Delivering cancer waiting times
A good practice guide

Updated July 2016
About NHS Improvement

NHS Improvement is responsible for overseeing foundation trusts, NHS trusts and independent providers. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future.

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.
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1. Introduction

1.1. Overview

Patients consider performance against the national cancer waiting times (CWT) standards to be an indicator of the quality of cancer diagnosis, treatment and care an NHS organisation delivers.

Delivering timely cancer pathways is crucial for the following reasons:

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

We recognise that many organisations either struggle to maintain compliant performance on a consistent basis or achieve below-standard performance.

1.2. How this guide works and who it’s for

The guide is designed to walk you through the essential elements of a pathway for suspected cancer; from pre-referral advice and outpatients, through diagnostics to patient admissions. It also covers key areas that support the effective operational delivery of a pathway for elective cancer treatment, including demand and capacity planning, cancer access policies and governance (performance management and reporting).

This guide is a collection of advice and expertise from the NHS Improvement Elective Care Intensive Support Team (IST), which has been developed since 2008 to support NHS organisations across the country to deliver high quality care pathways for patients and maintain low waiting times for treatment.

It complements our IST Elective care guide.¹

¹ www.nhsimas.nhs.uk/ist/referral-to-treatment-a-guide-for-managing-efficient-elective-care/
It is primarily written for NHS staff who are involved in any aspect of pathway management for suspected cancer and who want to know how they can best manage or deliver these pathways. This will include staff in acute trusts, NHS foundation trusts, area teams (ATs) and clinical commissioning groups (CCGs).

For those organisations that are finding delivery of the maximum waiting time standards challenging and/or who would like external assurance about their demand and capacity planning processes, please submit a request for our support to mailto: NHSI.ElectivelST@nhs.net.
2. Key to the guide

2.1. Understanding the principles and rules

The NHS has set maximum waiting time standards for access to healthcare. In England, those for cancer care fall under two headings:

- individual patient right (as per the NHS Constitution)
- waiting time standards to which the Department of Health holds individual providers and commissioners to account for delivery.

2.2. Individual patient rights under the NHS Constitution

The current maximum waiting times for patients in England for cancer care and their rights are set out in the NHS Constitution and the Handbook to the NHS Constitution.²

Patients with suspected cancer have the right to:

- access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible
- be seen by a cancer specialist within a maximum of two weeks from urgent GP referral for suspected cancer.

The handbook also lists the specific circumstances where this right no longer applies and those services where patients are not covered by the right.

2.3. Assessment of NHS performance: the provider standards

Government pledges on waiting times include:

- a maximum one-month (31-day) wait from the date a decision to treat (DTT) is made to the first definitive treatment for all cancers
- a maximum 31-day wait for subsequent treatment where the treatment is surgery
- a maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy
- a maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen
- a maximum two-month (62-day) wait from urgent referral for suspected cancer to the first definitive treatment for all cancers

• a maximum 62-day wait from referral from an NHS cancer screening service to the first definitive treatment for cancer

• a maximum 62-day wait from a consultant’s decision to upgrade a patient’s priority to the first definitive treatment for all cancers

• a maximum two-week wait (2WW) to see a specialist for all patients referred with suspected cancer

• a maximum 2WW to see a specialist for all patients referred for investigation of breast symptoms, even if cancer is not initially suspected.

These measures are set out in *Everyone counts: Planning for patients 2013/14*.3

**NHS providers**

NHS foundation trusts are held accountable through Monitor’s Risk Assessment Framework (RAF) and NHS trusts through the NHS Trust Development Authority’s (TDA) Oversight and Escalation Framework. Monitor and TDA are now both part of NHS Improvement. Recognising that NHS foundation trusts and NHS trusts are facing similar challenges, NHS Improvement is currently (July 2016) consulting on a new Single Oversight Framework to replace both the RAF and the Oversight and Escalation Framework.

2.4. **National guidance**

**Rules and definitions**

To ensure that reported performance is consistent and comparable across providers, the measurement and reporting of waiting times is subject to a set of rules and definitions. For cancer services this is the guidance on CWTs.4

It is important there is a consistent approach to the interpretation and implementation of national guidance across NHS organisations. In some circumstances it is for the NHS locally to decide how to apply these guidelines to individual patients, pathways and specialties. It is important these decisions are based on clinical judgement and made in consultation with NHS staff, commissioners and, of course, patients. The guidance is designed to ensure that reported waiting times are a true reflection of patients’ experiences.

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3 [www.england.nhs.uk/everyonecounts/](http://www.england.nhs.uk/everyonecounts/)
3. Managing capacity and demand

3.1. Overview

This section explores good practice principles for modelling demand and capacity for cancer services. These are:

- the outputs that services should look to gain from demand and capacity modelling
- good practice approach and what to avoid when undertaking the modelling
- mechanisms to build confidence and assurance around waiting times performance sustainability.

3.2. Guiding principles

The successful delivery of any maximum waiting-time standard (eg 2WW) is predicated on the following factors:

- patient pathways can deliver a short wait, and describe clearly what should happen, in what order and when
- a position balanced between demand and capacity
- a maximum number of patients waiting that is consistent with the level of demand and key pathway milestones, eg maximum time from referral for suspected cancer to the first outpatient appointment
- patients are treated in order of clinical priority and in a timeframe that meets the 2WW standard
- patients are actively managed against the pathway for their condition and its key milestones.

While all of these factors are important, a position balanced between demand and capacity is essential. If demand exceeds capacity the numbers of patients waiting will increase, waiting times will lengthen and the organisation will be less able to provide short waits.

Of equal importance is a size of waiting list that is consistent with the delivery of a 2WW target or a shorter target where internal stretch targets require this.

The best way to understand the dynamic between demand and capacity and to calculate maximum list sizes is to use a modelling tool. There are many different modelling tools, both commercial solutions and those developed in-house. The model an organisation chooses to use is not necessarily important as its function is to improve understanding and support discussions around how a service can predict demand and plan services accordingly.
3.3. Tips

- A position balanced between demand and capacity is essential.
- When demand exceeds capacity the number of patients waiting will increase, along with the waiting time for an appointment.
- Size of waiting list is equally important.
- Modelling tools can help you to understand demand and capacity.

It is very difficult to model services for the 31-day and 62-day standards in their entirety. In cancer services, pressure on the 31-day target should be seen as an indicator of true treatment capacity issues, rather than the 62-day target. However, key stages of a cancer pathway can be modelled separately to identify where the capacity constraints occur; for example, 2WW, waits for endoscopy, waits for imaging, waits for treatment once a DTT has been made.

Details of how to access the models we routinely use when helping client organisations to understand their particular service are given later in this section. The models explain issues such as the capacity appropriate to deal with variation in demand. More detailed guidance on modelling cancer services can be found in our guide *Capacity and demand guidance for cancer pathways.*

3.4. Dos and don’ts

The lists of dos and don’ts are based on our practical experience from helping organisations develop and use demand and capacity models. You could use them as simple checklists to help you avoid the most common pitfalls.

**Do**

- Involve clinicians from the start of the process.
- Adopt a logical and consistent approach to the process.
- Ensure the demand and capacity planning process is led by the general/service managers or cancer managers and involves the information team, rather than the other way around.
- Agree the common data requests based on the model inputs to avoid multiple ad-hoc information requests.

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• Decide what’s in and what’s out so you compare like with like in terms of demand, capacity and what procedures/patients are on the waiting list(s).

• Document important information and decisions about the data and any assumptions you have used, especially when building models at sub-specialty or consultant level. Try to keep this information in a separate spreadsheet in the model.

• Sense check data with those closest to the operational challenges, e.g. service managers should sense check data with bookings staff, and cancer managers should have a good overview of the service as a whole. This is especially important when verifying core capacity.

• Sense check data for logical relationships between related items, e.g. the size of a waiting list at the beginning and end of the year, and whether these look sensible when you look at how many patients were added and removed (for all reasons) over the year.

• Sense check any step changes in demand against national awareness campaigns. Check these are consistent with available national data on expected increases in referrals.

• Review demand and capacity on a rolling basis – monitor trends in demand and revise capacity plans if required.

• Share plans and ensure all the key stakeholders, including commissioners, are signed up to and understand the plans.

• Consider holding six-month, annual and one-to-three year horizon-scanning sessions with each specialty separately to develop plans for service changes, including those as a result of new technologies, and awareness campaigns – to include commissioners and finance.

• Work with commissioners to review retrospectively the impact of awareness campaigns.

Don’t

• Don’t become a slave to the models – they are used to support conversations and improve understanding, not to replace them.

• Don’t be concerned when the first run-through/population of the model does not work perfectly. Some of the data items may currently not be commonly requested reports and refinement may be needed to get them right.

• When looking at current core capacity, don’t count over-bookings, ad-hoc or out-sourced activity.

• Don’t see demand and capacity planning as a one-off exercise. Models should be regularly reviewed, particularly with regard to the anticipated level of demand.
Some data items may have been based on an educated/informed guess rather than hard data.

- Don’t forget that by its very nature, a modelled position will never exactly match reality. Even the most sophisticated model cannot predict the precise nature of the variables that were used to create the model scenario.

- Don’t model cancer services in isolation. They need to be considered in the context of the overall service and the various patient groups that pull on the same resources.

When working with NHS organisations to develop demand and capacity models, we often use a set of simple comparisons to sense check the initial inputs into the model. These include:

- comparing the number of referrals against the number of first outpatients seen in the last 12 months
- comparing the number of additions to the waiting list against actual admissions.

We consider whether any major differences in the above comparisons are explained by changes in the first outpatient or admitted waiting lists.

3.5. Information requirements

As stated above, service managers/cancer managers will need help from information colleagues to pull together the data items required to complete the demand and capacity models. It is important therefore that the operational management and information teams go through the models together to understand the data inputs. The information team will need to be clear about what is ‘in’ and what is ‘out’ when writing queries to extract the data. Experience shows that this can be an iterative process and it is usual not to get it right the first time.

While models subtly differ from each other, data items may include:

- 52 weeks of historical 2WW referral data (including breast symptomatic)
- 52 weeks of historical decision to admit (DTA)/additions to the waiting list data to include all patients types (cancer, urgent, routine), but with cancer patients clearly separated
- removal other than treatment (ROTT) rates for both first outpatient and admitted waiting list
- first outpatient attendances for the last 12 months (this data item may include cancer patients only if 2WW services are modelled separately)
- first outpatient did not attends (DNAs) for the last 12 months
- first outpatient DNAs rebooked for the last 12 months
• admissions for the last 12 months with cancer patients clearly separated
• cancelled admissions (if capacity was genuinely lost, ie cancellation on the day of surgery) for the last 12 months
• rebooked cancelled admissions for the last 12 months
• current sizes of the first outpatient and admitted waiting lists (both with and without dates)
• first outpatient and admitted waiting list sizes (both with and without dates) at the beginning and end of the 52-week referral/activity data collection period
• baseline core capacity to see first and follow-up outpatient attendances, including dedicated cancer slots (taking account of clinics lost due to annual leave, study leave, bank holidays, on-call, etc)
• baseline core capacity to undertake surgical procedures, including dedicated admission slots for cancer patients (taking account of sessions lost due to annual leave, study leave, bank holidays, on-call, etc).

Some of the data items (eg first outpatient ROTT rate, cancelled surgical admissions, where capacity was genuinely lost) are not routinely extracted. Perhaps surprisingly, robust, clean referral data are often quite challenging for organisations to extract. Given that referrals are the initial driver for the vast majority of cancer pathways, providers need to understand their demand data.

Agreeing (and testing) initial trawls and extraction of the common data items should standardise the requests made to the information team and avoid multiple ad-hoc requests where the specification of the data items may vary because of differences in individuals’ understanding of what is required. However, it is likely that when modelling cancer services, how specific requests can be may depend on the tumour site being reviewed.

3.6. Tips

• Collaboration between the service/cancer managers and information team is essential to pull together the data required for modelling.
• Where information is not available, clarify and document how figures are calculated.
• Testing initial data trawls and extraction helps the information team to standardise information request responses and avoid multiple ad-hoc requests.

3.7. Role of demand and capacity in supporting cancer care delivery

Some models include the option both to plan required dips in activity to meet the anticipated demand and to record ‘actuals’ as they occur. This is helpful as it provides
metrics against which delivery of the plan can be measured and service areas be held accountable for their individual performance.

For example, if a modelled waiting list is not at its predicted size at a particular time point, the base drivers can be reviewed to understand why. Given the waiting list size will be principally determined by the additions to and the removals from it (ie activity), you should be able to work out whether the level of demand differs from that anticipated or if the planned level of activity has not been delivered.

In reviewing demand and capacity dynamics, there is often a shortfall in capacity that adversely affects waiting times. These can be addressed by increasing the level of resource, making the current resource more productive or a combination of the two.

To model demand and capacity for cancer services it is important to have developed clinically agreed patient pathways, with clear timescales for each stage of the pathway. These are needed to determine the optimum waiting list sizes a service should aim to hold to deliver each stage of the pathway, within these agreed timeframes.

Links that signpost to some useful resources focused on increasing productivity are:

- Steyn: Improving patient flow website
- NHS Improving Quality: Productive operating theatres
- NHS Institute: Enhanced recovery
- Guidance on demand and capacity modelling

3.8. Getting help

Through working with NHS providers and commissioners, we have developed a series of demand and capacity models to help organisations to achieve an appropriate balance between the two, and to ensure that waiting lists are an appropriate size. These can be a helpful starting point for organisations seeking to better understand demand and plan capacity.

While it would appear that only our 2WW model has been specifically developed for a cancer pathway, many of the models can be used to model cancer services, either by modelling the entire patient pathway to include all patient types (cancer, urgent and routine) or to monitor only the cancer aspect of the pathway. Generally, we suggest modelling services in their entirety, but with the ability to separate out cancer services as necessary.

The following IST models are likely to be the most useful for modelling cancer pathways. These can be found with user guides on our website:6

6 https://improvement.nhs.uk/resources/
**IMAS: Two-week wait cancer capacity and demand tool:** To model the pathway between GP referral for suspected cancer and first outpatient attendance. This models patients who are on a 2WW pathway for suspected cancer only.

**Outpatient demand and capacity tools:** To model the pathway between GP referral and first outpatient attendance. This models the entire pathway, with cancer and urgent patients being a subset of all referrals.

**Endoscopy demand and capacity tool:** To model the demand for endoscopy service in its entirety. This models demand from all endoscopy patients, with cancer patients being a subset of demand.

**Diagnostic imaging demand and capacity tool:** To model demand for the radiology service, with the demand from cancer patients included as a subset.

**Inpatient daycase capacity and demand tool:** To model the demand for admission services from DTT to admission for treatment. The model can either model the entire service or just the demand from cancer patients if the capacity for the service is separated out.

The model outputs can inform and influence cancer pathway mapping and support work with CCGs and commissioners.
4. Governance: reporting and performance management

4.1. Overview

This section gives good practice governance principles that ensure confidence in the following areas of the cancer waiting times (CWT) system:

- good practice CWT leadership and staff structures for ownership and accountability, communication and engagement
- processes that ensure organisations can trust their cancer data
- mechanisms to build confidence and assurance around the sustainability of waiting times performance.

4.2. Cancer leadership structures

Each organisation that provides cancer services will have a distinctive leadership structure (the core cancer management team). We have seen different approaches in different providers to how it is structured and where it sits in the organisational structure. Some cancer structures work within an operational structure, i.e. sit within a clinical division, and others are separate from the operational structure, i.e. sit as a corporate function. One size will not fit all and there is no best structure for staffing NHS cancer services. What is essential is that organisations develop local governance structures that reflect the complexities of their organisations.

It is essential that:

- the remits and level of authority of the core cancer management team and individuals within the team are clear and communicated across the organisation
- accountability for cancer delivery is clearly identified
- board level support for the structure is articulated
- sufficient time is made available for individuals to enact their roles
- a clear governance framework is in place.

The commonest core cancer team management structures are outlined below, in terms of broad remits.

- **Executive director with a remit for cancer**: A single executive lead for cancer with board-level accountability for CWT and cancer delivery. This person is not usually the chief executive but this does not negate the need for the chief executive’s personal involvement when necessary. The chief executive or nominated deputy should sign off the cancer performance data before they are submitted.
- **Lead cancer clinician**: A designated clinical lead with overall responsibility for ensuring high standards of cancer clinical care across the organisation in a timely manner, leading on the development of the cancer strategy with directoral, managerial and clinical support. This person is usually, but not exclusively, a consultant with responsibility for facilitating delivery of CWT performance. This individual has professional management responsibility for the multidisciplinary team (MDT) clinical leads in their cancer-related roles.

- **Lead cancer manager**: A designated senior manager with responsibility for facilitation of the delivery of cancer waits. This manager has a corporate responsibility for cancer, including monitoring cancer waiting data quality, and implementation of the cancer strategy, as well as a possible lead role in co-ordinating peer review. They are usually responsible for managing the cancer trackers (MDT co-ordinators) and 2WW referral bookings office.

- **Lead cancer nurse**: A named lead nurse for cancer with co-responsibility for facilitating the delivery of CWT. This role should include responsibility for developing the cancer nursing strategy, and may incorporate a lead role in co-ordinating peer review. This person should have either direct line management or professional line management responsibility for cancer specialist nurses in the organisation, who in turn have a role in supporting patients through their cancer pathways in a timely manner. This person often has a professional line management link to the director of nursing.

- **MDT clinical leads**: A named lead from the MDT should be assigned for each of the tumour sites (as per peer review requirements). Each lead should be accountable for CWT delivery, management of the patient tracking list (PTL) (including data quality and completeness), breach avoidance and learning (with support from the relevant senior specialty manager).

### 4.3. Communicating cancer performance across the organisation

Cancer is an organisation-wide service, cutting across most specialties and diagnostic services. It is important to have formal and timely communication channels from the core cancer team to specialties and the wider organisation, and vice versa, so that specialties can keep the cancer team abreast of any challenges or planned service developments.

There should be formal meetings that support communication of CWT and the wider cancer agenda across the organisation:

- cancer performance meeting and local (tumour-level) cancer PTL review meetings (see Section 5: Core functions)

- cancer steering group/cancer board meeting – a monthly or quarterly meeting chaired by the cancer lead clinician or executive lead, attended by the cancer senior management team, MDT leads, and representatives from diagnostics and other cancer support services
the cancer lead manager should attend the organisation’s wider performance meetings (eg RTT PTL meeting) to raise awareness about cancer waits and to escalate issues

representatives of the cancer senior management team should attend specialty business meetings as appropriate, to provide updates on cancer performance issues and relevant national or local initiatives that will affect service delivery, eg cancer awareness campaigns.

4.4. Attributing accountability and responsibility for cancer waiting times within the organisation

Responsibility for CWT should be integrated into operational delivery structures. It should be clearly explained and known who is responsible for which elements of delivery of the CWT standards.

For example, the specialty/tumour site management team could be held responsible for ensuring the clinical service runs efficiently; there is sufficient capacity to meet demand, clinicians adequately prepare patients for each stage of their cancer pathway. The cancer core team could be held responsible for ensuring that MDT co-ordinators escalate any identified capacity issues to the service, that cancer patient tracking is undertaken in a conscientious and timely manner, and any concerns escalated to ensure fast resolution by the tumour site management team.

The executive lead for cancer should reinforce the lines of responsibility and ownership to ensure accountability for CWT delivery sits with those in a position to deliver, ie ultimate responsibility sits within the specialty, not within support structures such as the core cancer team, service improvement, etc.

MDT clinical leads and managerial leads (tumour site management team) for each cancer site should be accountable for CWT delivery, management of the PTL (including data quality and completeness) and breaches. The cancer lead clinician/executive lead should meet the tumour site management team at regular intervals to review tumour-level performance and agree remedial or improvement actions as appropriate. Outside of meetings, there should be clear lines for escalation.

4.5. Staff code of conduct

The culture of delivering services in line with nationally determined standards is deeply embedded in the NHS. While it is recognised that the framework of setting and complying with these ‘targets’ is ultimately in the interests of individual patients and the public, it is acknowledged this sometimes drives an unhealthy focus in NHS organisations on ‘hitting the target’. On rare occasions this has led individuals to act dishonestly in fear of failure.

The continual and relentless public scrutiny faced by organisations creates a challenging and demanding environment for NHS managers and staff, yet the public
must trust that services and the promises of timely treatment made in documents such as *The Operating Framework* and *The NHS Constitution* are delivered.

The *NHS Managers’ Code of Conduct*\(^7\) and the *Freedom to Speak Up*\(^8\) initiative impress on managers their responsibility to ensure that both they and their staff act at all times with integrity and probity; and staff can raise concerns about alleged wrong-doing in a blame-free and supportive environment.

### 4.6. Processes to build trust around cancer data quality

The key to building trust around cancer data quality is to implement validation (checking) systems to ensure the recording of data is accurate and complete. ‘Clean’ data are essential for effective pathway management and particularly before the mandatory uploading of information by all NHS acute trusts in England to the National Cancer Waiting Times database, hosted by Open Exeter (OE).

Most CWT databases have various integrated reports built in as standard which, when run, allow data conflicts to be flagged and subsequently, manually resolved. There should also be a monthly review of breaches and a sample of non-breaches to provide further assurance on data quality as well as learning opportunities. A programme of spot checks (eg one or two tumour sites per month) of what is contained in the hospital record compared to what is entered into the CWT database and patient administration system (PAS) is another robust data accuracy checking tool. These validation checks can also identify where staff training and supervision may be required.

### 4.7. Conflicts of interest

In addition to these basic data checks, organisations should adhere to best practice governance principles for avoiding conflicts of interest where self-reporting own performance data. For example, duties and responsibility for managing cancer performance and reporting cancer performance should be separated. Different individuals should do the following tasks:

- data input
- validation of input data
- performance management
- breach reporting.


\(^8\) www.nhsemployers.org/your-workforce/retain-and-improve/raising-concerns-at-work-and-whistleblowing
4.8. Board assurance

The provider board is responsible for ensuring it has the right level of knowledge and access to timely and accurate data to effectively challenge both good and non-compliant CWT performance. The core cancer team should provide support, guidance and training to the board so that it can enact this responsibility.

Board training

The chairman, chief executive, non-executive directors and other board members should receive basic training on CWT rules and the key factors influencing performance. There should be some awareness training around the metrics and key performance indicators (KPIs) used by the organisation to trigger alerts regarding potential performance issues. This knowledge and information will encourage the board to challenge performance, rather than just accepting compliant or ‘green’ performance as such, and move beyond asking questions such as ‘Are we going to breach the target?’ to those that are more relevant, such as ‘Exactly how long are patients waiting for?’

4.9. Reports to the board

The board should receive routine reports on CWT performance and also ask for exception and remedial action plans (as appropriate). Trend analysis and prospective reports can be more useful than retrospective reports as these allow managers to identify and avoid issues that may impact on performance.

Generally, good quality reports should include:

- graphical trend analysis
- benchmarking against the previous year’s performance and/or local or national comparators
- separation of breaches into those that are ‘unavoidable’ (patient choice and clinical reasons) and ‘avoidable’
- use of intelligent indicators such as median and percentile waiting times
- breach trend analysis.

The information in any one or a combination of these reports may trigger the board to instigate internal and/or external audits as appropriate.

4.10. Training

Each provider should consider what training and learning processes are needed to ensure organisational practice is in line with national rules and guidance. There should be basic CWT rules training for all staff involved in the delivery of cancer performance (managerial, administrative, nursing, clinical, including staff from diagnostic and other support services). Refresher training should form part of an annual training cycle and,
where possible, this should be essential training for staff directly involved in CWT delivery, eg clinical leads, managers, admissions and outpatient bookings staff, etc.

2WW bookings clerks and MDT co-ordinators should have in-depth role-related training that includes PAS, CWT database, diagnostic IT systems, tracking, access policy and practical implementation of standard operating procedures (as appropriate to the roles). Completion of this training should be monitored throughout the year and should form part of the annual staff appraisal process.
5. Core functions

5.1. Overview

This explains the core cancer functions, often but not necessarily delivered by a cancer team, in the operational delivery of the cancer standards.

It is important for local health and care economies (LHCEs) to take a pathway approach to managing cancer services. The cancer waits standards, particularly the Going Further on Cancer Waits standards, have been developed to help organisations manage patients’ care on a pathway and to remove hidden waits.

We recommend that organisations establish a detailed understanding of pathways at a sub-tumour site level. In urology, for example, there will be different pathways covering renal, bladder, prostate, testicular and penile cancers. The provider should establish key milestones for each pathway. Diagnosis of colorectal cancers, for example, may require a number of stages; while for many skin cancers, diagnosis and treatment are often one and the same.

Taking a pathway approach to managing cancer services brings the following benefits for cancer patients and NHS organisations:

- helps manage the cancer performance standards (at tumour site level)
- identifies hidden waits
- allows organisations to track patients correctly
- identifies any specialty-specific issues
- provides an opportunity to deliver more sustainable and timely services, and identifies key parameters that can be used in demand and capacity modelling.

NHS organisations must also consider the information flows required to support the management of patients in a pathway approach and the reporting tools that will help identify bottlenecks in cancer referral to treatment (RTT) pathways.

5.2. Patient tracking

Pathways

Due to the short timescales involved, organisations need to have in place staff, systems and processes to ‘pull’ cancer patients along their diagnosis and treatment pathways. To ‘pull’ a patient through a cancer pathway it is necessary to know what the pathway should look like (what the stages are) and how long each stage takes (how they fit together to deliver a 62-day pathway).

This level of understanding is necessary at the sub-tumour site level, eg there are separate pathways for renal, prostate, bladder, testicular and penile cancers, and not just one for urology.
Staff roles

Responsibility for daily tracking varies considerably among NHS organisations and may be covered by the MDT co-ordinator posts or may be part of several related roles with titles such as cancer pathway navigator, cancer data officer, cancer tracker and patient pathway co-ordinator. Similarly, while smaller organisations might have a lead cancer manager with line management responsibility for MDT co-ordinators, cancer information and the management of cancer waits, larger providers may spread these responsibilities over several roles.

Benefits to centralisation of this function into one or two job roles can include:

- easier assurance of adherence to rules, protocols and standard operating procedures
- ability of staff to share knowledge and experience
- clear lines of responsibility
- consistency across tumour sites/specialties/divisions
- clear pathways for escalation.

Benefits to decentralisation, including embedding staff in specialty teams, can include:

- closer integration with MDTs
- easier and more immediate communication with clinical nurse specialists
- better working with, and understanding of, the specialty/business unit
- supports corporate responsibility for the delivery of CWT within each business unit, rather than in a centralised cancer team
- better understanding among staff of the delivery of cancer services by the provider as a whole rather than by one of its services in isolation.

Whatever the staff configuration, several primary responsibilities are related specifically to cancer patient tracking:

MDT co-ordinator

- Daily/several days per week:
  - reviews a patient list for specific tumour site(s), with a focus on pathways requiring action such as arranging/expediting appointments
  - communicates with key administrative/bookings staff in outpatients, the inpatient waiting list, endoscopy, imaging, pathology, oncology, etc
• **Weekly:**
  o reviews all ‘at-risk’ patients for specific tumour site(s) in advance of pre-PTL and PTL meetings
  o reviews these again to ensure that PTL meeting actions have been carried out
  o contacts partner organisations such as tertiary/secondary providers if patients referred to/from these reviews are missing data/data quality reports (see Section 6.4: Tracking systems)

• **Ad-hoc:**
  o creates a detailed timeline of the pathway for each patient breaching any of the CWT standards, preferably at the time each treatment is recorded (not at month end)

**Two-week wait (2WW) office**

• **Daily:**
  o booking clerk reviews and chases all unbooked patients and escalates unresolved issues

• **Several days per week:**
  o booking clerk ‘hands over’ attended patients to relevant MDT co-ordinators
  o supervisor/manager reviews 2WW PTL and escalates concerns appropriately

**Specialty manager/support service manager (eg endoscopy, imaging)**

• **Several days per week:**
  o reviews a patient list for specific tumour site(s) or support service(s), focusing on pathways requiring action such as arranging/expediting appointments
  o reviews and actions escalations from 2WW office
  o takes the required action for patients escalated as per the provider escalation protocol (see Section 7.3: Access policy)

• **Weekly:**
  o reviews all ‘at-risk’ patients for specific tumour site(s) or support service(s) before pre-PTL and PTL meetings
  o reviews these again to ensure that PTL meeting actions have been carried out
Cancer manager

- Several days per week/ad-hoc:
  - ad-hoc discussion of ‘problem’ pathways with MDT co-ordinators
  - ad-hoc discussion of ‘problem’ pathways with 2WW office

- Weekly:
  - reviews all ‘at-risk’ patients before PTL meeting
  - reviews these again to ensure that PTL meeting actions have been carried out
  - weekly discussion with cancer managers at other providers regarding patients on shared PTLs
6. Reporting

Because of smaller patient numbers and shorter timescales, cancer information typically has a greater level of patient detail than might be found in relatively less urgent areas of elective care.

6.1. Tracking list

A detailed patient list is needed for patient tracking that shows all patients currently on a 31- or 62-day pathway and allows easy filtering by tumour site or hospital area (pathology, radiology, etc). This list should enable tracking staff to see clearly where each patient is in their cancer pathway, what next stage(s) each patient is awaiting and the deadline by which it needs to be done. It should be clear which patients are currently at risk of missing a milestone on their pathway.

The report should be live using data from the cancer information system, or at least be refreshed every day. While this report may look very similar to the PTL and must contain the same patients, the purpose and audience are different. The patient list helps MDT co-ordinators day-to-day and may require specific detailed data that are not necessary for the provider PTL.

It can be helpful to review the information and order of fields provided in the PTL to ensure they are ordered in a way that is most user friendly for booking staff, and that patients are ordered from longest wait at the top to shortest wait at the bottom. While patient-level detail is essential, a pivot table on a worksheet within the spreadsheet can provide a useful overview of patients and their respective wait, for each tumour site. It can also be helpful to remove any unnecessary fields from the PTL, to aid its usability and reduce the file size.

6.2. MDT meeting

The MDT meeting is not just a clinical discussion. It is important to discuss the patient pathway and teams should formally make time for this as part of the agreed minimum dataset for each patient discussed at the MDT meeting. It is also good practice for real-time data entry of information to support both cancer waits and national audit requirements. The National Cancer Intelligence Network has published advice on MDT development\(^9\) and The characteristics of an effective MDT\(^10\) gives further detailed information.

Part of the MDT co-ordinator role is typically to prepare the MDT meeting agenda each week. It is important that discussions and decisions at MDT meetings consider patients’ position and waiting time along their cancer pathway, and therefore it is necessary that the agendas contain breach dates where applicable. Ideally these are generated

\(^9\) [www.ncin.org.uk/cancer_type_and_topic_specific_work/multidisciplinary_teams/mdt_development](http://www.ncin.org.uk/cancer_type_and_topic_specific_work/multidisciplinary_teams/mdt_development)

\(^10\) [www.nhsiq.nhs.uk/media/2444560/ncatmdtcharacteristics.pdf](http://www.nhsiq.nhs.uk/media/2444560/ncatmdtcharacteristics.pdf)
automatically using the cancer information system. If this is not possible, the MDT co-ordinator should add dates manually.

6.3. Cancer patient tracking list (PTL)

A report to support the PTL meeting (and, if in place, the pre-PTL meeting) is required. The information should again be at patient level but need not necessarily contain all patients on a pathway. Provided the provider has sufficient assurance of data quality, timeliness and completeness on the cancer information system, this need only include patients whose pathways are at risk of breaching key milestone targets (either approaching the deadline without a date, or with a date beyond the deadline) for:

- a 2WW appointment (this may be less than 14 days depending on the local pathway/organisational stretch targets)
- a diagnostic test
- diagnosis
- MDT discussion
- transfer to a tertiary provider
- date of DDT
- treatment.

Where technically possible, it is good practice to distinguish new issues from any unresolved since the previous PTL meeting.

As well as a patient list as described above, it is also necessary to provide an overview to give a more visual feel for where patients are on their pathways, split by tumour site, hospital business unit, specialty, etc as appropriate. Ideally this will show how many patients are waiting at each key pathway milestone (DDT, diagnosis, etc).

The key principles for PTL overview reports are:

- **forward-looking**: what needs to happen next, not what has already happened
- **exception-based**: making it easy to identify those pathways which are cause for concern
- **summarised appropriately**: split by (sub) tumour site, specialty, business unit as required to fit the structure of the PTL meeting.

6.4. Tracking systems

NHS organisations typically have a stand-alone cancer information system in addition to the core PAS. To manage a patient through their cancer pathway it is necessary to understand the pathways patients are expected to take and to monitor patient waiting times and experience; information is needed for each pathway event for each patient.
As a minimum the cancer information system must allow staff to input data on key milestones such as:

- first outpatient appointment
- key diagnostic test or tests
- diagnosis
- DTT
- MDT discussion
- transfer to another provider
- treatment (or decision not to treat).

For milestones relating to appointments, request date, appointment/to come in (TCI) date and final attendance date must be recorded to enable prospective tracking.

The data required to track cancer patients will typically sit in a number of other systems as shown in Table 1.

**Table 1: Where data to track cancer patients can be found**

<table>
<thead>
<tr>
<th>Primary system</th>
<th>information</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAS</td>
<td></td>
<td>Demographics&lt;br&gt;Referrals&lt;br&gt;DNAs, cancellations and attendances&lt;br&gt;Forthcoming outpatient appointments</td>
</tr>
<tr>
<td>Pathology</td>
<td></td>
<td>New diagnoses&lt;br&gt;Histological staging information&lt;br&gt;Report highlights/text</td>
</tr>
<tr>
<td>Radiology</td>
<td></td>
<td>New diagnoses and ‘red flags’&lt;br&gt;Report highlights/text&lt;br&gt;Radiological staging information</td>
</tr>
<tr>
<td>Endoscopy</td>
<td></td>
<td>New diagnoses and ‘red flags’&lt;br&gt;Report highlights/text</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td></td>
<td>New treatment courses and subsequent treatments&lt;br&gt;Regime details</td>
</tr>
<tr>
<td>Radiotherapy</td>
<td></td>
<td>New treatment courses and subsequent treatments&lt;br&gt;Details, fractions, etc</td>
</tr>
<tr>
<td>PAS admitted waiting list</td>
<td></td>
<td>Treatment TCIs&lt;br&gt;Subsequent treatments</td>
</tr>
<tr>
<td>Theatres</td>
<td></td>
<td>New/subsequent treatments</td>
</tr>
</tbody>
</table>

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Where technically possible, the ideal is to implement automated information feeds from these primary systems into the cancer information system. This has the threefold benefit of reducing the time staff spend on manual data entry, keeping cancer tracking (and audit) data up to date and minimising transcription/data quality errors. Most providers have at least a basic feed of demographic information from PAS, but need to explore interfaces to other systems.

NHS organisations should use the range of data quality check reports available on the National Cancer Waiting Times database and ensure that any data discrepancies are resolved, jointly with other organisations in the case of shared pathways.

### 6.5. Breach analysis and reporting

The tolerances allowed by the national cancer waiting time standards accommodate patients who choose to wait longer for their treatment or for whom waiting longer is clinically appropriate, or where pathways include a complex element.

**Avoidable versus unavoidable breaches**

Analysis of waiting time standard breaches helps organisations distinguish between unavoidable breaches due to, for example, patient choice, a complex diagnostic pathway, or longer wait being a clinical exception and in the best clinical interest of the patient, and avoidable breaches due to administrative and/or capacity issues.

Where breaches are not explained by clinical reasons or patient choice (ie avoidable breaches), analysis will identify problems which need to be understood and addressed to eliminate unnecessary waits and improve patient experience. This will enable the organisation to determine if the breach was a ‘one-off’ event or if there are wider systemic problems requiring remedial action.

**Patient choice breaches**

If declaring that the primary reason for a breach is patient choice or patient non-co-operation, providers should be able to demonstrate that the patient asked to wait longer. It would not be appropriate to give this reason for a breach if the organisation had given the patient very short notice of an appointment or little genuine choice.

**Review of breaches**

A detailed review should be undertaken of each patient breaching any of the cancer waiting time standards and, as a minimum, detailed reviews of 31-day and 62-day breaches. Typically, this review is a ‘root cause analysis’ (RCA) for each breach, examining why it occurred. This is best done at the time the breach occurs, then reviewed and updated as necessary when the patient is treated. Analysis should identify the primary reason why a patient waited longer than the waiting time standard; that is the reason for the largest proportion of the breach. The Department of Health breach reason should be recorded.

Detailed breach analysis requires an assessment of the entire pathway by staff who understand the organisation’s processes, systems and local access policy. Analysis
should include a timeline of milestones along the patient pathway and how long the patient waited at each stage. Comparing the actual patient pathway against locally agreed milestones by tumour site or sub-tumour site pathway will help identify delays. The number of days of avoidable and unavoidable delay should be identified and recorded for each stage of the pathway and then aggregated for the whole pathway. Wherever possible, delays should be identified and recorded in real time as any delay could mean more patients having to wait unnecessarily in the future.

While the patient pathway timeline is often most easily drawn by the MDT co-ordinator or another member of the cancer administration team, the breach reporting and RCA process should be owned by the operational and clinical teams. Patient-level breach analysis reports are best completed within one month of the breach occurring and, where the breach was avoidable, actions taken immediately to prevent similar avoidable breaches. Breach analysis reports should be signed off by both the treating and lead clinician, and the findings and remedial actions taken should be reported at an appropriate forum, such as the MDT meeting, detailing the reason why the breach occurred and lessons learned.

Breach analysis of near misses (patients treated on day 61 or 62) is good practice and helps identify problems affecting a cancer pathway.

Ownership of the breach review process

To ensure accurate, consistent and transparent reporting of the reasons for breaches, individual RCA reports should be reviewed by an appropriate manager, often the cancer manager, before being aggregated to identify patterns and trends at tumour site, consultant and organisational level. Action plans should address any issues identified, giving clear timescales and responsibilities for action to prevent similar breaches.

To prevent avoidable breaches and promote organisational learning, breach reports should be shared with clinical, operational and management teams. Typically, these reports should be shared with teams at forums such as:

- tumour site MDT meetings: detailed patient-level breach analysis and overall trends and patterns
- provider cancer PTL meeting: trend analysis, review of previous week’s breaches, reasons and actions taken to prevent breaches
- specialty/business unit meeting: detailed breach reporting
- cancer board: aggregated breach reporting, including themes and lessons learned; monitoring delivery of actions in the breach action plan
- provider board: number and percentage of breaches and reasons for breach, trends in patterns and volume of breaches.
6.6. Data quality checks

Where there is no interface between the cancer system and original data source system, it is good practice to implement a reconciliation of the data held on the two. This assures the organisation of the accuracy of the cancer data and helps identify new diagnoses, treatments, etc.

Ideally, a regular (at least weekly) alert of missing information (items not already recorded on the cancer system) should be available to MDT co-ordinators, including:

- new histological diagnoses
- new radiology ‘red flags’
- patients added to the waiting list for chemotherapy or radiotherapy
- patients added to the admitted waiting list for common cancer-related procedures and/or under cancer surgeons.

In addition to these checks, information should be cross-checked on a monthly basis against these systems, as well as compared to clinical coding to ensure that no patients are missed off the monthly upload.
7. Processes and meetings

Organisations that successfully deliver against the cancer standards typically have two or three tiers of cancer PTL management, two of which sit within the core cancer service.

7.1. PTL meeting

Cancer PTL meetings should be held weekly, chaired by the senior manager responsible for the delivery of the cancer operational standards. Whether an organisation holds a joint cancer and RTT PTL ‘elective care’ meeting or a separate cancer meeting is not significant. It can be beneficial to hold a separate meeting if the cancer agenda is long or a dominant RTT 18-week agenda risks cancer issues not being fully reviewed or discussed. Benefits of a combined meeting are that cancer care remains part of standard elective care/access management, and efficient use of management time as often many of the same staff are involved in both meetings.

If a joint meeting is held, sufficient time and attention must be given to cancer issues; placing cancer before RTT on the agenda can help ensure this. The meetings need to be attended by the team with operational responsibility for delivering the standards.

PTL meetings must be action-orientated and focused on:

- performance management and accountability
- breaches and prospective management of patients along cancer pathways
- identification of pathway ‘exceptions’ – patients waiting too long at each or any stage of the pathway
- delivery of cancer pathways and any related bottlenecks
- monitoring and managing the number of patients waiting at key pathway stages (first seen, diagnostics and treatment).

Even if a live PTL is available online, a weekly snapshot PTL report should be produced, preferably a day or two in advance of the meeting so all staff have the same information ahead of discussion of the detail of a consistent PTL. Providers should hold PTL meetings at the same time each week.

It is important that any agreed actions are followed through and reviewed the following week to ensure they have been addressed. It is advisable to have an audit trail of the actions, including when they were completed. In addition, organisations will want to see the impact of the actions in the following week’s PTL report. Providers should have clear escalation processes to support staff where issues are not resolved between the weekly PTL meetings, often as part of a wider cancer escalation policy. The relevant service or general manager must take the lead in dealing with patient-level issues raised during the PTL meetings. Where service/business unit manager attendance is
standard, it is good practice for a more senior general manager also to attend on a less frequent basis.

7.2. Pre-PTL meeting/specialty meeting

Dependent upon the size of the organisation, it is often useful to hold tumour-site or local business unit meetings a day or two before the organisation-wide PTL meeting. Local meetings should also be held on the same day each week.

The purpose of the local meeting is to ensure:

- business unit managers are sufficiently prepared for the PTL meeting
- management plans are available at individual patient level
- most key issues have been addressed
- there is an action plan for resolution of those issues
- any issues that cannot be resolved within the business unit are escalated.

Review of the agenda and reports at the local business unit meetings is advised, with the meetings mirroring the requirements of the organisation-wide PTL weekly meeting. This will include a specialty-level review with patient-level enquiry, actions and follow through.

7.3. Access policy

The guidelines in Appendix 2 include key areas to be considered when developing a cancer access policy (CAP). Some providers include CAP details as part of a provider-wide access policy, including both cancer and elective access policy details, while others prefer to develop separate elective and cancer policies. Where organisations have implemented separate policies, they should cross-reference each other.

CAPs should be developed in partnership with all LHCE participants, including agreement in line with each partner’s clinical governance arrangements. Within an organisation, clinical leads, diagnostic leads and specialty managers should all be involved in discussion.

CAPs should be made available to the public, via the provider website and in formats suitable for those who cannot access web-based information, eg printed copies in outpatients or in the Patient Advisory Liaison service. Consideration should also be given to the languages in which they are produced. A summary of the completed policy may also be developed for patients.

The CAP should be supported by a series of standard operating procedures (SOPs) that can be adapted and amended as relevant local or national policy changes occur. These should include the escalation process for dealing with issues, with clearly set out timescales for response and resolution. The SOPs provide staff with a single reference point that enables them to understand their role in ensuring the CAP is consistently
applied throughout the organisation. These should be referenced, as appropriate, throughout the CAP. The SOPs may be provided as an appendix to the CAP.

It is important that LHCEs agree a local access policy which is shared with primary care colleagues, available to GPs electronically and signed off by commissioners. This will enable GPs to make patients aware of their rights to have treatment within the defined standards, and in accordance with the NHS Constitution. It will also help GPs outline to patients before referral the patient’s responsibilities to attend appointments and how cancelling or not attending appointments can delay timely diagnosis and treatment. LHCEs must ensure the appropriate mechanisms are in place locally to support this work.

In implementing CAPs, a formal launch of the policy, including road shows or training sessions for key groups of staff, is essential, along with ensuring staff are aware of the supporting SOPs (eg DNA or cancellation management).
8. Operational delivery

8.1. Pathways capable of delivering shorter waits

This section aims to explain how to deliver the cancer standards operationally, and the importance of a pathway approach.

Organisations are recommended to establish a detailed and good understanding of pathways at a tumour type level and not just at an aggregate tumour site level. This includes establishing where and when key milestones occur. For example, for a tumour site ‘X’, first outpatient attendances should occur on day 7 of a cancer pathway, and first definitive treatment after GP referral on a current cancer pathway before day 42.

A pathway approach to managing cancer services is essential to support NHS organisations because it:

- helps manage the cancer standards (at tumour site level)
- identifies hidden waits
- allows organisations to track patients correctly
- identifies any tumour site and specialty-specific issues
- delivers more sustainable services.

NHS organisations must also consider the information flows that will support the management of patients in a pathway approach and identify what reporting tools will help identify bottlenecks in cancer pathways. Services will benefit from establishing and monitoring agreed milestones and performance against targets.

8.2. Managing patients along their cancer pathway

Pre-referral

Some providers work with referrers to confirm referral criteria for tumour site pathways. As part of confirming referral criteria, it is good practice to establish a referral pro forma for each tumour site, which clearly includes the minimum dataset. This will enable the ready identification of patients who may be suitable for direct access diagnostic or one-stop clinic pathways. To improve the quality of referrals, providers should ensure an agreed referral pro forma, outlining criteria to ensure referrers have undertaken the necessary clinical evaluation before referring.

Providers will also benefit from agreeing arrangements for dealing with referrals where referral criteria have not been met. Providers may benefit from confirming urgent access pathways and milestones for non-cancer referrals, ensuring sufficient capacity is available, which may reduce inappropriate 2WW referrals.
8.3. Right to obtain treatment within the maximum waiting time

Providers should ensure patients are aware of their rights and what they need to do if their rights are not met. The DH guidance *Implementation of the right to access services within maximum waiting times*\(^{11}\) confirms that patients who are about to breach/have breached their maximum waiting time and who wish to be seen more quickly can ask for an alternative provider or appointment from the dedicated contact. Where possible, alternatives should include both NHS providers and private providers.

Commissioners, providers and GPs should work together to develop patient information leaflets that inform patients about the 2WW pathway, raise patient awareness of the process and support patients to fully co-operate in undertaking their pathway in a timely manner.

8.4. Centralised administrative teams

Some providers have established central booking teams for the scheduling of 2WW appointments. This enables a single point of receipt, and makes potential demand and capacity issues more visible. The central team may also have responsibility for booking diagnostic imaging and endoscopy appointments to enable timely access for direct access pathways where identified.

Staff with a responsibility for the referral management process, whether as part of a devolved structure or working in a central team, should receive appropriate and regular mandatory training in the following areas, which should also form part of the formal annual appraisal process:

- PAS referral registration and appointment booking functions (including processes relating to DNAs and cancellations), and discharging processes
- e-Referral system (ERS)
- provider elective access policy
- 18-weeks rules
- cancer waiting times rules.

8.5. Referral receipt

On a cancer pathway, the clock starts at the point of receipt of referral. It is therefore essential there is no delay between referral receipt and registration once it has been received within the organisation. e-Referral bookings should be encouraged as the primary method of referral, and all providers should have all suspected cancer 2WW services published on ERS, along with urgent and routine services, or have action plans with clearly defined timeframes in place to implement this.

Some providers have a central fax for the receipt of cancer referrals, where 2WW referrals are received, registered and then allocated to the relevant departments. Electronic faxes have the added advantage of being both quick and doing away with the need to scan documentation. Providers should ensure there is clear guidance about the management of referrals sent to other locations, to ensure they are promptly registered and there is timely contact to arrange an appointment.

Providers should clarify expectations with regard to referral registration. Good practice would suggest a maximum same-day referral registration. Referrals should be registered on the PAS and the provider’s cancer waiting time database no later than 24 hours after receipt, to enable cancer pathway monitoring by the cancer team and MDT co-ordinators/patient pathway co-ordinators.

Where providers have available clinic slots in ERS along with a dedicated fax service, there should be processes to ensure ERS referrals are checked and actioned at regular and frequent intervals, along with processes to ensure duplicate referrals are identified.

8.6. Scheduling appointments

Once the referrals have been registered, providers should contact patients to offer an appointment date within 48 hours of date of receipt.

Bookings staff should ensure patients receive any guidelines or instructions relevant to their appointment, such as fasting instructions, particularly where there is a one-stop clinic or a diagnostic procedure before their appointment.

**Straight to test (STT) pathways**

With clear referral criteria, there are opportunities to create straight to test (STT) pathways (where a diagnostic procedure is arranged as the first episode of care), enabling patients to get a diagnostic appointment within two weeks in place of an outpatient appointment.

An STT pathway can reduce the time from referral to diagnosis, and therefore enable earlier treatment (eg STT endoscopy). It can also improve patient experience by reducing the number of attendances required and providing earlier assurance of diagnosis.

A clear understanding of the clinical pathways for each tumour site pathway enables development of referral criteria to identify patients suitable for STT pathways.

As with 2WW capacity, it is important for providers to confirm clear escalation processes for bookings staff, if there are not enough STT appointment slots in the required time. The provider should ensure there is sufficient STT capacity, and where possible avoid booking patients into 2WW clinics with no diagnostic capacity.

8.7. One-stop clinics

One-stop clinics provide an opportunity for first new appointment, diagnostic and follow-up attendance to be consolidated into a single attendance for the patient. This has the
advantages outlined above in STT pathways, and can also potentially enable the confirmation of diagnosis and discussions of treatment plan in the one-stop clinic.

One-stop clinics may take time to establish, as there is a need to clearly understand requirements and enable suitable diagnostic/imaging/pathology support on the day of attendance, in addition to the clinical staff.

Providers should ensure patients receive any guidelines or instructions relevant to their diagnostic test, such as fasting instructions, before their appointment.

8.8. Booking appointments

Due to the short timeframes in ensuring timely but suitable access for 2WW patients, it is essential all patients are contacted by telephone to agree all appointment(s). Providers should clearly define expectations around contacting patients, including the number of times the provider attempts to contact patients by phone, and the need to enable contact on different days and times. The provider should ensure the contact centre is staffed to make calls outside business hours and ideally also at weekends.

If the patient cannot be contacted, the provider should ensure there is a process that requires confirmation of patient demographics and that they send a letter to the patient requesting them to make contact. It is good practice in patient correspondence and telephone conversations to highlight to the patient the urgent need for review, along with a need to exclude cancer, to help the patient understand the importance of making contact.

Although there is a requirement to schedule 2WW patients within 14 days, an aspirational timeframe can provide an opportunity to reschedule patients within the 14-day timeframe if they cancel their appointment or for any other reason the appointment does not go ahead. For example, the aspiration could be to offer appointments within seven days of receipt, with all patients dated within 10 days from receipt.

Patient correspondence should always be sent by first class post, and some providers also provide email and/or text confirmation of appointment times.

8.9. Clinic templates

Providers vary in their approach to managing capacity requirements for 2WW patients. In some providers, capacity is incorporated as part of existing templates, either as urgent appointment slots, or designated 2WW cancer slots within general clinics. Some providers have designated 2WW clinics, which means that other services can be planned to coincide with the clinic, and enables members of the team to be present in clinic, ie clinical nurse specialist. Designated 2WW clinics may also support one-stop clinics, where patients can attend for a diagnostic (for example), and then be reviewed with diagnostic results in clinic.
8.10. Utilisation and overbooking

Many services use overbooking to cope but it may be better to designate greater capacity to 2WW slots and have a mechanism for releasing unused slots. This will improve patient experience as overbooking is likely to lead to delays in clinic. 2WW capacity can fluctuate week on week, and it is important services have a good understanding of demand and capacity requirements for each tumour site, and ensure a minimum capacity is allocated for 2WW access each week. Where designated 2WW slots/clinics are allocated, it is important for providers to confirm a timeframe by which clinic appointments can be released for other urgent non-2WW appointments if they are not required for 2WW appointment capacity, eg 48 hours before the day of clinic.

8.11. Did not attends (DNAs)

DNAs are a costly waste of resource in the NHS so it is important for providers to have a plan to proactively manage them. As a minimum, organisations should be monitoring data around DNAs, such as DNA rates by specialty per month, and making a local decision on what an acceptable DNA rate is for the organisation or specialty to meet.

Providers may like to consider including a leaflet confirming their DNA policy with the booking letter. As cancer appointments should be offered with choice, and fully booked, there is an opportunity to ask the patient to write down the appointment details which helps them to commit these to memory. Vulnerable patient groups, such as suspected cancer patients, may be exempt from DNA policy for routine patients, according to the local agreement. National cancer waits guidance is clear that all cancer patients should receive a further appointment following a DNA, so reducing DNAs will maximise available capacity.

It will be essential for staff to directly book the new appointment with the patient at the time of contact. It is also good practice to advise the referrer of a DNA for patients with suspected cancer. Providers must ensure there are local policies on DNAs and patient cancellations, which reflect the spirit of cancer access guidance but are also in line with the organisation’s access policy.

Useful tools for managing DNAs are available.12

Pathway adjustment for DNAs to first attendance

If a patient does not attend their outpatient appointment or diagnostic clinic, which would have been recorded as DATE FIRST SEEN, then the clock can be stopped from the date of the receipt of the referral to the date the patient rebooks their appointment, as shown in Figure 1.

12 www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/dnas_-_reducing_did_not_attends.html
Figure 1: Pathway adjustment for DNA

UBRN, unique booking reference number

Pathway adjustment for admitted pathway

If a patient has to be offered a TCI date for admitted care (ordinary admission or day case) within the 31- or 62-day period, and the offer of admitted care is declined, the clock can be stopped from the date of the declined appointment to the point when the patient could make themselves available for an alternative appointment, as shown in Figure 2.

Figure 2: Pathway adjustment for admitted pathway

Management of initial appointment DNAs

If a patient does not attend their initial outpatient appointment, they will automatically be offered a further appointment. If a patient does not attend for a second time, it is good practice for the clinician (who will review all patient health records at the end of a clinic), to authorise the offer of a further appointment.

It is important that any decision to discharge a patient is a clinically-led decision based on the best interests of the patient. Ideally this decision is made with the patient.
The outpatient clinic receptionist is responsible for entering the DNA outcome on the PAS, but the 2WW office is generally responsible for rebooking any patients (on a 14-day pathway) who do not attend their appointment.

Where a patient on a suspected cancer pathway does not attend their initial appointment for the second time, they may be discharged and referred back to the GP/general dental practitioner. This is to ensure they are not left ‘unmonitored’ in the system. The hospital clinician should make the final decision if a patient is to be discharged back to the referring practitioner after two or more DNAs. This must be noted in the patient’s PAS entry or outpatient notes. Both the patient and the GP should be notified of the discharge.

8.12. Cancellations (by patient)

Patients have the right to cancel their appointment ahead of the appointment time, if they are unable to attend. If a patient cancels, it is good practice to agree a date for another appointment at the time of the cancellation where possible. Where a patient requests to rearrange their appointment, the appointments offered should be provided before their timed pathway milestone where possible to reduce the likelihood of potential breach. In the event a replacement appointment cannot be offered before the breach date, this should be escalated to the responsible manager. It is important to confirm the patient’s availability for a future appointment, along with a time they may be available to agree an appointment time. This will enable appointments to be negotiated with patients when they are available to both discuss and attend.

8.13. Subsequent cancellations (by patient)

Where a patient cancels a subsequent appointment, the consultant will need to review the notes to decide the most appropriate action. If the patient fails to attend a second appointment, the consultant or member of the clinical team should consider contacting them to discuss their non-attendance. Where there is subsequent or continued non-attendance, the consultant should consider whether it is appropriate to discharge back to the referrer. The provider access policy/CAP will need to set out this process. Both the patient and the GP should be notified of the discharge.

8.14. Cancellations (by hospital)

The cancellation of patients’ appointments by the provider is poor practice which inconveniences patients and reduces the efficiency of the service. Given the timeframes associated with 2WW access, the number of hospital cancellations should be significantly reduced by good adherence to leave notification policies.

Cancellations of patients’ appointments by the provider, particularly for 2WW pathways, should be a rare occurrence that should only be authorised where there are no other available or appropriate options for covering the clinic.

Providers should adhere to the following principles when developing local clinic/appointment cancellation policies:
• implementing policies encouraging clinicians to book annual leave requests for the year ahead

• a minimum cancellation timescale in place for requests to cancel clinics, eg minimum six weeks

• limiting ‘acceptable’ clinic cancellation reasons to sickness, immediate family emergency, etc

• implementing ‘fire-break’ clinics at six- to eight-week intervals to manage unforeseen circumstances.

8.15. Transfer of patients between providers

Referral pathways across providers

Where a patient is referred by one NHS provider to another NHS provider for cancer treatment, this is known as an inter-trust referral (ITR) or an inter-provider transfer (IPT).

The patient will continue on the 62-day standard if they were initially referred as a 2WW referral with suspected cancer or 2WW breast symptomatic, referred via the screening programmes, or upgraded to the cancer pathway as a consultant upgrade.

Where a patient’s care begins at the originating organisation (Provider A), treatment is undertaken at another provider (Provider B) and the patient is on a 62-day cancer pathway, both providers share responsibility for ensuring that the patient’s treatment is delivered within 62 days (in total) and ensuring that their respective parts of the dataset are uploaded.

While from a patient perspective timeliness of investigation and treatment should not depend on the hospital to which they are initially referred, in practice intervals between referral and treatment are generally longer for patients who require an IPT than for those treated at the hospital to which they were initially referred by their GP.

The national guidance\(^\text{13}\) (published April 2016) indicates all LHCEs should have an agreed policy covering patients who cross between providers from 1 October 2016. The agreed transfer date by which referrals to a treating provider should be received and after which the treating provider does not need to share a breach is recognized to be day 38. Day 38 is an agreed maximum transfer period and it is understood that locally many pathways may need the transfer date to be earlier than this. For some pathways, the diagnostic pathway can be comfortably arranged so that patients are in fact ready for transfer before these agreed transfer timescales. However, in some cases it is a challenging timescale to work-up patients for transfer to the treating provider, and this can be further complicated in pathways where a patient accesses services at three or four providers.

For the treating provider, receiving the patient at day 38 may be challenging both where preparation for treatment may take time and/or where scheduling of treatment to start on a particular day of the week is a significant factor, eg scheduling radiotherapy to start on a Monday.

To support smooth delivery of IPT pathways, it is vital that patients are appropriately ‘worked up’ at the originating organisation. Before transfer, diagnostic investigations should be undertaken and reviewed as appropriate. The patient should be transferred in a timely manner in line with an agreed minimum dataset and clinically agreed criteria.

For these pathways to be effective from a patient experience perspective, both the referring and receiving organisations have important roles to play.

**Collaborative working between referring and receiving organisations**

- Identify correct, named individual at receiving provider to send the referral.

- Develop an agreement of standardised good practice clinical pathways across providers. This work should be supported as part of a ‘network’ approach across providers. Where appropriate, agreements across the whole health community should be discussed and communicated, eg CT to be undertaken before first appointment for lung patients.

- Agree administrative processes for referring and receiving referrals across providers, including clarifying what constitutes a referral or a ‘worked-up’ patient, what clinical information/results should accompany the referral within an agreed timescale, how a transfer date will be defined, agreeing acknowledgement and communication expectations, agreeing processes and timings for escalation of issues and non-adherence.

- Develop and implement clear and comprehensive CAPs to ensure consistent application of cancer waiting times rules and equity of patient management, access to services and the expectations of the organisation, GPs and patients.

- Ensure clear communication of roles, responsibilities and contact details of key roles in each organisation.

- Ensure clear communication of escalation processes and timelines in relation to management of information between organisations.

**Referring provider**

- Identify correct, named individual at receiving provider to send the referral.

- Collate all relevant information, including minimum dataset, relevant health records, all diagnostic reports and images.

- Send written confirmation of decision to refer to the patient and their GP within 24 hours of decision to refer.
• Courier/send electronically all hard copies of the patient records to referrer within 24 hours of decision.

• Confirm the referral and records have been safely received.

Receiving provider

• Provide a named contact for referrals for each tumour site. Provide these contact points to referring providers.

• Confirm receipt of referrals and patients records, images, etc, with the referring organisation.

• Contact all referred patients within 24 hours of receipt of referral to arrange an appointment.
9. Diagnostics

Efficient booking of patients referred for diagnostic tests underpins delivery of 2WW cancer pathways. Below is a suggested list of tasks relating to the management of diagnostic processes, and staff should be aware of and understand their role in ensuring patients receive timely access to diagnostics.

9.1. Useful resources

NHS Improving Quality: *Rapid view of endoscopy services*¹⁴

NHS Improving Quality: *Challenges and improvements in diagnostic services across seven days*¹⁵

*The NHS Atlas of variation in diagnostic services*¹⁶

9.2. Paper referrals

Also refer to Section 8.5: Referral receipt.

Diagnostic departments should actively encourage the use of standard request forms to ensure the required information is clear and consistent, and to identify incomplete referrals. Referrer self-vetting criteria should be confirmed to minimise inappropriate referrals. Referral forms should also include clear requirements to flag urgent 2WW referrals.

Sufficient guidelines should be provided to enable administrative staff to book diagnostic tests, reducing the need for clinical input in this process. This should be supported by a clear escalation process, clarifying the necessary steps for staff needing to raise queries regarding specific diagnostic requirements or to escalate capacity issues.

As well as the training described above in Section 4.10, administration teams will also require confirmation of milestones for access to diagnostic tests, which should normally be completed within two weeks after referral.

9.3. Advantages of electronic referrals

Organisations should aim to transfer to electronic referrals as these enable single-point electronic capture of information and transfer to the diagnostic information system, providing:

- reduced clinical risk due to accurate demographics and legible clinical details
- the minimum data are provided on the referral before submission

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• instant availability of request in the diagnostic department
• reduced administrative time, eliminating referral registration
• reduced delays contributing to shortened inpatient stay and achieving access timeframes
• reduced paper and storage costs.

9.4. Registration of referrals

Also refer to Section 8: Operational delivery.

All referrals should be registered on the organisation’s diagnostic information system, and providers should set clear turnaround timescales for receipt of referral to registration. Referral registration on receipt is essential to ensure diagnostic departments can see what the real waiting list size is and make arrangements to accommodate 2WW cancer referral requests. Hard copy referrals should be registered before they are forwarded to clinical staff for vetting and a scanned copy of the referral should be retained. The use of electronic referral processes facilitates the automatic registration of referrals and the ability directly to vet referrals, with limited administrative input.

9.5. Pre-registration checks – the minimum dataset

Organisations should clarify the expected minimum data required for a referral to be valid, and consider implementing a standard referral pro forma. Regardless of the format of the referral (whether pro forma or traditional letter), it is considered best practice that all referrals should contain a minimum dataset and should be accurate and legible.

Organisations should have a clear process for managing incomplete referrals so as to not unfairly disadvantage patients. As well as a robust system for monitoring referral demand on an ongoing basis, by modality, to ensure capacity is sufficient to meet demand.

9.6. Vetting of referrals

Timely, clinically-led vetting of referrals will ensure they are appropriate, help identify whether an alternative diagnostic modality is more suitable for confirming diagnosis, and ensure adherence to Ionising Radiation (Medical Exposure) Regulations (IRMER) requirements (where applicable). Vetting of urgent 2WW cancer referrals should ideally be completed on the day or the morning of the following day. There should be a mechanism to ensure 2WW and suspected cancer referrals are prioritised for vetting.

The vetting can be carried out by an appropriately trained pool of staff which increases the vetting capacity and minimises delay in the process. The staff should follow clear protocols and be subject to ongoing monitoring and audit.
Where the radiologist feels the referral urgency may be revised, this should be discussed with the referring clinician before downgrading.

### 9.7. Electronic vetting of referrals

Referrals should be vetted in order of urgency and date of receipt to ensure there are no undue delays. Electronic vetting enables the referral to be available for booking immediately after vetting, rather than waiting for the paper copy to be returned to the booking team for review. Diagnostic information systems can provide functionality to enable electronic vetting of referrals, reducing the need to print referrals for the clinical team to review, and can enable electronic work lists to be produced which support prioritising the workload and reducing the variation in referral vetting times between patients.

### 9.8. Scanning protocols

Providers should ensure diagnostic areas (modalities) have standardised scanning protocols agreed by the diagnostic department.

The booking team should get clear principle-based guidelines for the booking diagnostic examinations. For each examination these should include:

- diagnostic procedures
- specific equipment requirements (ie differentiated by physical equipment limitations)
- the length of time slot required
- requirement for delayed imaging (ie nuclear medicine)
- who can perform the examination and when
- what preparation is required
- special patient instructions
- if there is a requirement for direct consultant participation, based on their clinical specialisation.

In addition, timeslots for procedures should be minimised with procedures falling into one of three or fewer time slots to facilitate capacity and demand planning, eg 10, 20 and 30 minutes.

### 9.9. Booking appointments

Diagnostic appointments should be booked correctly, quickly and efficiently. Due to the nature of the referrals, it is essential providers ensure a patient-focused process geared towards offering the patient a choice of appointments in a set time period, with urgent 2WW cancer referrals taking priority over routine appointments. Administrative staff should book patients under standard written guidance from the relevant clinician, eg
senior radiographers, radiologists and technologists. It is essential to have administrative cross-cover to ensure all modalities are booked to minimise the impact of absenteeism and leave.

9.10. Confirming appointments

In line with good practice, and for patients with suspected cancer in particular, it is important for providers to facilitate direct booking of diagnostics via an electronic booking system (ie ERS) or by proactively contacting the patient or enabling them to contact the department for an appointment following their outpatient attendance.

A diagnostic PTL will ensure patients are prioritised appropriately.

9.11. Patient preparation

Bookings staff should ensure patients receive any guidelines or instructions relevant to their diagnostic procedure, eg fasting instructions, before their appointment. They should also ensure patients have contact details for the department if they wish to seek further clarification or information about their procedure. A member of the clinical team should confirm if the patient requires more extensive preparation, eg pre-assessment may be required for certain procedures. Appropriate preparation of the patient before their appointment will minimise the likelihood of the cancellations on the day and the appointment having to be rescheduled.

Providers should ensure removal of paper diaries where an electronic schedule is available.

9.12. Scanner utilisation and scheduling

Providers should ensure they provide appropriate capacity to meet the demand and that the capacity is used effectively, so for example, DNAs are minimised and appointment slots not wasted. Where possible, diagnostic departments should work with tumour sites to align capacity to outpatient clinics, providing opportunities for one-stop attendances where this is possible.

Providers should therefore:

- work with specialties to align diagnostic capacity with outpatient attendance
- ensure booking requirements are based on key criteria (refer to Section 9.9: Booking appointments)
- confirm release timeframes where the equipment will be released for booking other procedures if the equipment time is not fully utilised
- have in place a system of ongoing monitoring of equipment to ensure effective utilisation
have a forward plan of scheduled service and quality assurance activities to minimise the effect these activities have on the capacity required to meet service demand.

Also see Section 8: Operational delivery, for general good practice guidance in establishing booking principles.

The capacity within the schedule should be sufficiently flexible to meet variations in demand such as emergencies, inpatients, urgent and planned patients. Extended day and weekend working will increase capacity to meet this variation as well as address any temporary backlogs in individual modalities.

9.13. Reporting

The National Imaging Board guidance\(^{17}\) states that investigations will be seen and accurately reported within as short a time as possible. It also stresses the importance of providing high quality and effective patient-centred imaging services to support the whole patient pathway through the reporting of images in a timely manner. The guidelines set an expectation that urgent cases will be reported immediately (within 30 minutes).

The guidance recognises that exceptions will occur where MDT discussions or specialist opinion is required and therefore states that a tolerance of 90% achievement is reasonable.

The demand and capacity tools mentioned above can be adapted to model reporting capacity instead of machine capacity to help to assess the level of work needed to achieve this standard.


The provider should ensure:

- there is ongoing improvement of reporting turnaround times until standards are achieved to support effective management of the service and appropriate support to clinical specialties and referrers

- ongoing monitoring of report turnaround time, including:
  - report completion turnaround times
  - report verification turnaround times (including minimum, average and maximum report times by modality to inform initiatives to reduce variation)
  - monitoring for those not reported within the agreed reporting timeframe, and ensuring follow-up and work prioritisation

• consultant rotas are designed to allocate the cover of sessions to a pool of reporting staff so they are not adversely affected by annual leave. Radiologist/consultant schedules could be revised to allow shorter sessions that enable more focused reporting and reduce the impact of annual leave and MDT meeting attendance on the modality

• radiographer/technologist/technician/advanced practitioner-led reporting to clinical protocols is in place to provide improved reporting times; this requires the agreement of the team and appropriate staff training

• a process for clinical audit is in place to ensure reporting quality is achieved, particularly where reporting is completed by non-consultant staff.

9.15. Management of DNAs

Also refer to Section 9.15: Management of DNAs.

Bookings staff should explain the DNA policy to the patient at the time of booking and remind patients of their responsibility to inform the organisation if they are unable to attend in advance. There should be clear expectations about patient management in the event of consecutive DNAs.

9.16. Unexpected findings

Diagnostic departments should ensure clearly defined processes to manage unexpected findings, so that there is a process for alerting referring clinicians and other appropriate people (GP, MDT co-ordinator) to results that may require urgent review. The procedures should ensure organisations meet the National Patient Safety Guidance, NPSA 16.18

The provider management team should manage and agree amendments to the unexpected findings procedure.

Where a referral is received internally (the patient is under the care of clinicians at the provider), it is important to notify both the referring clinician and the clinician referring for diagnostics, along with the MDT co-ordinator. Where a referral has been received by a clinician outside the provider, the procedure should ensure the referrer is advised, along with notifying the cancer management team within the provider.

It is essential that processes ensure receipt of patient alerts are acknowledged, and followed up where acknowledgment is not confirmed. Providers should include details of the relevant nominated contact for each tumour site, or a central point of receipt if appropriate.

18 www.nrls.npsa.nhs.uk/resources/?EntryId45=59817
10. Scheduling, pausing, booking, theatres

The efficient and timely booking of 2WW admissions requires a good understanding of demand and capacity requirements, and ensuring there is sufficient capacity for urgent 2WW cancer admissions, reducing the likelihood of cancellations of routine patients.

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<thead>
<tr>
<th>Good practice</th>
<th>Comments</th>
<th>What does good look like?</th>
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<tbody>
<tr>
<td>1. Operational managers must ensure 'to come in' (TCI) cards are completed for all 'decisions to admit' (DTA), and agree a timeframe for entering on PAS (eg on the day of clinic). It is essential there is a clear process that enables 2WW TCI cards to be readily identifiable. As part of completing the clinic after each session it is important that DTA cards are received where appropriate, and flagged anywhere they have not been received.</td>
<td>This will ensure that all 2WW TCI cards can be readily identified and prioritised for admission scheduling. Timely completion and registration of the TCI card will ensure that all the correct details, including the type of operation, patient details, any surgical kit requests and co-morbidities, are recorded. It also ensures the admitted patient tracking list (PTL) is kept up to date.</td>
<td>No patient waiting more than 1 hour to be placed on a waiting list for surgery. Organisations using electronic booking systems to reduce duplication of efforts and errors. Organisations using manual TCIs to ensure clear requirements for flagging 2WW admission requests.</td>
</tr>
<tr>
<td>2. General managers must check that 2WW patients are booked as a clinical priority. Where insufficient capacity is provided, there should be clear escalation processes to provide extra capacity. The service should investigate extra capacity in the first instance, to avoid rescheduling of routine patients where possible.</td>
<td>It is important 2WW capacity for admissions is provided in the specialty theatre session planning. This will enable timely admission and minimise the need for extra ad-hoc capacity and rescheduling of routine patients.</td>
<td>There should be clear timeframes for assessing and managing 2WW admission capacity for urgent and routine admissions where appropriate.</td>
</tr>
<tr>
<td>3. Timely, clinically-led review of prospective lists.</td>
<td>This should be done by looking at theatre lists 3–4 weeks in advance, for example, to ensure they are full and will not overrun. Lists should be led by a lead clinician with the experience and authority to increase them where possible.</td>
<td>A reduction over time of theatre lists that overrun and improved theatre list productivity. An opportunity to highlight shortfalls in 2WW capacity, so extra capacity can be arranged.</td>
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<td>Good practice</td>
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<tr>
<td>4. General managers should confirm with each tumour site internal milestone targets for DTA, particularly where patients are referred to other centres for treatment</td>
<td>It is important to complete this at tumour site level and for each pathway, as elements of care may be provided by different centres or within the provider. The milestones should be developed taking into account the need to ensure suitable time for treatment within target</td>
<td>Each specialty has clear milestones which are compliant with cancer wait time goals Early warning and escalation systems to detect deviations from the specialty-specific milestones</td>
</tr>
<tr>
<td>5. With 2WW pathways, it is essential that organisations telephone patients to arrange their admission, providing a choice of admission date The patient should be offered the soonest available admission date</td>
<td>Given the urgency of the admission timeframe, patients may not receive 3 weeks’ notice of admission Providers should ensure patients are advised of the need for admission before being contacted by the admissions team</td>
<td>Patients are contacted by admissions staff over the phone to be offered a choice of dates for surgery</td>
</tr>
<tr>
<td>6. Admissions staff must escalate if they do not have enough capacity to book the patient within target Providers should have an agreed escalation process</td>
<td>This helps manage capacity issues prospectively, and helps prevent patients waiting beyond the target admission time</td>
<td>Efficient and responsive systems to alert bookings staff to vacant lists to resolve capacity issues Clear escalation policies, along with clear roles and responsibilities, and named contact points when capacity issues are identified</td>
</tr>
<tr>
<td>7. Operational managers should meet with consultants to share their admitted PTL (those patients dated and undated)</td>
<td>Helps communicate progress against the national operational standards and make the individual consultants aware of their waiting list sizes</td>
<td>Consultants have an accurate understanding of the size of their admitted PTLs and casemix on a weekly basis</td>
</tr>
<tr>
<td>8. Operational managers should implement processes for double-checking TCI lists</td>
<td>Helps pick up errors or issues such as patients listed as coming in the next day but who failed to attend preoperative assessment List should be checked on paper and the PAS 2WW patients should be readily identifiable to ensure they are not cancelled on the day</td>
<td>Electronic booking systems that automatically flag patients with an imminent TCI who failed preoperative assessments or have not confirmed their TCI</td>
</tr>
<tr>
<td>9. A suggested 24-hour cut-off to creating</td>
<td>Avoids last minute reorganisation that leads</td>
<td>Booking systems that automatically</td>
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<td>Good practice</td>
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<td>final theatre lists should be agreed, with a clear escalation process and details of who is permitted to make any changes</td>
<td>to lists over running or running late</td>
<td>freeze theatre lists 24 hours before the day with good control systems to manage any changes</td>
</tr>
<tr>
<td><strong>10.</strong> All conversations with patients should be recorded clearly with dates and names in the waiting list entry on PAS</td>
<td>This includes conversations around patient choice and dates offered (earliest reasonable offer dates). If a patient has previously agreed to a reasonable offer which they subsequently cancel, the patient cancellation does not stop or pause the clock. However, as part of the rebooking process, the patient should be offered alternative dates for admission. If at the rebooking stage the patient declines another reasonable offer (i.e., within the start and end point of the 31- or 62-day period), then the clock can be paused. The clock is paused from the date of the earliest reasonable offer given as part of the rebooking process. The end of the pause will be the new date from which the patient states they are available</td>
<td>Waiting list systems with detailed accurate audit trails of contact with patients</td>
</tr>
<tr>
<td><strong>11.</strong> Staggered admission times should be used, with sufficient staff to admit patients. It is good practice to have a central admissions team to manage all inpatient/day case waiting lists</td>
<td>Helps prevent delays on the day of surgery and provides a better patient experience</td>
<td>Low waiting times for patients between admission time and operation start time (less than 2.5 hours on average)</td>
</tr>
<tr>
<td><strong>12.</strong> Where possible and clinically appropriate, look to pool surgical lists</td>
<td>Helps to offer patients more choice, equalise waiting lists for surgery and prevent patients waiting longer than necessary for treatment. Patients should be aware their surgery may not be performed by the clinician they have previously seen through their pathway</td>
<td>Patients have surgery performed by clinically appropriate staff with lower waiting times; the pooling of lists allows for optimal use of theatre capacity as well as clinical skills and expertise</td>
</tr>
<tr>
<td><strong>13.</strong> Where appropriate, preoperative</td>
<td>This will ensure the patient can be assessed</td>
<td>Preassessment as part of outpatient</td>
</tr>
<tr>
<td>Good practice</td>
<td>Comments</td>
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<td>assessment can be provided on the day. Where this is not appropriate, the patient should be provided with details of the preoperative assessment requirements, and the provider should ensure the patient is advised of the timeframe for being contacted to confirm their date for preoperative assessment</td>
<td>for admission and the admission date can be planned. It is important, where preoperative assessment cannot be undertaken on the day, to have agreed timeframes to contact the patient to arrange it</td>
<td>attendance can expedite arrangements for treatment, but may not always be appropriate. Robust systems are necessary for ensuring contact with patients to arrange reassessment within defined timeframes. Some providers will agree the admission date first, and plan reassessment around this date</td>
</tr>
<tr>
<td>14. Monthly reports should be run by the information team. They should be checked by the admissions team as part of normal data quality duties to pick up patients admitted to the hospital for another condition or as an emergency, but where the TCI waiting list entry was used on PAS incorrectly</td>
<td>Helps pick up pathways that administrators need to amend and also picks up patients not coming in for their surgery. Some patients disappear from booking lists and PTLs in this way</td>
<td>A reduction in patients admitted incorrectly using the waiting list entry each month</td>
</tr>
<tr>
<td>15. Each business unit or admissions office must confirm process for dealing with cancellations by the hospital</td>
<td>There are clear national standards for rebooking within 28 days patients whose operations have been cancelled on the day of their operation. It is important the admissions office can demonstrate its processes meet the requirements for this standard</td>
<td>All patients who are cancelled on the day to be redated within 28 days and to leave the hospital with a new date for their surgery – or for the treatment to be funded at the time and hospital of the patient’s choice</td>
</tr>
<tr>
<td>16. Agree key performance indicators (KPIs) for theatre productivity. For example, downtime between surgical cases</td>
<td>These can be identified from the productive operating theatre documentation and agreed</td>
<td>Regular review of KPIs with corrective actions devised</td>
</tr>
<tr>
<td>17. Organisations should aim to outline local timescales for periodic checks of theatre lists</td>
<td>This approach is seen as good practice to ensure theatre lists are fully booked and it helps to reduce cancellations on the day. Providers may want to change the timescales</td>
<td>6 weeks: check patients are booked 4 weeks: finalised lists 2 weeks: ensure equipment ordered Final 1-week review: to enable scheduling of urgent cases</td>
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<td>Good practice</td>
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<tr>
<td>18. General managers must ensure there are local policies in place to deal</td>
<td>This should clearly outline how patients who are vulnerable and the clinical needs of patients will be considered before discharging patients following a DNA or cancellation</td>
<td>There are visible and well-documented policies in admissions offices for bookings staff to use. Policies reflect up-to-date 2WW national guidance and are assessed regularly</td>
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<td>with DNAs and patient cancellations of operations, which reflect the spirit</td>
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<td>of 18 weeks and 2WW but are also in line with the provider’s access policy</td>
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<tr>
<td>19. General managers are advised to have audit arrangements to ensure good</td>
<td>Helps to pick up any training issues as well as keeping the admissions processes up to date. For example, outline timescales for dating patients and implementing escalation processes when there is no capacity to date patients</td>
<td>Yearly audit arrangements are carried out</td>
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<td>practice admissions processes are being followed</td>
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<td>20. General managers should ensure there are clear and detailed standard</td>
<td>Helps with cover arrangements for admissions staff, ensures staff are working to agreed practices and in line with the national 2WW rules. Also makes it easier to train new admissions staff</td>
<td>Clear and detailed standard operating policies with clear timelines and contact numbers</td>
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<td>operating procedures that are readily available to staff</td>
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<tr>
<td>21. General managers should ensure there are regular and detailed training</td>
<td>Relying on initial training offered at induction or training on the job by peers is insufficient to provide assurance of ongoing competency</td>
<td>Six-month training programmes in place, underpinned by a process to evaluate and assess competency</td>
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<td>programmes for admissions staff to support the use of any standard operating</td>
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<td>procedures, which clearly clarify differences between RTT 18-week patient</td>
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<td>management and 2WW patient management</td>
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</table>
11. Revisions process

The IST welcomes feedback from stakeholders on the use and contents of the guide. This feedback will be used to make any changes or updates.

Feedback can be provided to the IST: mailto: NHSI.ElectiveIST@nhs.net

12. Contact information

More information on managing elective and cancer care can be found on the NHS Improvement website.¹⁹

¹⁹ https://improvement.nhs.uk
**Acknowledgements**

The IST would like to acknowledge and thank the following individuals for their contribution to the creation of this guide:

<table>
<thead>
<tr>
<th>Colleague</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Mel Warwick</td>
<td>Aintree University Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>Badriya Maghrabi</td>
<td>Epsom St Helier NHS Trust</td>
</tr>
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<td>Vicky Shosanya</td>
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And members of the Intensive Support Team
Appendix 1: References

Everyone counts: Planning for patients 2013/14

Going further on cancer waits standards

Handbook to the NHS Constitution 2013

National Cancer Intelligence Network website – MDT development

NHS Constitution 2013

NHS Improvement resources

NHS Improving Quality – Rapid review of endoscopy services

NHS Improving Quality – Challenges and improvements in diagnostic services across seven days

NHS Improving Quality - Productive operating theatres

NHS Improving Quality - Reducing DNAs

NHS Managers Code of Conduct 2002

Royal College of Radiologists – Standards and recommendations for the reporting and interpreting of imaging investigations by non-radiologists, medically qualified practitioners and teleradiologists

Royal College of Radiologists – Standards and recommendations for the reporting and interpreting of imaging investigations by non-radiologists medically qualified practitioners and teleradiologists

Steyn Improving Patient Flow website
Appendix 2: Cancer access policy (CAP) development guidelines

This guidance advises what should be in the narrative of a policy and what should be included in the standard operating procedures (SOPs) that should be developed to underpin the access policy.

**Statement of intent**

**Policy**

The purpose of a cancer access policy (CAP) is to ensure patients are treated with equity and efficiency. It should be expressly focused around patient care, ensuring the best interests of the patients are foremost. The document needs to reflect the current cancer standards; it also needs to ensure compliance with the NHS Constitution and *Going further on cancer waits* documentation.

**SOPs**

The standards applicable at the time of writing should be clearly indicated and modified when these standards are updated. Any locally agreed additional rules or processes should also be clearly described.

**Sign off**

**Policy**

The CAP should be agreed and signed off by local health and care economy representatives. A review date should be clear and the individual(s)/group(s) responsible for the review stated.

**e-Referrals service (ERS)**

**Policy**

The CAP should describe the ERS management system.

**SOPs**

The standards should advise staff on how to process ERS referrals and where to escalate any problems or concerns.

**Access standards**

**Policy**

The CAP should clearly indicate locally and nationally agreed standards for access to care. Key performance indicators will be outlined in the policy. Details of reasonable notice should be included for cancer (both admitted and non-admitted pathways) and diagnostic pathways. The importance of treating patients in
chronological order, making allowances only for clinical urgency and patient choice, should be outlined.

**SOP**

The SOP will give details of patient pathways and indicate milestones and trigger points (time to first outpatient appointment (OPA), time to decision to admit (DTA), time to admission, etc) where escalation may be required.

**Definitions**

**Policy**

Key definitions will be included to guide staff in understanding the rules and their application. Any local anomalies or ‘special’ situations may be usefully described in supporting SOPs.

**Tips**


Please note this list should not be considered exhaustive and should be developed for the local health and care economies.

**Referral pathways**

**Policy**

Details of the processes required before referral, such as requirements on referral pro forma, including any prereferral work-up and diagnostic processes, should be outlined in the policy. The process for managing inappropriate referrals must be referenced. Any vetting performed as part of the internal referral management process should be included. The expectations associated with the content of patient letters (outpatient, diagnostic, preadmission and assessment) should be included.

**SOPs**

Details of the patient pathways, and actions to be taken if these are not adhered to, should be linked to the pathways (see Access standards above), including individuals who need to be contacted in the case of inappropriate referrals. Pathways scenarios/examples may be provided within the SOPs as illustrations of good/best practice.
Cancer referrals

Policy

The development of supporting SOPs will be determined by the integration or otherwise of elective and cancer requirements. The management of patients upgraded following a referral from another route should be described in the CAP.

Patient information

Policy

The CAP should advise on the written information available to patients and when they may expect to receive such information.

SOPs

Details of the information proffered to patients at key stages of their pathways can be detailed in the SOPs associated with patient pathways (see Access standards above).

DNAs and cancellations

Policy

The policy must note DNA and cancellations as separate events and indicate the action to be taken when each occurs. The policy should also indicate the action to be taken if or when the provider is the source of any cancellation.

Processes associated with both the planned and short notice cancellation of operations and/or procedures should be incorporated, as well as processes associated with planned and short notice clinic cancellations, and ensure cancer patients are not cancelled if this can be avoided.

SOPs

The SOP should offer details of the individuals to be notified of actions taken following patient cancellations and/or DNAs, and the escalation process associated with the management of vulnerable patient groups.

Training and role clarity

Policy

The role of training as an ongoing aspect of staff development as well as an integral aspect of induction should be outlined in the policy, identifying those individuals responsible for both delivery and assessing competence post training. The frequency of refresher training should be included as well as measures to be taken when staff fail to adhere to the policy. Clear links to local disciplinary and/or competency policies should be included.
Reporting suites

Policy

Details of the provider reporting suites, including the links between specific information and the report to which is aligned. There should also be links to inform users of which reports are available to them and the information each should encompass.

SOPs

Any audit processes indicating where problems arise and where appropriate action was not taken should be specified within the SOPs. The feedback methods, based on this information, should be outlined, including reports to provider boards.
NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

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