Interim Management and Support

DELIVERING CANCER WAITING TIMES

A Good Practice Guide

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INTRODUCTION

Overview

Achievement of the national cancer waiting times (CWT) standards is considered by patients and the public to be an indicator of the quality of cancer diagnosis, treatment and care NHS organisations deliver.

Delivering timely cancer pathways is crucial for the following reasons:

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

Despite consistent achievement of the cancer standards at a national level, it is recognised that many organisations either struggle to maintain compliant performance on a consistent basis or achieve below-standard performance.

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DIRECTOR, ELECTIVE CARE INTENSIVE SUPPORT TEAM
APRIL 2014

How the guide works and its intended audience

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

The guide is a collection of the advice and expertise from the NHS IMAS Elective Care Intensive Support Team (IST), which has been built up over the years through supporting various NHS organisations across the country delivering high quality pathways for patients and sustaining low waiting times for treatment.

Delivering Cancer Waiting Times – A Good Practice Guide is an accompanying guide to the NHS IMAS IST Elective Care Guide.

The intended audience for this document is primarily NHS staff who are involved in any aspect of pathway management for suspected cancer and who want to understand how best to manage or deliver these pathways. This will include staff within acute trusts, NHS Foundation Trusts, Area Teams (ATs) and Clinical Commissioning Groups (CCGs).

KEY TO THE GUIDE

INDICATES WEBSITE LINK – PROVIDING RESOURCE NAME AND LINK

INDICATES GOOD PRACTICE SUGGESTIONS

INDICATES PITFALLS AND CAUTIONS

EMAIL CONTACT DETAILS

Understanding principles and rules

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

- the individual patient right (as per the NHS Constitution);
- the standards by which, individual providers and commissioners are held accountable by the Department of Health for delivering (as per the NHS Operating and NHS Performance Frameworks)

Individual patient rights under the NHS Constitution

For English patients (from an individual patient perspective) the current maximum waiting times for cancer care are set out in the NHS Constitution and the handbook to the NHS Constitution. This can be found at:

NHS CONSTITUTION

HANDBOOK TO THE NHS CONSTITUTION 2013

The NHS Constitution sets out the following rights for patients with suspected cancer:

- 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;
- to be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.

The handbook also lists the specific circumstances where the right will cease to apply and those services which are not covered by the right.

NHS assessment of performance – the provider standards

In addition to the individual patient rights as set out in the NHS Constitution (and its supporting handbook) there is a set of waiting time performance measures for which the NHS is held to account for delivering by NHS England.

There are a number of government pledges on waiting times, including:

- 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 for the first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers);
- a maximum two-week wait to see a specialist for all patients referred with suspected cancer symptoms
- a maximum two-week wait 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 the current NHS England document: Everyone Counts: Planning for Patients 2013/14.

EVERYONE COUNTS: PLANNING FOR PATIENTS 2013/14

NHS Foundation Trusts

NHS Foundation Trusts are held accountable through Monitor via the NHS Foundation Trust (NHSFT) Compliance Framework.

NHS FOUNDATION TRUST COMPLIANCE FRAMEWORK

National guidance

Rules and definitions

In order 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 the guidance on cancer waiting times can be found at:

GOING FURTHER ON CANCER WAITS STANDARDS

It is important that 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 these guidelines are applied to individual patients, pathways and specialties. It is

important that decisions should be based on clinical judgment and in consultation with other NHS staff, commissioners and, of course, patients. The guidance is designed to ensure that reported waiting times are a true reflection of patients' experiences.

1. MANAGING CAPACITY AND DEMAND

Overview

This section of the cancer guide will explore good practice principles in relation to modelling demand and capacity for cancer services.

The following areas will be explored:

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

Guiding principles

The successful delivery of any maximum waiting time standard (e.g. two week waits) is predicated on the following factors:

- patient pathways are capable of delivering a short wait, and clearly describe what should happen, in what order and when;
- a balanced position between demand and capacity;
- a maximum number of patients waiting that is consistent with the level of demand and key pathway milestones e.g., maximum time from referral for suspected cancer to the first outpatient appointment;
- patients are treated in order by clinical priority; and against the two week wait standard;
- patients are actively managed against the pathway for their condition and the key milestones.

While all of these factors are important, a balanced position between demand and capacity is essential. If demand exceeds capacity then the numbers of patients waiting will grow and waiting times will lengthen and the ability to provide short waits will deteriorate.

Of equal importance is the size of the waiting list that is consistent with the delivery of a two week wait target or shorter where internal stretch targets dictate.

The most efficient way of understanding 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 and in-house developed solutions. The model an organisation chooses to use is not necessarily important – the models are there to improve understanding and support discussions around how a service can predict demand and plan services accordingly.

TIPS

- a balanced position between demand and capacity is essential
- when demand exceeds capacity then the number of patients waiting will grow, along with the waiting time for an appointment
- size of waiting list is equally important
- modelling tools will be useful to help establish a good understanding of your 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 the patient's cancer pathways can be modelled separately to identify capacity constraints. For example, two week wait, waits for endoscopy, waits for imaging, waits for treatment once a decision to treat has been made.

Later in this section are details on how to access the models that the IST routinely use when working with client organisations to help them understand their particular service.

Issues such as appropriate levels of capacity to deal with variation in demand are explained within the models.

Dos and Don'ts

The following list of dos and don'ts is based on the practical experience gained by the IST of helping organisations develop and use demand and capacity models. They are designed to act as simple checklists to avoid the most common pitfalls.

- 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 inputs of the models to avoid multiple ad-hoc information requests;
- decide what's in and what's out so you compare like for like in terms of demand, capacity and what is 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 and keep this information in a separate

spread sheet within the model;
- sense check data with those closest to the operational challenges e.g., service managers should sense check data with booking 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 for logical relationships between related data items e.g. the size of a waiting list at the beginning and end of the year. Does this make sense when you look at how many patients were added and removed (for all reasons) over that same period;
- sense check any step changes in demand against national awareness campaigns. Use national data available on expected increases in referrals to verify these;
- 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 six month, annual, and one to three year horizon scanning sessions to be held separately with each specialty to develop forward planning incorporating service changes 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.

- become a slave to the models - they are there to support conversations and improve understanding, not to replace them;
- be concerned when the first run through/population of the model doesn't work perfectly. Some of the data items may not currently be commonly requested reports and may require refinement to get them right. There may be some variation in the type of data that is required when modelling cancer services;
- when looking at current core capacity don't count over-bookings, ad-hoc or out-sourced activity;
- 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 of the data items may have been based on an educated/informed guess rather than hard data;
- forget that by their 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;

- 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, the IST often uses a set of simple comparisons to sense check the initial inputs into the model. These include:

- compare number of referrals against the number of first out patients seen for last 12 months with cancer referrals / activity reviewed separately;
- compare number of additions to the waiting list against actual admissions;
- consider whether major differences in the above can be explained by changes in the first outpatient or admitted waiting lists.

Information requirements

As stated above, service managers / cancer managers will need the help of information colleagues to pull together the various data items required to complete the demand and capacity models. It is important therefore that both the operational management and information teams go through the models together to understand the various data inputs. The information team will need to be very clear as to exactly what is “in” and what is "out" when they are writing queries to extract the data. Experience shows that this can be an iterative process and it's quite normal not to get it right the first time.

Whilst models are subtly different, the list of data items might well include the following:

- 52 weeks of historical two week wait 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), although with a clear separation of cancer patients;
- removal other than treatment (ROTT) rates for both the first outpatient and admitted waiting list;
- first outpatient attendances for the last 12 months (this may include cancer patients only if two week wait 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) for the last 12 months;
- rebooked cancelled admissions for the last 12 months;
- the current sizes of the first outpatient and admitted waiting lists (both with and without dates);

- the waiting list sizes of the first outpatient and admitted waiting lists (both with and without dates) at the beginning and end of the 52 week referral / activity data collection period;
- the 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.); and
- the baseline core capacity to undertake surgical procedures, including dedicated admission slots for cancer patients (again factored down for the elements as described above).

Some of the data items (e.g. first outpatient ROTT rate, cancelled surgical admissions, where capacity was genuinely lost) are not common sets of routinely extracted data. Perhaps surprisingly, robust, clean referral data is often quite challenging for organisations to extract. Given that referrals are, for the vast majority of cancer pathways, the initial driver it is important that providers 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 based on an individual's understanding of what is required. However it is likely that when modelling cancer services, requests may be a little more specific depending on which tumour site is being reviewed.

TIPS

- collaboration between the Service / Cancer Managers and information team is essential to pull together data required for the modelling;
- where information is not available, it's important to clarify and document how figures are calculated;
- testing initial data trawls and extraction helps information team standardise information request responses and avoids multiple ad hoc requests.

When working with clients to develop demand and capacity models, the IST often uses a set of simple comparisons to sense check the initial inputs into the model.

Some of these are set out below:

- compare number of referrals against the number of first outpatients seen for the last 12 months with cancer referrals / activity reviewed separately;
- compare number of additions to the waiting list against actual admissions;
- consider whether major differences in the above can be explained by changes in the first outpatient or admitted waiting lists.

Role of demand and capacity in supporting cancer care delivery

Some models include an option both to plan required dips in activity to meet the anticipated demand and also to record "actuals" as they occur. This is most helpful as it provides metrics against which the 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 a predicted size at a particular point in time, the base drivers can be reviewed to understand why this might be so. Given the waiting list size will be principally dictated by the additions and the removals from it (i.e. activity) one should be able to determine whether the level of demand differs from that originally anticipated or the planned level of activity has not been delivered.

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

There are many existing resources focused around increasing productivity and this paper does not aim to duplicate them. Colleagues however may find the following links offer help in signposting them to these resources:

STEYN IMPROVING PATIENT FLOW WEBSITE

NHS IMPROVING QUALITY – PRODUCTIVE OPERATING THEATRES

NHS IMPROVING QUALITY – ENHANCED RECOVERY

Getting help

Through its experience of working with NHS trusts and commissioners, the IST has developed a series of demand and capacity models designed to help organisations achieve an appropriate balance between demand and capacity, and to ensure that waiting lists are of an appropriate size. These models can act as a helpful starting point for organisations to better understand demand and plan capacity accordingly.

While it would appear that it is only the IST two week wait model which has been specifically developed for a cancer pathway, many of the models can be used to model cancer services, whether this is completed by modelling the entire patient pathway to include all patient types (cancer, urgent and routine) or to only monitor the cancer aspect of the pathway. Generally the IST suggests modelling services in their entirety, however with the ability to separate out cancer as necessary.

THE MODELS ARE FREELY AVAILABLE VIA THE NHS IMAS WEBSITE

It is likely the following IST models will be of more use than the others related to modelling of cancer pathways. Details and links of the models available are provided below:

TWO WEEK WAIT CANCER CAPACITY AND DEMAND TOOL

- To model the pathway between GP referral for suspected cancer to the first outpatient attendance. This will model patients who are on a two week wait pathway for suspected cancer only.

OUTPATIENT DEMAND AND CAPACITY TOOL

- To model the pathway between GP referral to first outpatient attendance. This would be used to model 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 would model demand for 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 for cancer patients included within the model as a subset.

INPATIENT / DAYCASE CAPACITY AND DEMAND TOOL

- To model the demand for admission services from decision to treat to admission for treatment. The model can either be used to model the entire service or just the demand for the cancer patients if the capacity for the service is separated.

ADVANCED FLOW THROUGH TOOL

- To model the entire pathway from referral to treatment (62 day standard) in weeks. Again this can be used to model just the cancer element of the service or the entire service.

The outputs of the models can be used to inform and influence cancer pathway mapping and support work with CCGs and commissioners.

For those organisations who are challenged in their delivery of the maximum waiting time standards and/or who wish to receive external assurance around their demand and capacity planning processes, requests can be made, to receive support from the NHS IMAS Elective Care Intensive Support Team (IST).

Details of NHS IMAS and the IST are available through the NHS IMAS website. NHS organisations can contact the IST Director, Nigel Coomber:

NHS IMAS INTENSIVE SUPPORT TEAM WEBSITE:
WWW.NHSIMAS.NHS.UK/IST

NIGEL.COOMBER@NHS.NET

2. GOVERNANCE – REPORTING AND PERFORMANCE MANAGEMENT

Overview

This section of the cancer guide will explore good practice governance principles in relation to CWT system confidence.

The following areas will be explored:

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

Cancer leadership structures

There is recognition there are special, distinctive leadership structures within each organisation that provides cancer services (the core cancer management team). The IST has seen a number of different approaches within different trusts to the way in which cancer is structured and where it sits within the organisational structure. The IST has seen cancer structures work well both within an operational structure i.e. sits within a clinical division, and separate to an operational structure i.e. sits as a corporate function within the organisation.

Although it is clear that one size will not fit all and that there is no one best staffing structure for cancer within the NHS, what is essential is that organisations develop local governance structures that reflect the complexities of their own organisations.

- It is vitally important 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 resource is made available for individuals to enact their roles; and
  - there is a clear governance framework in place.

The more common core cancer team management structures include the roles are outlined below, summarised 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 CEO but this does not negate the need for CEO personal involvement when necessary.
LEAD CANCER CLINICIAN	▪ A named designated clinical lead with an overall responsibility for ensuring high standards of cancer clinical care across the organisation in a timely manner, leading the development of the cancer strategy with director, managerial and clinical support. This person is usually but not exclusively a consultant with responsibility for facilitation of the delivery of CWT performance. This individual has professional management responsibility for the Multi Disciplinary Team (MDT) clinical leads in their roles as such, responsible for delivery of CWT within their tumour site.
LEAD CANCER MANAGER	▪ A senior manager should be designated with responsibility for facilitation of the delivery of cancer waits. This manager will have a corporate responsibility for cancer, including monitoring cancer waiting data quality, implementation of the cancer strategy, and may incorporate a lead role in coordinating peer review, and usually has the remit of management of the cancer trackers (MDT coordinators) and 2WW referral booking office.
LEAD CANCER NURSE	▪ A named lead nurse for cancer with co-responsibility for facilitating the delivery of CWT. This role should also include developer of cancer nursing strategy, and may also incorporate a lead role in coordinating peer review. ▪ This person should have either direct line management or professional line management responsibility for cancer specialist nurses within the organisation who in turn have a role to play in supporting patients through their cancer pathways in a timely manner. This person often has a professional line management link to the director of nursing.
MDT CLINICAL LEAD	▪ There should be a named lead from the MDT assigned for each of the tumour sites (as per peer review requirements). This same person should be accountable for CWT delivery, management of the PTL (including data quality and completeness), breaches avoidance and learning (with support from the relevant senior specialty manager, e.g. general manager).

Communicating cancer across the organisation

Cancer is an organisation-wide service, cross-cutting into the vast majority of specialties and diagnostic services. To maintain its importance as one of the organisation's clinical priorities, it is important there are formal and timely communication channels both from the core cancer team to specialties and the wider organisation, and vice versa, that specialties keep the cancer team abreast of any challenges or planned service developments.

There should be a number of formal meetings in place to 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 3: Core Cancer Function.
- cancer steering group /cancer board meeting – a monthly or quarterly meeting chaired by the cancer lead clinician or executive lead, attended by cancer senior management team, MDT leads, and representatives from diagnostics and other cancer support services.
- the cancer lead manager should also attend the organisation's wider performance meeting (e.g. RTT PTL meeting) to raise awareness around cancer waits and escalate issues.
- in addition, representatives of the cancer senior management team should attend specialty business meetings, as appropriate, to update on cancer performance issues and relevant national or local initiatives that will impact on service delivery e.g. cancer awareness campaigns.

Attributing accountability and responsibility for cancer waiting times within the organisation

Responsibility for CWT should be well integrated within operational delivery structures. It should be clearly explained and understood who is responsible for which elements of the delivery 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 step of their cancer pathway; and whilst the cancer core team could be held responsible for ensuring that MDT coordinators escalate any identified capacity issues to the service, that cancer patient tracking is undertaken in a conscientious and timely manner and concerns are escalated to speedy resolution by the tumour site management team.

The executive lead for cancer should reinforce the lines of responsibility and ownership to ensure accountability for cancer waits delivery sits with those in a position to deliver i.e. ultimate responsibility will sit within the specialty, rather than within the remit of 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 at regular intervals with the tumour site management team to review tumour level performance and agree remedial or improvement actions as appropriate. Outside of this meeting structure, there should be clear lines of escalation in place.

Staff code of conduct

The culture of delivering services in line with nationally determined standards is deeply embedded in the NHS. Whilst it is recognised that the framework of setting and complying with these "targets" is ultimately in the interests of individual patients and the public, there is an acknowledgement that sometimes this becomes an unhealthy focus within NHS organisations on "hitting the target" which has in a small number of cases led to individuals acting dishonestly in fear of failure.

The continual and relentless public scrutiny that organisations face presents a challenging and demanding environment for NHS managers and staff yet it is crucial that the public can both trust that services are being delivered, as well as the promises of timely treatment that the NHS has made in such documents as *The Operating Framework* and *The NHS Constitution*.

The *NHS Managers' Code of Conduct* impresses on managers their responsibility to ensure that both they and their staff act at all times with integrity and probity; and that indeed staff are able to raise concerns around alleged wrong-doing in a blame-free and supportive environment.

THE CODE OF CONDUCT FOR NHS MANAGERS

Processes to build trust around cancer data quality

The key to building trust around cancer data quality is the implementation of validation (checking) systems to ensure the data that has been recorded is accurate and complete. Clean data is crucial for effective pathway management and critically important prior to mandatory upload to the National Cancer Waiting Times database, hosted by Open Exeter, which collects information from all Acute Trusts across NHS England.

The majority of 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 for data quality as well as learning opportunities. A programme of spot checks (e.g. one or two tumour sites per month) of what is contained in the hospital

record versus what is entered into the CWT database and PAS is also a robust data accuracy checking tool. These validation checks also act as a tool to identify where staff training and supervision may be required.

Conflicts of interest

In addition to these basic data checks, organisations should also adhere to best practice governance principles around avoiding conflicts of interest in the case of self-reporting one's own performance data, for example there should be a separation of duties and responsibility around each of these elements: that there should be separate individuals undertaking the tasks of:

1. data inputting;
2. validating the data that has been inputted;
3. performance management; and
4. breach reporting.

Board assurance

It is the responsibility of the Trust Board to ensure 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 to enact this responsibility.

Board training

The Chairman, CEO, non-executive directors and the rest of the Board should receive basic training on CWT rules and key factors influencing performance. There should be some awareness training around the metrics and 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 moving beyond "are we going to breach the target" to more relevant questions such as "exactly how long are patients waiting?".

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 far more useful that retrospective reports as these allow managers to identify and avoid issues which 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 'unavoidable' (patient choice and clinical reasons) and 'avoidable';
- use of intelligent indicators such as median and percentile waiting times; and
- breach trend analysis.

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

Training

Each Trust should give full consideration to what training and learning processes need to be in place 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 form part of the essential training for staff directly involved in CWT delivery e.g. clinical leads, managers, admissions and outpatient booking staff, etc.).

There should be more in depth role-related training for 2WW booking clerks and MDT coordinators to include PAS, CWT database, diagnostic IT systems, tracking, access policy, and practical implementation of standard operating procedures (as appropriate to the roles). Achievement of this training should be monitored throughout the year and should form part of the annual staff appraisal process.

3. CORE FUNCTIONS

This section aims to explain 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 economies (LHEs) to take a pathway approach to managing cancer services. The introduction of the cancer waits standards, particularly the development of the Going Further on Cancer Waits standards, has been to help organisations manage patients' care on a pathway basis and to remove hidden waits.

GOING FURTHER ON CANCER WAITS STANDARDS

It is recommended organisations establish a detailed understanding of pathways at a sub-tumour site level – within urology, for example, there may well be different pathways covering renal, bladder, prostate and testicular cancers amongst others. Establish for each pathway where and when key milestones occur. For colorectal cancers, for example, there may well be a number of steps required in order to diagnose a patient's cancer; for many skin cancers, however, it is often the case that the diagnosis and treatment are one and the same.

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

- it helps manage the cancer standards (at tumour site level);
- it identifies any hidden waits;
- it allows organisations to track patients correctly;
- it identifies any specialty specific issues; and
- provides an opportunity to deliver more sustainable and timely services.

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

Patient tracking

Pathways

Due to the tight timescales involved it is not feasible for organisations to expect patient pathways to deliver themselves with no intervention. It is good practice for organisations to have in place staff, systems and processes to 'pull' cancer patients along their diagnosis and treatment pathways. In order to 'pull' a patient through a cancer pathway it is necessary to know what the pathway should look like (what the steps are) and how long each step takes (how they fit together to deliver a 62 day pathway).

This level of understanding is necessary at sub-tumour site level e.g. there is a separate pathway for renal, prostate, bladder, testicular and penile cancer and not just one for urology.

Staff roles

Responsibility for daily tracking varies considerably amongst NHS organisations and may cover one post of MDT Coordinator or may be part of several related roles with titles such as Cancer Pathway Navigator, Cancer Data Officer, Cancer Tracker and Patient Pathway Coordinator. Similarly while smaller organisations might have a lead cancer manager with line management responsibility for MDT Coordinators, cancer information and for the management of cancer waits, larger trusts may have these responsibilities spread 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;
- the ability of staff to share knowledge and experience;
- clearer lines of responsibility;
- consistency across tumour sites/specialties/divisions; and
- clearer pathways for escalation.

BENEFITS TO DECENTRALISATION, INCLUDING EMBEDDING STAFF WITHIN SPECIALTY TEAMS, MAY INCLUDE:

- closer integration with MDTs;
- easier and more ready communication with Clinical Nurse Specialists;
- better working with, and understanding of, the specialty/business unit;
- supports the corporate responsibility for the delivery of CWT within each business unit, rather than in a centralised cancer team; and
- staff get a better understanding of the delivery of cancer services as part of the wider trust, rather than in isolation.

Whatever the staff configuration there are several primary responsibilities with respect specifically to cancer tracking:

MDT Coordinator

DAILY/SEVERAL DAYS PER WEEK	▪ Review of a patient list for specific tumour site(s), with a focus on pathways requiring action such as arranging/expediting appointments ▪ Liaison with key administrative/booking staff in outpatients, the inpatient waiting list, endoscopy, imaging, pathology, oncology etc.
WEEKLY	▪ Review of all 'at risk' patients for specific tumour site(s) in advance of pre-PTL and PTL meetings ▪ Review to ensure that post-PTL meeting actions have been carried out ▪ Contact partner organisations such as tertiary/secondary trusts where patients have been referred to/from ▪ Review of missing data/data quality reports (see Tracking systems)
AD-HOC	▪ Detailed review of each patient breaching any of the CWT standards, preferably taking place as each treatment is recorded (not at month end)

Two Week Wait Office

DAILY	▪ Booking clerk reviews and chases all un-appointed patients and escalates unresolved issues.
SEVERAL DAYS PER WEEK	▪ Booking clerk 'hands over' attended patients to relevant MDT Coordinators. ▪ Supervisor/Manager reviews Two Week Wait PTL and escalates appropriately.

Specialty Manager/Support Service Manager (e.g. endoscopy, imaging)

SEVERAL DAYS PER WEEK	▪ Review of a patient list for specific tumour site(s) or support service(s), with a focus on pathways requiring action such as arranging/expediting appointments; ▪ Review and action escalations from Two Week Wait office; ▪ Act on patients escalated as per the trust escalation protocol (see ▪ Access policy).
WEEKLY	▪ Review of all 'at risk' patients for specific tumour site(s) or support service(s) in advance of pre-PTL and PTL meetings; ▪ Review to ensure that post-PTL meeting actions have been carried out.

Cancer Manager

SEVERAL DAYS PER WEEK/AD-HOC	▪ Ad-hoc discussion of 'problem' pathways with MDT Coordinators. Ad-hoc discussion of 'problem' pathways with Two Week Wait office.
WEEKLY	▪ Review of all 'at risk' patients in advance of PTL meeting; ▪ Review to ensure that post-PTL meeting actions have been carried out; ▪ Weekly discussion with cancer managers at other provider organisations regarding patients on shared PTLs

4. REPORTING

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

Tracking list

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

This report should be live using data from the cancer information system, or at be least refreshed every day. Whilst this report may look very similar to the PTL and must contain the same patients, the purpose and audience is different – the patient list is to help MDT coordinators day-to-day and may require data items specific to this which represent and unnecessary level of detail for the trust PTL.

It can be beneficial to review the information and order of fields provided in the PTL – and ensure the fields are ordered in a way which is most useable for teams of staff booking, and that patients are ordered from longest wait at the top to shortest wait at the bottom. Whilst patient level detail is essential, the use of a pivot table on a worksheet within the spreadsheet, can provide a useful overview of patients and their respective wait, for each tumour site. Additionally, it can be beneficial to remove any unnecessary fields from the PTL, to aid its usability and reduce the file size.

MDT meeting

The MDT meeting is not just a clinical discussion: it is important to discuss the patient pathway and teams should make time for this formally 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 Characteristics of an Effective MDT has further detailed information.

Part of the MDT Coordinator role is typically to prepare the MDT meeting agenda each week. It is important discussions and decisions at MDT meetings give consideration to patients' position and waiting time along their cancer pathway, and therefore necessary the MDT meeting agendas contain breach dates where applicable. Ideally this would be generated automatically using the cancer information system; if this is not possible then dates should be added manually by the MDT Coordinator.

NATIONAL CANCER INTELLIGENCE NETWORK WEBSITE: MDT DEVELOPMENT

Cancer PTL

A report to support the PTL meeting (and, if in place, the pre-PTL meeting) is required. This should again be at patient level but need not necessarily contain all patients on a pathway: provided the trust 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 Two Week Wait 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 decision to treat; and
- treatment.

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

In addition to 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 either tumour site or hospital business unit, specialty etc. as appropriate. Ideally this will show how many patients are waiting at each key pathway milestone (DDT, diagnosis etc.).

An indicative layout for three PTL-style overview reports is shown in **Error! Reference source not found.** but whatever format is used key principles are:

- **Forward-looking:** what needs to happen next and 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.

Tracking systems

NHS organisations typically have a stand-alone cancer information system in addition to the core Patient Administration System (PAS). To manage a patient through their cancer pathway it is necessary to understand the pathways that patients are expected to take

and, in order to monitor patient waiting times and experience, information is needed for each pathway event for each patient.

As a minimum the information system used for cancer patients must allow staff to collect data on key milestones such as:

- first outpatient appointment;
- key diagnostic test or tests;
- diagnosis;
- decision to treat;
- multi-disciplinary team (MDT) discussion;
- transfer to another provider; and
- treatment itself (or decision not to treat).

For milestones which relate to appointments the ability to record a request date, an appointment/TCI date and a final attendance date is vital to enable prospective tracking.

The data required to track cancer patients will typically sit within a number of other systems such as:

- demographics (PAS);
- referrals (PAS);
- DNAs, cancellations and attendances (PAS);
- Forthcoming outpatient appointments (PAS)
- new diagnoses (pathology);
- histological staging information (pathology)
- report highlights/text (pathology);
- new diagnoses and 'red flags' (radiology);
- report highlights/text (radiology);
- radiological staging information (radiology)
- new diagnoses and 'red flags' (endoscopy);
- report highlights/text (endoscopy);
- new treatment courses and subsequent treatments (chemotherapy);
- regime details (chemotherapy);
- new treatment courses and subsequent treatments (radiotherapy);
- details, fractions etc. (radiotherapy);
- treatment TCIs (PAS admitted waiting list);
- subsequent treatments (PAS admitted waiting list); and
- new/ subsequent treatments (theatres).

Where technically possible it is ideal to implement automated information feeds from these primary systems into the cancer information system. This has the threefold benefit of reducing the time staff are required to spend manually-entering data into the

database, keeping cancer tracking (and audit) data up-to-date and ensuring that transcription/data quality errors are minimised. The majority of trusts have at least a basic feed from PAS of demographic information but organisations should also explore interfaces to other systems.

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

Breach analysis and reporting

The tolerances provided by the national cancer waiting time standards are to take into account patients who choose to wait longer for their treatment, for whom waiting longer is clinically appropriate, or where pathways include a complex diagnostic element.

Avoidable versus unavoidable breaches

Analysis of waiting time standard breaches helps organisations identify and distinguish between unavoidable breaches (e.g. patient choice, a more complex diagnostic pathways, or that the wait was a clinical exception and that waiting longer was in the best clinical interest of the patient), and avoidable breaches due to administrative and capacity issues.

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

Patient choice breaches

In declaring that the primary reason for a breach is legitimately the result of patient choice or patient non-cooperation, Trusts should be able to demonstrate that the patient generated the delay by asking to wait longer. It would not be appropriate to state that patient choice was the reason for a breach if the organisation provided extremely short notice appointments or little genuine choice for patients.

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 should be undertaken. Typically, this review would be in the form of a ‘root cause analysis’ (RCA) for each breach, examining in detail the reasons why it occurred. This is best done at the time that the patient first breaches and 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 standards i.e. the reason which accounted for the largest proportion of the breach and should be recorded using the Department of Health breach reasons.

Detailed breach analysis requires an assessment of the entire pathway by staff who understand the organisation's processes, systems, and its local access policy. Analysis should include a timeline of key points along the patient pathway with 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 be helpful in identifying delays. The number of days of avoidable and unavoidable delay should be identified and recorded for each stage of the pathway and aggregated for the whole pathway. Wherever possible, delays should be identified and recorded in real time as any delay could contribute to more patients having an unnecessary wait in the future.

Whilst the patient pathway timeline is often, most conveniently drawn up by the MDT coordinator other member of the cancer administration team, the breach reporting and RCA process should be owned by the operational and clinical team. Patient level breach analysis reports are best completed within one month of the breach occurring and where the breach was avoidable actions should be put in immediately place to prevent further, similar avoidable breaches. Breach analysis reports should be signed off by both the treating and lead clinician and findings and remedial actions should be presented back at an appropriate forum, such as the MDT meeting, detailing the reason why the breach occurred and lessons learned.

Ownership of the breach review process

In order to ensure accuracy, consistency and transparency of the reasons for breaches the individual RCA reports should be reviewed by an appropriate manager, often the cancer manager, and aggregated to identify patterns and trends at tumour site, consultant and organisational level. Action plans should be drawn up to address any issues identified and should include clear timescales and responsibilities for action to prevent similar future breaches.

In order to prevent future avoidable breaches and promote organisational learning, breach reports should be shared with clinical, operational and management teams.

Typically this would include:

- tumour site MDT - detailed individual patient level breach analysis and over all trends and patterns;
- trust cancer PTL meeting - trend analysis, review of previous weeks' breaches, reasons and actions taken to prevent future breaches;
- specialty / business unit meeting - detailed breach reporting;
- cancer Board - aggregated breach reporting, including themes and lessons learnt. Monitoring delivery of actions within the breach action plan;
- trust Board – number and percentage of breaches and reasons for breach, patterns and the volume of breaches that occur by trend.

Data quality checks

Where an interface is not available it is good practice to implement a reconciliation of the data held on the cancer system with the original source systems. This is important both to offer organisational assurance of the accuracy of cancer data and to assist with the identification of new diagnoses, treatments etc.

Ideally a regular (at least weekly) alert of missing information should be available to MDT coordinators *showing items not already recorded on the cancer system* including:

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

In addition to these checks it is recommended that information is cross-checked on a monthly basis against these systems as well as compared to clinical coding to ensure that no patients are missed from the monthly upload.

5. PROCESSES AND MEETINGS

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

Trust PTL meeting

A Cancer PTL Meeting should be held weekly and be 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 large or if there is a risk the RTT 18 week agenda dominating to the detriment of cancer, with cancer issues not fully covered. Benefits of a combined meeting are that cancer remains part of standard elective care/access management, and that often many of the same staff will be involved making a joint meeting is potentially a more efficient use of management time.

If a joint meeting is used sufficient time and attention must be paid to cancer issues; it can be useful to place cancer before RTT on the agenda, in order to prevent the meeting being dominated by RTT 18 week issues. The meetings need to be attended by the team with the operational responsibility for delivering the standards.

The PTL meetings must be action-orientated and focused upon:

- performance management and accountability;
- breaches and prospective management of patients along cancer pathways;

- identification of pathway 'exceptions' – patients waiting too long at each step of the pathway;
- delivery of cancer pathways and any related bottlenecks; and
- 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 snapshot PTL report should be produced on a weekly basis, preferably a day or two in advance to enable discussion of the detail of a consistent PTL at the meeting without the distraction of staff having conflicting information. Providers should hold the 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 and when they have been dealt with. In addition, organisations will want to be able to see the impact of the actions in the following week's PTL. Providers should have clear escalation processes in place 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 additionally to attend on a less frequent basis.

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 prior to the organisation-wide PTL meeting; local meetings also need to be held on the same day each week.

The purpose of the local meeting is to ensure:

- the business unit managers are sufficiently prepared for the PTL meeting;
- to have management plans at individual patient level;
- to have addressed the majority of key issues;
- to have an action plan for those issues to be resolved; and
- to escalate any issues that cannot be resolved within the business unit.

It is advised a consistent agenda and reports are reviewed at the local business unit meetings which mirror the requirements of the organisation-wide PTL weekly meeting to ensure the same approach is taken at both levels. This will include a specialty-level review with patient-level enquiry, actions and follow through.

Access policy

Managers seeking to develop an effective Access Policy may find the guidelines in Appendix 2 (p 50) helpful; they include the key areas to be considered when developing a Cancer Access Policy (CAP). Some Trusts include cancer access policy details as part of a Trust wide access policy, including both Cancer and Elective Access policy details, whilst other Trusts have found it beneficial to develop separate elective and cancer policies. Where organisations have implemented separate policies, they should make reference to each other.

CAPs should be developed in partnership with all participants of the Local Health Economy (LHE), including agreement in line with each agencies clinical governance arrangements. Within the organisation, CAPs development should involve discussion with clinical leads, diagnostic leads, and specialty managers.

CAPs should be made available to the public, via the provider website although the policy should also be made available in formats for those who are not able to, or do not have access to web-based information. Examples include printed copies in outpatients or in the Patient Advisory Liaison service. Consideration should also be given to the languages there are produced in. 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) which can be adapted and amended as relevant local or national policy changes occur. SOPs should include the escalation process for dealing with issues that arise with clearly set out timescales for response and resolution. The SOPs provide staff with a single reference point which 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 LHEs have an agreed access policy in place. The agreed versions must be shared with primary care colleagues and be made 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 also helps GPs outline to patients prior to referral the patient's responsibilities to attend appointments and how cancelling or not attending appointments can delay timely diagnosis and treatment. LHEs 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 (for example DNA or cancellation management).

6. OPERATIONAL DELIVERY

Pathways capable of delivering shorter waits

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

It is important for local health economies (LHEs) to take a pathway approach to managing cancer services, which is particularly important for condensed pathways. Cancer standards have helped organisations manage patients' care on a pathway basis, along with removing hidden waits, ensuring patients have timely access to cancer services.

It is recommended organisations 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 at day 7 of a cancer pathway, and first definitive treatment after GP referral on a current cancer pathway to occur before day 42.

Taking a pathway approach to managing cancer services is essential in to support NHS organisations; it helps manage to the cancer standards (at tumour site level), it identifies any hidden waits, allows organisations to track patients correctly, identifies any tumour site and specialty specific issues and delivers more sustainable services.

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

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 considered good practice to establish referral proforma for each tumour site, which clearly includes the minimum data set, and 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 proforma has been agreed, which will provide the referral criteria to ensure referrers have considered the referral criteria, and undertaken necessary clinical evaluation before referring.

Providers will benefit from agreeing arrangements for dealing with referrals where referral criteria has not been met. Providers may benefit from confirming urgent access pathways and milestones for non-cancer referrals, and ensuring sufficient capacity is in place, which may reduce the number of inappropriate 2WW referrals.

Right to obtain treatment within the maximum waiting time

Providers should take steps to ensure patients are aware of their rights and of steps they need to take if their rights are not met. The DH Guidance, Implementation of the Right to Access Services Within Maximum Waiting times, confirms that patients who are about to breach/have breached their maximum waiting time, who qualify for the right, and who wish to be seen more quickly can request to be offered 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 to inform patients about the two week wait pathway, to raise patient awareness of the process and support patients in being fully corporative in undertaking their pathway in a timely manner.

Centralised administrative teams

A number of Trusts have established central booking teams for the scheduling of 2WW appointments. This enables a single point of receipt, as well as visibility of potential demand and capacity issues. The central team may also have responsibility for the booking of 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 mandatory training on a regular basis in the following areas which should also form part of the formal annual appraisal process:

- patient administration system (PAS) referral registration and appointment booking functions (including processes relating to DNAs and cancellations), and discharging processes;
- choose and book;
- provider elective access policy;
- 18 Weeks rules; and
- cancer waiting times rules.

Referral receipt

On a pathway for cancer, the clock starts at the point of receipt of referral, and therefore it is essential there is no delay between referral receipt and registration once it has been received within the organisation. Choose and Book should be encouraged as the primary method of referral, and all providers should have all suspected two week wait services published on Choose and Book, 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 can provide the added advantage of receiving the fax electronically, and enable timely processing, and negate the need to scan the documentation. Providers should ensure clear guidance regarding the management of referrals sent to other locations, to ensure they are registered in a timely manner, and to ensure 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 Patient Administration System (PAS) no later than 24 hours after receipt, and should also be registered on the provider's cancer waiting time database, to enable cancer pathway monitoring by the cancer team and MDT Coordinators/Patient Pathway Coordinators.

In the instance where Trusts have available clinic slots within Choose and Book along with a dedicated fax service, there should be processes to ensure Choose and Book referrals are checked and actioned at regular and frequent intervals, along with processes to ensure duplicate referrals are identified.

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, particularly where there is a one stop clinic, or where there is a diagnostic prior to their appointment, for example, fasting instructions.

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 be appointed to a diagnostic appointment within 2WW in place of an outpatient appointment.

The advantage of a STT pathway is it can reduce the time period from referral to diagnosis, and also enable earlier treatment (for example STT endoscopy). Additionally, it can improve patient experience by reducing the number of attendances required, as well as 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 Trusts to confirm clear escalation processes for booking staff, in the event there are insufficient STT appointment slots within the required time. The Trust should ensure there is sufficient STT capacity, and ideally avoid booking patients into 2WW clinics in the absence of diagnostic capacity where possible.

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. There are many advantages including those outlined above in straight to test pathways, but can also potentially enable the confirmation of diagnostic and discussions of treatment plan in the one stop clinic.

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

Trusts should ensure patients receive any guidelines or instructions relevant to their diagnostic test prior to their appointment, for example, fasting instructions.

Booking appointments

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

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

Whilst 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 should they cancel their appointment or for any other reason the appointment does not go ahead. For example their could be an aspiration that patients could be offered appointments, within 7 days of receipt, with no patients dated over 10 days from receipt.

Patient correspondence should always be sent by First Class post, and some Trusts also provide email and / or text confirmation of appointment times.

Clinic templates

Trusts vary in their approach to managing capacity requirements for 2WW patients. In some Trusts, capacity is incorporated as part of existing templates, either as urgent appointment slots, or designated 2WW cancer slots within general clinics. Some Trusts have designated 2WW clinics, which enables the planning of other services to coincide with the clinic, and also 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.

Overbooking

Invariably 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 Trusts 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, for example 48 hours before the day of clinic.

Did Not Attends (DNAs)

DNAs are a very costly waste of resource within the NHS and so it is important for providers to have a focused plan of action to proactively manage them. As a very minimum, organisations should be monitoring data around DNAs such as DNA rates by specialty per month and making a local decision on what is an acceptable DNA rate 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 to memory. Vulnerable patient groups, such as suspected cancer patients may be exempt from DNA policy for routine patients, according to the local agreement.

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 in place to deal with DNAs and patient cancellations, which reflect the spirit of cancer access guidance, but are also in line with the organisation's access policy.

There are useful tools for managing DNA's.

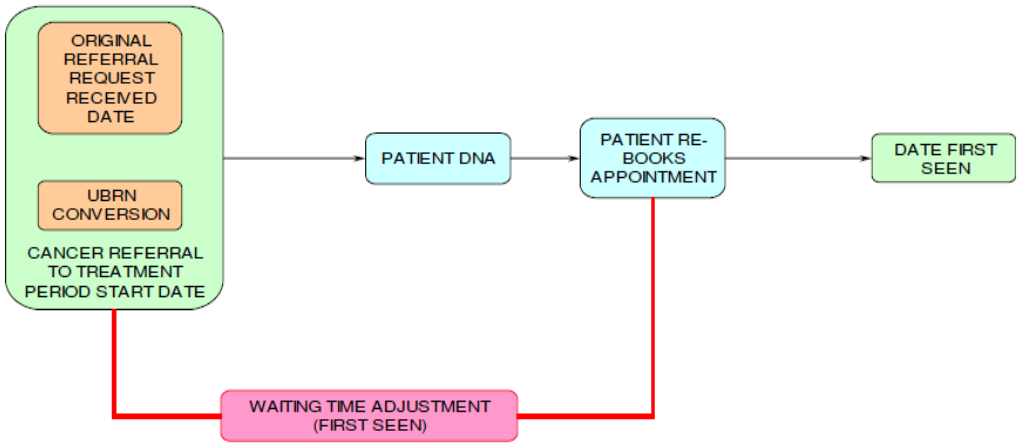
NHS IMPROVING QUALITY– REDUCING DNA'S

Organisations may also like to benchmark DNA performance against other organisations:

NHS COMPARATORS

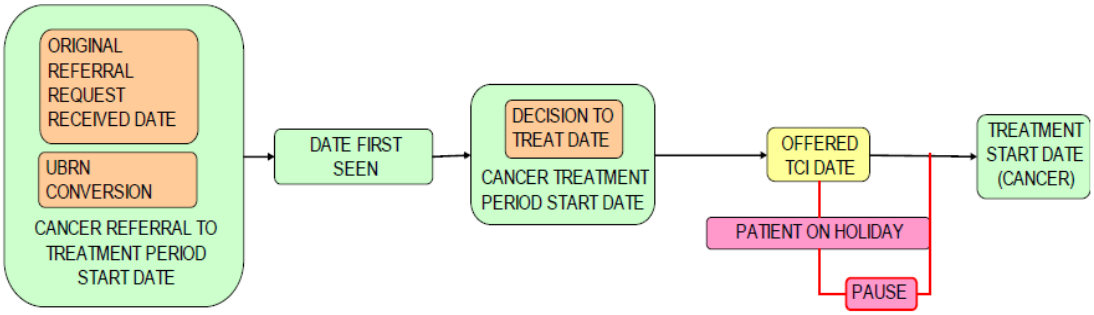
Pathway adjustment for DNAs to first attendance

If a patient DNAs their outpatient appointment or diagnostic clinic attendance that 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 below:



Pathway adjustment for admitted pathway

If a patient has to be offered a to come in date (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 the declined appointment would have been to the point when the patient could make themselves available for an alternative appointment as shown below:



Management of initial appointment DNAs

If a patient DNAs their initial outpatient appointment, the patient will automatically be offered a further appointment. Should a patient DNA for a second time, it is good practice for the clinician (who will review all patient hospital notes at the end of a clinic), to authorise for a further appointment to be offered.

When a patient DNAs twice the GP will be asked to ensure the patient still requires an appointment and re-refers if appropriate.

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 DNA their appointment.

Where a patient on a suspected cancer pathway DNAs their initial appointment for the second time, then they should be discharged and referred back to the GP/General Dental Practitioner (GDP). This is to ensure that the patient is not left "unmonitored" in the system. The hospital clinician must be informed before a patient is discharged back to the referring practitioner after two or more DNAs. This must be noted in the patient's PAS entry or outpatient notes.

Cancellations (by patient)

Patients have the right to cancel their appointment ahead of the appointment time, if they are unable to attend. In the event of a patient cancellation, it is considered 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 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.

Subsequent cancellations (by patient)

Where a patient cancels a subsequent appointment, it will be necessary for the notes to be reviewed by the consultant to decide the most appropriate action to be taken. If the patient fails to attend a second appointment, the consultant or member of the clinical team should consider contacting the patient to discuss their non-attendance at the appointment. Where there is subsequent or continued non-attendance, the consultant should consider whether is appropriate to discharge back to the referrer. This process will need to be set in the Trust Access / Cancer Access Policy.

Cancellations (by hospital)

The cancellation of patients' appointments by the hospital is very poor practice which causes inconvenience to the patient and reduces the efficiency of the service. Given the timeframes associated with 2WW access, incidents of hospital cancellations should be significantly reduced by good adherence to Trust 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 no other options to cover the clinic are available or appropriate.

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 e.g., minimum six weeks;
- limiting "acceptable" clinic cancellation reasons to sickness, immediate family emergency, etc.; and
- implementing "fire-break" clinics at six to eight week intervals to manage unforeseen circumstances.

Transfer of patients between provider organisations

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 be covered by 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 is commenced at the originating organisation (Trust A) and treatment is undertaken at another provider (Trust 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.

Whilst from a patient perspective, timeliness of investigation and treatment should not depend on the hospital to which they are initially referred, however, 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.

Although there is no nationally agreed transfer date by which referrals to a treating provider should be received and after which time the treating provider does not need to share a breach, in a number of health communities, day 38 or day 42 appear to be the commonly recognised agreed maximum transfer periods. For some pathways, the diagnostic pathway can be comfortably arranged so that patients are in fact ready for transfer in advance of these agreed transfer timescales. However, it is recognised that in a some cases it is considered a challenging timescale to work-up patients for transfer to the treating provider, an 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 or day 42 may be a challenging timescale to treat patients both in cases where preparation for treatment may take time and/ or where scheduling of treatment to start on a particular day of the week is significant factor e.g. 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. Prior to 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 Trust to send the referral;
- develop an agreement of standardised good practice clinical pathways across providers taking into account the good practice that is already being followed in several of the teams. This work should be supported as part of a "network" approach across a number of providers. Where appropriate, agreements across the whole health community should be discussed and communicated, e.g. TRUS biopsy to be undertaken by day 20 of the pathway for prostate patients, CT to be undertaken prior to 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 cancer access policies to ensure consistency of application of cancer waiting times rules and equity regarding the management of patients on a cancer pathway and access to services, and expectations of the organisation, GP and patient;
- ensure clear communication of roles, responsibilities and contact details of key roles within each organisation;
- ensure clear communication of escalation processes and timelines in relation to management of information between organisations.

REFERRING TRUST

- identify correct, named individual at receiving Trust to send the referral;
- collate all relevant information, including, minimum data set, relevant health records, all diagnostic reports and images;
- send written confirmation of decision to refer to the patient and their GP within 24hours of decision to refer;
- courier/send electronically all hard copies of the patients records within 24hours of decision to referrer; and
- confirm the referral and records have been safely received

RECEIVING TRUST

- 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.

7. DIAGNOSTICS

Efficient booking of patients referred for diagnostics 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.

Useful resources:

Transforming your Radiology Service, Focus on: Improving Booking Processes (No longer available electronically).

NHSIMPROVING QUALITY– RAPID REVIEW OF ENDOSCOPY SERVICES

NHS IMPROVING QUALITY – CHALLENGES AND IMPROVEMENTS IN DIAGNOSTIC SERVICES ACROSS SEVEN DAYS

THE NHS ATLAS OF VARIATION IN DIAGNOSTIC SERVICES

Paper referrals

Also refer to Section 6 Operational Delivery – Referral Receipt.

Diagnostic departments should actively encourage the use of standard request forms to provide clarity of required information 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 diagnostics reducing the need for clinical input in this process. This should be supported by a clear escalation process which clarifies the steps for staff needing to raise queries regarding specific diagnostic requirements, or who need to escalate capacity issues.

In addition to the training described in the Outpatients section above, administration teams will also require confirmation of milestones for access to diagnostics, which should normally be completed no greater than two weeks after referral.

Advantages of electronic referrals

Organisations should aim to transfer to electronic referrals as they 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 is provided on the referral before submission;
- 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; and
- reduced paper and storage costs.

Registration of referrals

Also refer to Section 6 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 upon receipt is essential to ensure timely vetting of referrals on the same day, or in the morning of the following day where received late in the day. This also ensures diagnostic departments have visibility of true waiting list size, and can make arrangements to accommodate 2WW cancer referral requests. Hard copy referrals should be registered prior to forwarding 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 to go direct to vetting, with limited administrative input.

Pre-registration checks - the minimum dataset

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

Organisations should have a clear process in place to manage incomplete referrals so as to not unfairly disadvantage the patient. Providers should have a robust system in place for monitoring referral demand on an on-going basis, by modality, to ensure capacity is sufficient to meet demand.

Vetting of referrals

Timely, clinically-led vetting of referrals will ensure referrals are appropriate, assist in identifying whether an alternative diagnostic modality is more suitable for confirming diagnosis, and ensures Ionising Radiation (Medical Exposure) Regulations (IRMER) requirements (where applicable) are adhered to. Vetting of urgent 2WW cancer referrals should ideally be completed on the day or the morning of the following day. There should be 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[1] which increases the vetting capacity and minimises the delay in vetting referrals. The staff should follow clear protocols and be subject to on-going monitoring and audit.

Where the radiologist feels the referral urgency may be revised, this should be discussed with the referring clinician before downgrading.

Please refer to Appendix Three for good practice principles.

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 once it has been vetted, rather than waiting for the paper copy to be returned to the bookings team for review. Diagnostic information systems can provide functionality to enable electronic vetting of referrals reducing the need to print referrals for review by the clinical team and can enable electronic work lists to be produced which support workload prioritisation and reduce the variation in referral vetting times between patients.

Scanning protocols

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

The booking team should be provided with clear principle-based guidelines for the booking of diagnostic examinations including for each examination:

- diagnostic procedures;
- specific equipment requirements (i.e. differentiated by physical equipment limitations);
- the length of time slot required;
- requirement for delayed imaging (i.e. Nuclear Medicine);
- who can perform the examination and when;
- what preparation is required;
- special patient instructions; and
- 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 less time slots to facilitate capacity and demand planning. For example, 10, 20 and 30 minutes.

Booking of appointment

Diagnostic appointments should be booked correctly, quickly and efficiently every time. Due to the nature of the referrals, it is essential Trusts ensure a patient-focused process geared towards offering the patient a choice of appointments in a set period, with urgent 2WW cancer referrals being dated in priority over routine appointments. Administrative

staff should book patients under standard written guidance from the relevant clinician, such as 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.

Confirming appointments

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

A diagnostic Patient Tracking List (PTL) will ensure patients are prioritised appropriately.

Patient preparation

Bookings staff should ensure patients receive any guidelines or instructions relevant to their diagnostic procedure prior to their appointment, for example, fasting instructions. They should also ensure patients have contact details for the department should 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. Pre-assessment may be required for certain procedures for example, interventional radiology and endoscopy. Appropriate preparation of the patient prior to 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.

Scanner utilisation and scheduling

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

Providers should therefore:

- work with specialties to identify opportunities to align diagnostic capacity with outpatient attendance;
- ensure booking requirements are based on key criteria (refer to booking section above);
- 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 on-going monitoring of equipment to ensure effective utilisation; and
- 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 6 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.

Reporting

The National Imaging Board guidance states that investigations will be seen and accurately reported within a 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 multi-disciplinary team discussions or specialist opinion is required and therefore stated that a tolerance of 90 per cent achievement is reasonable.

THE ROYAL COLLEGE OF RADIOLOGISTS – STANDARDS AND RECOMMENDATIONS FOR THE REPORTING AND INTERPRETING OF IMAGING INVESTIGATIONS BY NON-RADIOLOGIST MEDICALLY QUALIFIED PRACTITIONERS AND TELERADIOLOGISTS.

Reporting performance monitoring

The provider should ensure:

- there is on-going improvement of reporting turnaround times until standards are achieved to support effective management of the service and appropriate support to clinical specialties and referrers;
- on-going 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); and
- unreported monitoring for those not reported within the agreed reporting timeframe, and ensure follow up and work prioritisation.

- consultant rotas are designed to allocate sessions to be covered by a pool of reporters so they are not adversely affected by annual leave. Radiologists / Consultant schedules could be revised to allow shorter sessions that enable more focused reporting and reduce the impact of annual leave and multidisciplinary 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 training for the staff; and
- a process for clinical audit is in place to ensure reporting quality is achieved particularly where reporting is completed by non-consultant staff.

Management of DNAs

Also refer to Section ii Outpatients on management of DNAs.

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

Unexpected findings

Diagnostic departments should ensure clearly defined processes to manage unexpected findings, to ensure there is a process to alert referring clinicians, and other appropriate people (GP, MDT Coordinator), to results that may require urgent review. The procedures should ensure organisations meet the National Patient Safety Guidance, NPSA 16:

NATIONAL PATIENT SAFETY GUIDANCE, NPSA 16

Amendments to the unexpected findings procedure should be managed and agreed by the Trust management team.

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

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

8. 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.

	GOOD PRACTICE	COMMENTS	WHAT DOES GOOD LOOK LIKE?
1.	Operational managers must ensure that To Come In (TCI) cards are completed for all decisions to admit (DTA), and agree a timeframe for entering on PAS (for example 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 will be important that DTA cards are received where appropriate, and to flag anywhere they have not been received.	This will ensure that all 2WW TCI cards can be readily identifiable and prioritised for admission scheduling. The timely completion and registration of the TCI card will ensure that all the correct details including the type of operation, patient's details, any surgical kit requests and comorbidities are recorded. It will also ensure the admitted PTL is kept up to date.	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 TCI's should ensure clear requirements with regard to flagging 2WW admission requests.
2.	General Managers must check that 2WW patients are booked as clinical priority. Where insufficient capacity is provided, there should be clear escalation processes to provide additional capacity. The service should investigate additional capacity in the first instance, to negate rescheduling of	It is important 2WW capacity for admissions is provided within the specialty theatre session planning. This will enable timely admission, and minimise the need for additional ad hoc capacity, and rescheduling of routine patients.	There should be clear timeframes for assessing and managing 2WW admission capacity for urgent and routine admissions where appropriate.

	GOOD PRACTICE	COMMENTS	WHAT DOES GOOD LOOK LIKE?
	routine patients where possible.		
3.	Timely, clinically led review of prospective lists.	This should be done looking at theatre lists i.e. three to four weeks in advance to ensure lists are full and will not over run and should be led by a lead clinician who has the experience and authority to increase a list where possible.	A reduction over time of theatre lists that overrun and improved theatre list productivity. An opportunity to highlight shortfalls in 2WW capacity, so additional capacity can be arranged.
4.	General Managers should confirm with each tumour site, internal milestone targets for decision to admit, and in particular, where patients are referred to other centers for treatment.	It is important to complete this at tumour site level, and for each pathway, as there may be elements of care provided by different centers, or within the Trust. The milestones should be developed in consideration of ensuring suitable time for treatment within target.	Each specialty has clear milestones which are compliant with cancer wait time goals. Early warning and escalation systems in place to detect deviations from the specialty specific milestones.
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	Given the urgency of the admission timeframe, patients may not receive three weeks' notice of admission. Trusts should ensure patients are advised of the need for admission prior to being	Patients are contacted by admissions staff over the phone to be offered a choice of dates for surgery.

	GOOD PRACTICE	COMMENTS	WHAT DOES GOOD LOOK LIKE?
	available admission date.	contacted by the admissions team.	
6.	Admissions staff must escalate if they do not have sufficient capacity to book the patient within target. Provider organisations should have an agreed escalation process	This helps manage capacity issues prospectively, and helps prevent patients waiting beyond targeted admission time.	Efficient and responsive systems in place to alert booking staff to vacant lists in order to resolve capacity issues. Clear escalation policies in place, along with clear roles and responsibilities, and named contact points when capacity issues are identified.
7.	Operational managers should meet with consultants to share their admitted PTL (those patients dated and undated)	This will help communicate progress against the national operational standards and make the individual consultants aware of their waiting list sizes.	Consultants have an accurate understanding of the size of their admitted PTLs and case mix on a weekly basis.
8.	Operational managers should implement processes for double-checking TCI lists.	This helps pick up errors or issues such as patients who are listed as coming in the next day but who failed to attend pre-operative assessment. This list should be checked on paper and on the PAS. 2WW patients should be readily identifiable	Electronic booking systems in place which automatically flag patients with an imminent TCI who failed pre-operative assessments or who have not confirmed their TCI.

	GOOD PRACTICE	COMMENTS	WHAT DOES GOOD LOOK LIKE?
		to ensure they are not cancelled on the day.	
9.	A suggested 24hour cut off to creating final theatre lists should be agreed, with a clear escalation process and details of who is permitted to make any changes	This avoids last minute re-organisation that lead to lists over running or running late	Booking systems which automatically freeze theatre lists 24 hours before the day with good control systems in place to manage any changes.
10.	All conversations with patients should be recorded clearly with dates and names in the waiting list entry on PAS	This includes conversations around social pauses 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 (ie. 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.	Waiting list systems with detailed accurate audit trails of contact with patients.

	GOOD PRACTICE	COMMENTS	WHAT DOES GOOD LOOK LIKE?
11.	Staggered admission times should be used, with sufficient staff to admit patients. It is seen as good practice to have a central admissions team to manage all inpatient/day case waiting lists.	This helps prevent delays on the day of surgery and provides a better patient experience	Low waiting times for patients between admission time and operation start time (less than 2.5 hours average).
12.	Where possible and clinically appropriate look to pool surgical lists.	This helps to offer patients more choice, equalise waiting lists for surgery and prevents patients waiting longer than necessary for their treatment. Patients should be aware their surgery may not be performed by the clinician they have previously seen through their pathway.	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.
13.	Where appropriate, pre-operative assessment can be provided on the day. Where this is not appropriate, the patient should be provided with details of the pre-operative assessment requirements, and the Trust should ensure the patient is advised of the timeframe for contact with the patient to confirm date for pre-	This will ensure the patient can be assessed for admission, and enable the admission date to be planned. It is important, where pre-operative assessment cannot be undertaken on the day, to have agreed timeframes to contact the patient to arrange it.	Pre-assessment as part of outpatient attendance can expedite arrangements for treatment, but may not always be appropriate. Robust systems are necessary for ensuring contact with patients to arrange within defined timeframes. Some Trusts will agree the admission date first, and plan pre-

	GOOD PRACTICE	COMMENTS	WHAT DOES GOOD LOOK LIKE?
	operative assessment.		assessment around the admission date.
14.	Monthly reports should be run by the information team and checked by the admissions team as part of normal data quality duties to pick up those patients who were admitted incorrectly to the hospital for another condition or as an emergency but where the TCI waiting list entry was used on PAS incorrectly.	This helps pick up pathways that clerks need to amend and also picks up patients not coming in for their surgery. Some patients disappear from booking lists and PTLs this way.	A reduction in patients admitted incorrectly using the waiting list entry each month.
15.	Each business unit or admissions offices must confirm process for dealing with cancellations by the hospital	There are clear national standards for rebooking patients whose operations have been cancelled on the day of their operation within 28 days. It is important the admissions office can demonstrate their processes meet the requirements for this standard.	All patients who are cancelled on the day to be re-dated 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
16.	Agree KPIs for theatre productivity. For example downtime between surgical cases	These can be identified and agreed from the Productive Operating Theatre documentation.	Regular review of KPIs with corrective actions devised.

	GOOD PRACTICE	COMMENTS	WHAT DOES GOOD LOOK LIKE?
17.	Organisations should aim to outline local timescales for periodic checks of theatre lists.	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.	Six weeks check patients are booked, four weeks finalised lists, two weeks ensure equipment ordered, a final one week review to enable urgent cases to be scheduled. Trusts need to balance good theatre utilisation while ensuring suitable capacity for cancer patients, releasing cancer capacity at a particular timeframe for routine admissions.
18.	General managers must ensure there are local policies in place to deal with DNAs and patient cancellations of operations, which reflect the spirit of 18 weeks and 2WW but are also in line with the provider organisation's access policy.	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.	In admission offices, visible and well documented policies for booking staff to use. Policies reflect up-to-date 2WW national guidance and are assessed regularly.
19.	General managers are advised to have in place audit arrangements to ensure good practice admissions processes are being followed.	This 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.	Yearly audit arrangements in place and carried out.

	GOOD PRACTICE	COMMENTS	WHAT DOES GOOD LOOK LIKE?
20.	General managers should ensure there are clear and detailed standard operating procedures in place and readily available to staff.	This will help with cover arrangements for admissions staff, ensure staff are working to agreed practices and in line with the national 2WW rules. It will also make it easier to train new admissions staff.	Clear and detailed standard operating policies with clear timelines and contact numbers.
21.	General managers should ensure there are regular and detailed training programmes in place for admissions staff to support the use of any standard operating procedures, which clearly clarify differences between RTT 18 week patient management and 2WW patient management.	Relying on initial training offered at induction or training on the job by peers is not sufficient to provide assurance of ongoing competency.	Six month training programmes in place, underpinned by a process to evaluate and assess competency.

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10. REVISIONS PROCESS

Each month the IST will collect feedback from stakeholders on the use and contents of the guide. This feedback will be used to make any changes or updates the following month.

Feedback can be provided to the IST:

NHSIMAS.IST@NHS.NET

11. CONTACT INFORMATION

NHS Interim Management and Support - Intensive Support Team (Cancer):

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APPENDICES

APPENDIX 1: Website Addresses

Everyone Counts: Planning for Patients 2013/14

http://www.england.nhs.uk/everyonecounts/

Going Further on Cancer Waits Standards

http://www.ncin.org.uk/collecting_and_using_data/data_collection/gfocw

Handbook to the NHS Constitution 2013

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170649/handbook_to_the_nhs_constitution.pdf

National Cancer Intelligence Network Website - MDT Development:

http://www.ncin.org.uk/cancer_type_and_topic_specific_work/multidisciplinary_teams/mdt_development

NHS Comparators:

https://www.nhscomparators.nhs.uk/nhscomparators/login.aspx

NHS Constitution 2013

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/nhs_constitution.pdf

NHS Foundation Trust Compliance Framework

http://www.monitor-nhsft.gov.uk/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/compliance-framework-

NHS IMAS website:

www.nhsimas.nhs.uk/ist

NHS Improving Quality - Rapid Review of Endoscopy Services:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215123/dh_133058.pdf

NHS Improving Quality – Challenges and Improvements in Diagnostic Services across Seven Days:

http://www.nhsiq.nhs.uk/resource-search/publications/diagnostic-challenges-7-day.aspx

NHS Improving Quality - Productive Operating Theatres:

http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_operating_theatre.html

NHS Improving Quality - Reducing DNA's:

http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/dnas_-_reducing_did_not_attends.html

NHS Managers Code of Conduct 2002

http://www.nhsemployers.org/sitecollectiondocuments/code_of_conduct_for_nhs_managers_2002.pdf

Royal College of Radiologists – Standards and Recommendations for the Reporting and Interpreting of Imaging Investigations by Non Radiologists Medically Qualified Practitioners and Teleradiologists:

http://www.rcr.ac.uk/docs/radiology/pdf/bfcr(11)2_reporting.pdf

Steyn Improving Patient Flow website:

http://www.steyn.org.uk/

APPENDIX 2

Cancer Care Access Policy Development Guidelines:

STATEMENT OF INTENT

Policy

The purpose of a CAP is to ensure patients are treated with equity and efficiency and it should be expressly focussed around patient care ensuring the best interests of the patients are foremost. The document needs to reflect the current iteration of the Operating Framework and its stated standards; it also needs to ensure compliance with the NHS Constitution.

SOP

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 expounded.

Sign off

Policy

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

Choose & Book (C&B)

Policy

The CAP should describe the C&B management system

SOP

The standards should advise staff on how to process C&B 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 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 patient in chronological order, making allowances only for clinical urgency and patient choice.

SOP

The SOP will give details of patient pathways and indicate milestones and trigger points (time to 1st OPA, time to decision to admit, 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

The definitions, which may be presented in the format of a glossary for ease of use, should include:
'clock start', 'clock stop', 'social pause', 'entitlement to NHS treatment', 'active monitoring/surveillance', 'reasonable notice', 'standards for changing, amending or cancelling appointments by the provider', 'patient cancellations', 'did not attend (DNA) events', 'patient choice', 'reasonableness', 'consultant upgrades', 'patient fitness', 'downgrading referrals', 'thinking time', 'subsequent treatment', 'earliest clinically appropriate date', and 'transfers between providers'.

Please note this list should not be considered exhaustive and should be developed for the LHE.

Referral pathways

Policy

Details of the processes required prior to referral, such as requirements with regard to referral proforma, including any pre-referral work up and diagnostic processes should be outlined in the policy. The process for managing inappropriate referrals must be referenced. Any triage which is 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 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 within the cancer access policy ECAP.

Patient information

Policy

The CAP should advise of 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 Trust 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 avoidable.

SOP

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 on-going 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 and measures to be taken when staff fail to adhere to the policy noted. Clear links to local disciplinary and or competency policies should be included.

Reporting suites

Policy

Details of the Trust reporting suites, including the links between specific information and the report to which it will be 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 Trust Boards.