Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/GS/ID 6120

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Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Cancer Services and Radiotherapy policies.

You asked:

I wonder if you could get a complete copy including finance of the Trusts Cancer Policy.
On another issue, we are trying to get hold of copies of the two trusts Radiotherapy policy.

Trust response:

Please find below the current Cancer Services Access Policy and Procedure and the Radiotherapy Operational Policy as requested.

The Trust acknowledges that whilst Trust policies have a recommended review period of 4 years, or sooner if there are changes in practice, new equipment, law, national and local standards that would require an urgent review of the policy/procedure, the policy in question has been extended beyond this and the review has only recently commenced.

Please note: A policy review date is not an expiry date and a policy and procedure does not become automatically unfit for purpose solely because its review date has passed. The policy remains effective and in force.

Cancer Services Access Policy and Procedure

Requested/ Required by:	Cancer & Haematology Directorate
Main author:	General Manager – Cancer & Haematology
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Directorate:	Cancer & Haematology
Specialty:	Trust Management
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Document history

Requirement for document:	To support the monitoring and management of cancer waiting times in accordance with the latest version of the Department of Health Cancer Waiting Times Guide
Cross references:	1. Department of Health. *Cancer Waiting Times Guide* 2. National Backstop Policy (104+ day waits), NHS England 3. Going Further on Cancer Waits 4. Achieving World Class Cancer Outcomes, Cancer Research UK 5. Improving Outcomes Guidance – A Strategy for Cancer 6. Department of Health Cancer Reform Strategy 7. National Cancer waiting times Monitoring Dataset Specification 8. NHS Constitution for England, Department of Health 9. NHS England, A&E Attendances and Emergency Admissions 10. DOH overseas visitor guidance 11. RCGP Good Medical Practice for GPs 12. Access to Health Services for Military Veterans
Associated documents:	• Maidstone and Tunbridge Wells NHS Trust. *Patient Access to Treatment Policy and Procedure* [RWF-OPPPCS-C-TM2] • Maidstone and Tunbridge Wells NHS Trust. *Private Patient Services Policy and Procedure* [RWF-OPPP-PP-NC2]

Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	Policy created	November 2015
2.0	Updated to reflect Cancer Waiting Time Guidance Version 9. Waiting Times Guidance has mostly had repetition removed but guidelines for patient cancellations have been updated. The most significant changes in the policy to reflect this are in section 11. Job titles have also been updated.	August 2016

Policy statement for

Cancer Services Access

The purpose of this policy and procedure is to outline the Trust and Commissioner requirements for Cancer Access and Waiting Times.

The policy encompasses standard operational procedures for managing patient access to cancer services from booking, notice requirements, patients' choice and waiting list management for all stages of a referral to treatment pathway including discharge to primary care or other provider.

The intention of this policy and procedure is to ensure that referrals are handled efficiently and equitably, in line with national guidance and to ensure that the patient's best interests and wishes are at the forefront of the way Maidstone and Tunbridge Wells NHS Trust (MTW) operates.

The Trust will aim to ensure that:

- The management of patient access to services is transparent and that patients are managed, fairly, timely, accurately and according to clinical priority.
- Data is collected and recorded timely and accurately in order to support best practice and information governance standards and requirements.

This policy and procedure is applicable to all staff involved in managing and caring for a patient through their cancer pathway. All new members of staff to whom this policy is applicable will receive information and training on this document.

This policy and procedure is also made available to local commissioners and the Kent and Medway Cancer Collaborative.

Cancer Services Access Procedure

1.0 Introduction and scope

This policy and procedure describes how the Trust monitors and reports performance relating to Cancer Waiting Times and is consistent with the latest version of the Department of Health's Cancer Waiting Times Guide[1]. It includes national dataset requirements for both waiting times and clinical datasets.

It is vital that this policy and procedure is applied across all services to ensure that the Trust meets national cancer waiting time targets.

This policy aims to ensure that:

- As defined in the NHS Constitution, patients have the right to expect to be seen and treated within national operational standards ensuring timely diagnosis and treatment, equity of care and patient choice.
- Patients of the same clinical priority will wherever possible be offered dates for appointment or treatment in order, based on the number of days remaining on their cancer pathway, with the exception of patients showing flexibility to accept short notice appointments or To Come In dates (TCIs).
- All patients receive their first appointment/treatment within the targets set out in the latest version of the Department of Health's Cancer Waiting Times Guide (CWTG) taking into account clinical pathways and patient choice.
- Patients will be given reasonable notice and choice of appointments and TCI dates as defined within the policy.
- Administrative and clinical staff take responsibility for moving patients along the agreed clinical pathway in the timescale set out within this policy.
- All internal documentation/referrals clearly state all relevant target dates.
- Clinical support departments adhere to and monitor performance against agreed maximum waiting times for test/investigations in their department.
- Accurate data on the Trust's performance against the National Cancer Waiting Times is recorded in the Infoflex Cancer Database and reported to the National Cancer Waiting Times Database (NCWTDB) within nationally predetermined timescales.
- The cancer patient pathway is monitored by using Patient Administration System (PAS) functionality and Patient Tracking Lists (PTL) measuring the patient length of wait from referral to new outpatient appointment, diagnostic test and treatment. Patients on a cancer pathway are tracked using the Infoflex Cancer Database

This policy and procedure assumes all General Practitioners/General Dental Practitioners (GP/GDP) or other healthcare professional entitled to refer on the suspected cancer pathway are informing patients that they are being referred as for

suspected cancer and that it is a fast track pathway that will mean patients may be offered a series of appointments at short notice over a maximum two month period.

Related documents
The policy and procedure should be read and used in conjunction with the Trust's Patient Access to Treatment Policy and Procedure (RTT 18 weeks)

2.0 Definitions and glossary

Please note that other definitions are included throughout the document specifically within the treatment section (9.0).

- **2WW Two week wait:** The maximum waiting time for a patient's first outpatient appointment or 'straight to test' appointment if they are referred as a 62 day pathway patient.

- **31 day pathway:** The starting point for 31 day standard is the date that a patient agrees a plan for their treatment or the date that an Earliest Clinically Appropriate Date (ECAD) is effected for subsequent treatments

- **62 day pathway:** Any patient referred by a GP with a suspected cancer on a 2 week wait referral pro-forma, referral from a screening service , a referral from any healthcare professional if for breast symptoms and also where a routine referral has been upgraded by a hospital clinician must begin treatment within 62 days from receipt of referral

- **Breach:** A pathway which ends when a patient is seen/receives their first treatment outside the 14 day first seen, 62 day referral to treatment and/or 31 day decision to treat to treatment target times

- **CAU:** Clinical Administration Units. Each Operational Directorate across the Trust has a team of staff who carry out all administrative duties required to support the operational services

- **CNS:** Clinical Nurse Specialists. These use their own knowledge of cancer and treatment to co-ordinate the patient's care plan and act as the patient's 'keyworker'

- **COSD:** Cancer Outcomes and Services Dataset is the key dataset which is designed to define and deliver consistency in data recording, data submission and analysis across cancer in the NHS, including diagnostics, staging, treatment and demographic information. Data is submitted to the Cancer Registry and used for national reporting.

- **DTT:** Date of Decision to Treat. The date on which the clinician communicates the treatment options to the patient and the patient agrees to a treatment.

- **DNA:** Did Not Attend. Patients who have been informed of their appointment date and who, without notifying the hospital, fail to attend their appointment.

- **ECAD:** Earliest Clinically Appropriate Date that it is clinically appropriate for an activity to take place. ECAD is only applicable to subsequent treatments.
- **FDT:** First Definitive Treatment is the first medical intervention which is intended to remove, debulk or shrink the tumour. Where no anti-cancer treatment is planned, specialist palliative care is defined as the first definitive treatment.
- **FOBT:** Faecal Occult Blood Test. This test, which is part of the Bowel Screening Pathway, checks for hidden (occult) blood in the stool (faeces).
- **GDP:** General Dental Practitioner. These typically leads a team made up of dental care professionals (DCPs) and treats a wide range of patients, from children to the elderly.
- **GP:** General Practitioner. A physician whose practice consists of providing ongoing care covering a variety of medical problems in patients of all ages, often including referral to appropriate specialists.
- **Infoflex:** A Database system used to record all information related to patient cancer pathway by MDT co-ordinators, Clinical Nurse Specialist and Clinicians.
- **IOG:** Improving Outcomes Guidance. This is NICE guidance on the configuration of cancer services.
- **KOMS:** Kent Oncology Management System. This is the Kent Oncology service IT system that manages all patients and treatments in Oncology.
- **LMDT:** A Local Multi-Disciplinary Team Meeting where individual patients care plans are discussed and agreed taking place in only one organisation without video-links to another centre.
- **MDM:** A Multi-Disciplinary Team Meeting where individual patients care plans are discussed and agreed.
- **MDS:** Minimum Data Set. Minimum information required to be able to process a referral either into the cancer pathway or for referral out to other Trusts.
- **MDT:** A Multi-Disciplinary Team is a group of doctors and other health professionals with expertise in a specific cancer, who together discuss and manage an individual patient's care.
- **MDT Co-ordinator Multidisciplinary Team Co-ordinator:** Person with responsibility for tracking patients, liaising with clinical and CAU staff to ensure progress on the cancer pathway, attends the weekly patient tracking list (PTL) meeting, updates the Trust's database for cancer pathway patients

and assists with pathway reviews and changes. Also co-ordinates the MDT meeting and records the decision for onward progress along the cancer pathway

- **MTW:** Maidstone and Tunbridge Wells NHS Trust
- **NCWTDB:** National Cancer Waiting Times Database**.** All cancer waiting times General standards are monitored through the national Cancer Waiting Times Database.
- **Oncology:** The branch of science that deals with tumours and cancers.
- **PAS:** The Patient Administration System records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and Inpatient.
- **PTL:** Patient Tracking List. A complex spreadsheet used to ensure that cancer waiting times targets are met by identifying all patients on 62 day pathways and by tracking their progress towards the 62 or 31 day targets.
- **RCA:** Root Cause Analysis. This defines steps on a patient's pathway and identifies breach reasons. In the context of this Policy, this is not the same as the level of investigation involved in an RCA for, for example, a Serious Incident (SI)
- **SMDT**: A Specialist Multi-Disciplinary Team Meeting where individual patients care plans are discussed and agreed takes place across multiple organisations and involves support from a centre that is deemed to specialising in treating a particular tumour type.
- **TSSG:** Tumour Site Specific Group.
- **WTA**: Waiting Time Adjustment is a tool within the Cancer Waiting Time Guidance that allows Providers to add in a correction that adjusts the time a patient has been deemed to be on their referral to treatment pathway due to an element of patient choice (either a Did Not Attend for a first seen appointment or the declining of a reasonable offer for a To Come In date).

3.0 Duties

Please note that additional duties are outlined under sections 9.0, 10.0 and 11.0.

- **Chief Executive**

The Chief Executive has overall responsibility and accountability for delivering access targets as defined in the NHS Constitution and Operating Framework.

- **Chief Operating Officer**

The Chief Operating Officer is responsible for ensuring that there are robust systems in place for the audit and management of Cancer access targets against the criteria set within this Cancer Access Policy and Procedure document. The Chief Operating Officer will monitor Cancer waiting times through the Director of Operations for Planned Care as well as Directorate Performance meetings, reviewing all external reports for verification.

- **Trust Lead Cancer Clinician**

  Responsible for ensuring high standards of cancer clinical care across the organisation in a timely manner, leading the development of the cancer strategy with the Director of Operations for Planned Care, providing managerial and clinical support.

- **Trust Cancer Lead Nurse**

  Responsible for development of the cancer nursing strategy with professional line management responsibility for the Trust's cancer clinical nurse specialists and will also incorporate a lead role in coordinating peer review

- **Director of Operations for Planned Care**

  Responsible for the monitoring of performance in the delivery of the 14 day, 31 and 62 day standards alongside all cancer screening programmes and for ensuring the clinical directorate delivers the activity required to meet the cancer waiting time standards.

- **Tumour Group Clinical Leads**

  Responsible for ensuring performance of pathways are delivered and review of timelines for key steps as set out in the operational tumour pathway document.

- **General Managers**

  Responsible for the monitoring of performance in the delivery of the cancer standards and for ensuring the specialities deliver the activity required to meet the waiting list targets. They are also responsible for ensuring all patients are booked within 14 days by ensuring adequate capacity is available and reviewing twice weekly reports and resolving any breaches. In addition to this they are responsible for evaluating the impact of any process or service changes on 62 or 31 day pathways

- **Hospital Consultants**

  Consultants have a shared responsibility with their General Managers for managing their patients' waiting times in accordance with the maximum guaranteed waiting time.

- **Clinical Nurse Specialists**

  Clinical Nurse Specialists have a shared responsibility with their Consultants and General Managers for managing their patient's waiting times in accordance with the maximum guaranteed waiting time.

- **Assistant Director of Business Intelligence**

  Responsible for administering data required for managing and reporting cancer waiting times, activity and cancer outcomes. The Informatics Team ensures there is a robust Standard Operating Procedure for the external reporting of performance.

- **Cancer Access Manager**

  Responsible for monitoring delivery of key tasks by the MDT Co-Ordinators and the 2ww office team

- **Deputy Cancer Access Manager and Cancer Information Team** are responsible for running daily audits of all 2ww referrals and highlighting:

  - Patients booked to fail.
  - Patients with no appointment.
  - Any data entry issues.
  - Producing twice weekly reports for General Managers to resolve potential breaches.
  - Producing weekly reports showing compliance with 2ww standard in preceding week for discussion at weekly PTL meeting

- **2ww Office team and those Designated to make 2ww Outpatient Appointments**

  Responsible for receiving 2ww and breast symptom outpatient referrals and ensuring they are managed to comply with the Cancer Access Policy and Procedure document and in line with their job descriptions.

- **Booking Clerks/Medical Secretaries**

  Responsible for ensuring waiting lists are managed to comply with this Policy and Procedure document and in line with their job descriptions.

- **MDT Co-ordinators, Oncology Co-ordinators and Data Clerks**

  Responsible for monitoring the cancer pathway for patients following the 1st attendance, ensuring it is managed in line with this Policy and assisting in the pro-active management of patient pathways on PAS and Infoflex.

- **All staff (for whom this document applies)**

  All staff have a duty to comply fully with this Policy/Procedure and responsible for ensuring that they attend all relevant training offered
  All staff are responsible for bringing this policy to the attention of any person not complying with it.

  All staff will ensure that any data created, edited, used, or recorded on Trust IT systems within their area of responsibility is accurate and recorded in

accordance with this policy and other Trust policies relating to collection, storage and use of data in order to maintain the highest standards of data quality and maintain patient confidentiality.

All 2ww patient referrals, diagnostics, treatment episodes, and waiting lists must be managed on the Trust's PAS, Infoflex and KOMS systems. All information relating to patient activity must be recorded accurately and in a timely manner.

4.0 Training / competency requirements

All staff involved in the cancer pathway will be expected to undertake initial cancer waiting times training within the first 3 months of appointment within the Trust and regular updates will be provided.

- All MDT Co-ordinators should have quarterly training.
- The Cancer Access Manager is responsible for arranging relevant training.
- Training records are kept on the Database for Cancer Services, which is located on the Cancer shared G drive.

4.1 Infoflex cancer database training

Dependent on the individual user needs and access level required a member of the Cancer Information Team will arrange for the user to attend a training session or meet with them on an individual basis.

Staff will not be granted read/write access to the Infoflex Cancer Database system without the appropriate level of training being undertaken. There is a register of these users kept by the Cancer Information team, which is reviewed annually.

The Kent and Medway Cancer Collaborative has a responsibility to provide technical training for those who require it included within the funding allocated to the collaborative.

5.0 Cancer waiting times standard

The following list outlines the key cancer waiting times standards that the Trust must be compliant with

- All patients referred on a 2ww pro forma from GP/GDP with suspected cancer will be seen within 14 days of receipt of referral.
- All patients referred with breast symptoms will be seen within 14 days of receipt of referral.
- All patients referred by GP/GDP as suspected cancer or breast symptomatic who are subsequently diagnosed with cancer will commence treatment within 62 days of receipt of referral.
- All patients referred from screening programmes (bowel, breast, cervical) as suspected cancer who are subsequently diagnosed with cancer will commence treatment within 62 days of receipt of referral.

- All patients referred to the Trust as suspected cancer should be referred using the correct pro-forma.
- All patients who are upgraded by Consultants as suspected cancer will commence treatment within 62 days of the date of the upgrade.
- All patients diagnosed as a new cancer will receive treatment within 31 days of decision to treat (DTT), irrespective of treatment.
- All patients who are having a subsequent treatment for cancer will receive treatment within 31 days of the DTT or ECAD.

6.0 GP/GDP suspected cancer 2 week wait (2ww) referrals

- All suspected cancer referrals should be referred by the GP/GDP on the relevant cancer pro-forma provided and submitted via E-referral or Email via the Generic address: mtw-tr.KOC-Cancer-2WW@nhs.net
- All patients must be offered, and provided with, an appointment to be seen within 14 days of receipt of referral to comply with national standards and day 0 is the date the referral was received.
- The first appointment can be either an Outpatient appointment with a Consultant or investigation relevant to the referral i.e. 'straight to test'
- All 2ww referrals will be checked for completeness of the Minimum Data Set (MDS) by the 2ww team within 24 working hours of receipt of referral
- For 2ww referrals received by the Trust without the MDS the 2ww team will contact the relevant GP surgery by phone within 48 hours of receipt of referral to obtain the missing information. The referral process should begin i.e. OPA booked for patient whilst information is being obtained to ensure no delay is caused to patients pathway
- Persistent failure to provide a suspected cancer pro forma without the MDS will be result in the pro formas being returned to the GP practice and an appointment will not be booked until the pro forma is returned and the MDS is complete.
- Any 2ww referral received by the Trust for a service that the Trust is not commissioned to deliver will be sent electronically to an appropriate local provider with a copy for information sent electronically to the referring GP within 24 hours of receipt
- Any 2ww referral received inadvertently by the Trust which were meant for another Trust will be sent electronically to the intended provider with a copy for information sent to the referring GP electronically within 24 hours of receipt

- Where appropriate supplementary patient information leaflets are sent with 2ww appointment letters

- All patient pathway information is available via the Kent & Medway Cancer Collaborative website and patients can be directed to this if they require further information

6.1 Rare cancers
Rare cancers (children's, testicular and acute leukaemias) need to be treated within a 31 day period from receipt of referral rather than a 62 day period. Therefore the first appointment should be offered within the local standard of seven days from receipt of referral to ensure treatment target can be met.

6.2 Escalation
If an appointment is not available within 14 days of receipt or the first appointment offered is declined and another appointment is not available, the escalation process in Appendices Four and Five should be applied.

For departments that book their own appointments i.e. if a patient is to go straight to test in endoscopy, the 2ww wait office will enter the referral onto PAS within 24 hours of receipt and send the referral electronically through to the relevant department. If no appointment has been booked within seven days of receipt of referral, an email will be sent through to the department responsible for booking the appointment and copied to relevant managers within Cancer Services.

6.3 Breach reasons

- **Patient's choice**

  A patient must be offered two appointments within the 14 day target, and only if they decline both appointments offered can a breach reason of 'patient choice' be selected. This does not mean that the patients will be referred back to their GP, only that the reason for their breach of the 2ww standard will be recorded as 'Patient Choice'.

  All details of appointments offered must be entered in the additional information on both PAS and the Infoflex Cancer Database.

- **Outpatient capacity inadequate**

  If an appointment is not available within target time, or the patient declines the first appointment and a second appointment is not available within target time, the breach reason should be entered as "outpatient capacity inadequate". All details of appointments offered must be entered into the additional information on both PAS and Infoflex Cancer Database.

- **Patient cancellation**

  If a patient cancels their appointment, every effort must be made to rebook the appointment within the 14 days of receipt of referral. Patients who are unable to be booked within the 14 days from referral due to ill health, social or other reasons should be offered an appointment for when they will be available to attend outside of the 14 day target (waiting time adjustments may

apply – see **11.0 Waiting time adjustments**)

If it is not possible to offer an appointment either due to time constraints i.e. the patient cancelled on day 13 of pathway or no second appointment was available to offer within the target time, then the escalation process must be followed (see Appendices Four and Five)

Patients who cancel after day 11 of the pathway should be immediately booked into the next available appointment within 2 weeks, to reduce the impact on the 62 day pathway and prevent further pathway delays.

If the patient breaches the 2ww target the breach reason should be entered as "patient cancellation" and all information regarding the cancellation and alternative date offered should be entered on PAS and Infoflex Cancer Database.

- **Other reasons**

  For all other reasons i.e. clinical cancellation, administrative delay or other, the General Manager (or delegated deputy) will undertake a Root Cause Analysis and agree the breach reason prior to validation by the Cancer General Manager and upload to the NCWTD.

- **Patient DNA**

  Please see section 11.4

6.4 Upgrading referrals to 2ww

If the referral letter has, in the GP's opinion, not met the specified criteria or has not been referred on the appropriate pro-forma but the Consultant, on prioritising the referral, considers it as a suspected cancer referral, then the appointment should be booked within 2 weeks of receipt of referral and the Consultant must notify the 2ww office (see Consultant Upgrades Section 8.0 and Appendix Five). On PAS in 'notepad' staff should highlight that the referral has been upgraded.

6.5 Downgrading referrals from 2ww

A referral can only be downgraded with the consent of the referring GP. Therefore if a Consultant, on reviewing the pro-forma, considers the referral should be downgraded, they should contact the GP for agreement. Once agreement is reached, PAS must be amended by removing the 2ww waiting list episode and generate a new waiting list for the routine pathway, ensuring that the start is the same. The Infoflex Cancer Database must be amended to close the 2ww referral pathway.

6.6 Patients admitted as emergencies prior to 2ww first appointment

If admission is for the same condition, they will no longer be recorded against the two week standard. However, such a patient could be upgraded onto the 62 day upgrade pathway if the Consultant suspects cancer is the cause of the admission. Patients, who are admitted as an emergency for a different condition, continue with the existing 2WW suspected cancer referral pathway. If the patient is seen by the team relevant to the 2ww referral during the admission, then the admission date is classed as "first seen" and the 62 day pathway applies if the patient is subsequently diagnosed with cancer.

If the patient is not reviewed they will stay on the 2ww pathway unless the receiving clinician deems it inappropriate and, in consultation with the GP, removes the patient from the 2ww/62 day pathway.

6.7 Two referrals on the same day

If two referrals are received on the same day, both referrals must be seen within 14 days and, if two primary cancers are diagnosed, treatment for both cancers must start within 62 days of receipt of referral if clinically appropriate.

7.0 Screening pathways

7.1 Breast screening

All patients referred to the Trust for a biopsy from the screening service will be added to Infoflex for MDT discussion, at which point a 62 Day pathway begins. All pathways are then monitored until confirmation of diagnosis and on to treatment if relevant

7.2 Bowel screening

The Bowel Screening Service which is managed by Dartford and Gravesham NHS Trust (DGT), monitor all relevant patients in the Infoflex Cancer Database system. DGT manage the pathway from FOBT to the first screening assessment appointment and Colonoscopy. The 62 day pathway starts from when the patient accepts a date for a screening assessment appointment after a positive FOBT.

For patients from the bowel scope (flexi-sigmoidoscopy) screening programme, a 62 day pathway will start from the date of the scope when patient is found to have a suspected cancer. The Trust's MDT coordinators are responsible for the patients from this point and continue to manage the pathway to diagnosis and treatment where applicable.

Any patient who does not accept an appointment for a colonoscopy following reasonable offer attempts, the Bowel Screening Service will use the MTW template to inform the patient's GP that the patient has removed themselves from the 62 day pathway. The pathway will be closed using code 98.

If the patient subsequently attends and is diagnosed with cancer, they will be identified by the positive histology report and will be monitored against the 31 day standard.

(**Cancer waiting times guidance**[1]: specifically section 3.2.3)

7.2.1 Bowel screening surveillance

Patients being monitored under the surveillance scheme who are subsequently diagnosed with cancer will be monitored under the 31 day standard, not the 62 day pathway.

7.3 Cervical screening

Suspected cancer referral will be triggered by any of the following smear results:

- Moderate and severe dyskaryosis or
- Glandular neoplasia (query adenocarcinoma of cervix) or
- Invasive (query squamous cell carcinoma of cervix).

The pathway will start from receipt of result/referral from Cytology who are also responsible for sending all reports/results to the Gynaecology Department.

Patients who do not fulfil the above criteria but who are then subsequently diagnosed with cancer will be tracked on the 31 day pathway and should be entered within the Infoflex Cancer Database.

Patients will be seen in accordance with Quality Assurance screening recommendations.

The MDT Co-ordinator is responsible for entering patients onto the Infoflex Cancer Database and works closely with the Colopscopy co-ordinator in the Gynaecology department.

7.4 Management of first appointment from screening referrals

MTW is only responsible for screening patients at 1st appointment and the following applies:

- If a patient does not attend (DNA) their first screening appointment, another appointment should be offered.
- A waiting time adjustment applies from the receipt of referral to the date the patient makes contact to rearrange the appointment and all details must be recorded on the Infoflex Cancer Database.
- If a patient DNAs a second appointment offered they have removed themselves from the pathway and should be recorded on Infoflex Cancer Database as “DNA”. The GP should be informed by the clinician via clinic letter.
- If at a later date the patient contacts the screening programme and is subsequently diagnosed with cancer, the patient will be monitored on the 31 day pathway.
- If a patient declines the first appointment another appointment should be offered within 7 days, no pause will apply.
- Patients should be informed that they are on a fast track pathway and that they will be offered a series of appointments within a short timescale.

7.5 62 day breaches from screening services

If the 62 day standard is breached then the breach can be shared if the host screening service provider is different from the treating provider.

8.0 Consultant upgrades

Hospital specialists have the right to ensure that patients who are not referred urgently as suspected cancer referrals, but who have symptoms or signs indicating a high suspicion of cancer, are managed on the 62 day pathway.

Any patient who is not already on a 62 day pathway i.e. referred from a GP/GDP as a suspected cancer referral or with breast symptoms (i.e. 2ww), and who is not referred through the screening programmes may be upgraded onto a 62 day

pathway by the receiving specialty. The 62 day target starts on the date the upgrade decision is made.

8.1 The points on the pathway where a referral may be upgraded are:

- On receipt or triage of the referral where the referral may meet Improving Outcomes Guidance (IOG) criteria for suspicion of cancer.
- During or following the initial visit where there is a suspicion of cancer.
- During or following diagnostic procedures where the imaging or Histology/Cytology indicates or confirms the presence of cancer.
- On or before the multi-disciplinary team (MDT) meeting date.

Upgrade must occur before the DTT date. Patients not upgraded at this point will be measured against the 31 day DTT to first definitive treatment.

An upgrade is intended for suspected new primaries only, not those who may be suspected of a recurrence.

8.2 Who can upgrade patients onto a 62 day pathway?

The specialist team receiving the referral or reviewing the patient or diagnostic result can delegate the responsibility to upgrade the patient. This could be:

- Specialist Nurse / Practitioner, either by triaging the referral form/letter or at nurse led initial clinic.
- Specialist Registrar either by triaging the referral form/letter or at initial clinic.
- Radiologist / Histologist / other Trust clinicians on reviewing patients and/or diagnostics

8.3 Responsibilities

The Consultant or delegated member of the team upgrading the patient is responsible for informing the MDT Co-ordinator (by completing the upgrade pro-forma) that an upgrade has occurred, in order for the patient to be tracked on the correct pathway.

The MDT Co-ordinator will be responsible for tracking the patient and recording relevant data in the Infoflex Cancer Database.

If a patient has been upgraded to a 62 day pathway this must be communicated with the patient so they understand why they are being upgraded, and the GP should be notified by the upgrading clinician.

The number of patients ‘upgraded’ will be monitored monthly, Snapshot audits of patients will also occur to ensure that patients who should have been upgraded have been correctly. If an incident is found that a patient was not upgraded correctly then the Tumour Group Clinical lead will be asked to review the case with the appropriate clinician.

See Appendix Six for ‘Upgrade pro-forma’.

9.0 Treatments

9.1 First treatment

For newly diagnosed cancers all patients should be treated within 31 days of DTT date irrespective of the treatment.

First definitive treatment is normally the first intervention, which is intended to remove or shrink the tumour.

Where there is no definitive anti-cancer treatment almost all patients will be offered a Palliative intervention (e.g. stenting) or Palliative Care, which will be counted as the first definitive treatment.

Each new primary will require a new pathway to be created and this will include all skin squamous cell carcinomas (SCC) that are diagnosed, not just the first.

9.2 Subsequent treatments

This 31 day standard only applies to those treatments either curative or palliative that aim to remove/shrink or delay the growth/spread of the tumour/cancer and patients undergoing the following subsequent treatments will be treated within 31 days of DTT/ECAD:

- Surgery
- Anti-cancer drug
- Radiotherapy
- Other treatments

9.3 Recurrences

A recurrence is classed as subsequent treatment and is defined when a patient has been diagnosed and treated for an original primary and informed that they are free of disease and then cancer returns in the same site.

Clinical input is required to determine if the patient has a recurrence or a second primary in the same site.

Recurrent cases are monitored against the 31 day pathway only, irrespective of route of referral. Therefore if a patient on a 62 day pathway is diagnosed with a recurrence then they are removed from the 62 day pathway and will be tracked against the 31 day standard.

9.4 Metastases

Metastases are classed as a subsequent treatment and are defined as a tumour that has spread from another primary site. Data entry/monitoring are reliant on clinical input to determine if the treatment is to the primary or metastatic site. A metastatic treatment is classed as a first treatment only if there is an unknown primary.

If the primary is known and treatment is given to the metastatic site first this is still classed as a subsequent treatment and monitored under the 31 day pathway even if this occurs before the treatment to the primary site.

If the patient is on a 62 day pathway the clock does not stop with the metastatic treatment, it continues until the primary site is treated.

9.5 Treatment modalities

9.5.1 Surgery

This includes all outpatient, day case and inpatient surgical treatments where the intent is to remove the tumour. Admission date is classed as treatment date even if it is before the surgical procedure date.

If a patient is admitted as an emergency and during the admission undergoes surgery, which subsequently diagnoses a cancer, the admission date is still classed as the treatment date for the purposes of cancer waiting times.

If on receiving the Histology report, surgical margins are not clear of cancer, as long as the intent was to remove the tumour this will still be classed as a treatment.

If a diagnostic procedure is undertaken but it is subsequently found to have removed the entire tumour then this would be classed as a treatment.

If a wider excision is required following a previous cancer treatment but no tumour is found in the histology, this is still classed as a cancer subsequent treatment and tracked/reported for cancer waiting times.

If patients are admitted for a procedure which is intended to treat the cancer but on operating the surgeon is unable to proceed due to clinical findings, this would be classed as 'open and close' surgery and would still class as treatment as the intent was to treat. This does not apply if the patient is reviewed preoperatively and deemed unfit to proceed.

9.5.2 Anti-cancer drug therapy

This relates to:

- Chemotherapy
- Hormone therapy including thyroxin
- Other – including biological treatments
- Immunotherapy

A program of chemotherapy is counted as one treatment (not each cycle within the treatment program), but if the chemotherapy drug is changed during a program and a new program commenced a new record will be created if a new consent form was signed.

9.5.3 Radiotherapy

This includes*:*

- Chemo radiotherapy
- Teletherapy (beam radiation)
- Brachytherapy
- Proton therapy

Treatment start date is when the first session is provided and not when the planning appointment occurs.

Chemo radiotherapy (combined treatment) is defined as when radiotherapy and chemotherapy are delivered within a strict schedule so that they interact to make both treatments more effective.

The treatment date is the date the first modality is delivered.

9.5.4 Active monitoring

This could be either a first or subsequent treatment where the intention is for long term surveillance where the decision had been taken to monitor the progress of the disease. For example, a slow growing tumour where there is not an immediate problem and it is clinically appropriate to step back and monitor the situation until an active intervention is more appropriate, this should be discussed and agreed with the patient. Once patient has agreed this must be communicated to the patient's GP and recorded on the Infoflex Cancer Database

9.5.5 Specialist palliative care

Patients requiring symptomatic and supportive care provided by the Specialist Palliative Care Team; this could be either a first or subsequent treatment. Treatment commences when the team assess the patient. Treatment within a Hospice environment is classed as specialist palliative care.

9.5.6 Non-specialist palliative care

Patients requiring symptomatic and supportive care provided by a Consultant not specialising in palliative care, this could be either a first or subsequent treatment.

This includes patients previously recorded as on active monitoring and who will not be suitable for active treatment but do not require referral to Specialist Palliative Care but remain under the care of the clinical team for supportive care.

9.5.7 Other treatments

- **Radioactive iodine**

This should be coded as 'other' treatment and will need to meet the 31 day target.

- **Enabling treatments**

Most enabling treatments that are carried out prior to active treatments are not classed as first definitive treatments for example: Percutaneous endoscopic gastrostomy (PEG) / Radiologically-guided Insertion of Gastrostomy (RIG) tube insertions prior to radiotherapy are not classed as first treatment unless the radiotherapy commences during the same admission as the PEG/RIG then the date of admission is the date of first treatment.

However some exceptions do apply:

- Colostomy/colonic stent for bowel obstruction
- Insertion of oesophageal stent
- Non-small cell lung cancer stent
- Ureteric stenting for advanced cervical cancer
- Insertion of pancreatic stent, if the plan is to resolve the jaundice before the

patient has a resection or starts chemotherapy

- Gastrojejunostomy
- Monofer infusion
- Cystodiathermy

Other enabling treatments can only mark the end of the 62 Day period where a patient is having these prior to surgery. The scenario for this is where a patient is to have any enabling treatment and is admitted for this and remains an inpatient between this enabling treatment and the main surgery

Colostomy for bowel obstruction are only considered FDT if clinically the procedure would have been undertaken irrespective of any planned further treatment. This should be recorded in the clinic letters/documentation for audit purposes.

If the patient only undergoes colostomy due to the known side effects of another treatment e.g. prior to radiotherapy and the patient would not have otherwise needed the procedure, this cannot be classed as FDT.

- **Clinical trials**

If a patient is entered into a clinical trial and may or may not receive a placebo this would still count as first/subsequent treatment and treatment must still be provided within 31 days of DTT and should achieve the 62 day standard.

- **Blood transfusions**

If a patient is not planned to have active anti-cancer treatment, i.e. chemotherapy or radiotherapy, a blood transfusion would count as first treatment as part of a palliative care treatment package; in all other cases blood transfusion would not count as first treatment.

- **Lymph node excision**

If lymph node excision is purely diagnostic/staging then it is not classed as treatment. However, if the procedure is to excise cancer, then it would be classed as a treatment.

- **Exceptional treatments**

For patients who are offered treatments that require an application for funding to the CCG, the clock starts once the decision to have treatment is made and no pause will apply whilst waiting for funding confirmation.

9.5.8 No treatment / treatment declined

If a patient declines all treatment offered including active monitoring or decides to have their treatment privately then they should be recorded as “treatment declined” and removed from the cancer pathway.

The Consultant must ensure that the MDT Co-ordinator is advised so that the appropriate recording can be made within the Infoflex Cancer Database. The Consultant must also notify the patient’s GP of this decision.

9.6 Start of 31 pathway

9.6.1 Decision to Treat (DTT) Date

The Decision to Treat (DTT) date can be defined as: the date that a patient agrees a treatment plan for first or subsequent treatments. The DTT can only be changed if the patient decides they do not want the treatment originally agreed and a different treatment is discussed and agreed. If the patient is on a 62 day pathway, the DTT for the 31 day standard will be reset but the 62 day pathway would continue.

9.6.2 Earliest Clinically Appropriate Date (ECAD)

The earliest clinically appropriate date applies to patients whose treatment plan involves a sequence of more than one treatment modality, but where further decision to treat dates are not applicable e.g.

- Commence preparation for treatment (i.e. radiotherapy planning start date).
- Commence treatment itself, if preparation and treatment are to be carried out at the same time.
- If treatment is scheduled to be delivered on a specific date in a schedule with other therapies, the ECAD will be the date to be delivered i.e. 3 months hormone treatment for prostate cancer patients prior to Radiotherapy. The ECAD will be 3 months following start of hormone therapy.

9.6.3 Changes to ECAD

ECAD can be kept under review. An ECAD date can be changed once it is set, but only if the date has not passed. ECAD starts a 31 day cancer clock. If the patient is unwell after the ECAD then the ECAD cannot be reset and a wait time adjustment will not apply.

The ECAD can be set:

- A pre-determined date set by the clinician responsible for the patients care when it is anticipated that the patient will be fit to start the next stage of the care pathway.
- A date set during a clinical review (MDT / clinic appointment) or on receipt and review of test results, when it is anticipated the patient will be fit to start the next stage of the care pathway.

This will apply to all new patients/recurrences/metastatic disease and subsequent treatments.

Some examples of ECAD:

- If a patient is booked for a check cystoscopy following a treatment for cancer and during the cystoscopy a recurrence is diagnosed and resected then the ECAD and treatment is the date of the cystoscopy.
- If the patient is diagnosed but then booked for treatment, the ECAD is the date of the cystoscopy and the treatment must be booked within 31 days.
- Patient with rectal cancer to have radiotherapy then surgery 6 weeks post radiotherapy. ECAD date would normally be 6 weeks after radiotherapy

completed

- Patient with breast cancer to have surgery then radiotherapy. The patient would not be fit for radiotherapy until they can lift arm above their head. Therefore the ECAD date would be set when radiotherapy planning commences.

10.0 Identifying treatments

The treating clinician will be responsible for informing the MDT Co-ordinator that a treatment is planned. The MDT Co-ordinator will be responsible for tracking the patient and recording relevant data in the Infoflex Cancer Database.

10.1 Surgical treatments

It is the responsibility of the treating clinician to identify the treatment as a cancer treatment when adding the patient onto the waiting list.

The waiting list/admissions/medical secretary on entering the addition to the waiting list on PAS will select 31 day pathway. A date should be offered within 31 days of the DTT (or sooner if the 62 day target is before the 31 day target) and if not possible this should be escalated immediately to the relevant General Manager and MDT Co-ordinator.

Prior to escalation, investigation should include:

- Are there any legitimate waiting time adjustments to be made?
- Is the DTT date correct?

Options could include:

- Possibility of surgery being undertaken by another surgeon.
- Review of other patients listed to see if lists could be rearranged.

IMPORTANT NOTIFICATION

Care should be taken not to compromise other targets. However cancer patients should take priority taking into account clinical need. If additional theatre sessions are required, the relevant General Manager should be informed and if no response within 24 hours escalate to the Director of Operations for Planned Care.

10.2 Chemotherapy

The treating clinician will complete an electronic action sheet in KOMS confirming the DTT/ECAD. The chemotherapy booking staff will monitor the KOMS system to identify patients requiring appointment for treatment. If treatment is not possible within 31 days (or sooner if the 62 day target is before the 31 day target) this should be escalated immediately to the Lead Nurse for Chemotherapy.

The Oncology Patient Pathway Co-ordinator updates the action sheets with the relevant pathway and target dates and is responsible for entering the patient into the Infoflex Cancer Database and tracking the patient by entering treatment dates when known.

10.3 Radiotherapy

The treating clinician will complete an electronic action sheet in KOMS confirming the DTT/ECAD. The Radiotherapy booking staff will monitor the KOMS system to

identify patients requiring appointment for treatment. If treatment is not possible within 31 days (or sooner if the 62 day target is before the 31 day target) this should be escalated immediately to the Manager for Radiotherapy.

The Oncology Patient pathway Co-ordinator updates the action sheets with the relevant pathway and target dates and is responsible for entering the patient into the Infoflex Cancer Database and tracking the patient entering treatment dates when known.

11.0 Waiting time adjustments

11.1 Pauses

The following indicates when a pause can be or cannot be added to a patient's pathway:

No pauses will be allowed:

- For medical suspensions at any point in the pathway. The patient must not be removed from the 62 day pathway purely due to ill health.

- During the diagnostic phase of 62 day pathway (between date first seen and start of treatment) if an alternative modality is offered and the patient accepts. The patient must not be removed from the 62 day pathway purely due to medical fitness.

- For patient cancellations for treatment in non-admitted (outpatient) settings e.g. majority of radiotherapy and hormone therapies.

- For patient thinking time – Patients must be allowed thinking time at any part of their pathway without it affecting their pathway status. If patients request thinking time to consider their treatment options, the relevant CNS will maintain contact with the patient to enable swift responses to questions and decisions. This should be recorded on Infoflex accordingly.

Pauses are allowed for:

- If a patient DNAs their initial outpatient appointment

  (For the purposes of Cancer Waiting Times this would allow a clock 'pause' from cancer referral received date to the date upon which the patient rebooks their appointment. This does not apply for 18 week pathways).
- Treatment in an inpatient setting (ordinary admission or day case) where the patient declines admission providing that the offer of admission was 'reasonable'.

  (Offer of 'reasonable' for cancer patient is defined / interpreted as any offered appointment within a cancer referral to treatment period – as outlined in Cancer Waiting Times guidance). The patient must decline the offer and not cancel a pre-agreed date – an example would be where a patient is offered a surgical date in an outpatient appointment but chooses to wait for a different

surgeon. The first offered TCI must be recorded in the clinic letter/documentation for audit purposes.

- If the patient during a consultation, or at any other point, whilst being offered an appointment date states that they are unavailable for a set period of time (e.g. due to holiday or work commitments), even if the offer meets the "reasonable" criteria. This is considered a decline. The Waiting Time Adjustment (WTA) applied will be from the offer date until the patient makes themselves available again. The first offered appointment must be recorded within the relevant clinical system and a record made of the date that the patient will be available again. This will apply to admitted treatments (Cancer waiting times guidance[1]: specifically section 7.1.8)

Where a patient is offered a TCI ("to come in" date) but declines this date, the date that the patient will be available again for an alternative TCI must be recorded in the clinical documentation for audit purposes.

If a patient is offered a TCI but declines, for example, with one consultant in order to wait for an alternative consultant, the adjustment applied will be from the original reasonable offer to the new TCI date.

If the patient declines the TCI but is offered an alternative with the **same** consultant and the consultant is unable to appoint within target due to capacity issues, the only adjustment that can be made is from the original TCI date to when the patient has declared that they will be available again. If this is not recorded, the adjustment applied will be for one day only as it is assumed that the patient has declined the TCI but is declaring that they are available the following day.

11.2 Documentation

Any pause must be supported by clear documentation in Infoflex and PAS or other relevant clinical system.

It is the responsibility of the 2ww Wait Office to enter all pauses relevant to first appointment patient choice on Infoflex and update PAS.

An MDT Co-ordinator may request a WTA be applied at the weekly cancer PTL meeting. The Cancer Information Team, in discussion with the General Manager for Cancer and Haematology, is responsible for approving any adjustments and applying the adjustment in the Infoflex system. Adjustments must be validated prior to upload and checks made for any DNAd appointments and relevant pauses and entering them into the Infoflex Cancer Database.

If a discrepancy exists whereby the General Manager for Cancer & Haematology and the Cancer Information Team disagree that an adjustment is applicable, the query will be raised to the Director of Operations for Planned Care to make the final decision.

11.3 Patient cancellations

MTW will make every effort to reschedule patient appointments at the convenience of the patient. If a patient cancels an appointment then the following guidance must be followed:

- **First appointment**

2ww referral patients who cancel their first appointment should be offered another appointment within the two weeks of the referral being received.

- **Subsequent appointments**

  Patients who cancel an appointment/investigation date should be offered an alternative date within 7 days of the cancelled appointment (no waiting time adjustment will apply).

- **Multiple cancellations**

  All patients who are referred on either a 62 day GP pathway, screening pathway or breast symptomatic referral who cancel two consecutive appointments (i.e. outpatient, diagnostic investigation) will be contacted by an appropriate member of staff to identify any factors that may be stopping the patient attending and another appointment offered if the patient agrees.

  If this subsequent appointment is then cancelled, the patient will be informed further appointments cannot be offered and must agree that a letter will be sent to their GP stating that the patient has removed themself from the 62 day pathway.

  If the patient does not agree to a further appointment, they will be informed that they have removed themselves from the pathway and will be referred back to their GP.

  The 2ww office or MDT co-ordinator will contact the Consultant whose care the patient is under to agree that the patient will be discharged back to the GP and will update Infoflex accordingly.

  If the patient does not agree to being removed from the 62 day pathway, the Consultant will contact the patient by telephone to either agree an alternative appointment date or to gain consent that the patient will be removed from the pathway.

Whilst adjustments can be made when the patient states that they would be unavailable for a period of time (see **11.1 Pauses**), if the patient makes this clear from the outset before any diagnostic or treatment plan is agreed, appointments must not be offered that the patient would not be able to attend.

For example, if the patient states at the 1st seen appointment that they will not be available for two weeks immediately after the appointment and during the appointment the patient is referred for a CT scan, Radiology must not offer an appointment within the next two weeks knowing that the patient is not available.

If the patient did not state this during the 1st seen appointment and subsequently the patient cancels an appointment, this will be classed as the first patient cancellation.

Where a patient has multiple cancellations (3 or more) within their 62 day pathway, the consultant will be contacted to gain agreement that the patient has removed themself from the 62 pathway. This will be recorded in the Infoflex system.
This will not impact on their on-going management and if the patient is subsequently found to have cancer, they will be monitored against the 31 day target (see **Cancer waiting times guidance**[1]: specifically section 3.2.3).

11.4 Patient DNAs

Patients should be recorded as a DNA if they do not turn up to a clinic or diagnostic appointment, turn up late or turn up in a condition where the Trust cannot carry out

whatever was planned for them. For example if they have not taken a preparation they needed to take prior to the appointment (this also includes patients who have not complied with appropriate instructions prior to an investigation).

- **First appointment**

  All patients referred as suspected cancer including 2ww, screening, upgrade and breast symptomatic who DNA their first outpatient appointment should be offered an alternative date within 14 days of the DNA (the 18 week RTT clock will continue).

  A waiting time adjustment applies from receipt of referral to the date the patient makes contact to rearrange the appointment and all details must be recorded on the Infoflex Cancer Database.

  If the patient DNAs the second appointment/straight-to-test appointment offered, they should be referred back to their GP asking the GP to review, advise and re-refer under the 2 week wait system, if appropriate, and if the patient agrees to attend.

  The 2ww office will contact the Consultant that the patient was booked to see to agree that the patient will be referred back to their GP. This will be documented in the Infoflex Cancer Database. Once a patient has been referred back to their GP they can be removed from the 62 day pathway.

- **Subsequent appointments**

  If a patient DNAs an appointment at a subsequent point on the 62 day/31 day appointment it will be at the referring Consultant's discretion to either:

  a) Send the patient a further appointment or
  b) Refer the patient back to their GP.

  In the event of option a) Consultants should be mindful of the fact that a waiting time adjustment will not apply and that the patient will need subsequent appointments and treatment within the target time.

  In the event of option b) the patient should be removed from the pathway and will be monitored against the 31 day standard if cancer is subsequently diagnosed. The decision to remove the patient from the 62 day pathway will be recorded in the Infoflex Cancer Database.

11.5 Patients are uncontactable

If the patient is uncontactable at any time on their 62/31 day pathway, a record of the time and date of the call to them in the 'additional information' section on PAS should be made at the time of the call.

Two further attempts must be made to contact the patient by phone, one of which must be after 6.00pm.

Each of these calls must be recorded in real time in the 'additional information' section on PAS. These attempted contacts must be made over a maximum 2 day period.

In the event that the patient remains uncontactable:

- **For first appointments**

  An appointment will be sent to the patient offering an appointment within the 2ww standard, stating that the Trust has attempted to offer a choice of appointment, and that the patient should contact the 2ww wait office to

rearrange the appointment if it is inconvenient. If the patient subsequently DNAs that appointment they should be referred back to the GP to review and re-refer if necessary.

- **Appointments (other than first) on 62/31 day clinical pathway**

  Attempts to contact should be made as outlined above. In the event that contact cannot be made, the Consultant should decide:
  a) to send a “no choice” appointment by letter.
  b) to refer back to the GP.
  If Option a), no wait time adjustment will apply.
  If Option b), the patient is referred back to their GP, they will be removed from the 62 day pathway to review and re refer if necessary and will be monitored against the 31 day standard if cancer is subsequently diagnosed.

11.6 “Straight to test” first appointments

Patients who are referred by their GP with a suspected cancer, whose first attendance is ‘straight to test’ who attend but have not followed instructions for the procedure,(i.e. have eaten or not taken appropriate preparation), will be recorded as DNAs for the purposes of cancer waiting times and therefore another date will be offered within 14 days. A waiting time adjustment can be made.

When a patient has been admitted on to the ward and then discharged as ‘patient unfit’ with a reason entered into the comments box, i.e. patient has eaten. The deferred box should then be selected within PAS which places the patient back on to the waiting list and another TCI given within two weeks.

11.7 Patients are unavailable

If a patient indicates that they will be unavailable for 28 days or more on their pathway after their first appointment, the patient’s healthcare records should be reviewed by the managing clinician and a decision made whether to refer the patient back to the GP or continue the patient on the cancer pathway. In either case, the patient’s GP should be informed that their patient is not able to make themselves available for treatment within this time period, as they may wish to contact the patient. A waiting time adjustment will apply if the patient has made it known that they will be unavailable for a set period of time.

11.8 Patients on the bowel screening programmes

Patients on screening programmes that make themselves unavailable for 28 days or more under direction of the Consultant will be removed from the 62 day pathway. The patient’s GP and the bowel screening hub will be informed but the patient will continue to be managed within the Bowel Screening Programme and if subsequently diagnosed with cancer will be monitored on the 31 day pathway.

12.0 Administration standards

- All internal documentation/referrals/cards should clearly identify patients as a cancer target patient and if they are on the 31 or 62 day pathway by using the **‘Orange sticker’** system. This is a unified process across the Trust which requires all diagnostic requests to have an Orange Sticker attached to them so that staff receiving the request know that the patient is on a cancer pathway

- For electronic radiology requests the cancer pathway drop down will be selected.
- All requests for further tests /investigations must be made within 24 hours of the decision to proceed and a system put in place to pass onto the relevant department in the same working day.
- All letters associated with cancer patients will be identified on the digital dictation by a 'red flag' and be typed within 24 hours of the clinic/MDM/appointment.
- All MDM documentation, referral pro-formas, outcome pro-formas and MDM lists will clearly identify the relevant pathway and target date.
- All receiving departments must have a clear system in place for identifying and actioning cancer referrals/requests within 24 hours of receipt.
- Patients who do not have cancer should be removed from the pathway by the relevant clinician and the MDT Co-ordinator notified. This should then be recorded on the Infoflex Cancer Database within 48 hours.
- All reports must be reviewed and actioned by clinicians within 48 hours of receipt of report.
- In the event that any of these standards cannot be met the issue should be escalated to the relevant General Manager.

12.1 Outpatient pro-formas

IMPORTANT NOTIFICATION - All clinicians (excluding Oncology/Haematology) will complete an outpatient pro-forma when a patient attends an appointment. The pro-forma should be completed to confirm if removed off pathway, remaining on the 62 day pathway or being put onto a 31 day pathway.

A copy of the pro-forma should be made available to the MDT Co-ordinator of the relevant Tumour site for actioning. The MDT Co-ordinator should review the pro-forma and complete relevant data entry/tracking within 48 hours of the clinic appointment.

13.0 Diagnostics

The Trust will maintain a 2ww for all diagnostic "straight to tests" for patients on a cancer pathway and a 10 day turnaround for all subsequent Diagnostic tests on a patient's 31/62 day pathway.

- **Endoscopies**

If the appointment is 'straight to test' for an 'Urgent Suspected Cancer' pathway and no appointment is available with 14 days of receipt of referral, the Endoscopy and Surgery or Specialist Medicine General Managers should be informed immediately.

If it is not the first appointment on the pathway the Endoscopy and Surgery or

Specialist Medicine General Managers should be informed within 24 hours.
The Endoscopy and Surgery or Specialist Medicine General Managers will see and discuss options with the relevant Consultant or, in their absence the Lead Doctor for cancer within the speciality.

Options may include:

- Seeing additional patients within existing slots
- Seeing patients in non-cancer slots
- Transferring the referral to another Consultant if referrals are not already pooled
- Reviewing list cancellations
- Setting up additional lists

Any request for additional capacity should go to the relevant General Manager.

- **Radiology**

All patients should be booked into the next available slot as soon as possible after receipt of referral. If an appointment is being booked outside the specified period, this should be escalated to the Radiology General Manager.

- **Histopathology**

If a report cannot be provided within 5 days of receiving the specimen Cellular Pathology staff should contact the requesting Clinician and the Lead Histopathologist for the relevant tumour site.

Patient refuses diagnostic test
If a patient refuses a diagnostic test that would potentially diagnose cancer then the patient is considered to have removed themselves from the 62 day pathway. If cancer is subsequently diagnosed they will be monitored on a 31 day pathway.

14.0 Managing the transfer of private patients

Without prejudice, patients can choose to convert between the NHS and private healthcare and any point during their pathway. The exact 31/62 day pathway dates must be established within 48 hours of receipt of referral/notification.

15.0 Tertiary referrals

15.1 Process

Inter Provider Referral (IPR) Forms should be used for all outbound referrals for patients on a Cancer Pathway (Appendix Seven). IPR should be made in accordance with timescales and pathways agreed by the Kent Cancer Collaborative Policy i.e. the referral should be made no later than day 38 of the 62 day cancer pathway (in line with the 2016 breach allocation policy). Where the referral is not made via the oncology referral process, referral date will be taken as the Decision To Treat Date.

All documentation/information should be completed by the MDT Co-ordinator supported by the clinical team to ensure that all relevant clinical information is included. The MDT Co-ordinator needs to then ensure that the IPR form clearly states if a target applies and the appropriate target date.

Where possible information should be transferred between Trusts electronically, this should be done via a named NHS Contact. When there is a 62 day cancer waiting times breach on an inter-Trust pathway the breach reason will be shared between the referring and treating Trust as per policy. A Root Cause Analysis (RCA) will be undertaken for all patients referred over 38 days between organisations to understand reasons and implement actions to avoid recurrence. The RCA is completed by the Trust which completes the patient's pathway.

Breaches will be allocated as follows:

Scenario	Referral timeframe	Total timeframe	Allocation
1	> 38 days	≤ 62 days	100% of success allocated to the treating provider
2	≤ 38 days	≤ 62 days	50% of success allocated to the referring provider and 50% allocated to the treating provider
3	≤ 38 days	>62 days	100% of breach allocated to the treating provider
4	> 38 days	> 62 days, but treating trust treats within 24 days	100% of breach allocated to the referring provider
5	> 38 days	> 62 days and treating trust treats in >24 days	50% of breach allocated to the referring provider and 50% allocated to the treating provider

15.2 Clinical referrals

Clinical information about an inter-Trust referral comes to the Trust in a number of ways:

- Written referral from a Clinician to a department at MTW.
- Referral from a clinician who has clinical sessions at another Trust but the patient requires diagnostics/treatment at the MTW.
- MDT referral both Local Multidisciplinary Team (LMDT) and Specialist Multidisciplinary Team (SMDT).

- Histology reports.
- It is the expectation of MTW that all inter-Trust transfers into MTW are referred on or before day 38 of the patient's pathway.

15.3 Referrals from an LMDT to a SMDT

Referrals should be made to the SMDT in accordance with individual tumour specific guidelines using the agreed SMDT referral format. They should be made electronically to the appropriate person i.e. MDT /Lead Clinician via an nhs.net email account.

Referrals from a LMDT to a SMDT should be made within 24 hours of the decision to refer the patient. To avoid delays in SMDT discussion and clinical decision making, imaging and pathology required by the SMDT will be sent at the time the SMDT referral is made.

Details of the information required and where to send it can be found on the appropriate SMDT referral form. All SMDT referrals must specify the Cancer Waiting Times target (31 day/ 62 day) that applies to the referral and the breach date.

15.4 Consultant to LMDT/SMDT referrals

Where a Consultant in one organisation wants to refer a patient to a LMDT or SMDT at another Trust, that referral must be made within 24 hours of decision to refer. Referrals should be made in accordance with the LMDT/SMDT referral format including all relevant imaging and pathology, including details of cancer waiting times targets that apply to the referral.

15.5 Radiotherapy referrals

Clinicians referring patients to the Kent Oncology centre for assessment and/or treatment direct the tumour group MDT Co-ordinator to complete a first definitive oncology referral pro-Forma (available on Infoflex only) and send it to the dedicated Oncology pathway co-ordinator via email.

The Oncology pathway co-ordinator will then update the Infoflex database system with the referral details and the oncology registration team appoints the patient. Once the Oncologist has made a decision to treat they will complete the KOMS electronic action sheet and the patient will then be scheduled to begin treatment.

The treatment details are maintained in the Infoflex database system by the Oncology pathway co-ordinator until treatment commences. All Radiotherapy treatments are recorded as MTW activity.

15.6 Chemotherapy referrals

Clinicians referring patients to the Kent Oncology Centre for assessment and/or treatment direct the tumour group MDT Co-ordinator complete a first definitive oncology referral pro-forma (available on Infoflex only) and send to the dedicated Oncology pathway co-ordinator via email.

The Oncology pathway co-ordinator will then update the Infoflex database system with the referral details and then the oncology registration team appoints the patient.

Once the Oncologist has made a decision to treat they will complete the KOMS electronic action sheet and the patient will then be scheduled to begin treatment.

The treatment details are initiated in the Infoflex database system by the oncology pathway co-ordinator for MTW activity but Chemotherapy treatments are given at individual units and it is the individual unit's responsibility to commence the treatment details on Infoflex.

15.7 Potential breach

In the event that there is a potential breach due to a tertiary referral, the MTW MDT Co-ordinators/ Oncology pathway co-ordinator should inform the General Manager for Cancer and Haematology at MTW.

The General Manager for Cancer and Haematology will work jointly with the equivalent Cancer Manager at the Trust concerned to expedite diagnostics/treatment. If unable to resolve, the General Manager will escalate to the Director of Operations for Planned Care.

On receipt of referral the MDT Co-ordinator/Oncology pathway co-ordinator will be responsible for tracking the patient and entering the patient details on to the Infoflex Cancer Database ensuring the cancer status is correct at all times.

16.0 Weekly Cancer Patient Tracking List (PTL) Meeting

The weekly Cancer PTL meeting will be chaired by the Director of Operations for Planned Care or General Manager for Cancer and Haematology.

Attendees must include Cancer Access Manager, General Managers from the Clinical Directorates, Clinical Nurse Specialist (keyworker) for each tumour site where possible, plus and MDT Co-ordinators.

It is the responsibility of the MDT Co-ordinator to be able to present all pathway information on the following patients:

62 day patients

- All patients 40 day+ with diagnosis on the PTL but without DTT.
- All patients 40 day+ without diagnosis on the PTL.
- All patients with a treatment date outside of target.
- Tertiary referrals received after day 38.
- Tertiary referrals made after day 38.

31 day patients – all treatments

- All patients with a DTT without a treatment date.
- All patients with a treatment date outside of target.

Other patients

- All patients > day 104
- All patients with complex pathways to be discussed and plan agreed
- Any other patients on the pathway causing concern.

- All patients for whom escalation processes have been initiated unsuccessfully.

Local weekly tracking meeting
Weekly tracking meetings for each tumour group will take place and will be attended by the Clinical Nurse Specialist (keyworker) for their tumour group, MDT Co-ordinator, and AGM/CAU Lead.

Individual tumour sites may also hold consultant PTLs weekly as agreed with the clinician.

16.1 MDT Co-ordinator cover
The MDT Co-ordinators are expected to provide cover by a 'buddy up' system in periods of absence with relation to cancer waiting times and patient tracking.

17.0 Breaches of 31/62 day cancer target
For all breaches of the cancer target, the MDT Co-ordinator is expected to complete the patient record on the Infoflex Cancer Database, giving full information regarding the breach reason.

This will allow clinical and managerial staff to review key events, to take remedial action and to review the pathway as appropriate. The breach reasons that will be submitted to NCWT Database are as follows:

- Clinic cancellation
- Outpatient capacity inadequate
- Administrative delay
- Elective cancellation
- Elective capacity inadequate
- Delay to diagnostic test or treatment planning
- Complex diagnostic pathway
- Delay due to referral between Trusts

A Root Cause Analysis must be completed for each breach that occurs and a breach pro-forma can be found on the MTW intranet**.** These must be submitted by the Cancer Information team to the General Manager for their tumour site who will agree and confirm via email within two weeks of Month end.

These will be sent to the General Manager for Cancer and Haematology, Director of Operations for Planned Care as well as the Chief Operating Officer. On submission the General Manager for Cancer and Haematology will validate prior to month close and escalate to the Director of Operations for Planned Care as required.

17.1 Breaches over 104 Days
As per the national Backstop policy[2], more detailed root cause analysis is undertaken for any patient whose treatment is completed after day 104.

The speciality General Managers are responsible for completing the 104+ day RCA

form and obtaining appropriate clinical sign off for the root cause and any harm caused to the patient.

The 104+ day RCA form must be completed within two weeks of the national upload of that month and returned to the General Manager for Cancer and Haematology.

The root causes will be thematically analysed by the General Manager for Cancer and Haematology in conjunction with the Lead Cancer Nurse and the Lead Clinician for Cancer.

The General Manager for Cancer and Haematology will collate the tumour site, organisation first seen, treating organisation, treatment day, day of inter-provider transfer (if applicable), reason for delay, harm caused and who clinically signed off the RCA and will submit this to NHS Improvement by the monthly deadline.

18.0 Infoflex Cancer Database IT system

The Infoflex Cancer Database IT system is a network wide system used across the Kent and Medway area. It is used throughout the Trust to collect the National Cancer Registration Dataset including an electronic data transfer to the Cancer Registry. It is used to:

- Submit National Cancer Waiting Times minimum dataset.
- Monitor Trust performance relating to Cancer Waiting Times in real time.
- Submit Unify PTL on a weekly basis.
- Submit data to the National Clinical Audit Programme.
- Production of Clinical reports and MDT working to demonstrate compliance with Peer Review measures.

18.1 Entering patients on the tracking pathway

- **Suspected cancers – 2ww GP/GDP referrals**

On receipt of a 2ww referral from a GP/GDP, the 2ww wait office will record the referral (including known adjustments, referring symptoms and first appointment) onto the Infoflex Cancer Database within 24 working hours of receiving the referral.

The 2ww Co-ordinators are responsible for confirming a patient's attendance at the first appointment and recording the outcome, checking all dates are correct and that DNAs/breach reasons are entered correctly.

- **Suspected cancers – screening patients**

The MDT Co-ordinating team will be responsible for entering patients referred via the screening programme onto the Infoflex database system within 24 hours of receiving notification of the referral.

- **Suspected cancers – Consultant Upgrades**

For upgrade prior to initial appointments the 2ww Wait Office will be responsible for entering patient's details onto the Infoflex database system and allocating the patient

an appointment within the 2ww wait guidelines.

For upgrades at any other point of the pathway the MDT- Co-ordinator will be responsible for updating Infoflex and will begin tracking of the pathway.

- **Suspected / confirmed cancers (31 day patients)**

Patients not referred via a 2ww/screening/Consultant upgrade referral should not be entered onto the Infoflex Cancer Database until they have a confirmed cancer diagnosis. The only exception is patients with suspected cancer who are being discussed at an MDM.

Once a patient has been diagnosed with either a new cancer or recurrence, a record should be entered, within the Infoflex Cancer Database, selecting the appropriate Cancer Status (by the MDT Co-ordinator) within 24 hours of being notified.

18.2 Confirmed cancers

The MDT Co-ordinator is responsible for ensuring a patient with a newly diagnosed cancer has a record entered on the Infoflex Cancer Database, and keeping that record updated.

18.3 Recording information along the pathway

- **Date first seen**

The date first seen is the date when the patient is seen for the first time by a Consultant (or member of their team) this includes patients seen in a “straight to test” environment or in a clinic following the referral receipt. The 2ww office records this information in the Infoflex database system

- **Decision to treat**

The DTT date is the date that the patient and clinician agree the treatment plan for first treatment. This date identifies day one of the 31 day target ‘DTT to first treatment’ for all diagnosed cancers. The MDT-Co-ordinator/Oncology pathway co-ordinator will record the DTT date and the planned treatment type i.e. Surgery/Radiotherapy/Chemotherapy and change the cancer status within 48 hours of being notified.

- **Treatment**

Where a definite cancer has been diagnosed and treatment goes ahead as planned the MDT Co-ordinator will record the treatment date and change the cancer status appropriately within five working days of the treatment start date. Any offers of alternative dates for treatment that were declined by a patient will be recorded on PAS and should be checked as part of validation.

- **Cancellations and DNA**

If for any reason a planned event, i.e. appointment or TCI date is changed or the patient DNAs or cancels, the MDT Co-ordinator will record this within the Infoflex Cancer Database within 24 hours.

If a ‘pause’ applies the MDT Co-ordinator will request the Cancer Information Team to:

  - Calculate the waiting time adjustment

- Enter the number of days in the appropriate section within the Infoflex Cancer Database
- Enter the reason for the waiting time adjustment

18.4 Removing patients from the pathway

Where any patient has received a 'non cancer' diagnosis the MDT Co-ordinator will change the cancer status within the Infoflex database system within 72 hours of this being identified.

Where any patient who has a diagnosis of cancer who dies prior to commencement of any agreed treatment the MDT Co-ordinator will remove the patient from the pathway on the Infoflex database system within 72 hours of this being identified.

18.5 Producing a weekly patient tracking list

Using information recorded by the MDT Co-ordinator in the Next Key Event field on the Infoflex Cancer Database, Cancer Services Management will utilise Infoflex Cancer Database live in PTL to discuss patients and their pathway. The action log will be updated at the PTL meeting and RCAs discussed on a weekly basis to aid learning.
The Cancer Dashboard will be utilised to proactively manage cancer waiting times.

18.6 Submitting data to the National Cancer Waiting Times (NCWT) Database

Each identified responsible person (MDT Co-ordinator, General Manager for Cancer and Haematology and Cancer Information Team) will ensure that all data due for submission to the NCWTD is entered within the required cut-off deadline date.

The Cancer Information Team will review the quality of data and highlight any anomalies. Where anomalies are identified, the Cancer Information Team will liaise with the MDT Co-ordinator and/or escalate issues to the General Manager for Cancer and Haematology to reach a satisfactory conclusion.

19.0 The Multidisciplinary Team

19.1 The MDT Co-ordinator is responsible for:

- Arranging the MDT meeting.
- Ensuring all necessary patient information is available for effective team discussion.
- Ensuring all MDT meetings run effectively and all patients are discussed at the appropriate point on their pathway.
- Ensuring coordination and communication regarding individual patients between the team and its related teams in the Network if relevant.
- Ensuring all decisions about individual patients' management and the attendance of MDT members are recorded within 48 hours
- Ensuring the discussion date of each patient is recorded and the MDM record of discussion is completed within 48 hours

- Ensuring Next Key Event (database field in the Infoflex system that indicates the next clinical process in the patient's pathway) for each individual patient is checked and updated every 72 hours, chasing relevant departments for a response as required

- Supporting the General Manager for Cancer and Haematology with any general improvements and quality issues.

- Providing cover for MDT Co-ordinator via the buddy system in periods of absence.

- The MDT under the direction of the lead clinician for their TSSG body site will be responsible for accurate data collection in relation to the full Cancer Registration Dataset/National Clinical Audit Programme.

- The MDT Coordinator will ensure all data quality checks are undergone by the clinical team and that data is submitted to the National Audit Programme within published deadlines.

20.0 Changes to data

As the Infoflex Cancer Database is also used as a clinical database for MDTs and data submission to National Cancer Clinical Audits, data may be changed during data quality checks by the clinical teams. This may result in changes to core data items previously submitted to the National Cancer Waiting Times Database. If these changes occur after the data submission period has closed, clear record keeping and transparency must be maintained.

The following process will apply:

- All users to have details of submission dates. Reminders will be sent 7 days before close, 2 working days before close and once closed for both monthly and quarterly submissions.

- MDT Co-ordinator for each body site will be responsible for informing the Cancer Information Team of changes to data via spreadsheet.

- Cancer Information Team to store details of changes locally.

- Cancer information Team to change data on National Database.

- General Manager for Cancer and Haematology is to be notified of any changes that may result in a breach being recorded.

- Cancer Information Team to audit data on Infoflex Cancer Database against the National Cancer Waiting Times database prior to quarter close and year close and post close on a quarterly basis.

21.0 Monitoring and audit

It is the responsibility of the Cancer Information Team to run a weekly programme of

audits for data completeness and data anomalies.

Any data anomalies are highlighted to the relevant Tumour site MDT Co-ordinator for investigations and correction. Response to the Cancer Information Team must occur within 24 hours of the anomaly being raised in order not to delay the audit programme and to ensure accurate performance available at all times.

In addition, a regular data quality programme will be established to review the following:

- Comparative audit of data on the Infoflex Cancer Database and PAS.
- Comparative audit of diagnosis code on PAS, Infoflex Cancer Database and Healthcare Records
- Comparative audit of cases removed from the 62 day pathway and re-entered as 31 day patients within 4 weeks of removal.

This will involve a random selection of healthcare records from each tumour site to be reviewed and will be led by the Cancer Information Team.

The Cancer information Team will also capture numbers of patients 'upgraded' each month and will carry out a quarterly audit to ensure that patients are being 'upgraded' at the earliest opportunity

Findings will be presented by the General Manager for Cancer and Haematology to the Trust Cancer Board.

APPENDIX ONE

Process requirements

1.0 Implementation and awareness

- Once ratified the Policy Ratification Committee (PRC) Chairman will email this policy/procedural document to the Clinical Governance Assistant (CGA) who will activate it on the Trust approved document management database on the intranet, under 'Policies & Q-Pulse'.
- A monthly publications table is produced by the CGA which is published on the Trust intranet under 'Policies & Q-Pulse'; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.
- This policy and procedure is available on the Trust intranet. All staff are notified via email, of the policy and any amendments by the General manager for Cancer service. Printed copies of this document are uncontrolled.

This policy and procedure will be shared will all relevant CCGs, Cancer Networks, and Patient groups by the Associate Director of Operations – Surgery and Cancer

2.0 Review

- This policy and procedure is regularly reviewed and updated every 3 years.
- Please see Appendix Two for full consultation list.

3.0 Archiving

The Trust intranet retains all superseded files in an archive directory in order to maintain document history.

APPENDIX TWO

CONSULTATION ON: Cancer Services Access Policy and Procedure
Please return comments to: Director of Operations, Planned Care
By date: 14/07/2016

Job title:	**Date sent dd/mm/yy**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
The following staff MUST be included in ALL consultations:				
Clinical Governance Assistant	26/07/16	01/08/16	Y	Y
Please list key staff whose reply is compulsory before approval can be granted:				
Chief operating officer	07/07/16	14/07/16	N	N
Director of Operations, Planned Care	07/07/16	14/07/16	N	N
AD of Nursing for Planned Care	07/07/16	14/07/16	N	N
General Manager Cancer and Haematology	N/A	N/A	N/A	N/A
General Managers				
W&C	07/07/16	14/07/16	N	N
General Medicine	07/07/16	14/07/16	N	N
General Surgery and Urology	07/07/16	14/07/16	N	N
Head and Neck	07/07/16	14/07/16	N	N
Radiology	07/07/16	14/07/16	N	N
Clinical Director for Surgery	07/07/16	14/07/16	N	N
Clinical Director for Cancer and Haematology	07/07/16	14/07/16	N	N
Clinical Director for Clinical Support including Diagnostics	07/07/16	14/07/16	N	N
Please list other staff to be included in the consultation but whose reply is not compulsory:				
CCG	21/06/16	06/07/16	Y	Y
Assistant Director of Business Intelligence	07/07/16	14/07/16	N	N

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality. The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. **Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.**

Title of policy or practice	**Cancer Services Access Policy and Procedure**
What are the aims of the policy or practice?	The policy sets out the Trusts approach to the management of patients being treated on a 2week wait or 31/62 day cancer target to ensure that all patients are treated efficiently, equitably and in line with National Access guidelines
Identify the data and research used to assist the analysis and assessment	Staff consultation as defined in appendix two.
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no).** **If yes give details.**
Males or Females	No
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak English as a first language	Yes as they may have difficulty reading the policy but an interpreter can be sourced / provided.
People who have a physical disability	No
People who have a mental disability	Yes as they may have difficulty understanding the policy but assistance can be sourced to aid understanding if necessary.
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	The potential discrimination identified above is minimal and justifiable and therefore a stage 2 assessment is not required.

When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database on the intranet (Trust policies, procedures and leaflets):

No.	Title	Unique ID
4	2ww office process	RWF-OPPM-CSS45
5	2ww referral escalation process	RWF-OPPM-CSS46
6	Consultant upgrade pro-forma	RWF-OPF-CSS-NC-CAN3
7	Inter provider referral form	RWF-OPF-CSS-NC-CAN4

The Operational Policy For Radiotherapy Services

Contents

Introduction to the operational policy

This Radiotherapy operational policy provides key information regarding the delivery of our services to our users, including our vision and strategy for ensuring that our services are delivered safely and effectively and are aligned to the needs of our users.

The policy is intended for service users, Trust managers and all staff within Radiotherapy and research departments at East Kent Hospitals University Foundation Trust (EKHUFT) and the Maidstone and Tunbridge Wells NHS Trust (MTW).

This document provides the overarching framework for Radiotherapy services and is not intended to duplicate information contained within documented Radiotherapy and Trust policies, procedures and work instructions.

Radiotherapy mission and vision statements

Mission Statement

Radiotherapy fully adopts the Trusts values and visions

The Trust mission is:

- Our purpose is to provide safe, compassionate and sustainable health services.

Vision Statement

The Vision of the Trust is:

- To be a high performing, adaptable organisation, meeting the needs of our local community and those further afield with reputable and viable services, inside and outside the hospital.

The Objectives of the Trust are:

- Caring organisation
- Sustainable services
- Improvement driven

Radiotherapy values

Radiotherapy fully adopts the Trusts' values and behaviours across all of our services.

For EKHUFT, the Trust values are expressed through "We Care":

- People feel **cared** for as individuals
- People feel **safe**, reassured and involved
- People feel teamwork, trust and **respect** sit at the heart of everything we do
- People feel confident we are **making a difference**

For MTW, the Trust values are expressed as "PRIDE":

- **P**atient First: We always put the patient first
- **R**espect: We respect and value our patients, visitors and staff
- **I**nnovation: We take every opportunity to improve services
- **D**elivery: We aim to deliver high standards of quality and efficiency in everything we do
- **E**xcellence: We take every opportunity to enhance our reputation

Radiotherapy values and behaviours	
Behaviours	This operational policy
We always put the patient and carers first	• Ensure that all our staff and students are trained to meet the needs of our users and that they uphold professional and Trust standards within a diverse environment
We treat all our patients respectively with patience and supporting them prior to, during and after their treatment	• All patients are given written patient information and access to the Trust website. • All patients are supported by Macmillan site specialists and registered radiographers throughout their radiotherapy journey.
We continually strive to improve the service that we deliver working with national and local teams to develop our service	• All staff are encouraged to attend conferences and training programmes • All staff must maintain continuous professional development to enable them to maintain their competence • All staff have a competency pack on joining the department to enable them to progress within their profession with the aim to undertake more advanced practice • We meet regularly to review our incidents and errors in order to identify any need for change
We work consistently to raise our profile within the Trust and externally	• We encourage staff to attend external meetings and to present at national meetings • We participate in clinical trials, quality assessment, CQC visits and peer review
We work to improve cancer outcomes	• By improving treatment accuracy and embracing new treatment delivery techniques • All clinical staff are trained with the introduction of new equipment and procedures • By improving patient access to information.
To improve the clinical quality of radiotherapy through the expansion of technological	• Participating in clinical trials and implementing new treatment techniques. • Ensuring our patients have the best possible outcome

improvements	
We value the diverse staff group supporting them in all aspects of their role	• All staff and students are respected and treated equitably • Building on experience all staff have a mentor to aid a smooth transmission into the department. • All staff are provided with an induction pack to enable them to be aware of the culture of the Trust (Radiotherapy Services Induction RWF-RMGW501)

4. Services provided by Radiotherapy

4.1 The Radiotherapy department delivers External Beam Radiotherapy (EBRT) and Brachytherapy to patients for a range of cancers at its two sites in Maidstone and Canterbury.

4.2 The department provides a patient information and support service to all patients on Maidstone, Canterbury, Ashford, Margate and Medway sites.

4.3 Radiographers are trained to be able to provide limited medication and we are moving towards radiographer led prescribing.

4.4 We offer a radiographer led fiducial implant service on the Maidstone and Canterbury sites

Table 1: Radiotherapy departmental services at EKHUFT and MTW

External Beam	The KOC delivers EBRT to patients for a range of cancers at its two sites in Maidstone and Canterbury. The treatment is delivered as defined in the relevant Clinical Protocol according to anatomic site and treatment intent The centre is now undertaking SABR treatment for lung patients and is looking to extend this treatment to other diagnoses We have therapeutic radiographers within the oncology centre research departments on both sites .These staff are undertaking a range of activities to enable us to partake in clinical trials
Image Guided Radiotherapy	All patients are imaged prior to radiotherapy in the treatment position in accordance with local protocols and national guidance. These images are compared to digitally reconstructed radiographs (DRRs) produced during the planning process.

Organisational structure

The Kent Oncology Centre (KOC) is managed by the Maidstone and Tunbridge Wells NHS Trust and provides radiotherapy services for the population of Kent and Medway from two sites: Maidstone Hospital and Kent & Canterbury Hospital.

The radiotherapy services manager (RSM) is responsible for the line management of all therapeutic treatment radiographers and professional lead of the radiotherapy workforce across both sites

The RSM is responsible for the line management of administrative staff within radiotherapy

The RSM line managers all Macmillan therapeutic treatment radiographers, consultant radiographers, site specialists and Brachytherapy services

The clinical specialists have responsibility for the day to day management of the radiotherapy department and are responsible for defined areas of practice within clinical and managerial roles.

ORGANISATIONAL CHART SIMPLISTIC.d

Management team roles and responsibilities [1]

Job title	Post holder	Key roles and responsibilities1
Radiotherapy Services Manager	Mrs Christine Richards	Manages the radiotherapy service across the Maidstone and Canterbury sites Trust professional lead for therapeutic radiographers
Deputy Radiotherapy Services Manager	Mrs Karen Rich	Deputises for the RSM across the Maidstone and Canterbury sites
Consultant Clinical Oncologist	Dr Charlotte Abson	Clinical lead for the radiotherapy team

[1] These posts have management responsibilities for staff. This includes staff supervision, recruitment and induction, appraisals, performance management, training and development as well as responsibilities for health and safety in the workplace for staff patients and visitors. These responsibilities are defined in individual job descriptions and this operational policy.

5 Hours of operation

5.1. Radiotherapy services operate between 8.30-18.30 on the Maidstone site and 8.30-16.30 on the Canterbury site

5.2. Additional sessions are worked to meet national guidelines and capacity demands.

5.3. The RSM ensures that schedules and staff rotas enable the service to be covered being mindful of the skill mix requirement

5.4. The rotas are provided in advance to offer opportunities for staff to arrange any changes required.

5.5. In line with Trust policy all staff are required to document any additional hours worked, identifying the reason.

5.6. Three monthly staff rotas are provided for the treatment units. The radiographers arrange their own team rotas to ensure that the working hours are covered

On-Call

5.7. The service provides an on call provision Saturdays , Sundays and Bank holidays on the Maidstone site

6. Quality, governance and risk management

Quality management system

The radiotherapy services are accredited as part of the Kent Oncology Centre to the CHKS Oncology Standard and certified to ISO9001:2015

The Q Pulse document management system ensures that all policies, procedures, processes, instructions and data are readily accessible to radiotherapy staff

The Directorate Quality Manager is responsible for training staff in QMS management and the use of the Q Pulse system.

Internal quality audits are undertaken to obtain objective evidence of the effectiveness of the implementation and maintenance of the QMS.

The audits are undertaken by staff trained in audit and who are preferably independent of the personnel with direct responsibility for the processes being audited. Audits are completed to a planned schedule monitored by the directorate quality manager.

Audit outcomes are reviewed and corrective actions agreed and monitored by the Nursing, Radiotherapy and Administration Services Governance Group.

Radiotherapy policies, procedures, work instructions and data are reviewed regularly in accordance with the review period scheduled in Q Pulse when the document is made live.

The review period is agreed between the document author and the directorate quality manager and takes into account the potential impact of the process/documentation on the quality of our services. Where a review period is required, this should not exceed 3 years and documents may be reviewed more frequently than the scheduled review period if necessary.

The review is undertaken by the author or document authoriser/owner identified within Q Pulse.

The effectiveness of the QMS is reviewed at least annually by the Nursing, Radiotherapy and Administration Services Governance Group and reported by the directorate quality manager.

Radiotherapy audits

- National waiting time audit
- Avoidance of gaps

Information governance and security of confidential information

All staff are responsible for ensuring that they take all reasonable steps to maintain the security of confidential information, including:

- undertaking Trust mandated training in information governance,
- complying with the data protection legislation,
- maintaining and operating service information security measures,
- keeping passwords secure,
- ensuring the completeness and accuracy of records, including signing and dating entries.
- keeping patient notes secure in locked cabinets during non-working hours

Service leads are also responsible for:

- understanding and justifying confidential information held by their service,
- verifying access rights to confidential information,
- monitoring processes for tracking, storing, accessing and securing confidential information,
- reporting information governance breaches.

Health and safety

Health and safety roles and responsibilities

Heads of service are responsible for health and safety at work and other pertinent legislation relating to their service, including ensuring that:

- there are safe systems of work and effective control measures in place to protect staff, visitors and patients,
- there is a designated departmental safety officer (DSO), control of substances hazardous to health officer (COSHH), fire warden and first-aider within their service who are appropriately trained and have allocated time to undertake their duties,
- hazards to patients, staff or visitors are identified and the appropriate risk assessments and mitigation plans are completed, shared with staff and reviewed regularly,
- there are documented security measures in place to protect staff, premises, equipment and confidential information (see below) which are reviewed regularly,

It is the responsibility of every staff member to:

- follow health and safety policies, procedures, work instructions, systems of work and guidance,
- wear the personal protective equipment supplied to them (personal dosimeters),
- report potential health and safety risks to their head of service/line manager.

Each service has a trained departmental safety officer who provides health and safety advice and support to the head of the service.

The radiotherapy team meeting occurs every two months with the following agenda items

H&S
COSHH
First Aid
Fire Safety
Health and Wellbeing of Staff

Health and safety risks are recorded on the directorate risk register unless they are personal risk assessments where they are held confidentially in the staff member's electronic personal files.

Managing stress within the workplace

Heads of service are responsible for:

- conducting general work-based risk assessments and mitigation plans in conjunction with staff and reviewing regularly

- monitoring workloads, working times, overtime and annual leave to ensure that staff are not overloaded or overworked and are taking their leave entitlement
- providing additional support to staff during periods of change or when experiencing stress outside of work
- commencing an individual stress personal risk assessment and referring the staff member to Occupational Health where appropriate.

Staff should raise issues of concern with their line manager, Occupational Health, Human Resources or staff-side representative and work with their manager and Occupational Health to complete and follow the recommendations of a personal risk assessment.

General workplace stress risk assessments are recorded on the directorate risk register unless they are individual personal assessments where they are held confidentially in the staff member's electronic personal record, Trust Human Resources and Occupational Health.

Managing risk

Risks in Radiotherapy are managed in accordance with the Trust Risk Management policy

Potential risks that may impact on the quality of our services include:

- Insufficient staff
- Inadequate skill mix
- Lack of equipment

Recording and mitigating risk:

High or extreme risks require immediate action by the RSM and escalation to the General Manager

It is the responsibility of every staff member to report potential risks that they identify to their head of service/line manager.

Risks are graded in accordance with the Trust's risk categorisation matrix which combines the probability and consequences of a hazard into a single risk score.

All graded risks are held on the directorate risk register. Those risks graded high or extreme are also escalated to the Cancer Services Division risk register (MTW) and this is in accordance with Trust policy.

Escalated risks are reported into the Trust governance processes by the appropriate divisional risk lead.

Reporting and investigating errors, near misses, safety concerns and incidents

All staff have a duty to report errors, near misses, safety concerns and incidents in accordance with the Trust's incident management policy.

Service heads review these records to identify potential trends and any corrective actions necessary to resolve the problem.

Incidents are defined as adverse events that caused or could have caused (near-misses) unintended or unexpected harm, loss or damage to patients, carers, staff, visitors, equipment, confidential and business critical information and premises.

Incidents must be reported immediately through the Trust incident management processes - Datix

Errors and near misses are classified as incidents when an activity against protocol has been performed

Where the classification of an error/near miss is unclear, staff are encouraged to report the event as an incident in accordance with Trust policy.

Incidents are reported on Datix (in the first instance an incident should be reported verbally to a line manager/ head of service) and managed in accordance with Trust and departmental procedures

Access to the Datix e-form is via the Homepage of the Trust Intranet. Staff do not need a Datix password to complete an incident e-form.

Incidents are investigated by staff trained by the Trust in incident investigation.

<u>Communicating lessons learned</u>

Lessons learned from errors, near misses and incidents are feedback to staff via:

- Incident and Error Reporting meeting
- Radiotherapy Development Group meeting
- Service / Departmental meetings
- Updates to policies, procedures and work instructions
- Email
- One to one or team discussions

<u>Documentation</u>

- Business continuity plan Qpulse - RWF – KOC-PBCA7
- Risk assessments
- Risk Strategy
- Hazard profiles Qpulse – RWF-H&SPRT1

Speaking out safely / raising concerns

There is a safe mechanism for staff to raise legitimate concerns to the Trust, with the assurance that their concerns will be fully investigated and dealt with by the Trust and that the individual raising the concerns will receive feedback on the outcome of the investigation.

This mechanism is available to all staff, students and agency staff, contractors and volunteers who encounter issues of concern during their work on Trust premises.

Access to these policies and procedures is via the Trusts' intranet (see below for the policy and procedure details).

Documentation

- Speaking Out Safely policy and procedure (formerly Whistle Blowing) - MTW
- Raising Concerns (Whistle Blowing) policy and procedure - EKHUFT

Performance measurement

6.39. Patient questionnaire survey audits

6.40. Radiotherapy national RTDS data –reporting quantitative comparative data

6.41. Radiotherapy treatment unit activity

6.42. Radiographer performance is measured through the appraisal, preceptorship and competency process

Developing and supporting our staff

Induction

All staff (including trainees) must attend or complete on-line the corporate Trust induction before they start work within Radiotherapy services. Trust induction includes: equality & diversity training, health & safety, information governance, mental capacity and safeguarding, fire safety and infection prevention and control..

All radiotherapy staff are provided with an induction pack to provide information about the Centre, and a who's who, contact list.

All newly qualified radiographers undertake a preceptorship training package and throughout their career are supported with a competency pack from Band5 –band 8 .

Documentation

- Radiotherapy Services Induction
- Students Induction Checklist

Education, training and continuing professional development (CPD)

8.1. The department has an electronic education matrix which identifies all post graduate training and hyperlinks, other educational /mandatory training for all therapeutic radiographers

8.2. All therapeutic radiographers are required to maintain their professional registration. This is checked and documented annually and on appointment to ensure that they are compliant.

Professional/regulatory registration

8.3. New starters registration is checked with recruitment prior to starting new post

8.4. HCPC registration renewals are checked with the management.

Mentoring

8.5. All radiotherapy staff are given a mentor to support them

Authorising staff to perform key tasks

All staff are provided with a job description that identifies the key tasks that they are expected to be able to undertake

Staff extending their roles are required to undertake 'M' level training and signed off by identified assessors.

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Documentation

JD_Template[2].doc
OCT 2015.doc

JD template

Recruitment

All staff are recruited and employed in accordance with documented Trust policies and procedures.

To ensure that the multi-disciplinary department recruits appropriately qualified and experienced staff, the recruitment panel must also contain panellists able to provide professional advice on the applicants' suitability for employment:

Radiographers

Band	Minimum recruitment panel requirements
5 - 6	Two panellists including a Band 8A of above

7	Two panellists including a Band 8A or above therapeutic Radiographer
8A clinical	Three panellists including a: clinical Consultant, head of radiotherapy services, external SCOR representative
8A clinical Macmillan	Three panellists including a: clinical Consultant, head of radiotherapy services, external SCOR representative, Macmillan representative

Regulatory bodies, legislation, national guidelines

Organisation	Legislation, regulations, accreditation, certification, standards and guidelines
Care Quality Commission (CQC)	Health and Social Care Act Ionising Radiation (Medical Exposures) Regulations
Health and Safety Executive (HSE)	Health and Safety Act Ionising Radiations Regulations
Environmental Agency (EA)	Environmental Permitting Regulations
CHKS	ISO 9001 certification Accreditation for Oncology Services (MTW – excluding EME)
Medicines and Healthcare Products Regulatory Agency (MHRA)	Medical Device Regulations
Counter Terrorism Security Advisors (CTSA)	Security of our facilities
National Institute of Clinical Excellence (NICE)	Guidance, advice and standards for the provision of healthcare.
Professional bodies, colleges, academies and regulators (including IPEM, SCOR, RCN, RCSLT, AHCS, HCPC, NMC, RCT)	Professional standards and guidance. Delivery and assessment of training within Medical Physics.