that patient.

8.3.3 All escalations will be monitored by the MDT Coordinator or MDT Support Coordinator daily via the A1 list which will be sent out to Service Managers and their teams via email. The A1 list will be summarised and submitted by the Cancer Services Manager for review at the weekly Trust Performance Committee.

8.4 First appointment/STT patients exercising choice

8.4.1 In the event that a breach of the TWR standard (and resultant delay to a 62 day pathway) is expected due to a patient exercising their right to choose a date beyond 14 days, the relevant MDTC will escalate this at the weekly cancer PTL meeting where the CNS intervention will be considered.

8.4.2 At the discretion of the Cancer Services team, the process described in 8.4.1 will also be followed in the event that an undue delay as a result of patient choice is experienced at any other point in a cancer pathway.

8.5 Delays to diagnostic reporting

8.5.1 If histopathology tests remain unreported after 10 working days, the Cancer Services team will escalate overdue reporting to the General Manager of Surrey Pathology Services.

8.5.2 If tests remain unreported within a further 48 hours the MDTC will escalate to Cancer Services Manager for reporting at the weekly Trust Performance Committee.

8.5.3 Imaging department reporting timescales will be reported at the Trust Performance Committee weekly by the Imaging department.

8.6 First treatment capacity issues (ASPH treatments)

8.6.1 A delay to first definitive treatment will be determined by an expected inability to meet the timescale between DTT and treatment date, as specified in the timed pathways.

8.6.2 The Cancer Services team will discuss any definitive treatment appointment delays or target breaches with the Central Booking Office in the first instance.

8.6.3 If the delay is not resolved within a maximum 48 hours the Cancer Services team will raise the issue with the relevant Service Manager or deputy and, if still not resolved within a further 24 hours, with the Cancer Services Manager for further escalation at the weekly Trust Performance Committee.
8.7 Delays to tertiary treatments

8.7.1 In the first instance, delays to treatment at tertiary centres will be addressed at the relevant weekly virtual PTL meetings with partner organisations. This process will encompass an escalation between respective Cancer Services Managers at each organisation.

8.7.1 In the event that delays cannot be resolved within a suitable timeframe, and specifically, if there presents a risk that a shared patient will breach as the result of a delay at a tertiary centre, an escalation should take place via the Trust Performance Committee as far as the Chief Operating Officer to allow for this to be addressed between the two organisations.

8.8 Unexpected findings of cancer

8.8.1 Unexpected findings of cancer will follow the Trust’s guidance on this matter and be notified to the patient’s GP with a copy going to the two week wait office. The patient’s GP is then expected to refer the patient immediately as a two week wait.

9. Performance monitoring

9.1 Patient tracking

9.1.1 A detailed patient list will be maintained for the purposes of patient tracking. This will include all patients currently on a 31 or 62 day pathway and allowing filtering by tumour site.

9.1.2 Cancer Services will maintain the tracking tools via SCR and ensure that all staff are able 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, at all times.

9.1.3 In combinations with the tumour site timed pathways, the patient tracking process will make it clear which patients are currently at risk of missing a milestone on their pathway.

9.1.4 As set out in the Cancer Services SOPs, this report will operate as a live tracking system.

9.2 Timed pathways

9.2.1 Where applicable, progress will be monitored against agreed timed pathway milestones, designed to deliver the specific tumour site pathway within 62 days.

9.3 MDT meeting

9.3.1 MDT meetings will function with a dual purpose of ensuring sound clinical decision making as well as discussing the patient pathway – all teams should make time for this formally as part of the agreed minimum dataset for each patient discussed at the MDT meeting.

9.3.2 Real-time data entry of information - to support both cancer waits and national audit requirements – will be undertaken in each tumour site MDT meeting.

9.3.3 MDT meeting agendas will contain breach dates where applicable.
9.4 Cancer PTL

9.4.1 A report to support the PTL meeting will be generated. This will be produced to patient level and will include the necessary details of all patients requiring review and/or escalation; to include, as a minimum, patients at risk of breaching the following in line the agreed timed pathways:

- Two Week Wait appointments (this may be less than 14 days depending on the local pathway/ organisational stretch targets)
- Diagnostic tests
- Diagnosis
- MDT discussion
- Transfer to a tertiary provider
- Date of decision to treat
- Treatment
- 104 day backstop policy

9.4.2 The cancer PTL will also report in aggregate how many patients are waiting at each key pathway milestones.

9.4.3 Escalation of delays and/or incomplete actions not carried out within 48 hours of cancer PTL will be to the relevant ADO to ensure completion within 24 hours.

9.4.4 Escalation from tertiary PTL’s will be made to the relevant ADO in the first instance and COO if necessary.

9.5 Breach analysis and reporting

9.5.1 Breach analysis will be undertaken with the aim of distinguishing between unavoidable breaches (e.g. patient choice, complex diagnostic pathways, clinical exceptions) and avoidable breaches due to administrative and capacity issues.

9.5.2 Breach analysis will be undertaken for patients breaching the 31 day and 62 day pathway standards.

9.5.3 Regular breach analysis will also be undertaken against ‘near-misses’ of these standards. A near miss will be determined by treatment taking place after day 60.

9.5.4 In declaring that the primary reason for a breach is legitimately the result of patient choice or patient non-cooperation, it must be demonstrable that the patient generated the delay by asking to wait longer.

9.5.4 Where breaches were not for clinical reasons or patient choice (i.e. avoidable breaches), analysis will identify where there are systemic problems which need to be understood and addressed in order to eliminate unnecessary waits and introduce improvements in patient experience.

9.5.5 Any patient exceeding 104 days on a cancer pathway will be subject to a clinically led investigation of potential harm. This will be co-ordinated by the Trust Lead Cancer Clinician and cases will be notified to the Trust Medical Director.
10. Stakeholder engagement and communication

10.1 The following stakeholders were consulted during the production of this policy:
   Chief Operating Officer
   Trust Lead Cancer Clinician
   ADO Medicine
   Head of Performance

10.2 Communication of this policy will be done via the following methods:

   10.2.1 This policy will be disseminated through Aspire & global email
   10.2.2 Cancer Steering board
   10.2.3 Weekly Cancer PTL meeting

11. Approval and Ratification

11.1 This policy will be approved by the Trust Cancer Board.
11.2 The policy will be ratified by Trust Executive Committee.

12. Dissemination and Implementation

12.1 This policy will be published on the Trust intranet and internet sites.
12.2 All staff should adhere to the policy.

13. Review and Revision Arrangements

13.1 This policy will be reviewed every three years, or before if needed. This will be the
   responsibility of the Cancer Services Manager.
13.2 Triggers for early review may include a change in legislation, national guidance or local
   practice. Please note this is not an exhaustive list.

14. Document Control and Archiving

14.1 This is a trust-wide document and archiving arrangements are managed by the Head of
   Regulation & Accreditation and Information Content Manager who can be contacted to
   request master/archived copies.
14.2 On the intranet site, the document will be highlighted as green, when in date, amber 3
   months prior to review date, and red if expired.
14.3 Responsibility for archiving trust-wide policies lies with the Head of Regulation &
   Accreditation.
14.4 Electronic folders are set up to hold master copies.
14.5 Requests for retrieval of documents can be made to the Head of Regulation & Accreditation.
### 15. Monitoring compliance with this Policy

<table>
<thead>
<tr>
<th>Measurable Policy Objective</th>
<th>Monitoring/ Audit method</th>
<th>Frequency of monitoring</th>
<th>Responsibility for performing the monitoring</th>
<th>Monitoring reported to which groups/ committees, inc responsibility for reviewing action plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance at PTL</td>
<td>Register of attendance</td>
<td>Weekly</td>
<td>CSM</td>
<td>Trust Performance Committee</td>
</tr>
<tr>
<td>Timeliness of PTL actions</td>
<td>Ongoing review</td>
<td>Weekly</td>
<td>CSM</td>
<td>Trust Performance Committee as required</td>
</tr>
<tr>
<td>Monitoring of general policy compliance</td>
<td>Ongoing review</td>
<td>Weekly</td>
<td>CSM</td>
<td>Trust Performance Committee as required and ad-hoc escalation to ADO as required</td>
</tr>
</tbody>
</table>
APPENDICIES

Equality Impact Assessment Summary

Name of Author Sarah Dawson
Policy/Service: Cancer Operational and Escalation Policy for monitoring of cancer standards

Background
- Description of the aims of the policy
- Context in which the policy operates
- Who was involved in the Equality Impact Assessment

This policy is intended for use by all staff in the local health economy dealing with patients on a cancer pathway.

The main aim of this policy is to provide a framework for staff to escalate any issues in getting cancer patients diagnosed and treated within national and local target timescales.

This policy will not replace existing local and departmental operational policies and procedures but act as a supporting document.

The policy will be available to all staff at any time on the intranet and should be followed and adhered to at all time. It will be reviewed regularly to ensure that it accurately reflects changing local, regional and national priorities.

This impact assessment has been carried out by the Cancer Services Manager, Sarah Dawson with full involvement from the Trust Lead Cancer Clinician, Sarah Burton.

Methodology
- A brief account of how the likely effects of the policy were assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age)
- The data sources and any other information used
- The consultation that was carried out (who, why and how?)

This policy is not discriminatory in any way but is for all patients on a cancer pathway irrelevant of race / gender / belief etc.

Consultation was carried out with the Trust Lead Cancer Clinician, Divisional ADO’s and the Head of Performance.
## Key Findings
- Describe the results of the assessment
- Identify if there is adverse or a potentially adverse impacts for any equalities groups

It was not felt that these guidelines have any discriminatory factors or adverse outcomes for any equalities groups.

## Conclusion
- Provide a summary of the overall conclusions

This policy is aimed at providing a structured process for escalating any issues on a cancer patient’s pathway and to help staff identify the correct channels and timeframes for escalation. There will be no adverse outcomes for equalities groups and the policy is not discriminatory. They have been reviewed and approved by the relevant Trust staff.

## Recommendations
- State recommended changes to the proposed policy as a result of the impact assessment
- Where it has not been possible to amend the policy, provide the detail of any actions that have been identified
- Describe the plans for reviewing the assessment

No obvious adverse impacts identified. A 6 month review will be undertaken following implementation.
Guidance on Equalities Groups

<table>
<thead>
<tr>
<th>Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)</th>
<th>Religion or belief (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)</td>
<td>Sexual orientation including lesbian, gay and bisexual people (consider whether the policy/service promotes a culture of openness and takes account of individual needs)</td>
</tr>
<tr>
<td>Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)</td>
<td>Age (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)</td>
</tr>
<tr>
<td>Culture (consider dietary requirements, family relationships and individual care needs)</td>
<td>Social class (consider ability to access services and information, for example, is information provided in plain English?)</td>
</tr>
</tbody>
</table>